

**Investigation into the circumstances surrounding the
death of a man
at HMP High Down in May 2008**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

October 2009

This is the report of an investigation into the death of a man at HMP High Down in May 2008. He collapsed in his cell in the early afternoon just before he was due to have a visit from his family. Healthcare staff were called to his cell and cardio pulmonary resuscitation (CPR) was carried out. He was transferred by ambulance, to Epsom General Hospital, where he died shortly afterwards. He was 55 years old.

I extend my sincere condolences to the man's partner, family and friends and apologise for the delay in issuing this report.

HM Coroner for Surrey was informed of the Ombudsman's investigation. A post mortem was undertaken and it was noted that the man died of natural causes, from a heart attack.

The investigation was undertaken by one of my investigators and the report was written by another investigator. A review of the man's healthcare whilst in custody was commissioned from the local Primary Care Trust (PCT). I am grateful to the clinical reviewer and the clinical incident review panel for their report. I would also like to thank the Governor of High Down and his staff for their help and assistance.

I make two recommendations to the Head of Healthcare for a lead clinician to take responsibility for the review of medical conditions. I make one recommendation to the Chief Executive of the local PCT in relation to the response time by the ambulance service. I endorse the clinical review panel's recommendation for an electronic patient record system and the recording of medical entries. Lastly, I acknowledge the good practice of healthcare and prison staff for their prompt and professional response to the man's collapse and commend both High Down and HMP Coldingley for the transfer of Listeners to provide additional support for prisoners.

In this final report the Head of Healthcare has accepted the recommendation, however, the PCT has not yet responded to their recommendation. The man's family have commented on the draft report and they have asked three questions which they would like to be clarified. I have dealt with those comments on page 12.

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

Jane Webb
Deputy Prisons and Probation Ombudsman

October 2009

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SUMMARY

The man was remanded to High Down in July 2006. His first reception health screen document noted his history of diabetes, high blood pressure, asthma, depression and chest pain. He continued his medication and was located to a house block. He was sentenced to 14 years imprisonment at Crown Court in January 2007, for a firearm offence and Grievous Bodily Harm. Following his court appearance he returned to High Down.

In February 2007, the man had minor surgery for a hernia. He was assessed by a hearing specialist in April 2008, when it was noted that he had some hearing loss and was placed on a waiting list for a hearing aid.

In May, the man was preparing for a visit from his family, when he collapsed in his cell after his lunch meal. The alarm was raised by staff at around 3.00pm and a nurse, who was nearby, went to his cell. She saw that he was laying on his bed, he was unconscious, with a weak pulse and his breathing was poor. The nurse was joined by her colleagues and an emergency ambulance was called for at 3.05pm. His blood sugar level was checked and he was placed in the recovery position.

At 3.10pm, the man stopped breathing and cardio pulmonary resuscitation (CPR) was started by healthcare staff. At 3.15pm, healthcare staff asked for the ambulance service to be contacted again. Meanwhile, his family had returned to the visitor centre from the visits hall, after being told by prison staff that he was unwell.

The ambulance arrived at 3.30pm and paramedics took over CPR. The duty governor telephoned the visitor centre manager and asked him to tell the man's family that he was in a serious condition. They were told that they could follow the ambulance as it left the prison to go to the hospital. At 4.10pm he was transferred to hospital. At first his family were told he was being taken to a named hospital, but were contacted en route and told that he was actually going to another hospital.

The man died at 4.43pm in hospital. A governor and family liaison officer went to the hospital at 6.00pm to see his family, but were told that they had already left. The family were visited the next day by the family liaison officer and a colleague.

Two Listeners from Coldingley were escorted to High Down to assist staff and provide support to prisoners following the man's death. (Listeners are prisoners trained by the Samaritans to offer confidential support to other prisoners.)

Wing and healthcare staff acted promptly in response to the man's collapse and carried out resuscitation until the arrival of the paramedics. However, I am concerned that the ambulance took 25 minutes to arrive at High Down and make a recommendation to the local PCT in relation to the matter.

THE INVESTIGATION PROCESS

1. The Ombudsman's terms of reference and notices were sent to High Down shortly after the man's death. There has not been any response to the notices from either staff or prisoners. The investigation into his death was opened by an investigator who reviewed and took copies of his prison and medical files. Members of the Independent Monitoring Board and the Prison Officer's Association have not asked to see my investigators.
2. A clinical incident review panel held a meeting to discuss the medical care afforded to the man. The investigator was present during their discussions.
3. On 10 June 2008, one of my family liaison officers spoke to the man's partner by telephone. This provided an opportunity to explain the purpose of the investigation and to raise any concerns she would like explored by the investigator. His partner was understandably distressed as she had been at the prison visitor's centre waiting to see him on the day that he died. She was unaware of the serious situation developing in the prison for her partner until she was told by the visitor centre manager. His partner told my family liaison officer that she was concerned about the length of time it took the ambulance to arrive at the prison when she was told of the medical emergency. This is a concern I share, and I comment on later in the report.

