Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Adjei, a prisoner at HMP High Down, on 8 December 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 Michael Adjei, a prisoner at HMP High Down, died on 8 December 2020 from generalised peritonitis caused by twisting, obstruction and perforation of the sigmoid colon. He was 28 years old. I offer my condolences to Mr Adjei's family and friends.

The clinical reviewer considered that, overall, the mental and physical healthcare Mr Adjei received was equivalent to that which he could have expected in the community. However, she had a number of concerns about his care in the last few days of his life.

She considered that the nurses who assessed Mr Adjei on 6 and 7 December should have escalated their concerns and sought advice about his symptoms, despite his reluctance to be treated. She was also concerned that the emergency response when Mr Adjei was found unresponsive in his cell on 8 December was too slow and that staff were not wearing the correct Personal Protective Equipment (PPE) as required during the COVID-19 pandemic. The clinical reviewer was also concerned that staff did not record key information on Mr Adjei's medical record. In these respects, the clinical reviewer concluded that the care Mr Adjei received was not of the required standard and not equivalent to that which he could have expected to receive in the community.

I am also concerned that prison staff did not call a medical emergency code more quickly when Mr Adjei was found unresponsive in his cell on 8 December, although I note that the clinical reviewer is not able to say whether earlier intervention might have changed the outcome for Mr Adjei.

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 **August 2021**

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Summary

Events

1. Mr Michael Adjei had a history of mental health problems. In 2017, he was convicted of rape, attempted rape and theft and sent to HMP Pentonville.

2. In March 2019, he was transferred to a secure psychiatric hospital because of concerns about his bizarre behaviour. While he was there, he was diagnosed with volvulus (twisting) of the sigmoid colon (a medical emergency).

3. In April 2020, he was transferred back to prison, and on 12 October he moved to HMP High Down. On 1 December, Mr Adjei was moved to the prison's inpatient unit due to continued concerns about his mental health.

4. On 6 December, Mr Adjei reported pain from the left side of his neck and hiccups. He had a high temperature and a rapid pulse but did not want to be assessed further by healthcare staff. He agreed to see the GP the next day, however the GP was unable to see him because he was dealing with an emergency.

5. During the night of 7/8 December, the nurse checked Mr Adjei hourly. He noted that Mr Adjei was in bed and was still in bed when he checked him at 4.50am. When the nurse next checked him at around 6.15am, Mr Adjei was on the floor at the back of his cell, leaning on the radiator. The nurse was not concerned as Mr Adjei had slept on the floor before.

6. At about 6.35am, an officer checked Mr Adjei during her morning roll check and was concerned that he might burn himself on the radiator if he stayed there for too long. Mr Adjei did not respond to the officer or the nurse, so at around 6.40am, the officer radioed for response staff to go into his cell and move Mr Adjei away from the radiator. (Mr Adjei was on a 'three-man unlock', meaning that, due to his risk level, there had to be three officers before staff could safely go into his cell.) Response staff did not respond immediately because they were dealing with another situation in the prison.

7. The officer grew more concerned and she radioed for assistance again at about 6.48am, this time using an emergency medical code (requiring an immediate response).

8. Officers and nursing staff responded and went into Mr Adjei's cell at around 6.50am. They found Mr Adjei unresponsive and began cardio-pulmonary resuscitation (CPR). At 7.27am, paramedics confirmed that Mr Adjei had died.

9. The post-mortem report concluded that Mr Adjei died of generalised peritonitis caused by twisting, obstruction and perforation of the sigmoid colon.

Findings

10. The clinical reviewer considered that, overall, the mental and physical healthcare Mr Adjei received was equivalent to that which he could have expected in the community. However, she had concerns about the care he received in the last few days of his life.

11. The clinical reviewer considered that the nurses who assessed Mr Adjei on 6 and 7 December should have escalated their concerns and sought advice about his symptoms, even though Mr Adjei said he did not want to be assessed. She also considered that record-keeping during this period was inadequate.

12. The clinical reviewer also considered that the emergency response when Mr Adjei was found unresponsive was too slow and noted that staff were not wearing the correct Personal Protective Equipment (PPE) as required by prison policy during the COVID-19 pandemic.

13. The clinical reviewer therefore concluded that the care Mr Adjei received in the two days before he died was not of the required standard and not equivalent to that which he could have expected to receive in the community.

