

**Investigation into the death of a man
whilst in the custody of HMP & YOI Holme House in
December 2010**

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

June 2011

This is a report into the death of a man in December 2010, whilst in the custody of HMP Holme House. The man was 66 years old when he died. A post mortem showed that he died from an arterial bleed as a consequence of lung cancer.

He had not registered any next of kin details and efforts to trace family members by the police proved fruitless. I offer my sincere condolences to those touched by his death.

The investigation was carried out by one of my investigators. Both he and I would like to thank the Governor A and his staff, particularly Governor B, for their co-operation during the course of our enquiries.

I also thank North Tees and Hartlepool Foundation Trust for appointing the clinical reviewer to review the man's clinical care.

As the man died from natural causes, the findings of the clinical review play an essential part in my report. The review shows that the man received good care whilst in custody that was equitable to that which he could have expected in the community. I make no recommendations but do recognise the professionalism of the staff who responded to assist the man on the day of his death.

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.

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Acting Deputy Prisons and Probation Ombudsman

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CONTENTS

Summary

The investigation process

HMP Holme House

Key events

Issues

Conclusion

SUMMARY

1. On 3 August 2010, the man was recalled to HMP Durham having been released on licence back into the community after serving eight years in custody for sex offences. He had a medical history of high blood pressure and thyroid hormone deficiency, he was also a long term smoker. He had regular contact with healthcare staff whilst at Durham.
2. The man was transferred to HMP Holme House on 6 September. On arrival, he saw a nurse who recorded his prescribed medication, and blood pressure. In the weeks that followed, he again had regular contact with healthcare staff. There were three occasions when he was referred to outside hospital for treatment.
3. At approximately 8.15am, on Thursday 9 December, the man approached an officer as he was coughing up blood. The officer asked for medical assistance and a nurse responded immediately, assessing that an emergency ambulance was required. Whilst waiting for the ambulance, the man stopped breathing and no pulse was evident, so healthcare staff started Cardio Pulmonary Resuscitation (CPR). This was successful and he began breathing again.
4. The paramedics arrived and, whilst they conducted their assessment, the man went into cardiac arrest and they attempted to resuscitate the man until the prison doctor pronounced his death at 9.03am.
5. The man had not named any next of kin and therefore Holme House made all the necessary funeral arrangements, and the funeral service was conducted by the prison chaplain.
6. I conclude that the care and attention the man received at Holme House was equitable to what he could have expected to receive in the community. I make no recommendations. I am pleased to recognise the speed and professionalism of the emergency response.

THE INVESTIGATION PROCESS

7. The investigation was opened on 9 December 2010 when the my investigator issued notices announcing the investigation to staff and prisoners asking them to come forward if they had any information about the man to share. No one came forward as a result.
8. The investigator visited HMP Holme House on 15 December. He was given copies of all documentation relating to the man and saw where he lived. The investigator returned to Holme House on 11 January 2011 and interviewed two members of staff and one prisoner. The transcripts of these interviews are annexed to this report.
9. North Tees and Hartlepool Foundation Trust asked the clinical reviewer to review the man's clinical care. I am grateful to the clinical reviewer for his considered and timely report, which is also annexed to this report.
10. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and request a copy of the post mortem report. Upon completion, the investigation report will be sent to the Coroner to assist his enquiries into the man's death.

HMP HOLME HOUSE

11. Holme House is a category B prison for remanded and sentenced male adults. It opened in May 1992. The prison primarily serves the communities of the Tees Valley, South West Durham, East Durham and North Yorkshire. It has a total of six residential units, known as houseblocks one to six. It has an operational capacity of 994.
12. North Tees PCT provide the healthcare services at Holme House. There is an in-patient unit with 28 beds and 24-hour nursing care. The out of hours service is covered by the prison doctor with help from an emergency out-of-hours doctor service.
13. Holme House was last inspected by HM Chief Inspector of Prisons in March 2009. The Chief Inspector commented that:

“Holme House is a large male prison on Teesside. Though it is classed as a local prison, the great majority of its population are sentenced, and over a quarter remain at the prison for over six months, sometimes in low-risk security categories. This mixture of roles and populations presents considerable difficulties, but the prison had nevertheless made progress in all areas since the last inspection.

“The healthcare centre was a large facility on two floors, with access from both ends of the building and a chair lift at one end. The ground floor comprised an inpatient unit with 27 cells, one of which was a double cell. Fourteen of the beds were on the certified normal accommodation. Healthcare beds were regularly used inappropriately for the management of prisoners requiring extra supervision.”

