Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Darryl Judge, a prisoner at HMP North Sea Camp, on 19 August 2020

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

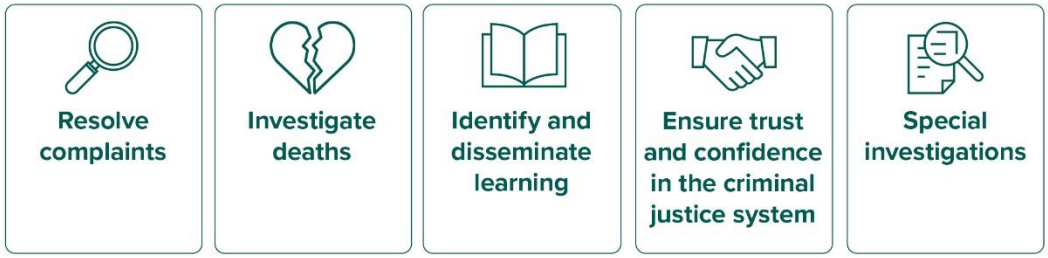
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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 Darryl Judge died in hospital on 19 August 2020 of a stroke while a prisoner at HMP North Sea Camp. He was 52 years old. I offer my condolences to Mr Judge's family and friends.

The clinical reviewer concluded that, overall, the healthcare Mr Judge received was equivalent to that he could have expected in the community. However, as Mr Judge had high blood pressure and was assessed as having a moderate risk of heart attack or stroke, she thought that alternative medication should have been considered when Mr Judge could not take statins.

We are concerned that the operational support grade who found Mr Judge collapsed on 15 August did not call a medical emergency code. We have previously made a recommendation to North Sea Camp about the importance of using such codes and it is disappointing that we are having to repeat the same recommendation.

We are also concerned that there was a short delay before an ambulance was called and that none of the prison staff who responded to the medical emergency had up to date first aid training.

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 **June 2021**

Contents

Summary 1

The Investigation Process 3

Background Information 4

Key Events 5

Findings 8

Summary

Events

1. In 1998, Mr Darryl Judge was sentenced to life in prison for murder. After spending time in several prisons, Mr Judge transferred to HMP North Sea Camp on 4 June 2020. In line with the prison's COVID-19 policy, Mr Judge isolated for two weeks. He was monitored by healthcare staff daily while in isolation.

2. A routine blood test on 23 June showed that Mr Judge had high cholesterol. A doctor did not consider alternative medication to statins (which Mr Judge could not take) to manage his high cholesterol and mitigate his risk of stroke.

3. At 6.37am on 15 August, a prisoner told an Operational Support Grade (OSG) that he had heard a strange sound in Mr Judge's room. The OSG found Mr Judge collapsed on the floor of his room. The OSG radioed the prison night manager asking for assistance but gave an incorrect location. When the night manager arrived, he called a medical emergency code. An ambulance was called at 6.45am. A prisoner and an officer put Mr Judge in the recovery position.

4. Healthcare staff were not on duty at the time. Nurses arrived at 7.17am and stayed with Mr Judge until paramedic staff arrived at 7.37am, some 50 minutes after an ambulance was called.

5. Mr Judge could not be taken to hospital in an air ambulance because they could not carry an officer as well.

6. When Mr Judge arrived at hospital, a CT scan confirmed that he had suffered a severe stroke and heart attack. Mr Judge's condition deteriorated, and he died at 10.05pm on 19 August, with his family at his bedside.

Findings

Clinical care

7. The clinical reviewer found that, overall, the healthcare provided to Mr Judge was equivalent to that which he could have expected to receive in the community. However, the clinical reviewer was concerned that alternative prescribing to statins was not considered to mitigate the risk of heart attack or stroke.

Emergency response

8. The OSG did not patrol overnight in line with the prison's expectations. She did not call an emergency response code blue when she found he had collapsed. When she radioed for 'assistance', she also gave an incorrect location.

