Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthon van der Hoven, a prisoner at HMP Exeter, on 8 June 2019

A report by the Prisons and Probation Ombudsman

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

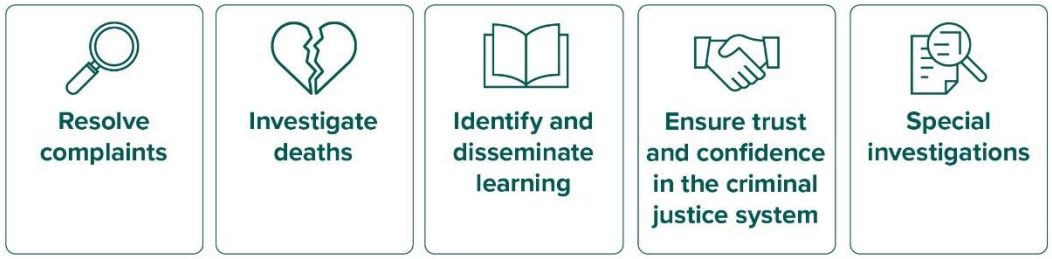
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

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 Anthon van der Hoven died on 8 June 2019 from the consequences of chronic alcohol misuse with sudden cessation of alcohol consumption at HMP Exeter. He was 51 years old. I offer my condolences to Mr van der Hoven's family and friends.

Mr van der Hoven had been recalled to Exeter the day before his death. He had a long history of substance misuse and regularly consumed large amounts of alcohol in the community. The clinical reviewer found that he received an appropriate standard of clinical and substance misuse care at Exeter which was equivalent to that which he could have expected to receive in the community.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman **January 2022**

Contents

Summary

Events

1. Mr Anthon van der Hoven was recalled to HMP Exeter on 7 June 2019 for breaching the conditions of his licence.

2. Mr van der Hoven used illicit substances and consumed large amounts of alcohol on a daily basis in the community. When he arrived at Exeter, he started an alcohol detoxification programme and was referred to the prison's substance misuse team. A prison GP prescribed him methadone (heroin replacement medication) and medication to reduce the symptoms of alcohol withdrawal. Nurses monitored him during the night.

3. On 8 May, a substance misuse nurse completed a full assessment and a prison GP prescribed Mr van der Hoven the same methadone dose that he received in the community. At approximately 2.00pm, a prison officer took Mr van der Hoven to receive his methadone and said that he looked unwell. A nurse saw him at about 2.24pm and another nurse saw him at about 2.44pm, and neither noted any particular concerns about his presentation.

4. At 6.55pm, a prison officer completed a roll check and saw Mr van der Hoven on his mattress on his cell floor. Mr van der Hoven was unresponsive and the prison officer radioed a medical emergency code. Another prison officer and two prison nurses attended and started cardiopulmonary resuscitation (CPR). Paramedics arrived at approximately 7.04pm and pronounced Mr van der Hoven dead at 7.38pm.

5. The post-mortem concluded that Mr van der Hoven had died from the consequences of chronic alcohol misuse with sudden cessation of alcohol consumption.

Findings

6. The clinical reviewer concluded that Mr van der Hoven received a good standard of clinical and substance misuse care at Exeter that was equivalent to that which he could have expected to receive in the community.

7. When he arrived at Exeter, Mr van der Hoven started an appropriate alcohol detoxification programme and he was prescribed medication to help with the symptoms of withdrawal. The substance misuse team completed a full assessment, and he was prescribed the same dose of methadone that he was receiving in the community.

8. We are satisfied that the clinical staff who attempted to resuscitate Mr van der Hoven attended the hot debrief and significant incident review and were given the opportunity to access support.

Recommendations

9. We have made no recommendations.

The Investigation Process

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

11. The investigator obtained copies of relevant extracts from Mr van der Hoven's prison and medical records.

12. NHS England commissioned a clinical reviewer to review Mr van der Hoven's clinical care at the prison.

13. Our investigation was delayed while we waited for the cause of death and the final clinical review.

14. We informed HM Coroner for Exeter and Greater Devon of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

15. We wrote to Mr van der Hoven's nominated next of kin, his ex-wife, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr van der Hoven's ex-wife asked about the substance misuse and clinical care he received in prison, in particular how his alcohol withdrawal was managed. She also asked why he was not located in the prison's healthcare unit. We have addressed her questions in this report.

16. Mr van der Hoven's family received a copy of the initial report. The solicitor representing his wife wrote to us pointing out some factual inaccuracies and omissions. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

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

Background Information

HMP Exeter

18. HMP Exeter holds up to 561 adult men and young offenders, and serves the courts of Devon, Cornwall and Somerset. Care UK provides primary health services and Devon Partnership NHS Trust provide mental health care.

