Investigation into the circumstances surrounding the death of a prisoner in July 2004 while in the custody of HMP Highdown

Report by the Prisons and Probation Ombudsman for England and Wales

December 2005

This is the report of an investigation into the death of a male prisoner in July 2004 in St Helier Hospital, Carshalton. The man had been found hanging in his room in the Healthcare centre at HMP Highdown on the morning of 2 July. He had been remanded into Highdown on the evening of 28 June.

I would like first of all to add my condolences to the man's family to those already expressed by the investigation team. My family liaison officer has been in contact with them as well. They were most gracious and helpful during what must still be a very difficult time, and I hope this investigation report will answer some of their questions. I know they have been particularly concerned that the man was not on a formal suicide watch and about difficulties in arranging visits to Highdown. I regret that, for reasons beyond my control, this report has been so long in the making.

I commissioned two officers to the investigation, the senior investigating officer was a deputy governor within the Prison Service and he was assisted by an investigating officer from my office. I asked the investigators to look at the circumstances surrounding the man’s death, to gather and analyse the evidence, conduct interviews and audit policies and procedures and to make known their findings and recommendations. I had myself visited Highdown in the immediate aftermath of the man’s death. My contemporaneous note suggests that on the day he was received, Highdown had received 50 prisoners. The man was the very last to be booked in.

The work of the investigation was considerably assisted by the goodwill of the then Governor and I am most grateful to her. I also appreciate efforts of the East Elmbridge and Mid Surrey Primary Care Trust who were commissioned to prepare a clinical review of the healthcare received by the man whilst he was at the prison. The actions of the doctor who attended to the man, who is a locum at Highdown, have been referred to the General Medical Council.

It is increasingly appreciated that prisoners are at enhanced risk of self-harm whilst detoxifying from illicit drugs. The sad story related in this report illustrates that withdrawal from alcohol can be no less dangerous. My report contains ten recommendations.

Stephen Shaw CBE
Prisons and Probation Ombudsman
December 2005

Summary

Following an incident at the home of his estranged wife, the man was charged with criminal damage and taken to Crawley Magistrates' Court. He was placed in the custody of Premier Custody Services and interviewed by a Community Psychiatric Nurse (CPN). The CPN was sufficiently concerned about the man's mental health that a court form warning of the risk of suicide or self harm was opened. He had a long-standing history of misusing alcohol and was experiencing withdrawal symptoms. He was remanded in custody and taken to HMP Highdown.

The court warning form raised sufficient concerns about the man's state of mind that the Prison Service's equivalent procedure, the F2052SH, should have been opened as a priority when he arrived at reception. This was not done, as there appears to have been an unwritten rule at reception that only healthcare staff could open the F2052SH form.

Relevant records were not available for healthcare staff in reception before they carried out their interview with the man. Important information, including the court's self-harm warning form, was left in a tray for collection by healthcare staff, but was only noticed after he had been interviewed and gone to the healthcare centre. He not only had a very recent history of self-harm but had on numerous occasions raised these concerns.

Because of the physical symptoms of alcohol detoxification, and his heart condition, the man was located in the healthcare centre and placed in a gated cell, to allow a greater level of observation. However, he was removed that cell because he was climbing the gate and there was a risk of injury. The decision to relocate the man may have been appropriate, but should have been accompanied by a minimum of four observations by staff each hour until the medical officer was able to review him.

The man remained in the healthcare centre and it seems that the detoxification symptoms lessened and he began to sleep well. There were concerns about his fluid levels, which were to be monitored, but 24 hours elapsed before the instruction was implemented. He was assessed by the locum prison doctor and by the prison's psychiatrist and was prescribed medication to relieve his symptoms. However, after four days as an in-patient, at 10:12am on 2 July, he was found hanging from a ligature in his cell.

It is clear that the staff who responded were extremely committed to reviving the man but were working in difficult conditions. His bed was fixed to the floor and the space between it and the wall was restricted. A period of time passed before the ligature could be cut down, as staff had to go to another part of the centre to get the cut down box. The electrical supply to the healthcare centre

was also inadequate in that there were no sockets in the cells or corridors. An extension lead had to be located before electrical equipment could be used.

Finally, there appears to have been some friction between staff at the prison and those in the outside hospital where the man was taken, and several hours passed before the prison was informed of his death.

Conduct of the investigation

The investigation was led by a deputy Governor of the Prison Service, who was appointed under the transitional arrangements between the Prisons and Probation Ombudsman and the Prison Service. He was assisted by an investigator from the Ombudsman's office. The Governor of Highdown made the prison and healthcare records available to the investigation team. Notices of the investigation were issued to staff and prisoners to inform them of the investigation.

