

**Investigation into the circumstances surrounding the death of
a man at HMP Holme House in October 2005**

**REPORT BY THE PRISONS AND PROBATION OMBUDSMAN FOR
ENGLAND AND WALES**

October 2006

This is the report of an investigation into the death of a man who died in October 2005, after suffering what appeared to be a fit in the healthcare centre of HMP Holme House. He was aged 42 and serving a 12-month prison sentence.

I offer my sincere sympathy and my condolences to the man's family and friends for their loss.

My office investigates the deaths of all prisoners in custody including those due to natural causes. In this case, the investigation was carried out by two of my investigators. They asked the North Tees Primary Care Trust (PCT) to commission an independent clinical review. I am also grateful to the then Governor of Holme House and to the governor who acted as liaison officer for my investigators.

On his arrival at Holme House, the man's mental health had given staff cause for concern. They immediately assessed his problems and put in place the care and support that he needed. This continued for two months until the man and staff jointly agreed that he was able to cope with life in prison without such an intensive support plan. Sadly, the man then suffered what nursing staff described as a fit. He stopped breathing twice and died in spite of staff attempts to resuscitate him.

I make two recommendations. I also identify two examples of good practice.

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- 1 Clinical review
- 2 Transcript of interview with a Staff Nurse who administered CPR

Summary

1. The man was accused of committing a number of offences over a 15-month period. He was remanded in custody in August 2005 to HMP Holme House in Stockton-on-Tees.
2. The man had suffered from depression for a number of years and had been prescribed anti-depressants. During the reception process at Holme House, he told staff that he had taken overdoses in the past and had recently been trying to reduce the amount of alcohol he was drinking. Staff were sufficiently concerned about his mental health to admit the man directly to the healthcare centre and to open an Assessment, Care in Custody and Teamwork (ACCT) plan for him. The man remained on the ACCT for almost all his time at Holme House.
3. Two days after his reception, the man moved from the healthcare centre into a shared cell in one of the houseblocks. He remained there for the following two months and received support from members of the Mental Health In-reach Team, especially as his court dates approached. He was also assessed by a psychiatrist on three occasions.
4. In September, the man was convicted of the charges he faced. In October, he was sentenced to 12 months imprisonment and ordered to register under the Sex Offenders Act.
5. On his return to Holme House after sentencing, the man was seen in reception by a mental health nurse. He told her that he had expected a longer sentence and denied having any thoughts of harming himself. Over the next few days, his mental health improved markedly and the ACCT plan was closed on 19 October. A post closure review was scheduled for 19 November.
6. On the evening of 21 October, the man's cellmate alerted staff to the fact that the man had suddenly lost consciousness three times during the previous three hours. He said that he appeared to snore loudly and was breathing noisily. Healthcare staff were called to the cell and decided to admit the man to the healthcare centre.
7. The following day, he was assessed by a prison doctor who asked for an electrocardiogram (ECG) that was conducted that afternoon.
8. At approximately 4.30pm, an officer unlocked the man's cell and told him it was time for tea. When the man did not respond, the officer called a colleague over and then went for help. A number of nurses went to the man's aid and tried to resuscitate him, unfortunately without success. Prison staff called an ambulance and the paramedics monitored the man's condition. At 5.12pm, the nursing staff and paramedics decided that there

was nothing more that could be done for him and they stopped the CPR. The prison doctor arrived at the prison shortly afterwards and certified death at 5.28pm.

9. I make two recommendations in the report. The first relates to the identification and treatment of prisoners who are alcohol dependent. The second deals with actions to be taken following clinical tests and examinations.
10. Attention is also drawn to two examples of good practice.

The investigation process

11. The investigation was opened by letter on 24 October, two days after the man died.
12. My investigators were given access to all the man's prison records, including his medical records. Having reviewed all the documents, they visited Holme House on 8 December 2005. During their visit, they spoke to the then Governor, a representative of the Prison Officers' Association, and to both uniformed and non-uniformed staff. They interviewed one member of the healthcare staff and spoke informally to others. They also spoke to a member of the Independent Monitoring Board (IMB), by telephone on 21 December.
13. One of my Family Liaison Officers contacted the man's next of kin to ask if they had any issues they wanted to raise. They asked questions about the man's health that I hope the inquest will answer (the Coroner has said that the post mortem results cannot be disclosed until then).
14. A member of staff of the North Tees PCT carried out a clinical review of the man's medical treatment. The report is at Annex 1.

