Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mohammed Dauhoo a prisoner at HMP Swaleside on 1 January 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 Mohammed Dauhoo died on 1 January 2018 at HMP Swaleside from an infection caused by a perforated bowel. He was 73 years old. I offer my condolences to Mr Dauhoo's family and friends.

Mr Dauhoo received treatment in hospital for an inflamed bowel between 4 and 18 December. During the days leading up to his death, he complained of severe abdominal pain. He was checked by healthcare staff but they had no major concerns. At around 7pm on 1 January, healthcare staff decided that Mr Dauhoo needed to go to hospital and an ambulance was called, but it was cancelled 10 minutes later and Mr Dauhoo was given morphine for the pain. He was found dead in his bed less than four hours later.

I am very concerned that staff missed an opportunity to send Mr Dauhoo to hospital for emergency treatment on the day he died. It is possible that the outcome could have been different if they had they done so.

It is very disappointing that when Mr Dauhoo was taken to hospital on 4 December he was handcuffed and remained restrained in hospital. This was clearly disproportionate. We have raised the inappropriate use of restraints with Swaleside previously and have drawn this serious and continuing failure to the attention of the Executive Director for Long Term and High Security prisons.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman **January 2019**

Contents

Summary

Events

1. In April 2013, Mr Mohammed Dauhoo was sentenced to 19 and a half years imprisonment for sexual offences. He was moved to HMP Swaleside on 21 December 2016. Mr Dauhoo suffered from several long-term health conditions including, chronic heart failure, high blood pressure and spondylitis. He had limited mobility and often used a wheelchair to get around.

2. On 28 February 2017, Mr Dauhoo reported intermittent abdominal pain and nausea to a prison GP who requested blood tests and an ultrasound scan. On 4 April, a GP saw Mr Dauhoo for a follow-up appointment and made an urgent gastroenterology referral under the NHS pathway that requires patients to be seen by a specialist within two weeks. Over the next seven months, Mr Dauhoo had further hospital investigations and healthcare staff monitored him frequently.

3. On 4 December, a nurse noted that Mr Dauhoo had passed a bright red stool and sent him to the hospital by ambulance. Hospital staff treated him for an inflamed bowel and he was returned to prison on 18 December.

4. On 29 December, Mr Dauhoo reported abdominal pain which continued over the next three days. On 1 January 2018, an officer became increasingly concerned about Mr Dauhoo's health and notified healthcare staff and a prison manager.

5. At 4pm, a prison paramedic examined him but found his clinical observations were normal. He examined him again at around 7pm, and this time assessed that he had deteriorated and needed to go to hospital. The control room called an ambulance at 7.07pm. However, a decision was made to cancel the ambulance around 10 minutes later. The prison paramedic gave Mr Dauhoo un-prescribed morphine instead.

6. At 11pm, an OSG noticed that Mr Dauhoo did not appear to be breathing and told a prison manager. Within minutes, a prison manager entered Mr Dauhoo's cell and noticed that his arm was cold to touch. He started cardiopulmonary resuscitation (CPR) and, at 11.05pm, used a radio to alert staff. At 11.06pm, he called an emergency medical code. At 11.11pm, a nurse noticed that Mr Dauhoo was not breathing, was cold to touch and did not have a pulse. He continued the resuscitation attempt until ambulance paramedics arrived. An ambulance paramedic pronounced that Mr Dauhoo had died at 11.38pm.

Findings

7. The clinical reviewer noted that, although much of Mr Dauhoo's care was good, the care he received on 1 January fell short of expectations. The prison paramedic made several assessments of Mr Dauhoo and we are concerned that having decided to send him to hospital, the ambulance was subsequently stood down and he issued un-prescribed morphine instead. We consider that this decision prevented Mr Dauhoo having access to potentially life-saving treatment.

8. We found deficiencies in the emergency response, although the delays would not have affected the outcome for Mr Dauhoo. Staff's attempts at resuscitation were inappropriate given he was clearly dead.