Prison and healthcare staff were interviewed by the investigators. A clinical review was commissioned from the Primary Care Trust.

On my own visit to Highdown, I met a member of the Independent Monitoring Board, the chair of the local branch of the Prison Officers' Association, the Head of the prison's Care Team, and the Suicide Prevention Co-ordinator. I also drew upon the IMB's Annual Report for important background information. I have found especially valuable the IMB's comments on the number of prisoners arriving at Highdown with "drug and alcohol problems", on the demands on reception staff, first night arrangements, and the difficulties visitors face in baking telephone bookings.

A family liaison officer was appointed and she was in contact with the family and the investigation team. At an early stage of the investigation, I also spoke with the man's parents.

HMP Highdown

Highdown is a local prison, for category B status prisoners, which was completed in May 1992. It has four house blocks with a mixture of single, double and treble occupancy cells, a segregation unit, and healthcare centre, with 29 in patient beds.

The most recent report from HM Chief Inspector of Prisons, dated February 2004, said that there had been improvements in some important areas; suicide and self-harm procedures, healthcare and resettlement particularly showed progress. The suicide and self -harm procedures were identified as good practice, but there were other deficits to be addressed - including support in the early days of custody, with reception, first night and detoxification all requiring improvement.

In general, the Inspectorate considered that Highdown appeared to be orderly, relationships between prisoners and staff were cordial, and many prisoners stated that most staff would help them if they had problems. The Inspectorate noted that there had been improvements in the provision of healthcare.

Key Findings

28 June 2004

The man was held in police custody from Saturday 26 June until Monday 28 June when he was taken to Crawley Magistrates' Court. Whilst at court, he was regularly monitored by staff. He had a legal visit for about 20 minutes and was offered lunch and a hot drink and lunch, but refused.

Later in the afternoon, at 4:12pm he was interviewed by a community psychiatric nurse, (CPN), for just over 30 minutes. The nurse noted that the man had a severe alcohol problem, and was drinking between one and two bottles of spirits per day. He believed that the man was suffering from an alcohol-induced psychosis. The man was convinced that other prisoners and the custody officers wanted to kill him. He told the nurse that he could hear people talking and plotting about him although no voices were audible to anyone else. The nurse also noted that the man had a pronounced tremor.

At about 5:15pm, the man was taken before the magistrates. He was refused bail and committed for sentence at Lewes Crown Court on a date to be fixed. He was remanded in custody and later taken to Highdown prison.

Whilst at court, the Senior Custody Officer (SCO) opened a suicide/self-harm warning form, stating that the man demonstrated "really bizarre behaviour, stated in court he poured petrol over himself". In interview, the SCO said that he remembered having enough concern about the man that he opened the self-harm warning form. He stated that he would have opened a F2052SH except that those forms were no longer in use at the court.

The man arrived at Highdown prison at 7:05pm and an officer on the desk began the reception processes. The officer spent a good deal of time with the man. He had read the self-harm warning form from the court and completed a cell sharing risk assessment where he stated that the man felt suicidal. He followed the routine in reception and left the record in a yellow box for healthcare staff to collect. The man then continued through the reception process and was searched and his property recorded.

A reception officer interviewed the man as part of the first night process. He completed the prison's induction booklet, recording that the man admitted to a drink problem and said that he had harmed himself about five years earlier. The reception officer had no other information to support these statements and did not have all the available paperwork, such as F2052SH forms, the warrant, Prisoner Escort Record (PER) forms or core record before he commenced the interview.

Neither the desk officer nor the reception officer commenced F2052SH procedures and there appeared to be an unwritten rule amongst staff that only healthcare staff can open them. This is contrary to the prison's Suicide

Prevention document, which states that all members of staff have clear responsibilities and any member of staff can raise an F2052SH form. It goes on to state that there is no discretion, and if a member of staff believes a prisoner to be at risk, if threats to self-harm have been made or an actual incident has taken place, then the F2052SH must be opened. The document specifically refers to reception and first night in prison staff who are required to talk to the prisoner and escort to ascertain whether the risk is current or historical, and must be prepared to initiate the F2052SH procedures themselves if necessary.

Reception officers had not had received up to date training in suicide and self-harm procedures and were confused about who should complete the F2052SH form. They also needed training to complete the cell sharing risk assessments correctly. The form completed for the man has been ticked to show that there was an open F2052SH as the officer had incorrectly assumed that the court warning form was its equivalent.

