

The death of a man in hospital on 20 April 2004

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

April 2005

Foreword

This is a report of an inquiry into the circumstances of the death of a man in hospital on 20 April 2004 whilst a serving prisoner at HMP Holme House.

All deaths of prisoners in custody are investigated, including those due to natural causes. The responsibility for carrying out these investigations traditionally fell to the Prison Service itself, but has now been passed to the Prisons and Probation Ombudsman (PPO) to bring independence and greater consistency to the task. In this case an investigator from the Prisons and Probation Ombudsman's staff carried out the investigation.

This investigation is into the death of a man who died in hospital following a brain haemorrhage. The man was serving a 4-month prison sentence at HMP Holme House at the time of his death.

My colleagues and I would like to extend our condolences to the man's family for their loss. We would also like to thank the Governor of HMP Holme House, and the other members of his staff who assisted us for their help. We found staff generally helpful. In particular, all the documentation we might require had already been gathered together for us.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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The man died in hospital in the early hours of 20 April 2004. At the time he was serving a sentence of 4 months imprisonment which had been imposed on 15 April 2004 but he was granted Release on Temporary Licence on 19 April after a risk assessment had been conducted at HMP Holme House.

The man was received at HMP Holme House on 31 March 2004. He was held on remand for one day then on 1 April he was convicted of 2 charges of breach of an Anti Social Behaviour Order and one count of being drunk and disorderly. He was sentenced to 4 months imprisonment at Guisborough Magistrates Court a fortnight later. The Pre-sentence report written for the magistrates on 14 April stated that he had a long history of alcohol misuse, which had escalated over the years.

My investigator visited HMP Holme House on 11 May 2004 and had detailed discussions about the circumstances of the man's death with the liaison governor, Healthcare Manager and governing governor.

The Reception Health Screen completed when the man first arrived at Holme House on 31 March 2004 noted that he had suffered from alcoholic fits 12 months previously so he was located in the prison's Healthcare Centre. The man remained in the HCC until on 18 April at approximately 0805 he was found not to be responding when called for treatment. Nursing staff went to check him and suspected that he had suffered a heart attack. An ambulance was called and the man was taken to a hospital in the community. He was given a brain scan and it was discovered that he had suffered a brain haemorrhage.

The decision to grant Release on Temporary Licence to the man was taken on 19 April by the duty governor at Holme House and the man died at 0115 the following morning. On reception at the prison the man had indicated that his next of kin was his son who lives in Hampshire.

When the man was transferred to hospital his son was informed that he was gravely ill. The Head of Regimes at the prison then informed the man's son of his father's death at approximately 0715 hours on 20 April. The son subsequently attended the prison to collect his father's belongings.

My investigator wrote to the man's son on 17 May 2004 and asked him if he had any concerns about his father's treatment. He did not reply. On 9 June 2004 my Family Liaison Officer rang the man's son. He told her that he had no concerns about the way his father had been treated.

In February 2005 a clinical review was undertaken by the Deputy Prisons and Probation Ombudsman. She is a qualified nurse and reaches two findings and conclusions at the end of her report. She observes that although the man had suffered alcohol induced fits and still drank heavily there is no evidence that he was prescribed an alcohol detoxification regime on arrival at Holme House. She also commends the actions of a Staff Nurse who commenced cardiac compressions promptly at the prison although the extent of the man's brain haemorrhage meant that deterioration was inevitable.

In the light of the Deputy Ombudsman's conclusions I recommend that Holme House review its procedures for commencing alcohol detoxification regimes and I also recommend that the nurse be formally commended for his determined efforts to revive the man.