14. We also consider that staff should have called an emergency medical code immediately when Mr Adjei was found unresponsive. The clinical reviewer was unable to say whether earlier intervention might have changed the outcome for Mr Adjei.

Recommendations

- The Head of Healthcare should ensure that:
    - staff keep accurate records on SystmOne of their interactions with patients;
    - when a patient's clinical observations are outside of the normal range, they should be checked again within regularly agreed timescales and assessed further if necessary;
    - where registered nurses have concerns about a prisoner's health, they should seek further advice and assessment (disclosing all relevant information), even if the prisoner has declined it;
    - patients with a high temperature are assessed for the symptoms of COVID-19 and, where indicated, the relevant test is undertaken.
- The Head of Healthcare and the Governing Governor should ensure that:
    - all healthcare and prison staff involved in resuscitating prisoners follow the relevant guidance for Airway Generating Procedures (AGP) and wear the correct Personal Protective Equipment (PPE);
    - training is in place so that staff know how to put on and take off the required additional PPE during resuscitation, until otherwise advised; and
    - face masks and gloves are correctly worn in line with local and national guidance, until otherwise advised.
- The Governor and Head of Healthcare should ensure that a code blue is called immediately when a prisoner is found unresponsive.
- The Governor and Head of Healthcare should share this report with the staff named in it so they are aware of the Ombudsman's findings.

The Investigation Process

15. The investigator issued notices to staff and residents at HMP High Down informing them of the investigation and asking anyone with relevant information to contact him. Three prisoners responded, two of whom agreed to be interviewed.

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

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

18. The investigator accompanied by the clinical reviewer interviewed thirteen members of staff, one prisoner and one former prisoner at High Down. The interviews were completed by video link and telephone due to the restrictions imposed as a result of the COVID-19 pandemic.

19. 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.

20. The Ombudsman's family liaison officer contacted Mr Adjei's mother and sister to explain the investigation, and to ask if they had any matters that they wanted us to consider. Mr Adjei's mother and sister received a copy of the draft report. They did not make any comments.

21. The initial report was shared with HMP Prison and Probation Service (HMPPS). HMPPS did not identify any factual inaccuracies. Their action plan is annexed to this report.

22. The initial report was also shared with NHS England. NHS England identified one factual inaccuracy, which we have addressed in this report.

Background Information

HMP High Down

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

HM Inspectorate of Prisons (HMIP)

24. The most recent full inspection of HMP High Down was in May 2018. Inspectors reported that standards overall had declined since the previous inspection. They found that health and social care provision was reasonable and emergency response arrangements were effective. They recommended a dedicated clinical lead be identified for the inpatient unit and multi-disciplinary team meetings be held to review all cases.

Independent Monitoring Board

25. 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 cross deployment of officers across the prison, and a relatively high staff turnover, had resulted in a high level of inexperienced staff manning the prison's inpatient unit. This had had a detrimental impact.

Previous deaths at HMP High Down

26. Mr Adjei was the fifth prisoner to die at High Down in the last two years. Of the previous four deaths, three were self-inflicted and one was from natural causes. There were no similarities with our findings in this case.

Key Events

Background

27. Mr Michael Adjei had a history of mental health problems. On 11 September 2017, he was convicted of rape, attempted rape and theft and taken to HMP Pentonville. He was initially sentenced to five years' imprisonment, but this was increased to seven years in December 2017.

28. On 2 March 2018, Mr Adjei was transferred to HMP Littlehey. Staff described his behaviour as increasingly bizarre and erratic. In November, he assaulted officers on two separate occasions. As a result of Mr Adjei's deteriorating behaviour, he was transferred to Chase Farm Secure Mental Health Hospital on 7 March 2019.

29. In March 2019, while at Chase Farm Hospital, Mr Adjei was diagnosed with volvulus (twisting) of the sigmoid colon (a medical emergency).

2020

30. On 8 April 2020, Mr Adjei was transferred back to prison. He arrived at Pentonville with an alert for HMPPS suicide prevention measures, known as ACCT. Following assessment, staff closed the ACCT alert after Mr Adjei told the reception nurse that he had no thoughts of suicide or self-harm. The reception nurse noted on Mr Adjei's medical record (known as "SystmOne"), "Mr Adjei does not have a mental health diagnosis and is not thought to have a mental disorder of any description."