HM Inspectorate of Prisons (HMIP)

19. The most recent full inspection of HMP Exeter was in May 2018. Inspectors found that there had been a failure to address the issues of violence, drugs and the lack of a sufficiently purposeful regime, and rated the prison 'poor' in terms of safety.

20. However, Inspectors reported that partnership working between the health providers and the prison and commissioners was good. GP services were good and very effectively led by the lead GP. Prisoners said that the overall quality of health services was good, and inspectors observed satisfactory interactions between health care staff and prisoners.

21. The integrated substance misuse team was well led and provided good support, and partnership working with the prison was good. New arrivals who needed clinical support for substance misuse were identified promptly and referred for first night prescribing. There was consistent daytime and night-time monitoring. regardless of location, and recording was excellent. Specialist nurses completed assessments promptly and made regular reviews.

22. Following the inspection HM Chief Inspector of Prisons invoked the Urgent Notification Protocol and wrote to the Justice Secretary setting out his significant concerns about safety at the prison. However, he reported that health services at the prison had improved and were mostly good.

23. HMIP then carried out an Independent Review of Progress in April 2019 to look at the progress made in implementing their key recommendations from the 2018 inspection. This did not look at healthcare as HMIP had not found significant concerns. They reported that there had not been a sufficient sense of urgency in the prison's response to a number of key recommendations. Nevertheless, there had been a proactive response to some recommendations in critical areas and there were credible plans to make further improvements in the future.

Independent Monitoring Board

24. 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 2019, the IMB reported that they were satisfied that services provided by Care UK were comparable with community provision. Prisoners were largely satisfied with the services provided.

Previous deaths at HMP Exeter

25. Mr van der Hoven was the 14th prisoner to die at Exeter since June 2017. Of the previous deaths, six were self-inflicted deaths and seven were from natural causes.

26. Since Mr van der Hoven's death, there have been four more self-inflicted deaths at Exeter and five deaths from natural causes.

Key Events

27. On 22 March 2016, Mr Anthon van der Hoven was remanded to HMP Exeter. On 19 April, he was sentenced to five years in prison for attempted robbery. He moved to HMP Maidstone on 31 May and was released on licence on 21 September 2018. He was recalled to Exeter on 7 June 2019 for breaching his licence conditions.

28. A prison nurse completed Mr van der Hoven's initial reception screen when he arrived at Exeter. Mr van der Hoven had a long history of using illicit substances (heroin, crack cocaine and benzodiazepines) and said he was consuming large volumes of alcohol every day. He said he had previously received support from the substance misuse team at Maidstone and had completed methadone reduction therapy there.

29. Mr van der Hoven also had a history of hypertension and post-traumatic stress disorder. He said he had suffered a fit on a least one previous occasion when he was sober, which was possibly related to alcohol withdrawal.

30. Prison nurses contacted Mr van der Hoven's community pharmacist who confirmed that he was prescribed 70mls of methadone (heroin replacement medication) a day.

31. A prison GP assessed Mr van der Hoven and noted that he was sweating, trembling and yawning. The GP noted that these were signs of alcohol withdrawal and prescribed medication to reduce his symptoms. Mr van der Hoven's urine tested positive for methadone and benzodiazepines (sedatives) and he was referred to the prison's substance misuse team.

32. A prison doctor assessed Mr van der Hoven as suitable for a normal location wing and he was allocated a single cell on the first night induction unit. Prison nurses checked Mr van der Hoven three times during the night and did not note any concerns.

Events of 8 June

33. On the morning of 8 June, Mr van der Hoven was seen by his prison Offender Manager, who explained the licence recall process, by an officer, who completed his induction, and by the prison chaplaincy team, who recorded that Mr van der Hoven was in bed, awake and that he confirmed that he wished to attend chapel.

34. At 9.45am, nurses gave Mr van der Hoven 20mls of methadone.

35. At 12.00pm, a substance misuse nurse assessed Mr van der Hoven and noted that he had received 20mls of methadone that morning. Mr van der Hoven said he felt uncomfortable and weak. The nurse noted that Mr van der Hoven was displaying moderate tremors and appeared mildly anxious. He was not sweating, was walking normally and he was able to maintain eye contact. Mr van der Hoven was prescribed 70mls of methadone in the community and the substance misuse nurse noted that he would continue to receive the same dose. Nurses gave Mr van der Hoven 35mg of chlordiazepoxide (for alcohol withdrawal).

36. At 1.30pm, a prison GP agreed to continue to prescribe Mr van der Hoven 70mls of methadone and noted that he was not displaying any signs of intoxication or over-sedation that morning.