A Healthcare nurse completed the first reception health screen and then saw the man. During the interview, the nurse noted that he suffered from depression and had covered himself in petrol on 26 June. In the nurse's opinion, the man's behaviour was "bizarre and agitated" and he was referred to the doctor because of his physical health and at his own request.

The prison medical officer on duty that evening interviewed the man, and remembered that he referred to photographs of his children. The doctor recalled having a sensible conversation with him despite the problems resulting from alcohol detoxification. The doctor has a good deal of experience as a prison medical officer. In interview with the investigators, he was unable to say whether he saw the self-harm warning form or not, but did state that if he had seen it he would normally have signed it.

The man was placed in the healthcare centre and located in a gated cell to enable increased observation. His first contact was with an officer on duty in healthcare, who was designated to carry out night duty but was not a permanent member of the healthcare staff.

This officer told the investigators that the man arrived in the healthcare at about 8:50pm. She had been told that he was withdrawing from alcohol. During the rest of the night he could not sleep, and she remembered making him about ten cups of coffee and having long conversations with him. She remembered him being polite, and asking her to call him by his first name. He spoke about his two daughters and told her about setting fire to the car. He also spoke about a photograph of him and his two daughters which he was concerned about and asked the officer for her opinion. She said that she was not there to judge him and said that if he was concerned he should speak to his solicitor.

29 June 2004

The following morning, a nurse on duty in healthcare noted that the man had

settled well into the regime of the unit but that he said that people wanted to kill him. She attributed this to alcohol induced psychosis.

Later in the morning, the prison's psychiatrist interviewed the man. They spoke at some length regarding the offence, his children and how remorseful he was. The psychiatrist noted that the man had a happy childhood and a good education. He also said that he and his wife had been separated for about seven months, but had previously been together for about ten years. He told the doctor about his heart condition and said he had a check up about 12 months ago, but kept missing his hospital appointments.

The psychiatrist noted that the man felt sad and discouraged about the future, he felt he had failed and felt guilty and disappointed in himself. Again he mentioned photographs of his children. She also recorded that he was experiencing alcoholic hallucinosis - visual and auditory hallucinations - saying that people were chatting outside and calling him a paedophile. It was noted that the man should be observed every 15 minutes. The psychiatrist has stated that she was not concerned about his mental state and that the man was placed on this level of observations because of his physical condition. Although she placed the man on a 15 minute watch, there are no records to support this or to communicate to other professionals caring for the man.

Later that day, the man was assessed by a locum Doctor, who noted his heart condition and the detoxification regime. He recorded that the man should increase his fluid intake and that he would refer him to a cardiac clinic because of his heart condition.

During the evening and night, the man continued to have visual and auditory hallucinations. He thought that his cell was flooded; he tried to unlock the gate and stated that he could hear his wife speaking on the telephone. He attempted to break the sink in the cell.

The officer in healthcare from the previous evening was on duty again that night and spoke to the man. She said that she was not concerned about him deliberately harming himself during the night, but was concerned because he was climbing on the bars of the gated cell and was concerned that he might fall and hurt himself. His hallucinations became worse during the night and the officer stated that he did not really speak to her but spoke more to himself. The night orderly officer was called and the man was moved to a room with a solid door and the officer said that he fell asleep within ten minutes of moving cells, which she felt was what he needed. Before the officer was about to leave the centre, she asked the man if he was all right and he thanked her and replied that he did not feel bad and had slept better than before.

30 June 2004

It was noted in the man's medical record that he continued to have visual and auditory hallucinations and he was seen by the medical officer in the morning and prescribed five milligrams of diazepam. He was still dehydrated and it

was decided that there should be an hourly record of his fluid intake, which was recorded on his inmate medical record. Healthcare staff said that the man had been out of his cell during the day, and had visited the association room where there was a television and reading materials.

It appears that the man went to sleep at about 11:30pm that night. In interview with the investigators, the officer, in healthcare, did not remember any further conversations with him that night as she believed that he was asleep. She said that she was not instructed to carry out any form of regular observations on him.
There appear to be two separate handover arrangements for night staff in the healthcare centre, one for healthcare staff and another for officers. This arrangement might mean that vital information was not passed on. There should be one general handover, with medical in confidence matters being dealt with separately.

1 July 2004

The man was woken by the nursing staff in the morning so that he could be seen again by the psychiatrist. The doctor noted that the man had breakfast but was still not drinking enough fluids. She said that he smiled during the interview and even cracked a joke. She encouraged his intake of fluids and increased the prescription of diazepam to ten milligrams.

At about 11:40am, healthcare staff saw the man again. The fluid and diet chart was commenced, a day after it was initially requested.