14. Each prison in England and Wales has an Independent Monitoring Board (IMB), which is made up of volunteers from the local community. The Board is responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are maintained. The 2009 annual report published by the IMB for HMP Holme House does not raise any issues relevant to this investigation.
15. Since 2004, when the Ombudsman commenced responsibility for investigating deaths in custody, there have been 19 deaths of prisoners in Holme House prior to the man's. Eight of those deaths were due to natural causes and there are no similarities with the death of the man.

KEY EVENTS

16. The man was born in November 1944 and lived in the Tyne and Wear area. He was a smoker, had a history of high blood pressure and thyroid hormone deficiency. He had been released on licence back into the community after serving eight years in custody for sex offences. He was recalled to HMP Durham on 3 August 2010 for breach of his licence conditions.
17. On arrival at Durham the man saw Nurse A and Nurse B who completed the First Reception Healthscreen. (This is designed to highlight any immediate mental or physical health problems requiring referral to the doctor or other specialist service). The man's blood pressure was recorded as 117/102 (The normal range for blood pressure is 100/70 to 140/90, although the pressure does vary throughout the day depending on the individual's activities. A blood pressure reading of greater than 140/90 is classed as high and a reading of 90/60 or below is classed as low.) His weight was recorded as 72.15kg (11st 5lb). He told the nurses that he smoked 20 cigarettes a day and had no intention of giving up, and that he was prescribed bendroflumethiazide (for high blood pressure) and levothyroxine (for thyroid hormone deficiency).
18. Later the same day a prison doctor, saw the man and confirmed the prescribed medication. The doctor noted that the man said that he felt very well.
19. On 26 August, Nurse C, a member of the mental health team, saw the man for an initial mental health assessment. The man said that he had no contact with family and friends. He had been divorced for many years and had not had contact with his son since birth. The nurse recorded that there was no evidence that the man had any mental illness. He told the nurse that prison did not bother him, he had no thoughts of self harm and expected to be transferred to HMP Holme House in the near future. The nurse assessed that there was no further action required from the mental health team.
20. The man transferred to Holme House on 6 September. He saw Nurse D on arrival who noted the medication he had been prescribed, that he had no thoughts of self harm and, despite advice being offered, refused to give up smoking. The nurse recorded the man's weight as 68kg (10st 10lb) and his blood pressure as 184/104 and referred him to the doctor. Later that afternoon the man saw prison doctor B at Holme House, who confirmed his medication.
21. On 16 September, the man saw prison doctor C as he complained of right sided chest pain when he coughed and shortness of breath when climbing stairs. The doctor examined him and diagnosed a chest infection. He prescribed a five day course of amoxicillin (antibiotic) and paracetamol (for pain relief).
22. Four days later, Nurse E checked the man's blood pressure check and recorded it as 132/93.
23. On 5 October, the man saw Nurse D as he complained of chest pain and had been vomiting through the night. The nurse recorded the man's blood pressure as very high at 208/128. The nurse gave him a Glyceryl trinitrate (GTN) spray

(for high blood pressure and angina) and immediately referred him to the doctor.

24. Prison doctor D saw the man within 30 minutes of him seeing Nurse D. The doctor recorded the man's blood pressure as 160/110 and he told the doctor that his pain soon subsided soon after he had the GTN spray. The man also told the doctor that both his parents had died of heart attacks in their late 70's. The doctor advised the man to rest in bed and prescribed aspirin, 75mg to be taken daily.
25. Two days later, Nurse F saw the man in his cell, at approximately 9.10pm, as he had told officers that he was experiencing chest pain. When the nurse entered the man's cell he was sat up and had no difficulty in breathing. The man told the nurse that he experienced pain periodically in his chest when he coughed, which became worse when he lay down. He also said that he was coughing up clear phlegm. The nurse recorded the man's blood pressure as 160/100 and advised him to sleep propped up and not to lay flat. The nurse told the man to report to the doctor in the morning but to contact staff immediately if he had any concerns.
26. The next morning prison doctor E, saw the man as arranged by Nurse F the man told the doctor that the sharp pain that had started the previous evening had completely eased and he felt back to normal. The doctor examined the man's chest and recorded that it was clear with no tenderness. The doctor noted that the man had been a smoker for many years and had a smokers cough. The doctor made the diagnosis that the man had chronic obstructive pulmonary disease (COPD) (restriction of the flow of air to and from the lungs causing shortness of breath) and prescribed a salbutamol inhaler (for relief of symptoms of COPD).
27. The man saw prison doctor D on 21 October. The doctor noted that the man had been a smoker since the age of 14, had already been prescribed antibiotics and an inhaler for a chest infection and chest pain. The doctor referred the man to the Rapid Chest Clinic (RCC) at University Hospital of North Tees (UHNT) for further investigation.
28. Seven days later the man saw Nurse G in his cell as he was coughing up small amounts of blood and experienced pain in the middle of his chest. The nurse had prison doctor D visit the man later that same evening. The man told the doctor that he had coughed up blood during the day but was now fine.
29. On 31 October, the man saw Nurse H at 8.47am as he was coughing up blood. The nurse recorded that there was a small amount of blood stained secretion in the phlegm that the man had coughed up. The nurse advised him to continue with his inhaler, and that healthcare were waiting to be notified of his appointment at the hospital. He was to be seen by the doctor the following morning.
30. The next day the man saw prison doctor F, as arranged. The doctor recorded that the man was not short of breath but had a mild wheeze in the left side of

