

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Asaru Pharaoh, a prisoner at HMP High Down, on 14 February 2021

A report by the Prisons and Probation Ombudsman



Our vision

To carry out independent investigations to make custody and community supervision safer and fairer



Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Asaru Pharaoh died from heart disease on 14 February 2021 at HMP High Down. He was 54 years old. I offer my condolences to Mr Pharaoh's family and friends.

The clinical reviewer was satisfied that the healthcare Mr Pharaoh received at High Down was equivalent to that he could have expected in the community.

I make no recommendations.

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

October 2021

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Summary

Events

1. In December 2008, Mr Asaru Pharaoh was convicted of sexual offences and sentenced to 22 years imprisonment. In January 2019, he was moved to HMP High Down.
2. Mr Pharaoh was overweight and an ex-smoker but had no significant health concerns. Prison healthcare staff offered him healthy living advice.
3. On 14 February, at 11.30am, an officer found Mr Pharaoh unresponsive in bed and called a medical emergency code. Staff attended and started cardiopulmonary resuscitation (CPR). Paramedics arrived at 11.40am but were unable to resuscitate Mr Pharaoh. They declared him dead at 12.19pm.
4. The post-mortem report concluded that Mr Pharaoh died from heart disease.

Findings

5. The clinical reviewer considered that the healthcare Mr Pharaoh received in prison was equivalent to that which he could have expected in the community.
6. We make no recommendations.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP High Down informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
8. The investigator obtained copies of relevant extracts from Mr Pharaoh's prison and medical records.
9. NHS England commissioned a clinical reviewer to review Mr Pharaoh's clinical care at the prison.
10. 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.
11. One of the Ombudsman's family liaison officers contacted Mr Pharaoh's next of kin, his mother, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not raise any concerns but asked for a copy of our report.
12. Mr Pharaoh's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.
13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy and amendments have been made to this report.

Background Information

HMP High Down

14. 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

15. The most recent full inspection of HMP High Down was in May 2018. Inspectors reported that a wide range of primary care services was available, with short waits for most clinics. Prisoners had prompt access to triage and nurse-led clinics on the house blocks, with other specialist services accessed from the health care centre, although non-attendance rates were too high. Reception health screening was thorough and identified health concerns, but prisoners waited too long to be assessed. Although health promotion activities took place, there was no strategic calendar of events or meaningful engagement with prisoner health representatives.
16. Inspectors carried out a scrutiny visit in March and April 2021. They reported that health care provision was poor and caused serious concern. There had been a lack of consistent leadership with four heads of healthcare in the year. There had been severe staff shortages and healthcare staff told inspectors that they felt compromised by the unmanageable demands on their time. Basic processes, such as making sure that emergency response bags were up to date and properly equipped, had failed. Prisoners continued to receive initial health screening on arrival, although not always promptly. Secondary health screening was not completed by healthcare staff which was very unusual. Prisoners were instead asked to complete a paper screening form which was added to SystemOne (electronic medical record). This meant that important information on prisoners' health could be missed.

Independent Monitoring Board

17. 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 some improvements but with much left to do. They were concerned about overcrowding and inadequate furnishings and privacy. Healthcare offered a wide range of services although GP waiting times were consistently up to a week.

Previous deaths at HMP High Down

18. Mr Pharaoh was the sixth prisoner to die at High Down since February 2019. Of the previous deaths, two were due to natural causes and three were self-inflicted. There are no similarities with Mr Pharaoh's case.

Key Events

19. On 2 December 2008, Mr Asaru Pharaoh was convicted of sexual offences and sentenced to 22 years imprisonment. On 25 January 2019, he was moved to HMP High Down.
20. When Mr Pharaoh arrived at High Down, he was overweight, with a body mass index (BMI) of 28.6 (25 and over is overweight; 30 and over is obese). He was also an ex-smoker. Healthcare staff offered him advice on smoking, diet and exercise. He declined a referral to the smoking cessation service. He was prescribed vitamin D at his request.
21. In September and October 2020, healthcare staff asked Mr Pharaoh to undergo blood tests for a bone profile and full blood count. Mr Pharaoh wanted to take vitamin D tablets and healthcare staff wanted to establish if there was any need for them. He said he would not have any blood taken and was removed from the waiting list.
22. There was nothing of note in Mr Pharaoh's medical records for the rest of 2020.

