Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Henderson, a prisoner at HMP Rochester, on 27 May 2021

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 John Henderson died on 27 May 2021 of heart disease at HMP Rochester. Mr Henderson was 54 years old. I offer my condolences to Mr Henderson's family and friends.

Mr Henderson had not been diagnosed with heart disease before he died. However, the clinical reviewer concluded that his health care was not equivalent to that which he could have expected to have received in the community and had some major deficiencies. When Mr Henderson's oxygen saturation was dangerously low, this was not followed up appropriately. His appointments with the hospital neurologist were not facilitated and he had no long-term care plan for his epilepsy.

I am also concerned that staff did not adequately complete roll checks or checks when Mr Henderson's cell was unlocked. He was found unresponsive by his cellmate an hour after staff had unlocked his cell. Lastly, I am concerned that staff attempted to resuscitate Mr Henderson, despite the fact that he was clearly dead. This was both undignified for Mr Henderson and distressing for staff.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **October 2022**

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Summary

Events

1. In April 2020, Mr Henderson was charged with robbery, remanded to custody and taken to HMP Elmley. He also had other outstanding charges. In July, Mr Henderson was sentenced to 12 weeks imprisonment. In August, Mr Henderson had several seizures, was admitted to hospital and diagnosed with epilepsy. He was prescribed medication to treat his epilepsy and high blood pressure.

2. In November, Mr Henderson was sentenced to a further 120 days imprisonment and in December to three years imprisonment. On 22 January 2021, Mr Henderson transferred to HMP Rochester. A nurse assessed him in reception and his observations were normal. Three days later, Mr Henderson's oxygen saturation level was dangerously low, at 85%. There is no record of any follow-up action being taken.

3. In February, a GP reviewed Mr Henderson who said he had been having seizures around once a week. The GP increased Mr Henderson's epilepsy medication and requested blood tests. On two occasions in March, the hospital neurologist tried to telephone Mr Henderson for prearranged appointments but did not manage to speak to him. He sent him a further appointment for August.

4. On 26 May, Mr Henderson's cellmate said that he had seemed his usual self. His cellmate said that he fell asleep while Mr Henderson was still watching television. A member of staff did roll checks at 8.45pm that evening and 6.00am the next morning when he said Mr Henderson was in bed. Another officer did a roll check at around 8.00am but did not look into Mr Henderson's cell, he only checked that the door was locked.

5. At 9.15am, an officer unlocked Mr Henderson's cell. He recalled that he thought Mr Henderson was in bed. Shortly before 10.30am, Mr Henderson's cellmate discovered that he was unresponsive and alerted another prisoner who went into the cell. They told staff who got Mr Henderson down from the top bunk and started resuscitation. Mr Henderson was completely rigid. Healthcare staff responded and continued CPR. Paramedics arrived, assessed Mr Henderson and immediately asked staff to stop CPR. They pronounced that Mr Henderson had died at 10.52am. Paramedics told staff that they thought Mr Henderson had been dead for around six hours due to his body temperature.

6. The pathologist concluded Mr Henderson died of ischaemic heart disease. This means that there is insufficient blood supply to the heart.

Findings

7. The clinical reviewer concluded that the clinical care Mr Henderson received was not equivalent to that which he could have expected to receive in the community and was "bordering on poor". Staff had not appropriately acted when his blood saturation was dangerously low on 25 January. He also had no long-term care plan for his epilepsy and his appointments with the hospital neurologist were not facilitated.

8. We are also concerned that one member of staff did not look into the cell when they did a roll check, while another did not check Mr Henderson's welfare when they unlocked him.

9. Lastly, we are concerned that staff attempted to resuscitate Mr Henderson when it was clearly futile. This was distressing for staff and undignified for Mr Henderson.

Recommendations

- The Head of Healthcare should ensure that staff taking physical observations of prisoners are aware of and take appropriate follow-up action when they record abnormal results.

- The Head of Healthcare should ensure that prisoners with long-term conditions have a robust care plan in place in line with National Institute of Clinical Excellence (NICE) guidance.

- The Head of Healthcare should ensure that all telephone consultations with outside hospitals are facilitated and their outcomes are recorded on prisoners' medical records.