his chest. The doctor advised the man to stop smoking and to drink fluids and arranged for him to see the nurse the next day to start a course of smoking cessation therapy.

31. Nurse I saw the man the next day as arranged. He told the nurse that he would try and give up smoking. The nurse prescribed NiQuitin lozenges (nicotine replacement therapy) to be taken as required.
32. On 4 November healthcare administration followed up the initial referral to the RCC at UHNT. An urgent faxed referral was sent to the doctor's secretary, respiratory consultant, at UHNT.
33. Four days later prison doctor, G reviewed the man's prescribed medication and no changes were made. The man's medication was reviewed a week later by prison doctor H, who also made no changes. However the doctor, on reviewing the man's notes, requested a blood pressure check and blood test due to the man's previous high blood pressure, and if it was greater than 150/90 he should be referred to the doctor. It had been arranged for the man to be seen by a nurse that afternoon but he did not attend the appointment. The medical records do not give any explanation for him not attending.
34. On 16 November, the man attended UHNT for his appointment with the respiratory consultant at the chest clinic. A risk assessment was completed that authorised two officers to escort him with the use of double cuffs which could only be removed for treatment purposes. (On each occasion a prisoner is escorted outside of the prison to hospital a risk assessment is completed which considers the risk to the public, potential for escape and likelihood of outside assistance. The assessment informs the decision about the number of escorting officers and the type of restraint to be used (single cuff, double cuffs or two metre long escort chain with cuff at either end). It also determines the circumstances and the authority required for the restraints to be removed. The risk assessment is reviewed each day that a prisoner is in hospital and amended where necessary.) The man returned to prison the same day following an initial assessment by hospital doctor A, who had referred the man for a computed tomography (CT) scan (a three-dimensional image of the inside of the body generated from a large series of two-dimensional X-ray images).
35. Five days later Nurse J saw the man for a general health assessment. The man told the nurse that he was still not interested in giving up smoking. The nurse recorded the man's weight at 64.8kg (10st 3lb), a loss of 3.2kg (7lb) since his arrival at Holme House, and his blood pressure as 178/100. The nurse referred the man to be seen by the doctor in accordance with prison doctor H's instructions.
36. The next day the man saw Nurse I as he complained of dry itchy skin on his elbows and knees. The nurse prescribed aqueous cream (non-greasy moisturiser) for him to apply as needed.
37. On 24 November, the man saw prison doctor F as a result of his history of high blood pressure. The doctor checked the man's blood pressure and recorded it

as 218/119 and referred him immediately to the emergency department at UHNT for further investigation. A risk assessment was completed that authorised two officers to escort him with the use of double cuffs and an escort chain which was to be used when treatment was underway. The man saw hospital doctor B, who discharged the man back to prison later that evening as his blood pressure was 158/86. The doctor confirmed in a discharge letter that nothing abnormal was detected and no further investigations were carried out.

38. The man attended UHNT for his CT scan on the morning of 3 December. A risk assessment was completed and the security arrangements were the same as his previous visits. The man returned to prison later that morning. The results of the CT scan had not been received by 9 December. The results of the scan showed that the man had advanced lung cancer and as a consequence he was likely to suffer from bleeding from the arteries at any time. Unfortunately staff at Holme House would not have been aware of this until after the events of 9 December.