HMP HIGH DOWN

4. Opened in 1982, HMP High Down was originally a local prison but in 2003 also took on the role of a category B training prison. There are six house blocks (A, B, C, D, E and F), each of which have three levels. The prison serves the Crown courts of Croydon and Guildford as well as the surrounding Magistrates courts.
5. Healthcare at High Down is commissioned by the local PCT and provided by Sussex Community Health Services. Sussex Forensic Medical Services provides the medical cover. There is a healthcare wing with an inpatient capacity of 23 beds in single cell accommodation. In addition to this, a day care facility, a wide range of primary care services are available.
6. The Independent Monitoring Board (IMB) whose members are appointed by the Secretary of State for Justice to independently monitor the delivery of services and the regime at the prison, published their most recent report in 2007. In the report the IMB say that they believed High Down was well run, with "the vast majority of staff committed to providing a secure, fair and decent regime for prisoners".
7. Her Majesty's Chief Inspector of Prisons conducted a full inspection of High Down in May 2006. She said in her report of this inspection,

"High Down, along with all local prisons, is under tremendous pressure as a result of the growth in the prison population. Despite this, the establishment had made considerable strides in a number of areas."

A follow up unannounced inspection took place in 2009.

8. I assumed responsibility for investigating all deaths in prison custody in 2004. There has been one other natural cause death since then and the investigation revealed no similarities to that of the man.

KEY FINDINGS

9. The man was born in London in 1953. He lived with his family in Kent and trained as a bricklayer and house builder. He had previous convictions in his teenage years, but none since 1969. In 2000, he was the victim of abduction and a serious assault which left him with post traumatic stress syndrome.
10. In July 2006, he was remanded to High Down for an alleged offence of GBH. This was his first time in prison. Entries from his personal file note that he was a polite and respectful and was a Listener. His partner spoke proudly about him being a Listener and said it was evident he made a huge impact on the other prisoners judging by the number of condolence cards she received. She told my family liaison officer that he took great pride in the role and got satisfaction in helping and supporting other prisoners.
11. A first reception health screen document noted that he had diabetes, asthma, high blood pressure, chest pain and depression. His medication was reviewed and a prescription chart prepared. He was located to house block 2. On 19 July, the doctor referred him for remedial exercise in the gym, having assessed him for high blood pressure and obesity.
12. An optician examined the man on 14 August and wrote that he should be referred to an ophthalmologist at a hospital for screening for glaucoma and his general eye care due to his diabetes. On 4 October, the doctor referred him to the general surgery clinic at the hospital as he suspected that he had an umbilical hernia. Three weeks later, he was seen at the hospital. Although the hernia was not causing him many problems, it was decided that minor surgery would be beneficial. On 21 November, the man was seen in the ophthalmology clinic. His vision fields were in the normal range and he did not need any further treatment.
13. He was sentenced to 14 years imprisonment at Crown Court in January 2007 and returned to High Down. On 13 February, he went to hospital for day surgery on his hernia and returned to High Down that evening. A nurse saw him on 8 March, as he was complaining of chest pain. On examination the nurse wrote that he was not in respiratory distress or short of breath.
14. The next day, the man was seen by the doctor as he was suffering with dizziness, loss of hearing and ear ache. On examination, the doctor wrote that the cause of the symptoms could be vertigo and medication was prescribed. He next saw the doctor on 24 December when he complained of a cough and an antibiotic was prescribed.
15. A nurse saw the man on 26 February 2008, when he attended a triage clinic saying he was experiencing deafness in both ears. The nurse referred him to an Ear, Nose and Throat (ENT) clinic at a hospital. On 4 April, he was seen by a doctor at a community hospital, ENT Department. The specialist wrote to the prison doctor, saying that the man was suffering from hearing loss and his name had been placed on a waiting list for a hearing aid.

