PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man while in the custody of HMP Holme House in December 2011

Report by the Prisons and Probation Ombudsman for England and Wales

June 2012

This is the report of an investigation into the death of a man, a prisoner at HMP Holme House. He died in December 2011 of chronic obstructive pulmonary disease (a disease of the lungs) and heart disease. He was 83 years old. I offer my condolences to his family and friends.

Our investigation was carried out by one of my investigators. The local Primary Care Trust commissioned a review of the clinical care he received.

The man was remanded into custody in March 2007. On arrival at HMP Holme House, due to his complex health needs he was immediately moved to the inpatient healthcare unit where he remained until being transferred to hospital on 10 December 2011. He died the following day.

The man's release from custody had been agreed by the Parole Board in July, subject to a suitable residential placement which addressed risk and met his healthcare needs. He refused to move to a residential care home and assessments and conversion of his own home then took some time. Unfortunately he died while still a prisoner. However, I am satisfied that staff at Holme House did all they could to progress his release and that, while in prison, he received a standard of clinical care equivalent to that he would have received in the community.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **June 2012**

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SUMMARY

1. The man was convicted of serious sexual offences on 15 March 2007, and sentenced to nine years imprisonment. He was remanded into custody and taken to HMP Holme House.

2. On arrival, staff recognised that he had poor mobility and required two walking sticks or a wheelchair. He suffered from arthritis, peripheral vascular disease (narrowing and hardening of the arteries that supply blood to the legs and feet) and chronic obstructive pulmonary disease (COPD - a disease of the lungs). He was moved to the inpatient healthcare centre where 24 hour healthcare was available.

3. The man underwent a femoro-femoral bypass operation (to improve blood flow to the legs) for his vascular disease in November 2007. Although his surgery was a success, he suffered with complications of vascular disease such as leg ulcers and gangrenous toes. In May 2010, he suffered a pulmonary embolism (a blood clot in the lung), contracted MRSA (methicillin-resistant staphylococcus aureus), and suffered from an obstruction of the bowel.

4. On 22 July 2011, the Parole Board approved the man's early release on licence. Because of the deterioration in his health and the need for 24 hour nursing care, the board determined that he required a suitable residential placement which met his healthcare needs and addressed his risk. His probation officer liaised with social services to find suitable accommodation for his release. He refused to move to a care home, so efforts were made to convert his own home to meet his needs. The other agencies were still in the process of arranging his release when he died.

5. On 10 December 2011, the man became seriously unwell and was admitted to hospital for observation after suffering from a worsening of his COPD. The duty governor spoke to his niece (his next of kin) to tell her that he had been taken to hospital.

6. On arrival at hospital, the man was seen by the doctor, who advised that a do not resuscitate instruction be put in place because of the extent of his illness. His condition remained unchanged until around 6.10am the following morning, when a nurse advised the prison escort staff that his condition was deteriorating. He died ten minutes later. He had not been restrained at hospital.

7. The duty governor telephoned the man's niece at 7.15am to break the news of his death. The post-mortem report confirmed the cause of death to be COPD and heart disease. He was cremated on 20 December 2011. Holme House contributed to the cost of the funeral.

8. We make no recommendations as a result of this investigation.

THE INVESTIGATION PROCESS

9. One of my Assistant Ombudsman's opened the investigation on behalf of the investigator at HMP Holme House on 30 December 2011. During his visit, he collected copies of the man's prison and medical records. Notices were issued announcing the investigation to staff and prisoners. We asked anyone with information about his death to contact the investigator but nobody came forward.

10. During the opening visit, the Assistant Ombudsman visited the healthcare unit, visited the man's cell and introduced himself to the staff on the wing. He also met five members of staff to discuss the care the man received while at Holme House.

11. The investigator later contacted Northumbria Probation Service and Sunderland Adult Social Services to discuss the man's planned release from prison. He had been deemed suitable for early release in July 2011, but due to difficulties in finding a suitable release address, he remained in custody until he died in December.

12. A review of the man's clinical care at Holme House was completed by clinical reviewers on behalf of the local Primary Care Trust. The review was delayed and eventually received on 26 March 2012.