Events of 9 December

39. At approximately 8.00am the man and his cellmate, left their cell to collect their breakfast. Some fifteen minutes later Officer A was approached by the man as he had just coughed up blood into his waste bin. The officer went to the treatment room on the houseblock and told Nurse G what had occurred. Nurse G asked the officer to return to the man and get him to put a sample into a clean plastic cup so she could examine it.
40. Officer A returned to the man's cell to find him collapsed on the floor with blood coming from his mouth. The officer asked Senior Officer A to immediately go and fetch Nurse G. Officer A went into the cell and placed the man in the recovery position to prevent him from choking. Officer A took the man's cellmate away from the cell.
41. Nurse G called for an emergency ambulance and additional healthcare assistance from the treatment room at 8.25am and went to the man's cell with the emergency treatment bag and oxygen. The nurse found no signs of breathing or a pulse and started cardiopulmonary resuscitation (CPR) with the assistance of Nurse K who had arrived at the cell. The nurses continued with CPR until the man responded by breathing on his own and had a strong pulse. Nurse G recorded the man's blood pressure as 240/140.
42. Paramedics arrived at 8.34am and took over the man's treatment and moved him from the cell onto the landing so they had more room to treat him. Shortly after his pulse faded and he stopped breathing. The paramedics restarted CPR and continued to do so until prison Dr G arrived who examined the man pronounced that he had died at 9.03am.
43. A hot debrief was held some forty five minutes later for all the staff involved in the incident and care and support was made available. Support was also offered to the man's cellmate and any other prisoners affected by the man's death.

44. As the man had not disclosed any next of kin to the prison, the prison family liaison officer, contacted the police and probation service in an attempt to establish if the man had any family. The police and probation service were unable to trace any next of kin. Therefore Holme House made all the arrangements for the man's funeral which was paid for by the prison service and conducted by the prison chaplain.

ISSUES

Clinical care

45. The clinical review has considered the care that the man received. The review noted that the man had been a life long smoker and it was noted that when he coughed there were traces of blood in his phlegm. The man was monitored regularly by healthcare staff and his symptoms improved.
46. However the man's condition deteriorated in October and the prison doctor referred him for assessment at the chest clinic at UHNT. The clinical reviewer commented as follows:

"The man had signs of a chronic chest condition and was referred appropriately by the prison doctor to the hospital's lung clinic."

"He was seen promptly at hospital on 16/11/2010 and appropriately a CT scan was arranged. This showed the presence of an advanced lung cancer that was necrotic and hence likely to bleed. A further outpatient appointment had been sent for urgent review of the man. Unfortunately he developed a massive hemoptysis (coughing up blood) at the prison. Staff followed Advanced Life Support protocols and attempted resuscitation. However due to the nature of the haemorrhage it was unsuccessful and he was pronounced dead at the prison.

"Patients may deteriorate rapidly and sustain exsanguinating hemorrhages due to lung cancer. Sudden deterioration of patients cannot always be predicted.

"Full procedures relating to death of prisoners in custody was followed and staff were given the appropriate support."

47. During the time from when the man was recalled back into custody on 3 August until the day of his death four months later, he had a total of 62 separate interventions with healthcare staff.
48. The clinical reviewer concludes that "all medical and nursing care was appropriate". The comprehensive and well maintained medical records show the level of interaction between healthcare staff and the man to ensure he received a good standard of care. I am satisfied that he received a standard of care that was equitable to that he could have expected to receive in the community.

Emergency response

49. I am pleased that staff acted with speed and professionalism during the emergency situation that took place on 9 December. I would like to recognise the efforts of the staff, in particular Officer A, in responding an incident that was clearly distressing.

Arrangements made after the man's death

50. I wish to recognise the efforts of the staff from Holme House in attempting to trace if the man had any next of kin and for making all the arrangements for his funeral. I find the actions taken by Holme House were appropriate and compassionate.

CONCLUSION

51. During his time at Holme House, the man had regular contact with the doctors and other healthcare staff which was well documented. I am satisfied that the care that the man received at Holme House was equitable to that expected in the community.
52. I believe that the man was treated with dignity and respect whilst he was in custody both at the prison and on the occasions he was admitted to hospital. Following his death Holme House appropriately followed the guidance given in Prison Service Order 2710, "Follow up to death in custody" in ensuring staff and prisoners were appropriately supported and all necessary arrangements were made for his funeral.