9. We are concerned that the decision to use restraints when Mr Dauhoo was taken to hospital in December did not take full account of his poor health, frailty and limited mobility and how this affected his level of risk. We are also concerned that Mr Dauhoo was restrained throughout his hospital admission.

Recommendations

- The Head of Healthcare should ensure that healthcare staff:
  - receive training to help detect and treat early warning signs of deterioration in prisoners with chronic conditions;
  - take and record observations as required;
  - know how to access appropriate clinical support; and
  - accurately record actions and decisions about prisoners ongoing care in their medical record.

- The Governor and the Head of Healthcare should review the reasons for the decision not to send Mr Dauhoo to hospital and ensure that respective roles and responsibilities in the decision making process are properly understood and communicated.
- The Head of Healthcare and clinical governance team at IC24 should review the decision-making process for the administration of un-prescribed morphine.
- The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including that:
  - staff promptly use an emergency code to effectively communicate the nature of an emergency and;
  - control room staff call an ambulance as soon as an emergency code is called.

- The Governor should ensure that there are sufficient staff on duty at all times with up to date training to administer basic life support in emergency.
- The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is not necessary or appropriate.
- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Investigation Process

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

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

12. The investigator interviewed six members of staff at Swaleside, and conducted one telephone interview, on 15 and 16 February 2018. He interviewed two members of staff from Swaleside at HMP Standford Hill on 20 March, and conducted a further telephone interview with a member of staff on 26 March.

13. NHS England commissioned a clinical reviewer to review Mr Dauhoo's clinical care at the prison. The clinical reviewer conducted one telephone interview with a member of staff on 20 February, and another on 8 March. She attended joint interviews with the investigator on 20 March.

14. We informed HM Coroner for Mid Kent and Medway District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

15. The investigator wrote to Mr Dauhoo's brother to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond to our letter.

16. 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 Swaleside

17. HMP Swaleside, on the Isle of Sheppey, is a long-term training prison and houses up to 1,112 men. IC24 Integrated Care provides primary healthcare at Swaleside. There is 24-hour nursing cover, which includes a qualified nurse and a healthcare assistant at night. There is a 17-bed inpatient unit. Minster Medical Group provides GP cover from 9.00am to 5.00pm on Monday to Friday, while Medoc provides an out of hours GP service. Oxleas NHS Foundation Trust provides mental health services.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Swaleside was in April 2016. Inspectors reported that prisoners had access to an appropriate range of primary care services and visiting specialists, although not all long-term conditions clinics ran regularly because staffing was inconsistent. Inspectors found that only five officers had received defibrillator training, which meant the prison could not guarantee that staff trained to use a defibrillator would be available in an emergency.

Independent Monitoring Board

19. 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 30 April 2017, the IMB reported that prisoners had made many complaints about lack of timely healthcare appointments.

Previous deaths at HMP Swaleside

20. Mr Dauhoo was the 12th prisoner to die at Swaleside since January 2015. Four deaths were due to natural causes, five were self-inflicted, one was a drugs overdose and one was a homicide. There have been three deaths since, two from natural causes and one awaiting classification.

21. We have highlighted the inappropriate use of restraints in several previous cases at Swaleside. In November 2017 and June 2018, we drew this serious and continuing failure to the attention of the Executive Director for Long-Term and High Security prisons. We have also previously made a recommendation about a delay calling an ambulance.

Key Events

22. On 19 April 2013, Mr Mohammed Dauhoo was sentenced to 19 and a half years in prison for sexual offences. He was moved to HMP Swaleside on 21 December 2016. Mr Dauhoo was aged 72 and suffered from several long-term health conditions including, chronic heart failure, pulmonary hypertension (high blood pressure in the blood vessels that supply the lungs) and cervical spondylitis (a type of osteoarthritis affecting the neck). He had limited mobility and often used a wheelchair to get around.