Background

HMP Holme House

15. Holme House is a purpose built local Category B prison that opened in May 1992. It houses convicted and unconvicted adult male prisoners and unconvicted male young adults. Prisoners are accommodated in six self-contained living units with integral sanitation in a mixture of single and double cells. The prison primarily serves the communities of Tees Valley, South West Durham, East Durham and North Yorkshire.
16. Holme House offers a variety of employment opportunities within its modern workshop complex. These are complemented and supported by a purpose-built Education Department offering both part and full time classes. The Prison Enterprise workshops consist of nine individual work/training areas and offer up to 182 full-time prisoner places based on a five-day week.
17. A first night centre has been established. This is a safer custody initiative that provides support to prisoners when they first arrive at Holme House. A Listener scheme operates on a 24-hour basis and is fully integrated into prison arrangements for those in need of support. (The Listener scheme, which operates in most prisons, is a prisoner peer group support system, with each Listener receiving training from the Samaritans.)
18. The healthcare centre has 28 in-patient beds, approximately half of which are occupied by prisoners undergoing detoxification. They are kept under medical observation for the first three to five days of treatment before moving on to the drug detoxification unit.

Key findings

19. When the man arrived at Holme House on the afternoon of Friday 19 August 2005, it was his first time in prison. During the reception process, he told staff that he had taken a drug overdose three times previously and added that he felt that he might harm himself again. He explained that he had been seeing his GP each month because of depression, stress and anxiety, but that he was unsure what medication his GP had prescribed. He had seen a psychiatrist in relation to his alleged offences. He also told staff that he wanted to kill himself. He had a stomach ulcer but he did not know the name of the medication he was taking for it. When asked about drug and alcohol use, he said that he had been in the habit of drinking 14 pints a day but that he had recently reduced this to eight pints. When asked whether he thought he needed treatment for his alcohol use, he replied that he did.
20. The man's mental health gave staff cause for concern and he was admitted to the healthcare centre where he was put into a safer custody cell. (This is a room designed and furnished to prevent a prisoner harming himself.) A member of the healthcare staff then opened an Assessment, Care in Custody and Teamwork (ACCT) plan for the man. The ACCT document describes the problems facing a prisoner at risk of harming themselves and implements a plan to give them the support they need to help them through a period of crisis. The senior nurse on duty that evening and two of her colleagues completed the immediate action plan section. They agreed that staff would make frequent observations of the man at irregular intervals. They explained to him that he could have access to a telephone if he wanted to call the Samaritans. They also told him that he could talk to a Listener if he wanted to.
21. In addition to the ACCT plan, staff also completed a Care Plan/Pathway document for the man. On the front cover, the reasons given for his admission to healthcare were 'Threats of suicidal ideation/mental health'. Page two of the form has a five-part risk assessment that includes sections on suicide or self-harm and alcohol and substance abuse. In the alcohol section, there is a positive answer to the question of whether the person has a known history of alcohol or substance abuse. The next question asks if the person is currently misusing alcohol and the reply has been recorded as 'No' and a hand-written note says 'States reduced'. But from the information the man had previously given staff, the reduction was very recent and his stated daily consumption of eight pints was four times over the Department of Health's recommended limit. The initial plan of action recorded a number of measures to address the man's mental health problems. However, the final entry said, 'Observe for signs of withdrawal from alcohol (states reduced intake – precautionary measure).' There is no further mention of treatment for his alcohol problems recorded by prison staff.