9. There was a short delay before the control room called an ambulance.

10. We are concerned that none of the prison staff who responded to the medical emergency had up to date first aid training.

11. Mr Judge could not be taken to hospital in an air ambulance because it could not take an officer as well. Mr Judge was taken to a closer hospital and his treatment was not delayed. However, Mr Judge should not have been prevented from travelling in an air ambulance and accessing that level of urgent care.

12. A hot debrief was not held on 15 August, the day of the emergency response. A debrief was held on 19 August after Mr Judge died, but staff involved in the emergency response were not invited.

Recommendations

- The Head of Healthcare at North Sea Camp should ensure that prison GPs consider alternative medication for prisoners with high cholesterol levels who are intolerant of statin medication.

- The Governor should initiate an investigation into OSG A's actions on the night of 14/15 August with a view to considering if further action is appropriate.

- The Governor should ensure that staff understand the circumstances in which they should call a medical emergency code (in line with Prison Service Instruction 03/2013).

- The Governor should ensure that staff responsible for calling an ambulance understand that they must call an ambulance as soon as an emergency medical code is called.

- The Governor of North Sea Camp should ensure that the minimum level of first aid trained staff is adhered to at all times.

- The Governor should develop a service level agreement with East Midlands Ambulance Service to ensure that prisoners receive equivalent access to urgent care in a medical emergency.

- The Governor of North Sea Camp should ensure that all staff involved in a serious incident are invited to a debrief.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP North Sea Camp informing them of the investigation and asking anyone with relevant information to contact her.

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

15. The investigator interviewed five members of staff and four prisoners at North Sea Camp on 12, 14 and 22 October and 16 November. NHS England commissioned a clinical reviewer to review Mr Judge's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff. All the interviews were conducted by telephone because of the COVID-19 pandemic.

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

17. One of the Ombudsman's family liaison officers contacted Mr Judge's sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not have any questions but asked for a copy of the report.

18. Mr Judge'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.

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

Background Information

HMP North Sea Camp

20. HMP North Sea Camp is an open resettlement prison near Boston in Lincolnshire. It holds around 400 men. Healthcare is provided by Nottinghamshire Healthcare NHS Foundation Trust and operates services Monday to Friday 7.15am – 6.15pm.

HM Inspectorate of Prisons

21. The most recent inspection of HMP North Sea Camp was in July 2017. Inspectors noted that the prison aimed to provide prisoners coming from closed conditions with a supportive environment, and that the risks they posed were managed proportionately. A range of appropriate primary healthcare services was provided and waiting lists for clinics were short.

Independent Monitoring Board

22. 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 July 2020, the IMB found North Sea Camp to be a safe and decent environment for all residents. They were of the view that the healthcare provision was as good, and in some areas better than found in the local community.

Previous deaths at HMP North Sea Camp

23. Mr Judge was the seventh prisoner to die at North Sea Camp and the second to die of a stroke since August 2018. Five of the previous deaths were from natural causes and one was drug-related. In November 2019, we made a recommendation about the importance of using medical emergency codes.

Key Events

24. On 28 May 1998, Mr Darryl Judge was sentenced to life in prison for murder. He spent time in a number of prisons.

25. He had a number of long-term health conditions, including Barratts Oesophagus (a pre-cancerous condition in the lining of the oesophagus), Chronic Obstructive Pulmonary Disease (a progressive lung disease) and high blood pressure.

26. On 4 June 2020, Mr Judge transferred to North Sea Camp. In line with the prison's COVID-19 policy, Mr Judge had to isolate for two weeks when he first arrived. While he was in isolation, the lead respiratory nurse assessed his COPD and healthcare staff monitored him daily for COVID-19 symptoms, which included having his blood pressure taken.

27. On 11 June, the lead respiratory nurse advised Mr Judge that he should shield after the mandatory isolation period because he was clinically vulnerable due to his COPD. Mr Judge agreed to move to the shielding unit on 18 June. As his blood pressure was within normal limits, healthcare staff stopped checking it routinely.