23. At an initial reception screen on 22 December, a healthcare assistant assessed Mr Dauhoo as not suitable for in possession medication and noted that he did not have any outstanding medical appointments. A prison pharmacist issued his prescribed medication, but there is no record of a GP review or that healthcare staff arranged for a secondary health screen. On 28 December, Mr Dauhoo told the healthcare assistant that he had stabbing pains in his abdomen and she noted that she would arrange for a nurse to see him. There is no record of a further review.

24. On 28 February 2017, Mr Dauhoo reported intermittent abdominal pain and nausea to a prison GP. The prison GP noted that Mr Dauhoo did not report rectal bleeding and requested blood tests and an abdominal ultrasound scan.

25. On 4 April, the prison GP saw Mr Dauhoo for a follow-up review and he reported difficulty swallowing, feeling sick and occasional diarrhoea. He spoke to Mr Dauhoo about the results of his blood tests, which identified mild anaemia and possible inflammation of unknown origin. He explained the ultrasound results, which showed some fluid around the bottom of the lungs, but nothing of note in the abdomen. Suspecting cancer, he made an urgent gastroenterology referral under the NHS pathway that requires patients to be seen by a specialist within two weeks.

26. On 19 April, a consultant gastroenterologist saw Mr Dauhoo at the hospital and requested a series of tests, including a gastroscopy (a procedure where a flexible tube is used to look inside the gullet, stomach and first part of the small bowel), a sigmoidoscopy (a procedure where a similar tube is used to look inside the lower part of the large bowel) and a computerised tomography (CT) scan.

27. The result of a sigmoidoscopy, performed on 2 May, was normal. Hospital staff could not undertake a gastroscopy due to food in Mr Dauhoo's stomach. A CT scan, performed on 12 May, showed thickening of the caecum (part of the large bowel) that suggested chronic colitis inflammation. On 23 June, a consultant gastroenterologist wrote to the prison recommending a colonoscopy (a procedure where a flexible tube is used to look inside the entire large bowel) and stating that he would arrange a follow-up with Mr Dauhoo to discuss his options.

28. Over the next five months, healthcare staff monitored Mr Dauhoo frequently and prison GPs prescribed tramadol (a pain relief medication), while they waited for gastroenterology investigations and a review. On 28 November, Mr Dauhoo had a gastroscopy at the hospital and the result was normal.

29. On 2 December, a nurse saw Mr Dauhoo for a review in his cell and he reported abdominal pain and blood-stained diarrhoea. She gave him loperamide (a medication used to reduce the frequency of diarrhoea) and told him to drink plenty of fluids. On 4 December, prison staff informed her that Mr Dauhoo remained unwell and she examined him in his cell. She noted that he looked pale, had a weak pulse and had passed a bright red stool. She requested an ambulance to take him to the hospital and he left the prison at 7.10am.

30. Hospital staff admitted Mr Dauhoo and a colonoscopy confirmed that the caecum showed evidence of chronic inflammation. Mr Dauhoo was returned to prison on 18 December and a prison paramedic saw him for a review. The following day, a prison GP prescribed prednisolone (a steroid medication to treat inflammation) and zomorph (a slow-release morphine based pain relief medication) as indicated by hospital specialists.

31. On 29 December, Mr Dauhoo informed prison staff that he felt unwell and they arranged for the prison paramedic to see him. Mr Dauhoo reported abdominal pain and asked for stronger pain relief medication. The prison paramedic took his clinical observations, which were all within the normal range, apart from a slightly low blood pressure reading (91/100 mmHg). He liaised with the prison GP via instant message who recommended paracetamol for Mr Dauhoo's increased pain.

32. The next day, a healthcare assistant saw Mr Dauhoo for a review and he reported abdominal pain and requested additional morphine. The healthcare assistant noted that she would discuss his presentation with a nurse but there is no record this took place. At interview, she told the clinical reviewer that she informed the prison paramedic about the outcome of her assessment.

