Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Saul Altal (aka Turner), a prisoner at HMP High Down, on 6 February 2020

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 Saul Altal, who also used the surname Turner, died from heart failure linked to drug use on 6 February 2020 at HMP High Down. Mr Altal was 36 years old. I offer my condolences to Mr Altal's family and friends.

The post-mortem found that he had a significant level of heart disease. He spent almost all his four weeks in prison in High Down's healthcare centre while his mental health was assessed. No symptoms of heart disease were observed and he did not complain of any.

We are satisfied that the healthcare Mr Altal received at High Down was equivalent to that he could have expected in the community.

We do, however, have some concerns, although we do not consider that they contributed to his death. We are concerned that Mr Altal did not have a secondary health screen, although it is unlikely that this would have picked up his heart disease.

We are also concerned that, despite staff's suspicion that Mr Altal had taken drugs and his history of substance misuse, no one submitted an intelligence report and he was not referred to substance misuse services for support.

We are also concerned that the officer who unlocked Mr Altal's cell on 6 February did not check on his welfare as he should have done. This did not affect the outcome for Mr Altal as he had been dead for some hours when he was found. It could, however, make a significant difference in other cases.

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 **December 2020**

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Summary

Events

1. Mr Saul Altal was remanded to HMP High Down on 8 January 2020, charged with burglary. He had been in prison before.

2. At a reception health screen, Mr Altal said he had not used drugs recently, so he was not given a drug test. He was concerned about his mental health, so was admitted to the healthcare centre for assessment. The next morning, a nurse tried to assess him, but Mr Altal was possibly under the influence of something and was abusive. The nurse referred him to a psychiatrist, but did not refer him to substance misuse services or submit a security intelligence report.

3. On 15 January, Mr Altal saw the psychiatrist., who prescribed antidepressants and said that he should remain in the healthcare centre for further assessment. That afternoon, Mr Altal did not go to his secondary health screen. There is no evidence that staff followed this up.

4. When the psychiatrist assessed him again the following week, Mr Altal did not report any improvement in his mood. The doctor assigned someone from the mental health team to work with him when he left the healthcare centre.

5. When he saw the psychiatrist on 29 January, Mr Altal said that his mood had lifted. The doctor recorded that he no longer needed to remain in the healthcare centre. When a suitable cell became available on 5 February, Mr Altal was moved to a shared cell on a standard prison wing.

6. Mr Altal was unwell during the night. His cellmate asked him if he was alright, and Mr Altal said that he was being sick.

7. In the morning, a prison officer unlocked the cell, but Mr Altal did not wake up. His cellmate told a prison officer that Mr Altal had been unwell and might need to see a nurse at some point. After about an hour, Mr Altal's cellmate called another prisoner to check on him, and this prisoner raised the alarm. Staff responded and attempted to resuscitate Mr Altal, but could not do so.

Findings

Healthcare

8. The clinical reviewer considered that the healthcare Mr Altal received was equivalent to that which he could have expected in the community.

9. The post-mortem found that Mr Altal had heart disease which contributed to his death. He was being observed in the healthcare centre for four weeks before he died. Healthcare staff did not observe any symptoms of heart failure and Mr Altal did not complain of any.

10. Mr Altal did not attend his appointment for a secondary health screen. We share the clinical reviewer's concern that this was not followed up, a matter we have drawn to the Head of Healthcare's attention in previous investigations. However, we do not consider that it would have altered the outcome in this case.

Substance misuse

11. Post-mortem reports found that Mr Altal had traces of synthetic cannabinoids in his system when he died, which indicated relatively recent use.

12. Despite a nurse's suspicion that he might be under the influence of something and his history of substance misuse, no one referred him for support with his substance misuse. We are also concerned that the nurse did not report her suspicions to the security department.

Unlock procedures

13. When officers unlock cells, they should check on a prisoner's wellbeing. The officer who unlocked Mr Altal on 6 February, did not do so. Although this did not affect the outcome for Mr Altal, it could make a significant difference in other cases.