28. On 23 June, a routine blood test showed that Mr Judge's cholesterol level was slightly higher that the recommended range. A prison GP assessed Mr Judge to be at moderate risk of heart attack or stroke. He did not prescribe statin medication because it was recorded in his medical records that Mr Judge had a sensitivity to it. There is no evidence that the GP considered alternative medication.

14/15 August 2020

29. On the night of 14/15 August, Operational Support Grade (OSG) A was responsible for patrolling at regular intervals during the night. She was required to tap electronic pegging points at various points around the wing (known as 'pegging'). The prison's Head of Security told the investigator that an officer should complete six to eight pegging rounds overnight, but according to the pegging records, the OSG only pegged twice – at 11.30pm and 4.30am.

30. A prisoner said he saw Mr Judge in the communal kitchen around midnight. He said Mr Judge collected hot water for drinks and returned to his room.

31. According to the Ambulance Service's records, someone at the prison told them that Mr Judge had been making 'noises' at 4.30am, but no-one checked him. We have not been able to identify the person who spoke to the Ambulance Service. The investigator spoke to four prisoners in neighbouring rooms, who told her that they did not hear noises or speak to the Ambulance Service. Pegging records show that OSG A was walking around the unit at 4.30am. The OSG also told the investigator that she completed a roll check (count of prisoners) between 4.30am and 5.00am. She said she did not notice anything unusual.

32. At 6.30am on the morning of 15 August, OSG A started her roll check. Prisoners who were not shielding reported to the office for the roll check. The OSG then went to the rooms of shielding prisoners to check them and complete the roll.

33. At 6.37am, a prisoner heard a gurgling noise coming from Mr Judge's room. He went to the door of Mr Judge's room and when there was no response, he asked another prisoner to help. OSG A was walking up the stairs to check prisoners who were shielding when the prisoner asked her to come to Mr Judge's room.

34. OSG A reached Mr Judge's room at about 6.39am, immediately unlocked the door and found him collapsed on the floor. Both prisoners went into Mr Judge's room. His trousers were around his ankles and the OSG thought that he had collapsed while trying to dress. She radioed the night orderly officer, an Acting Supervising Officer (SO) A, for assistance. She told him to go the wrong place in error, but the SO told the investigator this only caused a slight delay because he was in a prison van and quickly realised where the OSG was working that night.

35. CCTV footage shows that the SO A arrived at the unit at 6.42am. He went into Mr Judge's room for about 30 seconds, then left the room and radioed a code blue. He remained outside the room.

36. An officer arrived on the unit roughly two minutes later at 6.44am. He went straight into Mr Judge's room. Mr Judge was being kept warm under a blanket and the officer, with the assistance of a prisoner, put him in the recovery position. He checked Mr Judge's airway and removed some brown sludge from his mouth to clear his airway.

37. OSG B, who was working in the gate room, heard the code blue on the radio and called an ambulance roughly two minutes later at 6.45am. (The control room log recorded this as at 6.50am because the clock in the control room was five minutes fast.)

38. CCTV shows that OSG A left Mr Judge's room at 6.46am, leaving Mr Judge with the officer and the two prisoners. SO A remained in the doorway of Mr Judge's room. CCTV shows that he left the unit at 6.54am.

39. SO B arrived at the prison at roughly 6.50am, and went to find SO A to be briefed about the incident. However, when he got there, at 6.57am, he was told by the officer (who was still with Mr Judge) that SO A had already left the unit and had returned to the gate room. SO B left the room after about ten seconds to find SO A.

40. Healthcare staff had not started work for the day when SO A called the code blue. When the nurse arrived at the prison gate at roughly 7.10am, OSG B told her that there was a medical emergency. She asked gate staff to inform other healthcare staff when they arrived.