33. On 31 December, at 9.02pm, Mr Dauhoo told an officer that he had severe abdominal pain and requested additional pain relief medication. She spoke to a nurse who advised her that Mr Dauhoo had reached his medication limit for the day.

Events on Monday 1 January 2018

34. At 12.09am, the nurse saw Mr Dauhoo for a review and noted that he did not report nausea or vomiting and that his clinical observations were normal. She recorded that a GP needed to review his medication, although there is no record this was arranged.

35. At 9.30am, a prison paramedic saw Mr Dauhoo to issue his morning medication and he continued to complain of abdominal pain. He recorded that he would manage his symptoms with paracetamol until a GP could review his medication.

36. In her prison statement, an officer said she had known Mr Dauhoo for over a year and that it was out of character for him to complain. She said that she was so concerned about him that, during her lunch break, she contacted a prison manager to advise him of the situation. The prison manager told her that there was not much he could do if healthcare staff were satisfied with Mr Dauhoo, but that he would try to get to the wing.

37. At around 1.45pm, a healthcare assistant saw Mr Dauhoo for a review and to take his clinical observations. At interview, she told the clinical reviewer that Mr Dauhoo had a pulse rate in the region of 40-49 bpm (normal being 60-100 bpm). She said that she notified the prison paramedic and he asked her to try a manual blood pressure monitor. The healthcare assistant said that she was unable to get a reading manually and that she informed the prison paramedic, although there is no evidence of this.

38. At 3pm, an officer contacted the prison manager as he had not arrived and she had serious concerns about Mr Dauhoo's health. She said that she told him that she honestly thought Mr Dauhoo was dying and he said he would speak to the prison paramedic.

39. At around 3.45pm, the prison paramedic saw Mr Dauhoo for a review and noted that although he reported diarrhoea and vomiting, his abdomen was soft (a perforated bowel would normally cause an inflamed abdomen that is resistant to pressure). He took a normal blood pressure reading (118/62 mmHg) and issued Mr Dauhoo rehydration salts after he witnessed him vomit. At 4pm, following a request from the officer, the prison paramedic made an entry in the wing observation book stating that although Mr Dauhoo was consistently complaining of abdominal pain, seeking morphine and demanding to go to hospital, his clinical observations were normal.

40. At around 5pm, the prison paramedic attended the prison manager's office to brief him on Mr Dauhoo. In his prison statement, the prison manager said that the prison paramedic told him that he did not have any major concerns about Mr Dauhoo and that he was seeking an escort to hospital as he had become addicted to morphine-based medication. At 6.30pm, an officer checked on Mr Dauhoo and he told her that he continued to feel unwell. She contacted the prison paramedic, who saw Mr Dauhoo for a review and decided to send him to hospital by ambulance as his condition had deteriorated. She contacted the prison's control room and staff called an ambulance at 7.07pm.

41. Shortly afterwards, the prison paramedic had a discussion with the prison manager and told the investigator that he felt unable to assert himself when he was asked to explain why he had requested an ambulance. He said that the prison manager told him that it would be completely impossible to send him to hospital as he did not have enough staff to facilitate an escort and asked if there was anything else he could do instead. The prison paramedic said he could give Mr Dauhoo morphine to make him more comfortable.

42. At interview, the prison manager told us that he started making the escort arrangements and asked the prison paramedic to explain what had changed since his previous examination. At this point, he said the prison paramedic changed his mind and said he would issue morphine instead. The control room log shows the ambulance was stood down at 7.18pm.

43. At 8.30pm, the prison paramedic issued Mr Dauhoo 10mg of un-prescribed oramorph (liquid morphine). He made an entry in the wing observation book stating that Mr Dauhoo remained unwell and asked an Operational Support Grade (OSG) if she could check on Mr Dauhoo overnight. At 11pm, the OSG went to Mr Dauhoo's cell to check on him and looked through the observation

hatch. She noticed that Mr Dauhoo had a large duvet over him and could not be sure if he was moving or breathing. She notified a prisoner manager and continued to look for signs that Mr Dauhoo was breathing.