Later that morning or during the early afternoon, the man's mother telephoned (a fact of which he was informed). He gave his consent to his mother being contacted. New prisoners who are located in the healthcare centre should be assessed to identify whether they need help with arrangements such as completing PIN phone applications and visiting orders. The man was described as experiencing visual and auditory hallucinations, being confused and with bizarre behaviour. It is likely that assistance to expedite phone and visits contact would have been helpful to him.

At about 2:50pm, it was noted that there was a gradual improvement in the man's condition. He was moved to room number one, had a bath, ate his meals, took his medication and associated with the other patients. The medical record indicates that the man slept well that night.

2 July 2004

The prison was on a full lockdown (all prisoners locked in their cells) following allegations about a breach of security. Searches were being carried out at various locations around the prison and staff were instructed that prisoners must remain in their cells.

The man was due to participate in the prison induction programme that morning, as was customary for prisoners in the healthcare centre. The

induction would have informed him of all aspects of the prison routine including making telephone calls, visits, letters and making purchases at the canteen, and the role of the Listeners (prisoners trained by the Samaritans).

The first entry in his medical record for the day was at 10:12am. It read, “Saw inmate hanging – CPR started and ambulance ordered.”
Two Staff nurse’s entered the cell and state that they cut the ligature, administered oxygen and a healthcare officer took over cardio pulmonary resuscitation (CPR). In interviews, staff said that the man was in a confined space between a bed fixed to the floor and the wall and that it was difficult for them to work on him.

About three minutes later, at approximately 10:15am, the prison doctor received a call on code 1 alert to go to the inpatients area of the healthcare centre. She made her way from her office on the first floor to the ground floor and was unaware at the time exactly what the emergency was. She said that she did not hurry in response as she thought that the locum doctor was already in that part of the centre. However, on her arrival she found that the locum doctor was not present and so she took control. She checked for signs of a pulse and respiration, but found neither. In interview, she remembered three staff already working on the man and that a nurse got the defibrillator out on the bed. An ambulance was called at 10:20am.

The electrical system in the healthcare centre is out of date as there is no supply in the cells or corridors. The staff who attended to the man had to find an extension lead in order to use emergency medical equipment.

The defibrillator was an automatic external defibrillator, which advises the user of the course of action to be taken. The reading was that a shock should not be given and so the prison doctor decided that she needed to get venous access. Because the man was in a very tight location, she decided to move him to the other side of the bed and so they slid him under the bed. Once he was repositioned they continued to administer oxygen. The defibrillator was still attached and it then read “Keep clear”. The prison doctor managed to administer drugs to him and after about ten or fifteen minutes, his pulse returned and so the cardiac massage was discontinued but respirations carried on. At 10:45am the paramedics arrived and took over attending to the man.

The gate book records that the ambulance arrived at 10:35am and left for St Helier Hospital shortly afterwards at 11:04 hours. Both an air and road ambulance arrived at the prison. The air ambulance was kept waiting for 15 minutes for permission to land and it appears that prison staff were unclear about giving permission and also where it should land. The man remained in the care of the hospital intensive care unit until 7 July when he passed away at about 7:00pm. Initially, he was restrained but the restraints were later removed.
Bed watch officers were present at his bedside, but at the request of his wife and parents, they withdrew to another room. The prison liaison officer, considered that prison staff must remain to give support when necessary but

they were told to keep a low profile, and did so as far as possible.

No consideration was given to granting early release from custody, despite the wishes of the man's parents and wife who were concerned about the presence of prison staff in the hospital.

Although prison staff remained at the hospital they were not informed of the man's death until 4:50am on 8 July, some nine hours after it took place. Letters of condolence were sent to the family but very unfortunately the letter sent to the man's wife referred to the loss of her son. Although two separate letters were written, a clerical error meant that duplicate letters were sent. Errors of this kind can happen in the best organised office, but it hardly needs stating that the Prison Service must take extra care over letters to bereaved relatives.

Other issues considered by the investigators

There is some confusion about the locum doctor and the timing of the incident. He has said that he entered the cell at the same time as the two Staff nurses, but they do not mention this in their statements. He also said that he was working on the man for twenty to twenty five minutes before the prison doctor arrived. The locum Dr was only mentioned as present on one statement, although he himself said that he cut the ligature, which the two Staff nurses say that they did themselves. The locum Dr states that he went into the cell at the same time as the nurses, but their statements do not support this. The locum doctor states that he worked on the man for 20 to 25 minutes before the prison doctor arrived, but this is not consistent with other reports of the timings of the incident. I am aware of investigations by Surrey Police into these matters.