31. On 3 May, Mr Adjei masturbated in front of a female officer and said he was going to rape her. After this, Mr Adjei continued to display paranoid and erratic behaviour. Healthcare staff attempted unsuccessfully to arrange a transfer back to a secure hospital. They planned to discuss how to manage Mr Adjei's behaviour at a multidisciplinary team meeting, but he was transferred before the meeting took place.

HMP High Down

32. On 12 October, Mr Adjei was transferred to HMP High Down. From 8 to 9 November, staff monitored Mr Adjei under ACCT procedures due to his strange behaviour and his lack of engagement with officers. The mental health in-reach team reviewed his mental health but concluded that his issues were behavioural and not the result of a mental health condition, and that he therefore did not need mental health support.

33. Throughout November, Mr Adjei rarely left his cell or spoke to anyone. He frequently refused to eat and did not look after himself or his cell.

34. On 20 November, a supervising officer referred Mr Adjei to the mental health team again because officers were increasingly worried about his wellbeing. The mental health team subsequently referred Mr Adjei for a psychiatric assessment.

35. On 1 December, Mr Adjei was assessed by a psychiatrist. The psychiatrist concluded that he should be transferred to the prison's inpatient unit for further investigation into suspected schizophrenia. The psychiatrist assessed that Mr

Adjei did not have the mental capacity to refuse to be admitted to the inpatient unit, so he was escorted there in handcuffs later that day. Nurses checked him hourly, although there is no record that they took his clinical observations.

36. On 2 December, Mr Adjei still did not want to speak to healthcare staff and his mental state and mood were described as "unpredictable". It was recorded that Mr Adjei did not complain of any physical discomfort and no physical discomfort was observed, although there is no record that staff took any clinical observations.

37. Between 3 and 5 December, it was recorded that Mr Adjei did not raise any concerns about his physical health, although, again, there is no record of any clinical observations. On 5 December, it was recorded that Mr Adjei appeared in good physical health. The daily healthcare summaries noted that he continued to behave strangely, his cell was untidy, and he spent most of his time in bed or sleeping on the floor of his cell on his back.

6 December

38. Around 1.30pm on 6 December, Mr Adjei came back from the exercise yard, sat on the floor and complained of hiccups and pain on the left side of his neck. He told a nurse that this was normal and that he did not have any pain or discomfort anywhere else. He initially refused to have his vital signs taken, but eventually agreed after continued encouragement from staff. His temperature was high, his blood pressure was slightly above the normal range and his heart rate was fast.

39. A nurse looked up Mr Adjei's GP summary on SystmOne and noted that Mr Adjei had had a twisted colon two years earlier. She asked Mr Adjei when his last bowel movement was, and he said it was either that day or the day before, which she considered normal.

40. The nurse telephoned the nurse responsible for responding to emergencies, and told him that Mr Adjei had hiccups. The nurse told us in interview that he was not told that Mr Adjei had a high temperature and a raised pulse and that he did not, therefore, think he needed to assess Mr Adjei's prolonged hiccups in person. Instead, he sent the nurse a link to NHS England's guidance on how to manage hiccups.

41. At 2.22pm, a Healthcare Support Worker (HSW) checked Mr Adjei's vital signs again, but he refused to let her take his temperature. His heart rate was still high, but his hiccupping had stopped and he was a lot more comfortable. His blood pressure and blood oxygen levels were within the normal range. The HSW told us in interview that Mr Adjei was holding onto his stomach, but he did not reply when she asked him how he was feeling. The HSW reported her assessment results to the lead nurse. There is no record that Mr Adjei's blood pressure, pulse or respirations were checked again after this.

42. Later that day, two nurses went back to check on Mr Adjei. Mr Adjei told the nurses that he had felt unwell earlier but was better and did not want to be examined by anyone. A nurse suggested that he should go to hospital because they had struggled to take his vital signs due in part to his hiccups and in part because he would not co-operate. He said he felt fine and did not want to go to

hospital. A nurse told us that she had no reason to think that he did not have the mental capacity to make his own decisions at this point. They planned that a prison GP would see him the following day.

7/8 December

43. The HSW recorded that she spoke to Mr Adjei several times on 7 December asking after his shoulder and stomach pain. Mr Adjei said he felt okay, and she recorded that she did not see him hiccupping that day.

44. A GP was due to see Mr Adjei on the routine ward round but told us in interview that he was unable to see him as he was dealing with a medical emergency. The GP said that healthcare staff told him that Mr Adjei was stable, so he planned to see him the next morning.