22. Once an ACCT plan is opened, the first case review must be held within the next 24 hours. The man's first review was held at 10.30am the following day - well before the deadline. The discussion was chaired by a staff nurse acting as unit manager. A doctor was present, as was another staff nurse and the man. A further review was held at 2.00pm that afternoon and it was decided to move the man into a shared cell to help him begin to interact with staff and other prisoners. He was also referred to the Mental Health In-Reach Team.
23. The next review was scheduled for 9.00am the following day. The record of the meeting noted that the man told staff that, although he felt low, he was able to function. He also said that he feared being bullied and was given reassurance about this. It was decided that he would leave healthcare and move to one of the houseblocks where he would be encouraged to get involved in social activities. It was agreed that he would receive support from a Registered Mental Nurse (RMN) on the houseblock. On the same day, one of the prison doctors referred the man to a Consultant Forensic Psychiatrist.
24. The man was seen by a nurse on 21 August and told her that he felt his medication was not working. He had arrived in Holme House on a Friday evening and so healthcare staff had not been able to speak to his GP immediately to check what medication he had been taking. However, staff later contacted the surgery and confirmed that he had been prescribed Mirtazapine (an anti-depressant) but that he did not always take it as directed. The prison doctor then prescribed the same medication which was given to the man each afternoon.
25. On 26 August, the next review was held. The man said that he had suffered from depression for three years and that he occasionally felt like harming himself. He said that if he had tablets he would take an overdose. However, he was mixing with other prisoners during association periods and generally spent his time watching television. He had an appointment to see the psychiatrist the following week.
26. In September, the man was convicted at Teesside Crown Court and remanded to await sentencing. On his return to Holme House, he told staff that he wanted to kill himself. He was admitted to healthcare for observation and a doctor's appointment was made for the following morning. The following day, he was moved to a 'camera cell' and assessed by the doctor who ordered the observations to continue. The doctor also increased his medication to the maximum dose. On 4 September, the man was again seen by the doctor who said that he was well enough to return to the houseblock. He did so later that morning. A further review was held four days later. The man told the wing staff that, although he had thoughts of self-harm, he would not do anything. He was still waiting to see the psychiatrist.

27. The psychiatrist saw the man on 14 September in the healthcare centre and noted that he was taking an anti-depressant. After assessing the man, he concluded that he was dependent on alcohol, depressed and likely to harm himself if he had access to tablets. He arranged to see the man again a week or two later. At the ACCT review the following day, the man said that attending education classes was helping him because he had less time to brood. However, he was still feeling low. One of the wing's senior officers referred him to the Mental Health In-reach Team, and over the next few weeks the man received extra support from their staff.
28. On 21 September, he again saw the psychiatrist who said that the man was brighter than he had been during the previous consultation. He also felt that the risk of self-harm had lessened and proposed to review him again after the man was sentenced. The following day, as a result of the senior officer's referral, the man was assessed by a member of the In-reach Team. She recorded that he told her he had suicidal thoughts, although he had denied such thoughts when seen by the psychiatrist the previous day. She also observed that, as he had previously taken overdoses, all his medication was being given in soluble form.
29. Further ACCT reviews were held on 22 September and 6 October. On both occasions a member of the In-reach Team was present. The psychiatrist saw the man for the third time on October 5 and noted that, although the man looked 'low in mood', he did not seem anxious or depressed. However, he told the psychiatrist that he was feeling suicidal and had felt that way the previous weekend. The psychiatrist concluded that the man was low in mood because of his circumstances and that, although he spoke of suicide, he had no real plan. He proposed to see the man again three weeks later. As his court date for sentencing drew closer, staff from the In-reach Team monitored the man closely.
30. In October 2005, the man was sentenced to 12 months imprisonment with the requirement to register under the Sex Offenders Register. On his return to Holme House, he was seen by a mental health nurse in reception and they discussed his sentence. The man said that he was a bit shocked but that he had expected a longer sentence. He denied having any thoughts about self-harm and added that he was receiving adequate support. The nurse passed on this information to a member of the In-reach Team.
31. From then on, the man's mental health improved. The mental health nurse who saw him on 17 October noted, "Mood much improved, eating and sleeping well. Laughing and smiling appropriately." The ACCT review on the following day recorded that the man had a very positive attitude and was positive about the ACCT plan being closed. He had a good relationship with his cell mate and was now working, making up tea packs. A further review was held on 19 October when a member of the In-reach Team was present. They noted that the man was more settled as he had his release date. He was continuing to receive In-reach support.