37. At approximately 2.00pm, an officer went to Mr van der Hoven's cell to take him to receive his methadone from the medication hatch. At the prison's hot debrief after Mr van der Hoven's death, it was noted that the officer said that Mr van der Hoven was having trouble speaking, was sweating and was struggling to walk. (We were not able to interview the officer about this, as he left the Prison Service shortly after Mr van der Hoven's death, and he did not respond to our requests for an interview.)

38. At 2.24pm, a nurse gave Mr van der Hoven 40mls of methadone and did not note any concerns about his presentation.

39. At 2.44pm, a nurse gave Mr van der Hoven an intramuscular injection to reduce the muscle cramps associated with alcohol withdrawal.

40. At 4.51pm, a nurse gave Mr van der Hoven 35mg of chlordiazepoxide.

41. At 6.55pm, an officer completed a roll check and saw Mr van der Hoven on his mattress on the cell floor. As the officer could not get a response from Mr van der Hoven, he entered the cell and radioed an emergency code blue (which indicates that a prisoner is unconscious or not breathing) and the control room called an ambulance.

42. A Senior Officer (SO) immediately went to Mr van der Hoven's cell and assisted the officer with cardiopulmonary resuscitation (CPR). A nurse arrived at 6.57pm and noted that Mr van der Hoven was unresponsive and felt cold. Another nurse arrived shortly afterwards. A defibrillator did not detect a shockable rhythm and staff continued with CPR. Paramedics arrived at 7.04pm and took control of Mr van der Hoven's care. An air ambulance arrived at 7.19pm. At 7.38pm, paramedics recorded that Mr van der Hoven had died.

Contact with Mr van der Hoven's family

43. The prison appointed a family liaison officer (FLO) and identified Mr van der Hoven's ex-wife as his next of kin. The prison told us that at approximately 10.00pm, the duty governor arrived at Mr van der Hoven's ex-wife's address and broke the news of his death.

44. Mr van der Hoven's wife told us that she received a missed telephone call at 10pm which may have been from the prison. She said that at 4am on 9 June, police officers visited her and broke the news of his death.

45. The prison contributed to the cost of Mr van der Hoven's funeral in line with national guidance.

Support for prisoners and staff

46. After Mr van der Hoven's death, a prison manager 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.

47. The prison posted notices informing other prisoners of Mr van der Hoven'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 van der Hoven's death.

Post-mortem report

48. The toxicology report showed the presence of Mr van der Hoven's prescribed medications (mirtazapine, chlordiazepoxide, diazepam and methadone) all at low concentrations. The level of methadone was within the range documented as appropriate for methadone maintenance programmes and was not an excessive dose.

49. The post-mortem examination found that the cause of death was the consequences of chronic alcohol misuse with sudden cessation of alcohol consumption.

50. The pathologist noted that Mr van der Hoven was prescribed chlordiazepoxide in order to reduce the risk that he would develop significant alcohol withdrawal syndrome. He said that Individuals who regularly drink to excess are at risk of sudden death due to a cardiac arrhythmia (irregular heartbeat). In addition, Mr van der Hoven had an enlarged heart (one cause of which can be chronic excessive alcohol consumption) and there is a risk of arrhythmic death in individuals with an enlarged heart.

Findings

Clinical and substance misuse care

51. The clinical reviewer concluded that the clinical and substance misuse care Mr van der Hoven received at HMP Exeter was equivalent to, if not better than, that which he could have expected to receive in the community. The clinical reviewer found that healthcare staff delivered a comprehensive approach to Mr van der Hoven's clinical and substance misuse care.

52. When Mr van der Hoven arrived at Exeter, he was appropriately assessed, and healthcare staff implemented a standard alcohol detoxification programme. Prison GPs prescribed Mr van der Hoven medication to alleviate the symptoms of alcohol withdrawal and nurses monitored Mr van der Hoven during the night.

53. Mr van der Hoven was appropriately referred to the substance misuse service who completed a formal assessment. Prison GPs continued to prescribe methadone at the same dose he received in the community.

54. We were not able to interview the prison officer who apparently said that Mr van der Hoven was unwell when he took him to the medication hatch at about 2.00pm to receive his methadone on the afternoon of his death. However, Mr van der Hoven was detoxing and would therefore have felt unwell. We note that the nurses who saw him at about 2.24pm and 2.44pm did not record any concerns about him.

Staff debrief

55. The clinical reviewer was concerned that there no reference of a staff debrief taking place following a distressing situation such as failed resuscitation. The Regional Governance Manager for HMP Exeter told us that following a death in custody, clinical staff involved in the emergency response attend the prison's hot debrief and the significant incident review. Staff are offered support and any immediate learning is identified. We are satisfied that the clinical staff who attempted to resuscitate Mr van der Hoven attended the hot debrief and significant incident review and were given the opportunity to access support. We do not make a recommendation about this issue.

Inquest

56. The inquest, heard on 9 May 2023, concluded that Mr van der Hoven died from natural causes.

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