- The Governor should review the prison's local instructions on unlocking and welfare checks to ensure that:
  - staff are clear about the type of check required, when they should do it, and how the check should be carried out;
  - a welfare check is carried out on all prisoners at or before unlocking; and
  - staff carry out checks in accordance with the prison's local instructions and relevant national guidance.
- The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate in accordance with European Resuscitation Council Guidelines

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Rochester informing them of the investigation and asking anyone with relevant information to contact her.

11. Due to the COVID-19 pandemic, the investigator was unable to visit the prison. She obtained copies of relevant extracts from Mr Henderson's prison and medical records via email.

12. The investigator interviewed 13 members of staff and two prisoners via the telephone and video conference. NHS England commissioned a clinical reviewer to review Mr Henderson's clinical care at the prison. They jointly interviewed healthcare staff. NHS England later commissioned another clinical reviewer to provide an addendum clinical review to the original clinical review report.

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

14. One of the Ombudsman's family liaison officers contacted Mr Henderson's sister, to explain the investigation and to ask if she had any matters they wanted the investigation to consider. She asked the following questions:

    - Why was Mr Henderson not found until 10.20am on 27 May?
    - Did Mr Henderson's cellmate notice him having a seizure as they shared a bunk bed?
    - When was Mr Henderson last checked?
    - Why did healthcare staff do CPR when Mr Henderson had clear signs of rigor mortis?
    - Were the bruises on Mr Henderson's face caused by an oxygen mask?

15. The police and pathologist noted that there were no signs of injury to Mr Henderson's face and therefore we are unable to comment on the last question further. The rest of Mr Henderson's sister's questions are answered in this report.

16. Mr Henderson's sister received a copy of the initial report. She did not make any comments.

17. 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 Rochester

18. HMP & YOI Rochester is a category C resettlement prison. It holds up to 695 adult and young male offenders in eight residential units and has a separate segregation unit. Oxleas NHS Foundation Trust provides healthcare services at the prison.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Rochester was in October 2021. Inspectors found that overcrowding needed to be reduced and the condition of living accommodation improved. They noted that the prison had responded successfully to mitigating the risks presented by the COVID-19 pandemic. However, they also found that, as the prison recovered from this, progress was slow. Too few prisoners were engaged in useful activity. However, inspectors also noted that there was a chronic shortage of staff.

20. Inspectors found that primary healthcare staff were committed and enthusiastic and provided a good quality service, although there was inadequate space to provide the full range of services effectively. There were long waiting times for some clinical monitoring procedures. COVID-19 restrictions meant that patients' long-term conditions were managed by GPs from a local practice. All prisoners they reviewed had a care plan, although they had not all been involved in these and some reviews were overdue. Inspectors found that no formal multidisciplinary meetings were held to discuss complex cases, so treatment options could be shared.

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 March 2021, the IMB reported that despite the difficulties presented by the COVID-19 pandemic, Rochester continued to provide a stable, safe and decent environment for prisoners. The IMB reported that there were positive relationships between staff and prisoners and the key worker system had continued throughout the pandemic.

22. The IMB found that healthcare appointments and waiting times to see the GP were equivalent to the community and substance misuse and mental healthcare were good. However, they found that some healthcare appointments were missed due to poor communication and there were sometimes delays in medication administration.

Previous deaths at HMP Rochester

23. There were no deaths at Rochester in the two years before that of Mr Henderson. There has been one self-inflicted death since.

Psychoactive Substances (PS)

24. Psychoactive substances (PS), previously known as ‘legal highs’, are an increasing 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.

25. 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.

Key Events

26. On 6 April 2020, Mr Henderson was arrested for an offence of robbery. Two days later, he appeared in court, was remanded to custody and taken to HMP Elmley. Mr Henderson told a nurse that he had no mental health issues or thoughts of suicide or self-harm. Mr Henderson told a GP that he misused alcohol, they assessed his withdrawal symptoms and prescribed him medication to try to lessen these. Mr Henderson tested positive for cannabinoids.

27. On 15 July, Mr Henderson was sentenced to 12 weeks imprisonment for offences of assault and criminal damage and remained on remand for other offences.

28. On 17 August, Mr Henderson had several seizures. He was taken to hospital by ambulance. He remained in hospital and was diagnosed with epilepsy. On 25 August, Mr Henderson returned to Elmley and was prescribed amlodipine (to treat high blood pressure) and levetiracetam (to treat epilepsy) in line with the hospital discharge summary.