Further discrepancies arose during the interview with the locum doctor for this investigation. He had prepared a written statement, which he read to the tape, and this included the following discrepancies: On page four of his statement he stated that "doctor said because there is no space around here to put that trolley we will push that bed and pull the patient out". However, in the same paragraph he stated "Now this is after 20 to 25 minutes have passed at this time, at this moment I requested staff to send for doctor ….. because doctor … is upstairs doing sick parade"

He stated that he was working on the man for 20 to 25 minutes before the prison doctor arrived, but also that he was not in the room at the time the prison doctor arrived because he was in the office making sure the ambulance was allowed in.

During a routine visit by the investigator to Highdown it was mentioned that two nurses, nurses, who worked for a nursing agency, had made statements about the locum doctor's actions on 2 July. These nurses had been working elsewhere in the healthcare centre when the man harmed himself. Neither the investigator nor the prison liaison officer had previously been aware of these statements and copies were obtained. The statements raised sufficient concern for the matter to be referred to Surrey Police, who after investigation

referred the matter to the Crown Prosecution Service (CPS). The CPS concluded that there was insufficient evidence to pursue criminal proceedings against the locum doctor. The case was referred by the PPO to the General Medical Council (GMC) for their consideration.

The Fitness to Practice Panel of the GMC considered the locum doctor's case in January 2009. In February 2009, the Panel found that his fitness to practice was impaired and determined that his name should be erased from the Medical Register. Although he subsequently appealed, the appeal was then withdrawn and the locum doctor's name was erased from 4 November 2009.

Conclusions

It is apparent that the man experienced symptoms of withdrawal following a protracted period of alcohol abuse. At the time of the alleged offence against his wife and her property, he had drunk a substantial amount of alcohol. Together with the medication he was taking, this must have contributed to what is described by his family as behaviour that was out of character. It was his first offence of any kind and he was described as a kind and thoughtful man with a strong and caring relationship with his family. There is no evidence to suggest that he had been responsible for inappropriate behaviour with his children, or that his life was in danger. It would appear that at the time of making the remarks he was withdrawing from alcohol and suffering auditory and visual hallucinations.
The Community Psychiatric nurse interviewed the man at court and confirmed the extent of his alcohol problem and the effects of the early stages of detoxification. Auditory and visual hallucinations had already begun whilst he was there. Court staff recognised the risk and appropriately completed a self-harm warning form, which highlighted that he had poured petrol over himself after setting fire to his wife's car.

The court's suicide warning procedures should have been succeeded by the prison's own self-harm procedures, F2052SH, which should have been opened at reception at Highdown. There were several missed opportunities throughout his stay at Highdown when a F2052SH should have been opened and the prison's protocol was not followed. Subsequently, the man was moved from a gated cell, without either a medical officer's review of the decision or regular recorded checks on his condition. This added to the risks that were already present.

The man was located in healthcare for five days, in the course of which there were deficiencies in the care and treatment of his detoxification symptoms. He was dehydrated and there were delays in monitoring his fluid intake. After he was discovered hanging, staff responded well despite the constraints of space and the absence of electrical sockets. The healthcare staff should be praised for their valiant efforts to revive the man. The prison doctor took charge of the incident and through the strenuous efforts of her and the team his breathing and circulation were restored.

Recommendations

Once a suicide self-harm warning form has been completed at court, the First night in prison officer, the senior officer in reception and doctor should review the information and consider whether to open the prison's suicide and self harm procedures.

Reception staff should be reminded that all staff are responsible for opening these procedures if a prisoner indicates that he will harm himself. They should be trained appropriately in suicide and self harm awareness.

All prisoners placed in a gated cell must be checked regularly and, if they are moved during patrol state, the medical officer should review the situation at the earliest opportunity. Prisoners removed from gated cells without the medical officer's authorisation should be placed on a frequent watch.

All staff in the healthcare centre should take part in a general handover report, and a separate handover for nursing staff should only refer to medical in confidence matters.

Newly received prisoners who are located in the Healthcare department should be allowed a reception phone call, should be helped to complete a Pin Phone application and an application for a visiting order. They should also have access to a television and radio.

Rooms in the healthcare centre should be appropriately equipped. They should have electricity sockets and fixed beds should be positioned to allow ready access by staff.

The Governor should consider issuing fish knives to all staff as an immediate aid to cutting ligatures.

The prison's contingency plans should be revised to include the arrangements for an air ambulance.

The Governor should remind senior colleagues of the need to give timely consideration to the release on temporary licence for prisoners who are critically or terminally ill in hospital.

A memorandum of understanding should be drafted between Highdown and the local hospitals, which should include a protocol for staff on bed watches and for hospital staff to identify their respective roles and responsibilities.