13. One of our family liaison officers contacted the man's niece to discuss the investigation and concerns she had about the care her uncle received. She explained to the family liaison officer that her uncle was an elderly man and her family accepted his death as being the result of natural causes. She said that her family had no concerns about the care he received in prison and preferred not to have any further involvement with the investigation

14. This report has been forwarded to the local coroner to assist his enquiries.

HMP AND YOI HOLME HOUSE

15. HMP Holme House detains adult males who have either been remanded into custody or convicted. It also accepts a small number of young offenders. The prison serves the communities of Tees Valley, South West Durham, East Durham and North Yorkshire. Holme House holds a maximum of 1212 men.

16. Healthcare services at the prison are commissioned by County Durham Primary Care Trust (PCT). There are GP surgeries and registers for patients with diabetes, respiratory problems and other chronic conditions. Older prisoners are offered well-man checks. There is an inpatient healthcare centre with 28 beds providing 24 hour nursing cover. The man lived in the healthcare centre throughout his time at Holme House.

Her Majesty's Inspectorate of Prisons

17. HM Chief Inspector of Prisons conducted a full unannounced inspection of Holme House in 2010, and commented:

> "The inpatient unit contained 28 beds, which were not part of the certified normal accommodation. At the time of the inspection, ten beds were occupied. Admissions to the unit were clinically appropriate. Facilities were stark but adequate to meet need."

Independent Monitoring Board

18. There is an Independent Monitoring Board (IMB) in every prison, appointed by the Secretary of State for Justice. Members of the Board are unpaid volunteers from the local community and have full access to the prison. They help to ensure that standards of care and decency are maintained. In their 2011 annual report, the Board wrote:

> "2011 has been a very challenging year for Healthcare staff. The early part of the year saw the Healthcare provision continuing at the high standard the Board has come to expect. In February 2011 they were presented with an award for 'rapid improvement in performance' by North Tees and Hartlepool Foundation trust which was an excellent way to end the time with the trust before the commencement of the contract with Care UK in April. Despite all the 'teething problems' [with the introduction of the new healthcare provider] it is to the credit of the Healthcare staff that they maintained the level of service they did and that they have again begun to perform to their usual high standards, given the staffing constraints".

KEY EVENTS

19. The man was convicted of serious sexual offences on 15 March 2007, and sentenced to nine years imprisonment. He was remanded into custody and taken to HMP Holme House.

20. He was seen by a nurse for his reception health screening. He had poor mobility and required either two walking sticks or a wheelchair. He told the nurse that he was a regular smoker. He had arthritis, peripheral vascular disease (narrowing and hardening of the arteries that supply the legs and feet), chronic obstructive pulmonary disease (COPD - a disease of the lungs), and an ulcer on his right leg. He immediately moved to the inpatient healthcare centre due to his poor mobility and healthcare needs.

21. The following month, the man was seen by an occupational therapist, who conducted an environmental assessment to determine if he required any special equipment to improve his mobility. He was subsequently moved to a cell for people with disabilities. He was also seen by a tissue viability nurse for advice on the treatment and prevention of pressure sores and ulcers. He was assessed by a physiotherapist who was able to suggest some light exercise to improve his mobility.

22. Because the man had complex health needs, healthcare staff at Holme House thought that he might receive a better continuity of care if he transferred to a prison more suited to his needs. The modern matron spoke to the Governor of HMP Acklington to discuss a possible transfer. Acklington agreed to accept him and a transfer took place on 21 September. However, after only four days, on 25 September, he returned to Holme House because staff at Acklington were unable to cope with his health problems.

23. On 27 September, the man was seen by a doctor. His body and legs were very swollen and his abdomen enlarged. She diagnosed right sided heart failure and prostate hypertrophy (increase in the size of the prostate). To ease some of his discomfort, he had a cathether fitted.

24. The man attended hospital on 20 November, for a femoro-femoral bypass operation (which diverts blood flow around blockages in the femoral artery to improve circulation to the legs). He recovered well from the operation and returned to Holme House on 27 November.

25. The man's deteriorated further and he became bed-bound for most of the day, requiring help with basic hygiene. He needed assistance moving from his bed to his wheelchair because he was unable to stand up on his own. Although the bypass operation was a success, he suffered from the complications of vascular disease such as leg ulcers and gangrenous toes. This resulted in amputation of his right big toe in June 2009.

26. The man's health remained generally unchanged until May 2010. He continued to see healthcare staff daily and remained in the inpatient centre. Physiotherapy staff suggested a hoist to transfer him safely from his bed to

his commode. He had become doubly incontinent and required incontinence pads at all times. The same month, he suffered a pulmonary embolism (a blood clot in the lung), contracted MRSA (methicillin-resistant staphylococcus aureus), and suffered from an obstruction of the bowel due to constipation. He was a lifelong smoker. This aggravated his COPD and meant that he suffered from repeated chest infections which had to be treated with regular doses of antibiotics and steroids.