41. The nurse went to Mr Judge's room immediately with an emergency medical bag and arrived there at 7.17am. Mr Judge was in the recovery position on the floor next to his bed, with a pillow under his head and duvet covering his body. He was cold, pale and clammy and his pulse was weak. When other healthcare staff arrived a minute or so later, they turned Mr Judge onto his back and provided oxygen, while trying to take his blood pressure and oxygen level.

42. Paramedic staff arrived at 7.37am, some 50 minutes after the prison called for an ambulance.

43. Mr Judge was critically ill and paramedic staff requested an air ambulance, but this was refused as the helicopter could not carry an officer as well as Mr Judge. He was taken to Boston Pilgrim Hospital by ambulance, escorted by one officer, arriving at roughly 8.20am. He was not restrained on the escort to hospital.

44. Mr Judge was admitted to the intensive care unit and placed on a ventilator. A scan later that morning confirmed that he had suffered a severe stroke and heart attack. Hospital staff contacted Mr Judge's family, who visited him that night.

45. The same day, the prison granted Mr Judge release on temporary licence (ROTL) due to the severity of his condition. He was accompanied by a prison officer to provide support.

46. Mr Judge's condition deteriorated and on 16 August he was transferred to Queens Medical Centre Hospital in Nottingham. His condition continued to deteriorate and at 8.10pm on 19 August, hospital doctors decided to withdraw life support. Mr Judge died at 10.05pm with his family at his bedside.

Support for prisoners and staff

47. A debrief was not held on 15 August when Mr Judge was discovered. A debrief was completed on 19 and 24 August with those staff who had been with Mr Judge in hospital.

48. The prison posted notices informing other prisoners of Mr Judge'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 Judge's death.

Post-mortem report

49. The post-mortem examination found that Mr Judge died from cerebral and cerebellar infarcts (a stroke) caused by thromboembolism (an obstruction of a blood vessel by a blood clot) from mural thrombus overlying myocardial infarction (a heart attack), with coronary artery atherosclerosis (narrowing of the arteries caused by a build-up of plaque).

Inquest

50. The inquest into Mr Judge's death concluded on 8 March 2022, with a verdict of natural causes.

Findings

Clinical care

51. The clinical reviewer considered that, overall, Mr Judge's clinical care was equivalent to that which he could have expected to receive in the community. She noted that routine healthcare clinics for monitoring long-term conditions were not running at North Sea Camp because of the pandemic. Healthcare staff had been advised to carry out checks at prisoners' room doors instead. The clinical reviewer found this arrangement was reasonable in the circumstances and in line with national guidance but recommended that the Head of Healthcare should review it if restrictions continued.

52. The clinical reviewer was concerned that the GP did not consider an alternative to statins to treat Mr Judge's high cholesterol in June 2020. She considered that alternative medication could have mitigated the risk of a heart attack or a stroke. We make the following recommendation:

    The Head of Healthcare at North Sea Camp should ensure that prison GPs consider alternative medication for prisoners with high cholesterol levels who are intolerant of statin medication.

Night patrols

53. When interviewed, OSG A could not explain why records showed she had not pegged her rounds hourly that night. Pegging rounds overnight is an important way of ensuring a physical presence around the wing for the safety and security of prisoners.

54. OSG A is employed via an agency and is not subject to the Prison Service's disciplinary processes. We recommend:

    The Governor should initiate an investigation into OSG A's actions on the night of 14/15 August with a view to considering if further action is appropriate.

Emergency response

55. When OSG A found Mr Judge collapsed on the floor, she radioed the orderly officer for 'assistance', rather than radioing a medical emergency code. She said at interview that this was her first 'emergency response' and she panicked. She said she knew that a code blue should be used when someone was not breathing, but she did not radio the code blue because although Mr Judge was unconscious, he was still breathing.

56. OSG A also gave the wrong location to the orderly officer when she called him for assistance. Although SO A told the investigator that the incorrect location did not cause a significant delay, it is vital that prison staff communicate accurate information in an emergency.