45. During the night of 7/8 December, a nurse (also known as "Nurse X") checked Mr Adjei hourly. He recorded at various points that Mr Adjei was in bed, sometimes appearing to be talking in his sleep, and that he was still in bed when he checked him at 4.50am.

46. When a nurse next checked him between 6.15am and 6.20am, Mr Adjei was on the floor at the back of his cell, leaning on the radiator. The nurse told us in interview that he knew Mr Adjei had slept on the floor before, so he did not think anything was wrong.

47. Between 6.35am and 6.40am, an officer checked Mr Adjei during her morning roll check. She noticed that Mr Adjei was leaning on the radiator and was concerned he would burn himself if he stayed there for too long.

48. An officer spoke to the nurse and they both returned to Mr Adjei's cell to speak to him. Mr Adjei did not respond, so between 6.40am and 6.45am, the officer radioed for response staff to come to move Mr Adjei away from the radiator. Mr Adjei was on a 'three-man unlock', meaning that, due to his risk level, there had to be three officers present before staff could go into his cell. Mr Adjei was also considered to be a risk to women, so the officer told us she did not want to go into his cell alone. She said she did not call an emergency code when Mr Adjei did not respond to her because she thought he was just sleeping. She also said that Mr Adjei would often not respond to staff, so it was not unusual.

49. As it was a routine call not an emergency call, response staff did not respond immediately because they were dealing with another situation in the prison. The officer told us in interview that she grew more concerned about Mr Adjei's appearance, so she radioed for assistance again at approximately 6.48am, this time using a medical emergency 'code red' (indicating a prisoner has severe loss of blood or burns).

50. Three officers responded to the code red and went into Mr Adjei's cell at approximately 6.50am, closely followed by a Custodial Manager (CM), a nurse and other nurses. Mr Adjei was unresponsive and staff could not find a pulse. They moved Mr Adjei away from the radiator and put him in the recovery position. At 6.52am, a CM called a medical emergency 'code blue' (indicating a prisoner is not breathing). Staff began cardio-pulmonary resuscitation (CPR) after two to three minutes.

51. At approximately 7.00am, a prison paramedic who had just arrived on shift, was told that there was a code blue in the inpatient unit. She went straight to Mr Adjei's cell, arriving at 7.07am.

52. The ambulance crew arrived at approximately 7.17am. After it was agreed that there had been no signs of life for over 20 minutes, paramedics confirmed at 7.27am that Mr Adjei had died.

Contact with Mr Adjei's family

53. Mr Adjei had nominated his mother as his next of kin. the prison's family liaison officer (FLO), went to her home at 10.45am on 8 December and broke the news of Mr Adjei's death to her. High Down maintained contact with Mr Adjei's family and offered to contribute to the costs of the funeral in line with national instructions.

Support for staff

54. A senior manager chaired a debrief for 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.

Post-mortem report

55. A post-mortem examination identified Mr Adjei's cause of death as generalised peritonitis (inflammation of the inner abdominal wall) caused by volvulus (twisting), infarction (obstruction of the blood supply) and perforation of the sigmoid colon.

56. Post-mortem toxicology tests showed no signs of drug or alcohol use.

Findings

Mr Adjei's clinical care

57. The clinical reviewer noted that, prior to his death, most of Mr Adjei's health issues were behavioural and/or mental health concerns, although Mr Adjei had no diagnosis of any mental illness at the time of his death. The clinical reviewer considered that, overall, the mental and physical healthcare Mr Adjei received was equivalent to that which he could have expected in the community.

58. However, she had concerns about the healthcare he received in the two days before his death.

59. Mr Adjei's clinical observations were abnormal on 6 December and the clinical reviewer said that it would be normal practice in these circumstances for staff to consider the presence of an infection and complete regular temperature, pulse and respirations checks. If these or blood pressure levels remained outside normal limits, a further assessment should be undertaken.

60. The clinical reviewer was satisfied that every effort was made to persuade Mr Adjei to have an additional assessment on 6 and 7 December, but she was concerned that his refusal to have his observations taken or be assessed further was not documented on SystmOne.

61. The clinical reviewer also considered that, although Mr Adjei was refusing to be assessed further, the nurses who assessed him on 6 and 7 December should have escalated their concerns about him and sought further advice from a nurse or the GP, who should have been told that Mr Adjei had a high temperature, rapid pulse and a previous history of volvulus of the sigmoid colon. The nurse or the GP would have then been in a position to make an informed decision about his treatment.