16. The man had no more contact with healthcare staff until May. After the lunchtime meal, he was waiting in his cell to be taken to the visits hall for a visit from his partner, daughters and a friend. At about 2.58pm an alarm was raised by wing staff reporting that he had collapsed in his cell. A nurse was going into the house block at the time and she responded to the shouts for help and went to his cell. She found him lying on his bed with his feet on the floor. The nurse noted that he was unconscious, his breathing was poor and he was cyanosed. (Cyanosis refers to a bluish tint to the colour of the skin, especially around the mouth, indicating lack of oxygen.)
17. As staff knew that the man had diabetes, the nurse checked his blood sugar level which was within normal range. A pulse could be detected, although it was weak, and a blood pressure reading of 149/87 (the normal range for blood pressure is 130/80) was noted. Within three minutes, more healthcare staff arrived and he was placed in the recovery position, on his side with his chin raised in order to keep an airway open. At 3.05pm, the healthcare staff asked the communications room to telephone immediately for an emergency ambulance.
18. A radio call was put out for the doctor to go to the man's cell, and emergency equipment of a defibrillator, oxygen and an airway tube was asked for. At 3.10pm, he stopped breathing and cardio pulmonary resuscitation (CPR) was started by the healthcare staff. A nurse asked again for the estimated time of arrival of the ambulance and a second call was made to the ambulance service at 3.15pm.
19. Meanwhile, the man's visitors had returned to the visitor's centre from the visits hall, as prison staff had told them the visit would not take place as he had experienced "a funny turn". The man's partner was obviously distressed and concerned about her partner's health. The visitor's centre manager received a telephone call from the duty governor who said that the man was very ill and had stopped breathing. The visitor's centre manager gave the information to the man's family, and then sat with them whilst they waited for further news.
20. The emergency ambulance arrived at the man's cell at 3.30pm and the paramedics took over CPR from nursing staff. His partner had seen the ambulance arrive at the prison and the visitor's centre manager told her that he was being taken to hospital. (The duty governor had already told them that the family could follow the ambulance to the hospital.)
21. At 4.10pm, the paramedics transferred the man to the ambulance and he was taken to hospital. The Orderly Officer telephoned the visitor's centre manager straightaway and asked him to explain to the man's partner that he was in a serious condition. The family were advised that they should go to a nearby hospital as soon as possible. The visitor's centre manager told the man's partner this information and she said that the friend would drive to the hospital. En route to the hospital his partner was contacted by telephone to inform her that he had actually been taken to another hospital and so the

family made their way there. The man was taken to the Accident and Emergency Department where his death was confirmed at 4.43pm.

22. The Governor and family liaison officer left High Down at around 6.00pm and made their way to the hospital to see the man's family. They were told that the family had already left the hospital and arrangements were made to visit them the following day.
23. As the man had been a Listener, it was agreed that outside support would be needed for his fellow Listeners at High Down and for other prisoners. Two trained Listeners were escorted that evening from HMP Coldingley to High Down, to provide additional support and assistance to prisoners on the house block.
24. A letter of condolence was sent to the man's partner by the Governor of High Down. Funeral expenses were offered to his family. The prison's family liaison officer attended his funeral and at the same time a memorial service was held in the prison chapel.

ISSUES

Clinical care

25. A review of the man's clinical care was undertaken by the Quality and Clinical Governance Manager for the local PCT, a doctor and a clinical incident review panel.
26. The clinical reviewer reviewed the man's medical records, incident reports from prison and healthcare staff and the post mortem report. He found that his first reception health screen document was completed appropriately with an established history of his medication for his medical conditions. A body mass index was not recorded which would have indicated that he was considered clinically obese. However, he did lose weight within his first six months in prison.
27. Medical records were judged to be generally good with entries dated and signed. Nevertheless, some names were not printed so identifying who had made the entry was difficult. At the time of the man's death, an electronic patient record system was not in operation and the panel thought that implementing an electronic system would provide an auditable trail of staff entries.
28. My investigator made enquires with the healthcare unit at High Down on 16 June 2009, and was told that they are still waiting for an electronic patient document system. However, a system is expected to be implemented within the near future. I therefore endorse the panel's recommendation that an electronic patient record system should be made operational as soon as the infrastructure is in place.
29. The man was seen regularly in the diabetic clinic, had eye tests, blood screening, and offered a weight reduction programme. However, the clinical reviewer noted that it was unclear whether healthcare staff took overall control of his care. He wrote,

“Despite having a past history of chest pain there is no record of an electrocardiograph (ECG).” (An ECG monitors the heart rate.)

The clinical reviewer wrote that aspirin had not been prescribed and there were no proactive moves taken to monitor the medication prescribed for the man's blood pressure and cholesterol levels. He concluded that,

“A lead clinician needs to take responsibility to see that targets of healthcare, such as those used in general practice in the Quality Outcomes Framework, are achieved.”

Procedures should be in place to ensure that a lead clinician takes responsibility of medical conditions and this monitored in line with the Quality Outcomes Framework.