44. Shortly afterwards, the prison manager arrived at Mr Dauhoo's cell and noticed that one of his arms appeared to be in a strange position. He entered the cell, found that Mr Dauhoo's arm was cold to touch and checked for a pulse. He started cardiopulmonary resuscitation (CPR) using one hand, and with the other, at 11.05pm, he used a radio to alert prison and healthcare staff. He asked staff to bring a defibrillator, although at the time he could not remember the name and asked for the "jump leads". At 11.06pm, he called an emergency medical code blue (which indicates that a prisoner is unconscious or not breathing).

45. At 11.11pm, a nurse arrived and took over from officers. He noticed that Mr Dauhoo was not breathing, was cold to touch, did not have a pulse, had a stiff neck and his pupils were fixed. He attached a defibrillator to Mr Dauhoo, but it did not detect a shockable rhythm and he continued CPR. Paramedics arrived at the prison at 11.19pm, and at Mr Dauhoo's cell at 11.24pm. The paramedics assessed Mr Dauhoo and at 11.38pm they pronounced that he had died.

Contact with Mr Dauhoo's family

46. At around 12.30am, the prison Governor arrived at the prison to assist. At interview, he told the investigator that staff identified that Mr Dauhoo had named a friend as his next of kin. However, it later transpired that he had a brother and there were difficulties confirming a correct address. The Governor considered the risk of Mr Dauhoo's brother finding out about his death from other prisoners with illicit mobile phones, the time of night and the distance of 60 miles to his next of kin's address, before deciding to visit later that morning.

47. At 7.45am, the Governor appointed an officer as the prison's family liaison officer. At 8am, the Governor, the officer and a prison Imam left for Mr Dauhoo's brother's address. At 9.30am, they broke the news of Mr Dauhoo's death and offered their condolences and support. The family liaison officer provided ongoing support to Mr Dauhoo's brother until his funeral, which took place on 19 January. The prison contributed towards the cost, in line with national policy.

Support for prisoners and staff

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

49. The prison posted notices informing other prisoners of Mr Dauhoo'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 Dauhoo's death.

Post-mortem report

50. The post-mortem examination found that Mr Dauhoo had died of an abdominal infection that was caused by faecal material from a perforated bowel entering the peritoneal cavity (a space that can occur between two layers of membrane that form the lining of the abdominal cavity). Toxicological analysis showed a high

level of morphine in Mr Dauhoo's blood. However, this did not correlate with the urine level and was believed by the pathologist to be due to changes in body fluids after death.

Findings

Clinical care

51. Mr Dauhoo had suffered from several long-term medical conditions for some time prior to his admission to Swaleside. Healthcare staff appropriately monitored his conditions through regular reviews and prison staff facilitated his outside hospital appointments. The clinical reviewer considered that, overall, the care Mr Dauhoo received at Swaleside was equivalent to that which he could have expected to receive in the community. There was however one aspect of Mr Dauhoo's care that fell short of expectations, namely the events on 1 January, when his health deteriorated.

52. When the healthcare assistant took Mr Dauhoo's clinical observations, she could not obtain a blood pressure reading and spoke to the prison paramedic. Although there is no record of her assessment or their discussion, a failure to obtain a blood pressure reading is usually because the blood pressure is very low. The clinical reviewer considered it reasonable to assume that Mr Dauhoo had low blood pressure when the healthcare assistant saw him and she found it hard to understand why the prison paramedic obtained a normal reading later that afternoon. She noted that although Mr Dauhoo may have been experiencing a brief improvement in his condition, a bowel perforation does not usually present variable symptoms.

53. When the prison paramedic saw Mr Dauhoo at around 7pm, he decided to send him to hospital. At interview, he told us that Mr Dauhoo's condition had deteriorated and he was not happy with his presentation. An ambulance was called at 7.17pm but a decision was taken to cancel it around 10 minutes later and the prison paramedic gave Mr Dauhoo un-prescribed morphine instead.

