Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Philip Huggins, a prisoner at HMP Frankland, on 23 June 2022

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 Philip Huggins died of cardiorespiratory arrest (when the heart stops functioning adequately) on 23 June 2022 at HMP Frankland. He was 66 years old. I offer my condolences to his family and friends.

The clinical reviewer concluded that the clinical care that Mr Huggins received at Frankland was equivalent to that which he could have expected to receive in the community.

It is concerning that prison staff did not provide the CCTV footage for 23 June. This meant that we could not fully explore whether a roll check, conducted around an hour before Mr Huggins was found collapsed in his cell, was completed in line with expected standards. This was particularly important in this case as a prisoner who lived close to Mr Huggins' cell told us that he heard a shout for "help" earlier in the night.

I am also concerned that the officer who found Mr Huggins unresponsive did not open the cell door to attend to him until a prison manager and healthcare staff arrived.

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 **March 2023**

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Summary

Events

1. In 2005, Mr Philip Huggins was convicted of murder and sent to prison for life. On 11 July 2017, he was transferred to HMP Frankland. Mr Huggins was diagnosed with hypertension (high blood pressure), atrial fibrillation (an irregular heartbeat), Type 2 diabetes and several other long-term health conditions.

2. On 10 May 2022, Mr Huggins told a prison nurse that he had experienced chest pains for three weeks and what felt like irregular heart rhythms. Ambulance paramedics, who were at Frankland, found that there were changes to Mr Huggins' electrocardiogram (ECG) results and he was transferred to hospital. Mr Huggins returned to Frankland that day.

3. On 14 June, a nurse saw Mr Huggins when he complained of dizziness. He told the nurse that he had fallen and banged his head. The nurse arranged for Mr Huggins to be reviewed the next day and for daily blood pressure checks.

4. At about 4.20am on 23 June, a prisoner who lived two cells away from Mr Huggins heard someone shout "help" twice. The prisoner said that the shout came from a nearby cell, but he could not be certain which one.

5. At about 5.45am, an officer and an operational support grade (OSG) carried out a roll check. The officer said that all of the prisoners were asleep in their beds. The investigator has been unable to view the CCTV footage of the roll count because the prison did not save the recording.

6. At about 6.45am, an officer carried out another roll check. He looked into Mr Huggins' cell and saw him lying on the floor, with blood on his back. The officer radioed a medical emergency code blue (which indicates that a prisoner is unconscious or not breathing). The officer shouted through the cell door, but Mr Huggins did not move. The officer did not open the cell door but waited for prison staff to arrive.

7. At about 6.50am, a supervising officer, a custodial manager and two nurses arrived and went into the cell. Mr Huggins was unresponsive, he had no pulse, his pupils were dilated, he was cold and had pale skin.

8. The nurses started chest compressions and applied a defibrillator, which advised that there was a non-shockable rhythm. A nurse inserted a nasal airway and gave Mr Huggins oxygen. At 7.40am, paramedics confirmed that Mr Huggins had died.

Findings

Clinical care

9. The clinical reviewer concluded that the care that Mr Huggins received at Frankland was of a good standard and was equivalent to that which he could have expected to receive in the community.

Roll check

10. We cannot be certain about the quality of the roll check that we were told was conducted at 5.45am on 23 June because Frankland did not retain and provide us with CCTV footage. It is possible that the prisoner who said that he heard a shout for "help" earlier in the night might have overheard Mr Huggins trying to ask for assistance following a collapse that led to his death. However, without further evidence, we cannot know what happened.

Emergency response

11. The officer who found Mr Huggins unresponsive on the floor of his cell at 6.45am radioed a medical emergency code but did not open the cell door until a prison manager and healthcare staff arrived. While we recognise that it is difficult for staff to make instant decisions, it is critical that staff act quickly when there is a potentially life-threatening situation, and we would usually expect prison staff to go into a cell in case there is a chance of saving someone's life.

Recommendations

- The Governor should ensure that relevant CCTV footage is retained and provided to the Ombudsman's office following a death in custody, in line with national instructions.

- The Governor should ensure that staff are made aware of and understand their responsibilities during a medical emergency, including that they go into cells as quickly as possible in a potentially life-threatening situation.

The Investigation Process

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

13. The investigator obtained copies of relevant extracts from Mr Huggins' prison and medical records.

14. The investigator interviewed a member of staff and a prisoner by telephone on 7 October.

15. NHS England commissioned an independent clinical reviewer to review Mr Huggins' clinical care at Frankland.

16. We informed HM Coroner for County Durham and Darlington of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

17. Mr Huggins had no next of kin.

18. We shared the initial report with the Prison Service. There were no factual inaccuracies.

Background Information

HMP Frankland

19. HMP Frankland is a high security prison. It holds up to 852 men. There is 24-hour inpatient care. Spectrum CIC Healthcare provide primary care, GP, substance misuse and pharmacy services. Tees, Esk and Wear Valleys Mental Health NHS Foundation Trust provides mental health services.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Frankland was in January 2020. Inspectors reported that in a survey of prisoners, 38% described GP services as good and 41% described the overall quality of healthcare as good. Inspectors found that skilled nurses cared for prisoners with complex long-term health conditions and that healthcare staff provided an impressive range of primary and secondary health clinics.