Recommendations

- The Head of Healthcare should ensure that all new prisoners are offered a secondary health screen. If they do not attend, there should be a follow up process and this should be reflected in the monthly audits.
- The Operational Manager and the Head of Healthcare should ensure that all staff are aware of their responsibilities to tackle the use of illicit drugs, including submitting intelligence reports and referring prisoners to substance misuse services where appropriate.
- The Operational Manager should ensure that staff are aware of their responsibility to ensure prisoners' welfare at unlock.
- The Operational Manager should share a copy of this report with Officer A and arrange for a senior manager to discuss the Ombudsman's findings with him.

The Investigation Process

14. 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.

15. The investigator visited High Down in February 2020. He obtained copies of relevant extracts from Mr Altal's prison and medical records.

16. The investigator interviewed two members of staff and three prisoners at High Down. NHS England commissioned a clinical reviewer to review Mr Altal's clinical care at the prison. The clinical reviewer interviewed two members of High Down staff.

17. 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.

18. One of the Ombudsman's family liaison officers contacted Mr Altal's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Solicitors representing Mr Altal's mother asked about bruising to his head and spine. They also asked for the dates that Mr Altal was in the healthcare unit and the rationale for this. We have addressed these questions in this report.

Background Information

HMP High Down

19. HMP High Down is a local prison in Surrey, which holds up to 1,150 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 nursing cover.

HM Inspectorate of Prisons

20. The most recent full inspection of HMP High Down was in May 2018. Inspectors reported that drugs were easily available. They were particularly concerned about the prevalence of psychoactive substances (PS). Governance and partnership arrangements for healthcare were good. Demands for mental healthcare were high but services were good. Nurses and prison officers in the healthcare unit worked collaboratively to deliver respectful care.

Independent Monitoring Board

21. 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 2019, the IMB reported that prisoners said that drugs were easily available in the prison. There had been a 68% increase in reported drug finds.

Previous deaths at HMP High Down

22. Mr Altal was the ninth prisoner to die at High Down in the last two years. Five of the previous deaths were due to natural causes and three were self-inflicted. We have previously identified an issue over staff failing to check prisoners' wellbeing when unlocking cells. We have also made a recommendation about prisoners receiving secondary health screenings. We found both these issues relevant again in this investigation.

Assessment, Care in Custody and Teamwork

23. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

24. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

25. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies

the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Psychoactive Substances (PS)

26. Psychoactive substances, previously known as 'legal highs', are a 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 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. 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. HMPPS continue to analyse data about drug use in prison to ensure new versions of PS are included in the testing process.

Key Events

29. Mr Saul Altal was remanded to HMP High Down on 8 January 2020, charged with burglary. He was using the surname Turner at the time. He had been in prison before and was on licence when arrested. His licence was subsequently revoked.

30. At an initial health screen with a nurse, Mr Altal said that he had had contact with a mental health team that morning in police custody, and they had recommended that he be held in the healthcare centre. He said he had used drugs in the past, but not for some time, apart from cannabis. He expressed concerns about his mental health, and the nurse arranged for him to be admitted to the healthcare centre for review.

31. The next morning, a nurse recorded that Mr Altal was under the influence of an illicit substance. The nurse noted Mr Altal's history of depression and drug use, but had to stop the assessment when Mr Altal became verbally abusive. He referred him to the psychiatrist for further assessment.

32. That evening, another nurse assessed Mr Altal. He told her that he felt low and had trouble sleeping. He said he did not use drugs or alcohol, though the nurse noted that his record suggested this was not true. He said that he had been hearing voices for the previous six months. The nurse confirmed that he had been referred to the psychiatrist.

33. Prisoners in the healthcare unit are checked hourly. Records indicate that over the following days Mr Altal slept well at night. During the day, he came out of his cell and mixed with other prisoners in the day room. Although he had minimal interaction with staff, they had no concerns about him.