29. On 19 August, staff found two litres of fermenting liquid in Mr Henderson's cell. Staff submitted an intelligence report (IR) and noted it in the observation book. On 12 November, Mr Henderson was sentenced to 120 days imprisonment for offences of racially aggravated harassment and theft. On 10 December, a letter addressed to Mr Henderson tested positive for Psychoactive Substances (PS).

30. On 11 December, Mr Henderson was sentenced to three years imprisonment for an offence of robbery. Healthcare staff assessed him and had no concerns about his mental health or risk to himself. Mr Henderson applied to transfer to HMP Rochester.

HMP Rochester, 22 January 2021 onwards

31. On 22 January 2021, Mr Henderson transferred to Rochester. A nurse assessed his mental health and noted no concerns. His observations were normal. A GP continued his epilepsy and blood pressure medication. This continued to be in his own possession, as it had been at Elmley.

32. On 25 January, during a secondary reception screening, Mr Henderson's oxygen saturation level was 85%. This is an abnormally low reading which could be potentially life threatening. There is no record of any follow-up action taken. It was not possible to interview the nurse who had taken the reading as they had stopped working at the prison.

33. On 31 January, Mr Henderson's cellmate told staff that Mr Henderson had had two seizures the night before. Mr Henderson confirmed this to the nurse and said he had been taking his epilepsy medication. They referred him to a GP to be reviewed. On 10 February, a GP reviewed Mr Henderson. They noted that he said he had been taking his medication and would review him in a couple of weeks. They also noted that they would send an urgent task to administration staff to chase Mr Henderson's neurology appointment.

34. On 24 February, the hospital neurology consultant wrote to Mr Henderson at Rochester indicating that he had a telephone appointment on 4 March at 11.30am.

35. On 25 February, a GP reviewed Mr Henderson. Mr Henderson said that he had been having seizures around once a week. The GP increased Mr Henderson's epilepsy medication and requested blood tests. The GP noted that he was due to have a telephone appointment with a neurologist in March. The GP wrote to the neurologist to inform them of the increase in Mr Henderson's medication.

36. On 8 March, the neurologist wrote to the Head of Healthcare to indicate that he had not been telephoned as expected for his appointment with Mr Henderson on 4 March and they would arrange another appointment.

37. On 9 March, the neurologist telephoned two different numbers at the prison to speak to Mr Henderson but was unsuccessful in doing so. He noted that he had not been able to reach Mr Henderson and sent another appointment for a telephone consultation with him on 24 August.

38. On 2 April, two litres of fermenting liquid were found in Mr Henderson's cell and he appeared to be under the influence. He was subjected to disciplinary charges and an IR was submitted.

39. On 19 May, a GP reviewed Mr Henderson's blood tests which showed a slightly high level of cholesterol but were otherwise normal. The GP noted that he advised Mr Henderson to exercise and not to drink alcohol. On 23 May, Mr Henderson rang his son. His speech was very slurred.

40. A prisoner moved into Mr Henderson's cell around this time. He told the investigator that Mr Henderson was a quiet prisoner. Mr Henderson told the cellmate about his seizures and advised him what to do if he saw him having one. The cellmate said that Mr Henderson only took his epilepsy medication when he felt that he needed it. He said that Mr Henderson kept the medication that he did not use in his drawer. The cellmate said that never witnessed Mr Henderson having a seizure. The cellmate said that Mr Henderson got on well with other prisoners who "looked out for him".

41. Staff and prisoners we spoke to said that Mr Henderson was a quiet prisoner who kept to himself quite a lot. They did not have any concerns that Mr Henderson was taking illicit drugs.

42. On 26 May around 5.30pm, an officer unlocked Mr Henderson's cell for association. Mr Henderson and his cellmate went in and out of their cell several times during the next hour and spoke to various prisoners. Around 6.30pm, an officer locked both prisoners in their cell.

43. At 6.45pm, an officer did a roll check. He could not specifically remember checking Mr Henderson but said he would have opened his observation panel and checked that he was in there.

44. The cellmate said that Mr Henderson had seemed his usual self that day. The cellmate fell asleep around 10.00pm as usual. He said that Mr Henderson usually stayed awake until around 1.00am watching television.

45. Around 8.45pm, an OSG did a roll count of prisoners. The OSG said this involved opening each observation panel and checking the right number of prisoners was in the cell.