14 February 2021

23. CCTV shows that at 10.44am on 14 February 2021, Officer A opened Mr Pharaoh's door and stayed at the cell door for around 20 seconds. In his statement, the officer said that Mr Pharaoh's television was on loud, but that he heard a response and assumed that Mr Pharaoh was still waking up. (He said that Mr Pharaoh usually stayed up late at night playing video games.)
24. At 11.11am, Officer A went to Mr Pharaoh's cell again. He told the investigator that he thought he saw Mr Pharaoh on his left side with his eyes open watching television. He thought he told him not to forget to use the kiosk and to collect his food as that side of the landing would be first for dinner. He also spoke to him about helping to clean some cells that afternoon. He was not sure if Mr Pharaoh responded but thought he just carried on watching television.
25. At 11.30am, Officer B went to Mr Pharaoh's cell and asked him, from the cell door, if he had had any dinner. Mr Pharaoh did not respond so Officer B went into the cell. Mr Pharaoh was lying on his back, with his head to one side and appeared asleep. He tried to wake him, but he did not respond. He called Officer C and she attended. She could not rouse Mr Pharaoh either and she called a code blue (a medical emergency code used when a prisoner is unconscious or having difficulty breathing).
26. The control room log says that the code blue was called at 11.30am. It does not say when the ambulance was called but it arrived at 11.40am so it is unlikely there was a delay calling it.
27. Officer C checked to see if Mr Pharaoh was breathing or had a pulse and as she detected neither she started cardiopulmonary resuscitation (CPR). (She and Officer B were unable to get Mr Pharaoh onto a flatter surface.) A Custodial Manager (CM) arrived and told Officer B to lock up the prisoners. Officer A also arrived and with

the CM and Officer C managed to move Mr Pharaoh to the floor. Between them they did six rounds of compressions before healthcare staff arrived.

28. At 11.35am, two nurses arrived at the cell with a Healthcare Assistant (HCA). The HCA helped officers with CPR and both nurses set up the oxygen. Other nurses attended the scene. A defibrillator was applied which advised no shock and oxygen was administered. Mr Pharaoh was cold to touch.
29. At 11.40am, paramedics arrived and moved Mr Pharaoh to the landing before continuing with resuscitation efforts. They were not successful, and he was pronounced dead at 12.19pm.

Contact with Mr Pharaoh's family

30. On 14 February, the prison appointed a Supervising Officer (SO) as the family liaison officer. In line with Prison Service guidance, High Down offered a contribution to the costs of Mr Pharaoh's funeral.

Support for prisoners and staff

31. After Mr Pharaoh's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
32. The prison posted notices informing other prisoners of Mr Pharaoh'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 Pharaoh's death.

Post-mortem report

33. The post-mortem report concluded that Mr Pharaoh died from ischaemic heart disease caused by thrombosis of the left coronary artery (blood clot in the artery that supplies the heart), which in turn had been caused by coronary artery atheroma (build-up of fatty deposits that narrows the artery).

Findings

Mr Pharaoh's clinical care

34. The clinical reviewer concluded that the clinical care Mr Pharaoh received in prison was of a reasonable standard and equivalent to that he could have expected to receive in the community.
35. Although there was conflicting information in the records about his smoker status, he was offered the opportunity for smoking cessation advice but declined it. He was overweight but lifestyle advice was offered, as recently as January 2021.
36. The clinical reviewer noted that healthcare staff had not offered Mr Pharaoh any of the general wellbeing checks offered to people aged 40-74. The Head of Healthcare told the clinical reviewer that COVID-19 had impacted healthcare provision, staffing levels and the regime in general. The clinical reviewer acknowledges that the community has also been impacted and has not made a recommendation.
37. However, between January 2019 and February 2020, Mr Pharaoh was not offered an over 50s health check even though this was before the COVID-19 pandemic. The clinical reviewer has noted this as a point of concern but recognised that the initial and secondary health screens were conducted to standard. As such, she does not make a recommendation.

Checks on the morning of 14 February 2021

38. The prison provided us with a CCTV timeline for the morning of 14 February 2021, when Mr Pharaoh was found unresponsive in his bed. The timeline says that at 10.44am, Officer A opened Mr Pharaoh's door and appeared to be engaging with Mr Pharaoh for around 20 seconds. In his statement, he said that Mr Pharaoh's television was on loud but that he thought he heard a response from him.
39. It would appear, on the evidence available, that an adequate check was made on Mr Pharaoh at 10.44am and that he was alive at that time.
40. Officer A returned to Mr Pharaoh's cell at 11.11am. He said that Mr Pharaoh was on his left side, had his eyes open and appeared to be watching television. Officer B said in his statement that Mr Pharaoh was on his back and appeared to be asleep when he found him unresponsive at 11.30am. It is possible that Mr Pharaoh suffered a cardiac event between those two times.

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