34. On 15 January, Mr Altal saw the psychiatrist. The psychiatrist noted that Mr Altal was not very co-operative. He said that he heard voices, but the doctor did not think it likely that these were hallucinations. Nor did he think that Mr Altal was clearly depressed, though he described him as very irritable. The psychiatrist prescribed mirtazapine (an antidepressant) and said that Mr Altal should remain in the healthcare centre for a further week and be reassessed. That afternoon, Mr Altal did not attend an appointment for a secondary health screen.

35. On 21 January, the psychiatrist assessed Mr Altal again. Mr Altal did not report any improvement in his mood despite a week of taking mirtazapine. The psychiatrist noted that he would assign someone from the mental health team to provide ongoing support when Mr Altal was discharged from the healthcare centre. In the meantime, the psychiatrist said he should remain in the healthcare centre for at least a further week.

36. Over the next few days, Mr Altal slept well, but did not interact much with either staff or prisoners. He took his medication as directed, and staff had no concerns about his physical health. When Mr Altal saw the psychiatrist again on 29 January, he said he felt better. He was due to appear in court after 10 February, and said he intended to plead guilty. The psychiatrist noted that Mr Altal did not appear to be at risk of self-harm and his mood had lifted. He recorded that Mr Altal no longer needed to be located in the healthcare centre. That afternoon, a

care co-ordinator introduced himself to Mr Altal as his care co-ordinator for after his discharge from the healthcare centre.

5 to 6 February

37. On the evening of 5 February, Mr Altal was discharged from the healthcare centre. He arrived at Houseblock 3 at 5.13pm, and was put into a shared cell. The cellmate told the investigator that Mr Altal did not look well and was pale. He arrived in the cell after everyone had been locked up for the evening. Mr Altal said that he had a problem with drugs, and the cellmate said that his appearance confirmed this.

38. The cellmate took his own medication and went to bed on the bottom bunk at about 10.00pm. When he went to bed, Mr Altal was still awake, sitting in a chair.

39. The cellmate said that Mr Altal disturbed him a few times in the night by moving about. More than once, the cellmate heard him being sick in the toilet. At one point he asked Mr Altal if he was alright, and Mr Altal replied, "I just feel ill and am throwing up."

40. High Down told the investigator that they could not provide cell bell records for that night because of a technical fault. The cellmate told the investigator that he did not press the cell bell during the night, and assumed that Mr Altal would press the bell if he needed to.

41. At approximately 8.00am, Officer A unlocked the cell. CCTV footage showed that he put his head inside the doorway but did not go into the cell. Officer A said that Mr Altal appeared to be asleep. The cellmate came out of the cell and spoke to Officer A. Officer A said that the cellmate told him that Mr Altal had kept him awake going back and forth between his bed and the toilet all night. Officer A said that he glanced into the cell and saw Mr Altal lying in bed, and presumed he was still asleep.

42. Over the next 50 minutes, the cellmate kept walking in and out of the cell, preparing himself for a visit. He told another prisoner that he was concerned that Mr Altal had not moved, and did not seem to be reacting to loud noises. The other prisoner went into the cell and looked at Mr Altal. He thought that Mr Altal was asleep, but his eyes were slightly open. The cellmate told the investigator that he thought Mr Altal was still asleep because he had been awake all night. The cellmate then went for a shower.

43. At the showers, the cellmate told Officer A that he was worried about Mr Altal and thought he might need to see a nurse. Officer A was supervising another prisoner at the time so could not leave. Officer A said he did not get the impression the cellmate thought the situation was urgent, so he decided to check Mr Altal when he was back on the landing. Officer A told two other officers that the cellmate had mentioned that Mr Altal had been unwell and might ask to see a nurse. Officer A told the investigator that the three officers agreed that someone would check Mr Altal once 'free flow' (when prisoners move from their wings around the prison) was over.