Events of 27 May

46. On 27 May around 6.00am, the OSG did another roll count of the wing. He told the investigator that both Mr Henderson and his cellmate were in their beds. A CM said that when he got onto the wing around 7.30am that morning the night OSG was still there. They told him that the officer on an early start had not arrived. An Officer arrived at 7.45am. He checked that all the cell doors on the wing were locked but did not look into the cells.

47. At 9.15am, an officer unlocked cells on the wing, including Mr Henderson's. The officer said that he thought Mr Henderson was lying in his bed. The cellmate went in and out of his cell a few times before going to the exercise yard. After returning, the cellmate went in and out of his cell a couple of times along with other prisoners.

48. At 10.27am, the cellmate returned to his cell. At 10.28am, he put his head out of the cell and another prisoner, went into the cell. The cellmate told the investigator that it was unusual for Mr Henderson to stay in bed until that time so he called his name, touched his leg and shook it slightly. He said that his leg was cold. The cellmate became concerned at this point so, at 10.29am, he left the cell and gestured to a second prisoner, to come into his cell. The second prisoner went into the cell for around 30 seconds. He told the investigator that he checked Mr Henderson for a pulse and when he touched him he noticed that he was cold. The second prisoner thought that he was dead and went to the wing office to get help. The cellmate initially continued to try to rouse Mr Henderson but then realised that he was stiff and was therefore dead so his efforts were futile and he stopped.

49. The second prisoner went to the wing office downstairs and told two officers that Mr Henderson was in his cell and he thought he was dead. Both officers went straight to the cell and went inside at 10.31am. Mr Henderson was lying face down on the top bunk with his arms crossed. He did not respond to staff who shouted his name and put a hand on his back. An officer radioed a code blue. Staff in the control room requested an ambulance immediately. An officer left the cell to get the defibrillator. The cellmate told an officer that Mr Henderson had epilepsy and the officer was concerned that he might be having a seizure. He tried to clear the cell and immediate vicinity of prisoners. The officer told the investigator that he could not start CPR himself as he needed other staff to help get Mr Henderson down from the top bunk.

50. An officer got the defibrillator from the wing office and told a CM and a SO, who were there, what had happened. They all went straight to Mr Henderson's cell. The CM stood on a chair and turned Mr Henderson over, who he noted was completely rigid. He immediately thought that Mr Henderson was dead. Along with the SO and officer, they moved him from the top bunk to the floor. They checked for signs of life and the SO moved his arms from across his chest which was difficult as they were stiff. The SO started chest compressions and the CM attached the defibrillator.

51. Having heard the code blue, a nurse went to get emergency bag while a second nurse went straight to the cell with a smaller emergency "grab bag". He arrived there six minutes after the CM had gone into the cell. When he got there officers were carrying out CPR. He noted that Mr Henderson appeared stiff and checked for signs of life. Other healthcare staff arrived and they administered oxygen via Mr Henderson's nose as his jaw was stiff and they could not insert an airway. Staff continued CPR and the governor, instructed staff to move Mr Henderson out of his cell so that there was more room.

52. Paramedics arrived and assessed Mr Henderson. They noted he was stiff and asked staff to stop CPR. They pronounced that Mr Henderson had died at 10.52am. Paramedics noted that Mr Henderson's temperature was approximately 30 degrees Celsius. They told staff that when people die they generally lose one degree Celsius per hour and Mr Henderson had therefore been dead for around six hours. Staff put Mr Henderson back into his cell.

53. The cellmate told staff that Mr Henderson had not been taking his epilepsy medication. Staff later found twelve tablets in his cell. He said that other prisoners on the wing had been encouraging him to take his medication. The cellmate told the investigator that he had slept throughout the night and was not aware of anything unusual. However, he said that the prisoners in the cell next door to him had told him the next morning that they had heard noises coming from his cell around 5.00am and had been banging on the walls but he did not hear this.

54. Police found fermenting liquid in Mr Henderson's cell which later tested as having 2% volume of alcohol (this is low).

55. After Mr Henderson died, several IRs were submitted detailing what prisoners had told staff. Some prisoners claimed that Mr Henderson had been given drugs by other prisoners to intentionally harm him, others that he was used to test the strength of PS when it arrived at the prison and he was filmed and others claimed that he used PS of his own volition.