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 November 2021, the IMB reported that the physical environment in the healthcare unit was no longer suitable for the size of the prison. They found that staffing in healthcare was an ongoing challenge and that waiting times for clinics were a concern.

Previous deaths at HMP Frankland

22. Thirteen prisoners died from natural causes at HMP Frankland, six of whom died as a result of COVID-19, at HMP Frankland in the two years before Mr Huggins' death. There was also one self-inflicted death in the same period. One prisoner died from natural causes since Mr Huggins' death. There are no significant similarities between our findings in this investigation and those of the other deaths.

Key Events

23. On 1 September 2005, Mr Philip Huggins was convicted of murder and sent to prison for life. On 11 July 2017, he was transferred to HMP Frankland.

24. Mr Huggins was diagnosed with hypertension (high blood pressure), atrial fibrillation (an irregular heartbeat), Type 2 diabetes and several other long-term health conditions. Mr Huggins was significantly overweight.

25. On 25 August 2017, a nurse sent Mr Huggins to hospital because he had chest pain. Hospital staff found that he had had a heart attack. Mr Huggins underwent a procedure to fit stents (short tubes used to widen blocked or narrow coronary arteries).

26. On 10 May 2022, Mr Huggins told a nurse that he had experienced chest pains and what felt like irregular heart rhythms for three weeks. A prison GP told the nurse that if his condition deteriorated, Mr Huggins should be sent to hospital. That day, ambulance paramedics, who were at Frankland, found that there were changes to Mr Huggins' electrocardiogram (ECG, a test to check the heart's rhythm) results. He was subsequently transferred to hospital. Mr Huggins returned to Frankland that day after hospital staff found that all of their tests were within normal ranges.

27. On 14 June, a nurse saw Mr Huggins as a medical emergency. Mr Huggins told him that he felt dizzy and said that this often happened. He told him that he had fallen and banged his head but had not lost consciousness. The nurse saw mild bruising to the back and top of Mr Huggins' head. He noted that Mr Huggins' blood pressure was within the normal range while sitting and very low while standing. He advised Mr Huggins that he should tell healthcare staff if he thought that he had symptoms of a head injury. He also planned for him to be reviewed the next day and arranged for daily blood pressure checks.

28. Between 15 and 18 June, healthcare staff checked and recorded Mr Huggins' blood pressure, which was noted to be within the normal range.

29. On 20 June, Mr Huggins told officers that he was "going to pass out". The officers advised him to lie on his bed, but when a nurse arrived to assess Mr Huggins, he was standing on the landing talking to other prisoners. Mr Huggins told the nurse that he could not lie down every time he felt that way. She noted that his clinical observations were within the normal range.

Events of 23 June 2022

30. At about 4.20am on 23 June, a prisoner heard another prisoner shout "help" twice. He lived two cells away from Mr Huggins. He told the investigator that the shout came from a nearby cell, but that he could not be certain that it was Mr Huggins who had shouted. He said that he did not call for assistance because he went back to sleep.

31. At about 5.45am, Officer A and an Operational Support Grade (OSG) carried out a roll check on B Wing. The officer said that he could not remember who checked Mr Huggins' cell because they walked down the landing together. He said that it was

bright and sunny outside, so they did not have to put the cell lights on to have a clear view into the cells. He said that he had no interaction with any of the prisoners on the wing, which he said meant that they were all asleep in their beds. The investigator has been unable to view CCTV footage of the roll check because Frankland did not save the recording.

32. At about 6.45am, Officer B carried out another roll check. When he looked into Mr Huggins' cell, he saw Mr Huggins lying on the floor. He radioed a medical emergency code blue (indicating that a prisoner is unconscious or not breathing and which triggers the control room to call an ambulance immediately). He looked into the cell again and thought that he could see blood on Mr Huggins' back. He therefore radioed a medical emergency code red (used for severe blood loss). He shouted through the cell door, but Mr Huggins did not move. He told the investigator that Mr Huggins had fainted the previous week, and so he thought that he had fainted again.

33. Officer B did not open the cell door but walked along the landing to wait for prison staff to respond to the emergency call. He said that they arrived about a minute later.

34. At about 6.50am, a Supervising Officer (SO) and a Custodial Manager (CM) went into the cell followed by two nurses. They found Mr Huggins lying on the floor, facing towards the window. The nurses saw dark red blood in and on the toilet and on the floor. Mr Huggins was unresponsive, he had no pulse, his pupils were dilated, he was cold had pale skin.

35. Nurse A started chest compressions and Nurse B applied a defibrillator which advised that there was a non-shockable rhythm. Nurse A inserted a nasal airway and gave Mr Huggins oxygen. Both nurses and the CM continued chest compressions.

36. At 7.08am, ambulance paramedics arrived and took over life support. At 7.40am, they confirmed that Mr Huggins had died.