30. The clinical reviewer commented,

”When the man collapsed in May, the standard of care from the officers and healthcare staff appears to have been exemplary. They did an excellent job with their resuscitation attempt until the paramedics arrived.”

There is no record or information in the man’s medical notes to indicate whether a defibrillator was used as part of the resuscitation attempts, although one was taken by healthcare staff in response to the emergency call.

I am pleased to note the prompt and professional conduct of the officers and healthcare staff who attended to him following his collapse.

31. The response time from the ambulance service was noted by the clinical review panel to be below the standard expected. An extract from the Department of Health NHS fact sheet on Ambulance Trusts reads,

“Ambulance services are expected to reach 95 per cent of emergency calls within 19 minutes. Response time starts when details of the telephone number of the caller, the exact location of the incident and the nature of the chief complaint have been ascertained. Response time ends when the emergency response vehicle arrives at the scene of the incident. A response within 19 minutes means 19 minutes 0 seconds or under.”

32. The man’s partner raised this matter when she spoke to the family liaison officer. His partner saw the ambulance arrive after she had left the visits hall to return to the visitor’s centre. She thought that it seemed some time from being told he was unwell until she saw the ambulance arrive.

33. The emergency ambulance was requested at 3.05pm. This time was noted in High Down’s communication occurrence log and again at 3.15pm. The arrival of the ambulance was 25 minutes after the communications rooms first made contact with the service, which is outside the standard expected by the Department of Health. I endorse the panel’s recommendation.

The local PCT should follow up through the contract monitoring process, the ambulance’s timescale in attending to the man’s collapse in May 2008.

Support from the Listeners

34. The Residential Manager and Duty Governor contacted Coldingley prison to ask two Listeners to come to High Down to support the man’s fellow Listeners, other prisoners and staff. The Orderly Officer at Coldingley made the necessary arrangements, including obtaining the agreement of the local Samaritans. This enabled the High Down Listeners to meet together on the evening of his death. This was an example of imaginative good practice.

Conclusion

35. It was a tragic coincidence that the man was taken ill as his partner and family waited in the visiting hall to see him. I doubt whether the earlier arrival of the ambulance would have affected the outcome for him, but it is clear that this should be considered further to prevent future delays.

I commend High Down and Coldingley for working together so effectively on the night of the man's death and will draw my report to the attention of both Governors.

Family response to draft report

36. The man's partner asked my colleague to look at three points for clarification following the draft report.
1. When did lunch end?
 2. Why was his cell not checked until 2:58pm when he had visitors in reception at 2:00pm?
 3. Why did he not have an ECG given his chest pains/history?
37. Lunch is served on house block six from 12.00 – 12.30pm and prisoners eat their meals in their cells. They are then unlocked at around 1.30pm to move to other parts of the prison to take part in the afternoon prison regime.
38. My investigator made contact with the Residential Manager for a response as to why the man was not ready for his visit at 2.00pm.

The Residential Manager sent the following reply:

“I have managed to get a little more confirmation in relation to the man's whereabouts prior to his visit. I have received confirmation that he was attending the forgiveness course that week. The Officer's statement states that he had returned from reception to the house block, so I think he must have gone to reception after the course. I do recall just after the death when collating all information that I was informed that he had been on this course, then gone to reception. I believe he worked in there. Someone informed me that he wanted to return to the house block to change into nicer clothes for his visitors; unfortunately I can only find evidence from a statement that the Officer submitted stating that he returned from reception to the house block for the visit, it does not state anything about the clothes. I have spoken with the Governor from the care team and the FLO and they both recall being informed of this also.”

39. With reference to an ECG procedure. The clinical reviewer noted this to be an issue in his report. A recommendation was accepted by the Head of Healthcare to ensure prisoners with medical conditions are monitored in line with the Quality Outcomes Framework. I am unable to offer any explanation as to why no ECG was offered to the man, but am assured that steps have

been taken to ensure a chronic disease framework will be established so that prisoners identified as needing further medical procedures to manage their illness will receive appropriate medical investigations.

RECOMMENDATIONS

For the Head of Healthcare

1. Procedures should be in place to ensure a lead clinician takes responsibility of medical conditions and this monitored in line with the Quality Outcomes Framework.

Accepted – “We are developing a new patient pathway for chronic diseases based on national guidelines and using QOF. As part of this work a lead clinician will be identified. We are hopeful that during 2009/10 TPP System One will be available at High Down and this will assist us in monitoring follow ups more accurately than we have been able to do with paper based records.”

For the local Primary Care Trust

1. The local PCT follow up through the contract monitoring process, the ambulance’s timescale in attending to the man’s collapse in May 2008.

Waiting for a response from the PCT