44. The cellmate spoke to another prisoner when he got back to the wing, the prisoner and said he was concerned about Mr Altal. The prisoner went into the

cell. He told the investigator that Mr Altal's eyes were slightly open, his mouth was open and his lips were dry. He spoke to him and touched his shoulder, with no response. He then held the back of his hand to Mr Altal's mouth and nostrils, but could not feel any breathing. He shouted, "This guy's dead." A prisoner was on the landing outside the cell and CCTV footage showed him calling to staff and pointing to the cell. Two officers were nearby and immediately went into the cell.

45. An officer tried to get a verbal response from Mr Altal but without success. He touched Mr Altal's arm, which was cold, and he saw that his eyes were open. The officer radioed a code blue emergency (meaning a prisoner is not breathing or is having difficulty breathing). This prompted the control room to call an ambulance. Prison records showed that the code blue was called at 9.09am and ambulance service records showed that the call was received at 9.10am.

46. CCTV footage showed that three other prison officers and a nurse arrived within a minute and went into the cell, shortly followed by further staff. The prison officers moved Mr Altal and his mattress from the bed onto the floor. The nurse left to get the emergency medical bag.

47. Another nurse arrived and began cardiopulmonary resuscitation (CPR) briefly. An officer arrived at the cell and switched on his body-worn video camera, and a Healthcare Assistant (HCA) applied a defibrillator (a machine that assesses and, in some circumstances, restarts the heart). A paramedic working in the prison, arrived at the cell. She noted that Mr Altal had visible rigor mortis and was displaying no signs of life. Having assessed Mr Altal, she and the nurse agreed that Mr Altal had died and that CPR should not continue.

48. A prison GP arrived at the cell and pronounced Mr Altal dead at 9.20am. In his notes, the prison GP said that rigor mortis was apparent and Mr Altal was likely to have been dead for at least six hours.

Contact with Mr Altal's family

49. Mr Altal had not given the details of his next of kin when he arrived at the prison. An officer, the prison's family liaison officer (FLO), traced Mr Altal's sister and broke the news of her brother's death to her on the telephone. Later that day, The FLO travelled with the Operational Manager and one of the prison's senior managers, to Mr Altal's mother's home and met her and other family members. In line with Prison Service guidance, High Down offered a contribution to the costs of Mr Altal's funeral.

Support for prisoners and staff

50. After Mr Altal's death, the duty operational manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

51. The prison posted notices informing other prisoners of Mr Altal'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 Altal's death.

Post-mortem report

52. Post-mortem toxicology tests showed that Mr Altal had traces of 'Spice' (a type of PS) in his system, indicating relatively recent use, and the toxicologist noted that Mr Altal may have been experiencing the effects of this drug at the time of his death.

53. The post-mortem report concluded that Mr Altal died as a result of coronary artery thrombosis (a blood clot in the heart), caused by coronary atheroma (a build-up of fatty deposits in the arteries around the heart), with 'Spice' (PS) toxicity as a contributory factor.

54. The pathologist noted that Mr Altal had significant heart disease. He commented that the use of PS is associated with abnormal heart rhythms and heart attacks, and that it appeared likely that PS contributed to Mr Altal's death.

55. The post-mortem report stated that there was no evidence of bruising or other injury to Mr Altal's neck or head.

After Mr Altal's death

56. An intelligence report after Mr Altal had died noted that prisoners on the wing were overheard discussing Mr Altal's death. They speculated that Mr Altal must have taken drugs given to him by someone on the wing the night before he died.

Findings

Mr Altal's clinical care

57. The clinical reviewer concluded that the clinical care Mr Altal received in prison was of a reasonable standard and equivalent to that he could have expected to receive in the community.

58. Mr Altal was promptly referred to mental health services on arrival at High Down, regularly reviewed by the psychiatrist, and treated with antidepressants. There were plans in place for ongoing support from the mental health team after he was discharged from the healthcare unit. He was discharged following advice from the psychiatrist, once a suitable cell was identified.

59. Mr Atal was observed by healthcare staff for the four weeks that he was accommodated in the healthcare centre and they recorded no symptoms of heart disease.