Contact with Henderson's family

56. At 11.20am, a SO was appointed as family liaison officer (FLO). The FLO and a SO went to Mr Henderson's sister's home address and broke the news of his death and offered their condolences. In line with Prison Service policy, they offered a contribution to funeral expenses. The FLO remained in contact with Mr Henderson's next of kin who visited the prison and the Governor.

Support for prisoners and staff

57. After Mr Henderson'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.

58. The prison posted notices informing other prisoners of Mr Henderson'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 Henderson's death.

Post-mortem report

59. The pathologist concluded that the cause of Mr Henderson's death was ischaemic heart disease. This means that there is insufficient blood supply to the heart. There were no illicit drugs or alcohol detected in Mr Henderson's system and the pathologist concluded that, "toxicology did not add to the cause of death".

60. Mr Henderson had been prescribed amlodipine and this was not detected in his system. Levetiracetam, which Mr Henderson had also been prescribed, was detected but at a lower level than would have been expected

Findings

Clinical Care

61. The clinical reviewer concluded that the clinical care Mr Henderson received was not of the required standard and not equivalent to that which he could have expected to receive in the community. He noted that the level of care offered to Mr Henderson was "bordering on poor" and identified some major deficiencies.

Oxygen saturation

62. The clinical reviewer noted that Mr Henderson's oxygen saturation reading of 85% on 25 January was abnormally low. This could have been potentially life threating and could have indicated a serious health condition requiring further examination and treatment. There is no record of any follow-up action being taken and it was not possible to interview the nurse who took the observation as they no longer worked at the prison. There is no evidence that healthcare staff measured Mr Henderson's oxygen saturation again in the four months before he died. We endorse the clinical reviewer's recommendation that:

    The Head of Healthcare should ensure that staff taking physical observations of prisoners are aware of and take appropriate follow-up action when they record abnormal results.

Epilepsy care

63. The clinical reviewer concluded that Mr Henderson should have had an epilepsy long-term care plan to monitor, review and provide advice about his care and treatment. He also noted that there is some evidence of a link between heart disease and epilepsy and given the low oxygen reading on 25 January coupled with Mr Henderson's high cholesterol it was particularly concerning that no further investigations were undertaken. We endorse the clinical reviewer's recommendation that:

    The Head of Healthcare should ensure that prisoners with long-term conditions have a robust care plan in place in line with National Institute of Clinical Excellence (NICE) guidance.

64. A consultant neurologist tried to speak to Mr Henderson on two occasions on the phone in March, having previously informed the prison of these appointments. He was unsuccessful in doing so and offered Mr Henderson a further appointment in August. The clinical reviewer concluded that the prison therefore caused an unacceptable delay of five months for Mr Henderson to potentially be reviewed by a neurologist. Unfortunately, he died before this appointment in August.

65. The Head of Healthcare accepted that the prison needed to improve their access to telephone consultations with the hospital which had become a standard way of communicating with prisoners since the COVID-19 pandemic. He told the investigator that it was hard to get hospitals to ring the right number at the right time or get prisoners to wait in healthcare for hours waiting for their telephone call.

Despite these difficulties, Rochester needs to ensure that they facilitate prisoners' hospital appointments. We endorse the clinical reviewer's recommendation that:

The Head of Healthcare should ensure that all telephone consultations with outside hospitals are facilitated and their outcomes are recorded on prisoners' medical records.

66. The second clinical reviewer provided an addendum to the first clinical reviewer's clinical review. He concluded that there was no evidence which linked Mr Henderson's heart disease with his diagnosis of epilepsy. However, he also cited the raised risk of heart disease in those with epilepsy or taking anti-epileptic medication.

67. The investigator asked the second clinical reviewer whether the level of levetiracetam in Mr Henderson's blood was indicative that he had been taking his medication. He noted that the level was below a standard therapeutic level but indicative that he had taken at least some of his antiepileptic medication in the two to three days before his death. Mr Henderson was also prescribed amlodipine but this was not detected by the toxicology tests post-mortem. However, he noted that the toxicology report noted that Mr Henderson's blood sample was "in poor condition" and he could not therefore be sure whether this meant that Mr Henderson had not been taking this medication at all.

68. The first clinical reviewer concluded that it was appropriate that Mr Henderson was assessed as suitable for in possession medication. Given the uncertainties about whether Mr Henderson was taking his medication and the lack of evidence that this was relevant to his death, we make no further recommendation here.