27. The man's Parole Eligibility Date (PED) was 13 September 2011. In preparation for his parole review his solicitor was provided with a copy of his parole dossier (containing a report from his probation officer) and medical files. She requested that, in line with Prison Service Order 6000 (Parole release and recall), compassionate circumstances should be considered as part of his parole review. She argued that his health was very poor and, being wheelchair bound, his risk of re-offending was reduced.

28. The Parole Board noted that because of the deterioration in the man's health, he had been unable to undertake any work to address his offending behaviour. However, on 22 July 2011, the Board considered his solicitor's representations and decided that he was suitable for early release on licence. Medical reports indicated that his health would not improve and that he was unlikely to return to an independent lifestyle. The Board decided that his release would depend on a suitable residential facility which met his healthcare needs and allowed the risk he presented to children to be managed.

29. A medical report submitted to the Parole Board indicated that the man would need full time nursing care after his release from custody. The report also confirmed that the care given would need to be provided in a residential setting rather than in his own home. He declined the offer of a residential care home, and wanted to return to his own home.

30. A worker from Northumbria Probation Service and a worker from Sunderland Adult Social Services met the man to discuss his release plans. Because of his offences they explained the risks to his health and personal safety if he returned home. He said that he was aware of the possible risks but still wished to return home. The worker from the Probation Service informed the prison that because he had the mental capacity to make his own decisions, they could not compel him to move into a residential home.

31. Social Services told the man that she was unsure if his own home was suitable as it had remained empty for the four years he had been in custody. An assessment of need was conducted by occupational health staff, who advised that a hospital bed, hoist and a carer would be required if he were to move home. She also spoke to the police, who confirmed that a panic button could be fitted, and his niece (his next of kin), who agreed to do his weekly food shopping for him.

32. On 1 December, the man complained to healthcare staff that he had been up all night coughing. Two days later, he was found coughing up large amounts

of sputum. His temperature was taken and the prison doctor asked nursing staff to keep an eye on him. When his condition showed no signs of improvement on 7 December, a sample of his sputum was sent off to be tested.

33. The man had an unsettled night on 8 December, having to sleep with the upper section of his bed elevated to aid his breathing. He continued to cough up large amounts of sputum and appeared to be confused.

34. At 1.45pm on 10 December, as part of a routine check, a Healthcare Assistant (HCA) found him looking very unwell. She told the nurse in charge that she was going to put him to bed so he could rest. The nurse came to check him to find him looking flushed and sweaty. He was experiencing respiratory failure. At 2.00pm that day, a doctor assessed him and decided that he should be admitted to hospital for observation. She thought that he was suffering from a worsening of his COPD. She advised that a 'one hour' ambulance (rather than an immediate emergency ambulance) should be requested. He was given oxygen while waiting to transfer to hospital.

35. His condition deteriorated further and at 2.20pm the nurse asked that the 'one hour urgent' ambulance be changed to a 'blue light emergency' ambulance. His breathing became abnormal and his heartbeat became rapid. Paramedics arrived at 2.31pm and he was taken to hospital. He was neither restrained during the journey nor during his stay. The duty governor spoke to his niece (his next of kin) to tell her that he was seriously unwell and had been admitted to hospital.

36. On arrival at hospital, the man was seen by the doctor. The doctor thought that he could be suffering from a chest infection, placed him on a drip to re-hydrate him and gave him oxygen. The doctor advised him that because of the extent of his ill health, a do not resuscitate instruction had been placed on his hospital file.

37. The man's condition remained unchanged until around 6.10am the following morning, when a nurse came to check on him. She became concerned and asked a colleague to assist her. Another nurse came into the room, checked him and advised the prison escort staff that he was seriously unwell. His condition deteriorated rapidly and he died at 6.20am.

38. The duty governor telephoned the man's niece at 7.15am to break the news. Hospital staff had already been in touch with her. At 7.45am, both officers returned to the prison. The duty governor saw them to offer support. Notices were put up in the prison informing staff and prisoners of the death.

39. At 8.00am, the prison nominated a family liaison officer (FLO). She telephoned the man's niece at 8.30am to introduce herself and explain her role. She arranged to meet her the next day and drive her to the hospital.