54. The clinical reviewer considered that worsening symptoms without explanation in the community would normally prompt an urgent assessment. We are therefore concerned that the prison paramedic decided to issue un-prescribed morphine instead of sending Mr Dauhoo to hospital.

55. While we recognise the prison paramedic may have felt under pressure from prison staff to delay a hospital transfer, he should have requested further clinical input if he felt unable to insist himself that an ambulance was necessary. At interview, the prison paramedic told us that, as a relatively inexperienced staff member, he was not aware there was an out of hours GP service he could contact. He said that he thought it was reasonable to administer morphine, as this is what he had done in the ambulance service.

56. The clinical reviewer considered that if the prison paramedic was concerned there may be something seriously wrong with Mr Dauhoo, but thought the ambulance could be deferred, then it would have at least been beneficial to take his clinical observations before he left. We agree. We also consider that the prison paramedic should also have arranged for the OSG to check Mr Dauhoo at regular intervals overnight and given her clear instructions on what warning signs to look for.

57. The clinical reviewer concluded that while it was not possible to say whether a hospital transfer would have saved Mr Dauhoo's life, it might have led to further intervention to try to prevent his death. Although we recognise that there might not have been the opportunity to monitor Mr Dauhoo's declining health in the community, in prison, where healthcare staff are available, it is important that staff effectively identify life-threatening conditions and take appropriate action. We make the following recommendations:

The Head of Healthcare should ensure that healthcare staff:

- **receive training to help detect and treat early warning signs of deterioration in prisoners with chronic conditions;**
- **take and record observations as required;**
- **know how to access appropriate clinical support; and**
- **accurately record actions and decisions about a prisoner's ongoing care in their medical record.**

The Governor and the Head of Healthcare should review the reasons for the decision not to send Mr Dauhoo to hospital and ensure that respective roles and responsibilities in the decision-making process are properly understood and communicated.

The Head of Healthcare and clinical governance team at IC24 should review the decision-making process for the administration of un-prescribed morphine.

Emergency response

58. Prison Service Instruction (PSI) 03/2013, Medical Response Codes, requires prisons to have a two code medical emergency response system. Swaleside'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 for healthcare staff to attend with the appropriate emergency equipment.

59. An OSG called for assistance over the radio network shortly after she noticed that Mr Dauhoo did not appear to be breathing, but she did not use a medical emergency code. This meant that a nurse did not attend immediately and that the control room did not call an ambulance, causing a delay. The OSG told the investigator that although she considered calling a code blue, the fact she could not see Mr Dauhoo properly caused her to panic. Although calling an emergency code earlier is unlikely to have changed the outcome for Mr Dauhoo, in other circumstances, any delay could be crucial.

60. The OSG did not enter Mr Dauhoo's cell immediately and chose to wait for assistance. She told the investigator that her understanding was that she could enter the cell at her own discretion, but could not recall a specific policy. Although this caused a short delay in Mr Dauhoo receiving attention, she was not sure if he was breathing and she was on her own. We consider that her decision not to open the cell until support arrived was reasonable in the circumstances.

61. Although we are satisfied that a prison manager entered Mr Dauhoo's cell promptly, we are concerned that he asked for assistance instead of calling a code blue, causing a further delay. We are also concerned that he could not remember the name of a defibrillator and that he did not have up to date training in first aid. While we consider that this did not affect the eventual outcome for Mr Dauhoo, the ability of prison staff to administer emergency first aid in future cases could be crucial to saving a prisoner's life.