Everyone, including the man, agreed to close the ACCT document. The post-closure interview was scheduled for 19 November.

21 and 22 October

32. At 9.30pm on Friday 21 October, wing staff called a nurse to examine the man in his cell. His cellmate had told staff that the man had lost consciousness three times since 6.30pm that evening. This happened very suddenly, and was followed by the man making loud, snoring-type sounds. The nurse examined the man and then admitted him to the healthcare centre. At 10.00pm, she opened a care plan for the man in which she set out the risks he faced and what action was to be taken. She recorded that he should be located in a 'camera cell' and be frequently observed during the night and the observations recorded. She also stipulated that his blood sugar levels should be recorded and the doctor should see him in the morning. However, none of the cells in the healthcare centre with a camera was available when the man arrived. Instead, he was put into a safer custody cell. The medical records do not contain any observations.
33. The following day, the man was examined by a doctor who noted in the medical record that observations were to continue and that he would be reviewed on Sunday. The doctor also asked for an ECG and this was done at 2.45pm. The printout for the test was not saved in the medical record but an entry recorded the result as "?normal", indicating that staff queried whether the result was normal. The man's notes do not record any action being taken to clarify the result.

The Head of Healthcare should remind staff of the importance of taking timely and appropriate action following clinical tests and examinations, and documenting the action taken.

34. At approximately 4.30pm, an officer unlocked the man's cell and told him it was time to get his tea. The man did not respond, so the officer called him again. The man was lying on his bed and appeared to be snoring and breathing loudly. The officer was concerned about his health and called another officer over before going for medical help.
35. A charge Nurse was the first to arrive and he thought that the man had had a fit. He placed him on his side in the recovery position, and noted that the man's breathing was loud and his colour good. Shortly afterwards, a staff nurse arrived. However, the man suddenly stopped breathing and his skin turned bluish, showing that his blood did not have enough oxygen in it. He had no pulse. Staff turned the man onto his back and began to administer cardio pulmonary resuscitation (CPR). The man began to recover and staff noted that he had a weak pulse and his colour had improved. They again placed him in the recovery position.
36. The staff nurse asked the second officer to report a 'code blue' medical emergency and ask the communications staff to call an emergency

ambulance and additional medical staff. Prison records show that an ambulance was called at 4.41pm.

37. At this point, two further staff nurses arrived. The first staff nurse told them that the man had had an epileptic fit. After about 30 seconds in the recovery position, the man stopped breathing again and staff resumed CPR. The charge nurse called for further staff to help administer CPR on the man. One of those who responded also fetched the bag of emergency equipment from the outpatients section. The second and third staff nurses assisted in giving CPR to the man.
38. Another nurse then brought the defibrillator to the cell. (A defibrillator is a machine that treats victims of sudden cardiac arrest by delivering a shock to the heart. It passes a current through to the heart to trigger it and return it to normal regular cardiac rhythm.) He attached the machine to the man and followed the instructions it gave. The defibrillator shocked the man three times and staff continued CPR. Shortly before 5.00pm, the paramedics arrived and they monitored and assessed the man. They attached a heart monitor to him and this showed that there was no heart rhythm. At 5.12pm the nursing staff and paramedics agreed that nothing more could be done for the man and they stopped the CPR. Staff had also contacted one of the prison doctors and he arrived at 5.25pm. He certified the man dead at 5.28pm.
39. A governor and a family liaison officer went to the home of the man's sister to break the sad news of her brother's death. They offered her support and help with the cost of the funeral. They also invited her to visit the prison at a later date, which she did. The governor and the family liaison officer attended the man's funeral. I commend the Governor and his staff for the sensitive and caring contact they had with the family.
40. The day after the man's death, a debrief was held for all staff who had been involved in the resuscitation attempt. Those present discussed what happened and what had been done for the man. It was also an opportunity to look at the support offered by the prison's Care Team.