40. The prison contacted the man's social worker to inform her that the man had died. She explained that, only a few days earlier, a hospital bed, hoist and

other mobility equipment had been installed at his house. She said that she had been in the process of making arrangements for a carer before contacting the prison to discuss his release date.

41. The post-mortem report confirmed the cause of death as chronic obstructive pulmonary disease and heart disease. The man was cremated on 20 December 2011. Holme House contributed to the cost of the funeral.

ISSUES

Clinical care

42. The clinical reviewer completed a review of the man's clinical care. They comment in their report:

> "The man was an elderly gentleman with very significant medical conditions. He [had stayed] in the hospital wing of the prison since… 2007. He has severe peripheral vascular disease which required major surgery and despite this he had multiple complications from it. He had evidence of ulcers, gangrenous toes which required amputation and recurrent cellulitis. Due to his smoking history, he also had quite severe chronic obstructive pulmonary disease, cor-pulmonale and ischaemic heart disease.
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> [He] was referred to secondary care as clinically indicated and his OPD clinics were organized as per schedule. It was noted that he did refuse to attend few of his OPD appointments.
>
> His condition was such that he was totally dependent on the nursing staff for all his care. He was bed bound and needed a hoist to move him. He was doubly incontinent and required nursing care 24 hours a day. He had special air mattress to prevent pressure sores. He also received all the ancillary services like physiotherapy, chiropodists and tissue viability nurse as needed.
>
> The treatment he received while in prison was compatible [with] the care he would have received if he was in the community. Due to his illness, he would have been in [a] nursing home environment if he was in the community.
>
> It is important to note that he was not restrained when he was critically ill in hospital".

43. We are satisfied from the clinical review that the man received care equivalent to that he would have received in the community.

Parole

44. The man's Parole Eligibility Date (PED) was 13 September 2011. His solicitor made representations asking that his very poor health be considered as part of his parole review. On 22 July 2011, the Parole Board decided that he was suitable for early release on licence. However, the Board decided that, because of his health problems, his release would depend on the availability of a suitable residential placement.

45. The man would have needed full-time nursing care on his release from custody but he refused to move to a residential home and the social services team could not require him to do so. Instead, he wanted to return to his own

home. However, this had remained empty for four years while he was in prison and required significant adjustments before he could live in it. Social services needed to carry out an assessment of need with the occupational health team to ensure that it was safe for him to return home. They then had to install appropriate equipment and arrange appropriate care. Arrangements were almost in place for his release at the time of his death.

46. Documents provided by Holme House show that prison staff had made appropriate attempts to expedite his release. However, it took some time for the required occupational health assessment to reach social services.

47. It is unfortunate that four months after the Parole Board made its decision, the man remained in custody and died while still a prisoner. But the Board had specified that any release plan would depend on a suitable residential placement. Efforts were made by the different agencies involved to provide him with suitable accommodation, but were hampered by his refusal of a residential care home and the difficulties encountered in assessing his needs in the community and providing appropriate facilities.

Next of Kin notification

48. At 7.15am on 11 December, the duty governor telephoned the man's niece to inform her of her uncle's death, but hospital staff had already telephoned to break the news to her. Later that morning, the prison's family liaison officer telephoned her to introduce herself.

49. Prison Service Order (PSO) 2710 describes the action to be taken following a death in custody. While the PSO does not give definite instructions as to how the news should be broken to next of kin, it does advise of the need to: "arrange notification to the next-of-kin and any other person reasonably nominated by the prisoner as soon as possible in a suitable manner giving an accurate factual account of what has happened". The PSO states that the preferred method of notification would be face to face.

50. While we would normally expect this to happen, and it would have been preferable to so, in the particular circumstances of this case we are satisfied that, the decision was not inappropriate. The man's niece had already been informed by telephone that her uncle had been taken to hospital seriously ill. She explained to our family liaison officer that the family accepted his death as that of an elderly man through natural causes.

CONCLUSION

51. The man was very unwell when he arrived at Holme House in 2007. Due to his health and mobility problems, he stayed in the inpatient healthcare unit, where he remained until being taken to hospital on 10 December 2011. He died the next day. The clinical reviewers think that the clinical care which he received while in custody was of a good standard, comparable with the care he would have received in the community.

52. It is unfortunate that, despite the man's release being authorised by the Parole Board in July 2011, he was still in custody in December. Although his refusal to move to a care home contributed to the delay, the assessment and conversion of his own home then continued throughout the autumn. We do not think that staff at Holme House contributed to this delay.