62. The control room log shows that an officer called an ambulance at 11.06pm, but the ambulance log states they received the call at 11.10pm. The officer told the investigator that she contacted staff to confirm that an ambulance was required and used a computer to check the time. She said there was a few minutes delay before the operator answered the phone, but the ambulance log indicates a ring time of three seconds. We consider that the ambulance log is the more reliable and we conclude therefore that there was a delay of four minutes between the calling of the code blue and calling for an ambulance. We therefore make the following recommendations:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including that:

- **staff promptly use an emergency code to effectively communicate the nature of an emergency and;**
- **control room staff call an ambulance as soon as an emergency code is called.**

The Governor should ensure that there are sufficient staff on duty at all times with up to date training to administer basic life support in an emergency.

63. In a recent investigation into another death at Swaleside, we found that there was also a delay calling an ambulance. We made a recommendation in that case to ensure control room staff call an ambulance immediately. The prison accepted the recommendation and told us that reminder notices were placed in the control room and that the Governor had agreed with South East Coast Ambulance Service to have one of their radios on site, allowing prison staff to be able to communicate directly with ambulance crews. We therefore make no recommendation.

Resuscitation

64. When a nurse arrived at the scene, he checked for breathing and started CPR. This was despite there being clear signs that Mr Dauhoo had died, which included that he was cold to touch, he had no pulse, there were signs of rigor mortis, and his pupils were fixed and dilated. He told the investigator that he felt compelled to start CPR because he had not had formal death verification training. We agree with the clinical reviewer that verification of death and recognition that life is extinct, such as the presence of rigor mortis, are not necessarily the same thing.

65. We understand the commendable wish to attempt and continue resuscitation until death has been formally recognised, but consider staff should understand that they should not undertake CPR in these circumstances. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. Swaleside's resuscitation policy is clear that staff should not attempt resuscitation if rigor mortis is present. European Resuscitation Council Guidelines 2015 say, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile …", such as the presence of rigor mortis. In 2016, the British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued revised guidance about making appropriate resuscitation decisions. The guidance says that every decision should be made on the basis of a careful assessment of each individual's situation. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is not necessary or appropriate.

Restraints, security and escorts

66. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

67. When Mr Dauhoo went to hospital on 4 December a prison manager authorised two officers to escort him using double handcuffs. "Double cuffing", when the prisoner has his hands handcuffed in front of him and then has one wrist attached to a prison officer by an additional set of handcuffs, is usually required for moving category A or category B prisoners in good health. Although he was category B prisoner, Mr Dauhoo was an elderly wheelchair user suffering from severe abdominal pain. There is no record of medical input into the use of restraints.

68. At interview, the prison manager told the investigator that it is not normal procedure to double cuff prisoners who use a wheelchair. He said that although he probably should have annotated the risk assessment to reflect this, he would have advised the escort officers not to use double cuffs. However, at 9.45am, another prison manager authorised escort officers to remove double cuffs and to apply an escort chain instead (an escort chain is a long chain with a handcuff at each end, one of which is attached to an officer). Records show that although staff removed the escort chain for scans and treatment, Mr Dauhoo remained restrained throughout his hospital admission.

69. We can see no justification for the use any form of restraint, far less of double cuffs, on a prisoner who used a wheelchair and posed little risk in light of the circumstances at the time, and we consider this action was both unnecessary and undignified. We are also concerned that Mr Dauhoo remained restrained throughout his hospital admission despite having limited mobility and presenting as significantly ill.

70. The risk assessment was based entirely on the prison's view of his offence with little or no consideration of his health and mobility at the time or how this affected this risk he presented, as is required by the 2007 High Court judgment. Whenever restraints are used, the risk assessments must accurately reflect the risk posed at that time to ensure proportionality and to maintain human dignity. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of the prisoner and are based on the actual risk the prisoner presents at the time.

71. We have previously expressed concerns about the inappropriate use of restraints on very sick and elderly prisoners at HMP Swaleside, and the prison has committed on each occasion to address these failings. In October 2017 and in June 2018 we drew our concerns to the attention of the Executive Director, Long Term and High Security Prisons. In response, he has established a group safety team who will liaise with the prison regularly and test their compliance with our recommendations. We are satisfied that this action is appropriate.

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