62. The clinical reviewer also considered that the GP should have recorded the reasons why he did not see Mr Adjei on 7 December on SystmOne.

63. The clinical reviewer was also concerned that despite having a high temperature, Mr Adjei was not assessed or tested for COVID-19 in the days before his death.

Emergency response

64. After prison staff entered Mr Adjei's cell, they did not start CPR before the CM arrived and then there was a further delay of approximately 2 – 3 minutes. We share the clinical reviewer's view that CPR should have been started when staff first found Mr Adjei unresponsive in the cell.

65. The clinical reviewer was also concerned that the wrong equipment was passed to a nurse (which meant there was a delay before rescue breaths were started), and that chest compressions were not continued while the nurse was attempting to gain an airway, attach the bag valve mask and start rescue breaths.

66. In addition, the clinical reviewer was concerned that not all nurses and officers were wearing Personal Protective Equipment (PPE) correctly during the resuscitation, so were not complying with the Resuscitation Council or Local

CNWL COVID-19 guidance. This was therefore an infection prevention and control risk.

67. In the light of her concerns about inadequate record keeping, about a failure to escalate concerns appropriately, and about the emergency response. the clinical reviewer concluded that, in these respects, the care Mr Adjei received was not of the required standard and not equivalent to that which would have been expected in the community.

68. We make the following recommendations:

The Head of Healthcare should ensure that:

- **staff keep accurate records on SystmOne of their interactions with patients;**
- **when a patient's clinical observations are outside of the normal range, they should be checked again within regularly agreed timescales and assessed further if necessary; and**
- **where registered nurses have concerns about a prisoner's health, they should seek further advice and assessment (disclosing all relevant information), even if the prisoner has declined it.**

The Head of Healthcare should ensure that patients with a high temperature are assessed for the symptoms of COVID-19 and, where indicated, the relevant test is undertaken.

The Governor and the Head of Healthcare should ensure that:

- **all healthcare and prison staff involved in resuscitating prisoners follow the relevant guidance for Airway Generating Procedures (AGP) and wear the correct Personal Protective Equipment (PPE);**
- **training is in place so that staff know how to put on and take off the required additional PPE during resuscitation, until otherwise advised; and**
- **face masks and gloves are correctly worn in line with local and national guidance, until otherwise advised.**

Delay in going into Mr Adjei's cell

69. When a nurse checked Mr Adjei and saw that he was on the floor at the back of his cell, leaning against the radiator, we consider he should have been more alert to the possibility that Mr Adjei could have been seriously unwell. Although we appreciate that Mr Adjei had slept on the floor before, we consider that a nurse should have tried to speak to Mr Adjei at this point and considered urgent medical assistance if he did not respond.

70. As Mr Adjei was considered to be a risk to women and was on a 'three-man unlock', we consider it reasonable that the officer did not go into his cell alone. However, when Mr Adjei failed to respond to the officer and a nurse, we consider that they should have called an emergency 'code blue' immediately. If they had

done this, emergency response staff would have arrived more promptly and begun efforts to revive Mr Adjei earlier.

71. The clinical reviewer was unable to say whether earlier intervention could have prevented Mr Adjei's death, but any delay may be crucial in medical emergencies.

72. We recommend:

The Governor and Head of Healthcare should ensure that a code blue is called immediately when a prisoner is found unresponsive.

The Governor and Head of Healthcare should share this report with the staff named in it so they are aware of the Ombudsman's findings.

Allegations made by prisoners

73. The investigator interviewed a prisoner who contacted the PPO saying he had information relating to Mr Adjei's death. The prisoner alleged that staff mistreated Mr Adjei while he was on House Block 5, before he was moved to the inpatient unit, and provided some details of the alleged circumstances and names of staff members who he said were involved. The investigator followed-up the prisoner's concerns and interviewed the relevant staff members, but no evidence was found to support the prisoner's allegations.

74. The investigator also interviewed one of two prisoner healthcare orderlies who contacted the PPO with information relating to Mr Adjei's time on the inpatient unit. (The other healthcare orderly declined to be interviewed.) The orderly told us he had told officers in the healthcare unit that Mr Adjei should be in hospital, as he appeared to be unwell. However, we are satisfied that officers continued to bring Mr Adjei's circumstances to the attention of healthcare professionals for assessment. As officers are not medically trained, they rightly defer to healthcare colleagues to decide on someone's medical care. As a result, the orderly's information did not impact on the findings of this investigation.

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