Issues considered during the investigation

The man's physical health

41. Most of the man's contact with medical and nursing staff was related to his mental health problems. However, he was also treated for a number of physical ailments during the two months he was in Holme House.
42. On 9 September, he saw a doctor who prescribed ibuprofen (a painkiller) for backache. Four days later, he still had backache and was given a gel for his back to ease the pain. On 23 and 26 September, the man again attended healthcare with back pain which he described as a chronic problem he had had for three or four years. He was given soluble paracetamol and the gel to relieve the pain. There are no further references to back pain in the man's medical records.
43. The man then attended the healthcare centre with mouth ulcers. On 3 October 2005, the doctor gave him Bonjela gel but he returned two days later, as the mouth ulcers were still there. The nurse on duty gave him a mouthwash to use, and the man did not attend again with this problem.
44. On 17 October, the man was seen by a nurse as he had ear problems. He was referred to a doctor who examined him two days later. The doctor diagnosed that he had a viral upper respiratory tract infection and prescribed medication to treat the problem.
45. The clinical reviewer notes in his review (Annex 1) that, apart from the missing ECG printout, the medical records were in good order and documented well the treatment given. He says that this suggests, "... that the man had ready access to nursing and medical care as appropriate."

The man's mental health

46. The man's mental health problems were identified by the staff who spoke to him during the reception procedures as he entered Holme House. They acted immediately to provide for his safety and support. Staff in the healthcare centre and on the wing continued to support the man throughout his time in prison, particularly in the days before he was sentenced. After sentencing, the man's mental health improved considerably and the ACCT plan was closed. But the man was assured of continuing support from staff and a review was scheduled for a month's time. Sadly, he died only three days after the closure of the ACCT document.
47. The ACCT procedures were completed to a high standard. When the man arrived at Holme House, staff were sufficiently concerned about his mental health to admit him directly to the healthcare centre. They then opened an ACCT plan for the man, to put in place the enhanced level of support he

needed. Review meetings were held regularly and the man was always present. The staff who attended the reviews were drawn from a small pool of people who had daily contact with the man and could assess his needs. They included wing and healthcare staff and members of the In-reach Team. Many of the notes made by staff on the record of daily contact are informative and indicate that staff spent time talking to the man about how he was feeling. In addition, the man was seen by mental health nurses on a regular basis and was assessed three times by a consultant psychiatrist.

The man's alcohol problems

48. The first reception health check form used by Holme House stipulates that anyone drinking more than about 20 units of alcohol per day should be referred to the prison doctor for treatment. It also has space for the prisoner to say whether or not he would like help with alcohol and drug use. When the man arrived at the prison, he told staff that he had, until recently, been drinking 14 pints a day (28 units), but had now reduced this to eight pints (16 units). He added that he would like help with the problem. While 16 units was below the threshold to trigger a referral to a doctor, it was close to the limit, especially as only two weeks earlier the man's consumption had been well over the threshold. The Department of Health recommends that men should drink no more than 28 units per week, which indicates the seriousness of the man's problem with alcohol.
49. However, there is no record that the man saw a doctor for further assessment, monitoring or treatment to manage his alcohol withdrawal. There is also nothing to indicate that an alcohol detoxification programme was considered. Apart from the note on the care plan to observe for signs of withdrawal, the only other mention of alcohol problems was in the letter the psychiatrist sent medical staff after he saw the man on 14 September. He described the man as 'alcohol dependent' and noted that he described 'getting the shakes' and not remembering what he had done after drinking alcohol. The lack of a care plan for alcohol addiction is disappointing, and is in stark contrast to the excellent care the man received for his mental health problems.

The Governor and Head of Healthcare should remind staff of the importance of the prompt identification of, and treatment for, all prisoners who are alcohol dependent.

Recommendations

- **The Governor and Head of Healthcare should remind staff of the importance of the prompt identification of, and treatment for, all prisoners who are alcohol dependent.**

The recommendation was accepted

- **The Head of Healthcare should remind staff of the importance of taking timely and appropriate action following clinical tests and examinations, and documenting the action taken.**

The recommendation was accepted

Good Practice

- **The prison's contact with the man's sister was sensitive, caring and professional.**
- **The ACCT procedures were completed to a high standard and the man received first rate care for his mental health problems.**