Substance misuse

69. After Mr Henderson died, there was a substantial amount of intelligence from prisoners that he had either been coerced into taking illicit substances, made to test them for others or taken them of his own free will. We have not been able to substantiate any of these allegations. Similarly, the Head of Security, said that he had interviewed the prisoners involved after Mr Henderson had died and he had not been able to substantiate any of the intelligence received about him.

70. The post-mortem concluded that Mr Henderson died of natural causes and illicit drug use did not contribute to his death. We therefore make no further recommendations here.

Roll checks and unlock procedures

Roll checks

71. Mr Henderson was found dead in his cell by his cellmate around 10.30am on 27 May. Rigor mortis was present, indicating that he had been dead for some time when he was found. (Rigor mortis generally starts to set in between two and six hours after death.) Furthermore, based on his temperature, paramedics estimated that he had been dead for around six hours.

72. A roll check is primarily a security check to count prisoners to ensure they are present in their cells, but it is also an opportunity for any immediate concerns about prisoners' safety to be identified and addressed.

73. Mr Henderson was locked in his cell at around 6.30pm on 26 May. His cellmate said that they watched television as usual together that evening and he fell asleep around 10.00pm, while Mr Henderson continued to watch television as usual. An officer did a roll check at 6.45pm and an OSG did a further roll check at 8.45pm. The next morning the same OSG did a roll check at 6.00am. The OSG did not notice anything unusual and said that Mr Henderson was in his bed. Given his position, lying on his front, in the top bunk, we do not think it unreasonable that staff did not notice anything was wrong during these checks despite the fact that Mr Henderson was most likely dead at this point.

74. An officer checked Mr Henderson's door was locked around 8.00am but did not look into the cell. The officer told the investigator that when he was first trained, he had been told to get a response from prisoners when doing the morning roll check but that when he arrived at Rochester officers and managers had told him just to check that the doors were locked as it was not necessary to wake prisoners up at that time. He added that due to the position of beds, or prisoners blocking their observation panels it was impossible to see some prisoners through their observation panel. Since Mr Henderson's death, the officer said that he now ensures he can see a prisoner during a roll check and gets a response from them if he cannot see them.

Unlock procedures

75. PSI 75/2011, *Residential Services*, says:

> "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.
>
> "The appropriate 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."

76. At 9.15am, an officer unlocked Mr Henderson's cell. The officer told the investigator that when he unlocks prisoners' cells in the morning he looks through their observation panels first to check that they are in the cell and it is safe to unlock the door. He then unlocks the cell and opens the door slightly ajar. He said that he does not check prisoners' welfare or get a response from them.

77. Mr Henderson was found unresponsive by his cellmate over an hour after staff had unlocked their cell. While we accept that this delay would not have made any difference to the outcome for Mr Henderson, it may do in other situations in the future.

78. We are concerned that roll checks and welfare checks when prisoners are unlocked are not being carried out adequately to ensure prisoner and staff safety at Rochester. We make the following recommendation:

The Governor should review the prison's local instructions on roll checks, unlocking and welfare checks to ensure that:

- **staff are clear about the type of check required, when they should do it, and how the check should be carried out;**
- **a welfare check is carried out on all prisoners at or before unlocking; and**
- **staff carry out checks in accordance with the prison's local instructions and relevant national guidance.**

Resuscitation

79. European Resuscitation Council Guidelines for Resuscitation (2015), which were shared with prison managers in September 2016, introduced new staff guidance about when not to perform CPR. The Guidelines say, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile." They define examples of futility as including the presence of rigor mortis.

80. Body worn camera footage shows that Mr Henderson was completely rigid when he was found. Paramedics estimated he had been dead for six hours. Staff found it difficult to move Mr Henderson's arms from his chest to start resuscitation. Staff present thought that Mr Henderson was dead. However, a CM said that he would always start resuscitation if he found a prisoner unresponsive until a medical professional told him to stop.

81. The healthcare staff who responded continued the resuscitation. A nurse said that he would always continue CPR. He said that in order to make the decision to stop CPR he needed further training. He said he had recently had his immediate life support training but it was not covered by this. The Governor had also been present when staff were trying to resuscitate Mr Henderson.

82. The guidelines are clear that CPR should not be carried out where it would be futile. 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. 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 inappropriate in accordance with European Resuscitation Council Guidelines.

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