Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Carpenter, a prisoner at HMP Moorland, on 6 July 2021

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 l 020 7633 4100

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

Summary

1. 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.

2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

3. Mr Robert Carpenter died on 6 July 2021 of acute myocardial ischaemia (when the blood flow to the heart is reduced and prevents oxygen reaching the heart) caused by heart disease while a prisoner at HMP Moorland. Mr Carpenter was 67 years old. I offer my condolences to Mr Carpenter's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Carpenter received at Moorland was of a good standard and equivalent to that he could have expected to receive in the community. The clinical reviewer was satisfied that Mr Carpenter was supported to access external healthcare appointments in a timely and appropriate manner and made no recommendations.

5. We found that Mr Carpenter showed clear signs of rigor mortis when staff entered his cell on the morning of 6 July. Despite this, operational staff attempted resuscitation. Trying to resuscitate someone who is clearly dead, is distressing for staff and undignified for the deceased.

6. It is important that prison staff are trained to recognise the point at which CPR is futile and we make one recommendation accordingly.

Recommendations

- The Governor and the Head of Healthcare should ensure that all operational staff are aware of the signs of rigor mortis and fully understand the circumstances in which they should not start, or continue, resuscitation, in line with Resuscitation Council Guidelines.

The Investigation Process

7. NHS England and NHS Improvement (NHSE&I) commissioned an independent clinical reviewer to review Mr Carpenter's clinical care at HMP Moorland.

8. The PPO investigator has investigated non-clinical issues, including Mr Carpenter's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

9. The investigator interviewed one member of staff by telephone on 29 December 2021.

10. The PPO family liaison officer wrote to Mr Carpenter's next of kin to explain the investigation. They did not respond to our letter.

11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Moorland

12. There were eight deaths at Moorland in the two years before Mr Carpenter's death in July 2021. Of these deaths, seven were from natural causes (one death was related to COVID-19) and one was drug related. Following a death in March 2021, we made a recommendation relating to the use of CPR. This was also an issue in this investigation.

Key Events

13. On 7 November 2019, Mr Robert Carpenter was sentenced to seven and a half years imprisonment. He was sent to HMP Hull and transferred to HMP Moorland on 3 February 2021 during the COVID-19 pandemic.

14. Mr Carpenter was at a moderate risk of developing complications from COVID-19, and he followed prison advice to isolate when he arrived at Moorland.

15. Mr Carpenter had a complex history of physical health concerns including epilepsy, strokes, asthma, indigestion, cognitive impairment, incontinence and abdominal aortic aneurysm (a bulge in the main blood vessel running from the heart to the stomach). Mr Carpenter also had a diagnosis of depression.

16. The clinical reviewer said that Mr Carpenter's long-standing conditions were appropriately monitored and that care plans were in place. The prison supported him to access necessary external appointments for his heart, epilepsy and digestive concerns.

17. On 15 March 2021, a prison occupational therapist assessed Mr Carpenter's care needs. He made a referral for a social care assessment and mobility aids, including a new wheelchair. Mr Carpenter had a social care support package in place following the assessment. He had assistance with cleaning his cell, and the clinical reviewer is satisfied that his location was appropriate for his needs.

18. On the morning of 6 July 2021, an Operational Support Grade (OSG) was conducting a roll count at approximately 6.05am. She could not see Mr Carpenter through the observation panel, and he did not respond to her morning call. She called for assistance and two officers attended the wing at 6.10am. They notified Oscar 1 (the call sign for the duty manager in charge of the prison) that they required assistance and would be entering the cell.

19. Upon entering, they found Mr Carpenter unresponsive and leaning against the wall whilst seated on the toilet. One officer said in his statement that Mr Carpenter was pale and stiff. He started cardiopulmonary resuscitation (CPR) while Mr Carpenter remained seated. The other officer radioed a code blue (an emergency code which indicates a prisoner is not breathing or is having difficulty breathing). The prison called for an ambulance immediately.

20. Both officers moved Mr Carpenter to the floor following unsuccessful CPR attempts. The investigator viewed camera footage, and Mr Carpenter's body appeared to remain rigid in a seated position. One officer said that Mr Carpenter was stiff and that he "had gone". Oscar 1 arrived at Mr Carpenter's cell and told the officers to continue CPR until the paramedics arrived.

21. The paramedics arrived at Mr Carpenter's cell at 6.29am. The paramedics told prison staff to stop CPR and confirmed that he had died. They said that he had been dead for some time.

22. Healthcare at Moorland is not 24 hour and the healthcare team were not on duty at the time of Mr Carpenter's death. The Head of Healthcare was notified of Mr Carpenter's death when they came on duty at 8.10am.

Post-mortem report

23. The Coroner concluded that Mr Carpenter died of acute myocardial ischaemia (lack of oxygen to the heart) caused by ischaemic heart disease (blood vessels to the heart are blocked or too narrow). He also had severe coronary artery atheroma (build-up of fat preventing blood flow to the heart) which did not cause but contributed to his death.

Non-Clinical Findings

Emergency Response

24. Mr Carpenter was found unresponsive on his cell toilet at approximately 6.05am. An officer immediately started CPR. In his prison statement, he confirmed that Mr Carpenter was very pale and stiff.

25. Body worn video camera footage viewed by the investigator shows that Mr Carpenter had clear signs of rigor mortis (rigor mortis is the stiffening of the body after death and normally appears within the body around two hours after death) and was rigid when he was found in his cell. The officer can be seen stopping CPR and moving Mr Carpenter to the floor, assisted by his colleague. He told Oscar 1 that Mr Carpenter was "stiff" and that he had "gone".

26. Oscar 1 told the investigator that, as a non-clinical member of staff, she would always start CPR, even if she thought someone had died.

27. The Royal College of Nursing Guidelines say that in the prison estate the primary judgment to be made is whether rigor mortis is present. The answer should inform the decision about commencing CPR.

28. The European Resuscitation Council (ERC) guidelines state that in such cases, a non-clinician may make a diagnosis of death but is not verifying or certifying death. Mr Carpenter showed clear signs of rigor mortis and resuscitation would have been futile.

29. We are concerned that officers started and were instructed to continue with resuscitation. Although we understand that staff were doing what they thought was right, trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. Prison staff need to be trained to recognise the point at which CPR is futile, rigor mortis is beyond this point.

30. We make the following recommendation:

    The Governor and the Head of Healthcare should ensure that all staff are aware of the signs of rigor mortis and fully understand the circumstances in which they should not start, or continue resuscitation, in line with Resuscitation Council Guidelines.

31. None of the staff involved were up to date with emergency first aid training. Following a previous death, in January 2022 the prison committed to providing annual CPR refresher training for all staff. We have not made a further

recommendation here as we note that Mr Carpenter's death occurred before the prison had made this commitment.

Sarah Stolworthy
Assistant Ombudsman

October 2022

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 l 020 7633 4100