57. There should be no delay in finding and responding to a medical emergency. While we cannot be certain that it affected the outcome in this case, such a delay could be crucial in other emergencies. We make the following recommendation:

The Governor should ensure that staff understand the circumstances in which they should call a medical emergency code (in line with Prison Service Instruction 03/2013).

Emergency response

First aid

58. Prison Service Instruction (PSI) 29/2015, First Aid, says that there should be at least one member of staff trained in 'First Aid at Work' and sufficient numbers of staff trained in 'Emergency First Aid at Work' to provide emergency first aid to staff and prisoners at all times of the day and night. It says that the 'First Aid at Work' certification is valid for three years and employers should arrange requalification and retraining before certificates expire. It also says that if the first aider does not retrain or requalify before the expiry date, they are no longer considered competent to act as a first aider in the workplace.

59. The Head of Residence & Safety said that, as healthcare provision at North Sea Camp is not 24 hours, there is always a member of staff on duty who is first aid trained in case of a medical emergency.

60. OSG A said that she did not provide first aid to Mr Judge as she was not trained.

61. SO A, who arrived about three minutes after the OSG, did not provide first aid either. The officer, who arrived two minutes after the SO, cleared Mr Judge's airway and put him in the recovery position with the help of a prisoner.

62. SO A and the officer were both out of date with their first aid training. The SO last attended a first aid course in 2013 and the officer in 2017 when he joined the Prison Service. The Head of Residence & Safety said that the officer should have attended a refresher course in March 2020 but was prevented by the COVID-19 restrictions.

63. We make the following recommendation:

The Governor should ensure that the minimum level of first aid trained staff is adhered to at all times.

Delay in calling an ambulance

64. PSI 3/2013, *Medical Emergency Response Codes*, says that an ambulance must be called immediately when a medical emergency code is called. In this case there was a delay of roughly two minutes before an ambulance was called. Although we cannot say if this affected the outcome for Mr Judge, we know that delay of even a few minutes can make a critical difference in a medical emergency. We recommend:

The Governor should ensure that staff responsible for calling an ambulance understand that they must call an ambulance as soon as an emergency medical code is called.

Transfer to hospital

65. Ambulance records show that paramedic staff requested an air ambulance, but East Midlands Ambulance Service refused the request because the helicopter could not take both Mr Judge and a prison officer.

66. A representative from East Midlands Ambulance Service told the investigator that air ambulances "use certain aviation exemptions when flying, including landing in confined spaces, and also landing at hospital pads, and that these exemptions are not available when 'third parties' who are not directly involved in patient care are in the helicopter". They said that there was no difference in the transfer time in Mr Judge's case because he was taken to a closer hospital for treatment.

67. North Sea Camp is an open prison, accommodating prisoners who are trusted to complete their sentences with minimal supervision. A probation officer at the prison told the investigator that Mr Judge had to be accompanied by a prison officer to all external appointments because she had not yet completed an Offender Supervisor risk assessment. She said that Mr Judge was due to attend a ROTL (Release on Temporary License) board on 24 August to complete this and that ROTL boards are normally scheduled for 11 weeks after a prisoner's arrival at North Sea Camp.

68. While we understand that it made little difference in Mr Judge's case, the non-availability of an air ambulance could be crucial in a future medical emergency. North Sea Camp does not have a Service Level Agreement with East Midlands Ambulance Service.

69. We make the following recommendation:

The Governor should develop a service level agreement with East Midlands Ambulance Service to ensure that prisoners receive equivalent access to urgent care in a medical emergency.

Hot debrief

70. There was no hot debrief on 15 August. SO A said that as Mr Judge had not died that day, he considered that a debrief was not needed. He said that he spoke to OSG A on the day to remind her of the need to use emergency response codes.

71. There was a hot debrief with prison escort officers on 19 August when Mr Judge died in hospital. A second (cold) debrief was held in the prison chaplaincy on 24 August. None of the staff involved in the emergency response were invited to either debrief. We make the following recommendation:

The Governor of North Sea Camp should ensure that all staff involved in a serious incident are invited to a debrief.

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