60. National Institute for Health and Clinical Excellence (NICE) guidelines and Prison Service Order (PSO) 3050, *Continuity of Healthcare for Prisoners*, set out the expectation that prisons ensure continuity of care for prisoners. This includes that all new prisoners should be offered a secondary health screen, equivalent to a primary care assessment when registering with a new GP in the community. Mr Altal did not attend his secondary health screen and no one followed it up. Although this does not comply with NICE guidance, the clinical reviewer said that the health screen would not have identified Mr Altal's heart disease.

61. In a previous report we recommended that High Down conduct audits of successful completion of secondary health assessments. This was accepted, but the prison said that as Mr Altal was offered a screen (even though he did not attend), this was not picked up by the audit. This raises the question of what constitutes a successful completion. Prisoners may not attend appointments for a variety of legitimate reasons. We make the following recommendation:

    The Head of Healthcare should ensure that all new prisoners are offered a secondary health screen. If they do not attend, there should be a follow up process and this should be reflected in the monthly audits.

62. Solicitors representing Mr Altal's mother asked about bruising to his head and spine. The post-mortem report does not refer to any such injuries, and we are therefore unable to comment further.

Substance misuse

63. Post-mortem toxicology tests found that Mr Altal had traces of PS in his system when he died, which was likely to have contributed to his death.

64. In their last report on High Down in 2018, HM Inspectorate of Prisons said that drugs were easily available in the prison. The Independent Monitoring Board annual report for 2019 also raised this issue. High Down updated their Drug Strategy in 2018.

65. There were no intelligence reports during Mr Altal's time in High Down that indicated he was using substances. The ambulance service reports said that no drug paraphernalia were found in his cell. The police searched the cell, as well as rubbish that Mr Altal's cellmate removed from their cell on the morning of 6 February, and did not find any drug-related detritus. We have not been able to establish where or when Mr Altal obtained drugs in prison.

66. Healthcare staff in reception at High Down carry out drug screening if the prisoner discloses drug use in the previous month. Mr Altal had a history of drug misuse, which he admitted to and which was known from his record. On reception to High Down, however, he did not disclose recent drug use so was not tested.

67. On 9 January, a nurse noted in his medical file that he might have been under the influence of a substance, but did not submit an intelligence report.

68. We are concerned that despite his history, and suspicion of being under the influence, Mr Altal was not offered a referral to substance misuse services. The clinical reviewer recommended a review of the referral process to substance misuse services. We make the following recommendation:

The Operational Manager and the Head of Healthcare should ensure that all staff are aware of their responsibilities to tackle the use of illicit drugs, including submitting intelligence reports and referring prisoners to substance misuse services where appropriate.

Unlock procedures

69. When officers unlock cells, they should take active steps to check on a prisoner's wellbeing. The Prison Officer Entry Level Training (POELT) Manual states:

> "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead."

70. Prison Service Instruction 75/2011, *Residential Services*, states:

> "Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight … but staff unlocking them have not noticed that the prisoner had died. This is not acceptable...
>
> "[Differing] arrangements will depend on the local regime, but there need to be clearly understood 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 will need to check on their well-being, for example by obtaining a response during the unlock process."

71. Officer A said that he thought Mr Altal was still asleep when he unlocked his cell on 6 February. When the cellmate told him that Mr Altal had been awake through the night, he thought it likely that he would be tired. While this is of course possible, he should still have checked on Mr Altal's welfare in line with the instruction.

72. We are satisfied that the failure to check did not affect the outcome for Mr Altal, as he had been dead for some hours when he was found. However, it could make a significant difference in other cases.

73. In a previous investigation we found deficiencies in unlock procedures at High Down. In response, the Operational Manager issued a Notice to Staff (143/2018), reminding staff that they must check prisoners' wellbeing when they unlock cells. Unfortunately, the issue has arisen again, so we make the following recommendations:

The Operational Manager should ensure that staff are aware of their responsibility to ensure prisoners' welfare at unlock.

The Operational Manager should share a copy of this report with Officer A and arrange for a senior manager to discuss the Ombudsman's findings with him.

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