Contact with Mr Huggins' family

37. On 23 June, Frankland appointed a family liaison officer. Mr Huggins did not name a next of kin and prison staff were unable to locate any family. Mr Huggins' funeral took place on 22 July. The prison paid for its cost in line with national instructions.

Support for prisoners and staff

38. The Head of Reducing Reoffending 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.

39. The prison posted notices informing other prisoners of Mr Huggins' 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 Huggins' death.

Post-mortem report

40. A post-mortem examination established that Mr Huggins died from cardiorespiratory arrest (when the heart stops functioning adequately).

Findings

Clinical care

41. The clinical reviewer concluded that the care that Mr Huggins received at Frankland was of a good standard and was equivalent to that which he could have expected to receive in the community. Mr Huggins was seen and monitored in the Long-Term Conditions Clinic for his underlying health conditions.

42. The clinical reviewer has made a recommendation which is not directly related to Mr Huggins' death but which the Head of Healthcare will need to address.

Roll check

43. Prison Service Instruction (PSI) 75/2011 on residential services says that four formal roll checks should be carried out each day. Prison staff are not required to obtain a response from prisoners who appear to be asleep during a night-time roll check but if there are immediate concerns about a prisoner's welfare, they should take appropriate action.

44. A prisoner said that at about 4.20am on 23 June, he heard another prisoner shout "help" twice in a nearby cell. This prisoner lived very close to Mr Huggins but told us that he could not say that it was Mr Huggins who shouted. Officer A said that he and the OSG carried out a roll check at 5.45am. He said that they could see clearly into all of the cells and that his recollection was that all of the prisoners on the wing were asleep.

45. At 6.45am, when Officer B conducted a further roll check, he found Mr Huggins lying on the floor of his cell.

46. The prisoner who said that he heard a shout for "help" said that he did not know which cell it came from and that he did not take any action to alert staff. It is possible that this shout came from Mr Huggins' cell but in the absence of additional evidence, we cannot know what happened.

47. We asked Frankland to provide us with CCTV footage but were told that it was not available, and that footage of the night had not been retained. PSI 64/2011 on managing prisoner safety instructs that any evidential CCTV footage must be gathered and retained following a death in custody. PSI 58/2010 on the Prisons and Probation Ombudsman requires prisons to provide all relevant material to the Ombudsman.

48. Had we been able to view CCTV footage of the morning's events, we would have been able to make an informed judgement about whether the roll check was completed adequately. We therefore make the following recommendation:

    The Governor should ensure that relevant CCTV footage is retained and provided to the Ombudsman following a death in custody, in line with national instructions.

Emergency response

49. PSI 24/2011 on management and security at nights requires that all prisoners are locked in their cells during night state. Under normal circumstances, the night manager must give authority to unlock a cell during night state, and no cell should be opened unless at least two or three members of staff are present, one of whom should be the night manager. However, the PSI states that the preservation of life must take precedence. It says that where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the night orderly officer and an individual member of staff may go into the cell on their own. However, night staff should not take action that they feel would put themselves or others in unnecessary danger.

50. The PSI states that before going into a cell, staff should make every effort to obtain a verbal response from the prisoner. This, together with what the member of staff observes through the cell door observation panel and any knowledge of the prisoner, should inform a rapid dynamic risk assessment of the situation and a decision about whether to enter immediately or wait for assistance.

51. Frankland's local policy on opening cell doors during the night state says that prisoners must only be unlocked at night when it is absolutely necessary to do so and that such instances would include a medical emergency. The local policy states that if the member of staff who discovers an incident considers that there is an urgent situation, where a prisoner is in immediate serious danger, they must radio the control room giving as much information as possible. The member of staff should make a dynamic risk assessment of the situation and if they decide to enter the cell, the control room must be informed of that decision. The control room should then inform relevant staff, including the night manager and healthcare.

52. When Mr Huggins was found unresponsive, the prison was in night state. Officer B had relieved the night shift staff on the wing and was carrying out a morning roll check. When he found Mr Huggins unresponsive on the floor of his cell, he promptly radioed a medical emergency code blue. On closer inspection, he also saw blood on Mr Huggins' back and radioed a medical emergency code red. He initially thought that Mr Huggins had fainted. He had a cell key but did not open the cell door and waited for prison and healthcare staff to arrive. He told us that he understood that he was allowed to open a cell door on his own, but that he had been advised in training not to do so in case anything happened. He said that he would probably not open a cell door on his own at night in any circumstances.

53. We recognise that it is difficult for staff in such situations to make instant decisions, but when there is a potentially life-threatening situation, it is essential to act quickly. Officer B identified that Mr Huggins was bleeding and seemingly unconscious. In these circumstances, we would normally expect prison staff to go into a cell as soon as possible in case there is a chance of saving someone's life. We therefore make the following recommendation:

    The Governor should ensure that staff are made aware of and understand their responsibilities during a medical emergency, including that they go into cells as quickly as possible in a potentially life-threatening situation.

Inquest

54. The inquest, held on 30 June 2023, concluded that Mr Huggins died from natural causes.

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