

**Circumstances surrounding the death of
a prisoner at HMP Holme House in July 2006**

**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 prisoner who died in July 2006 at HMP Holme House. The man was a remand prisoner who had not been in prison before. The post mortem indicates that he died from suppurative bronchitis and pneumonia due to chronic obstructive pulmonary disease. He was 82 years old.

I offer my sincere condolences to the prisoner's family.

I am grateful to the Governor of Holme House and his staff for their co-operation during this investigation. I would also like to thank the North Tees Primary Care Trust that conducted the clinical review into the prisoner's care and treatment whilst in prison.

The Prison Service is increasingly expected to care for very elderly prisoners. Indeed, the man was the oldest prisoner ever received at Holme House. The clinical review indicates that he was monitored well during his time there. He had regular access to nursing and medical staff as required, and was given appropriate medications for his conditions.

I have made two recommendations. They focus on obtaining information at the earliest possible opportunity in respect of a prisoner's mental health, and the importance of holding a timely debrief for all relevant staff following the death of a prisoner. I also endorse the recommendation made by the clinical review in regard to the completion of medical records. However, I have also highlighted the good practice demonstrated in the way in which the prisoner's family were told of his death, and the sensitivity shown to them generally by the prison.

Stephen Shaw CBE
Prisons and Probation Ombudsman

October 2006

CONTENTS

Summary.....	4
The investigation process.....	5
HMP Holme House	6
Key Events	7
Events after the prisoner's death	10
Clinical review and post mortem report.....	12
Issues	13
Recommendations and Good Practice.....	15
Annexes.....	16

SUMMARY

The prisoner was pronounced dead in a single cell in the Healthcare Centre at HMP Holme House in July 2006. He was 82 years old. The post mortem indicates that he died from suppurative bronchitis and pneumonia due to chronic obstructive pulmonary disease.

The man was a remand prisoner who had been at Holme House for about one month. Prior to his arrival at Holme House, he had been a voluntary inpatient at a local Mental Health Unit. Despite a lengthy stay at the unit he was never diagnosed as suffering with any mental health problems.

The man entered prison with a number of serious health problems that included chronic obstructive pulmonary disease (COPD), ischaemic heart disease (IHD), as well as diabetes. He was given the appropriate medication for these conditions and, in view of his age and clinical needs, it was decided that he should stay in the healthcare centre. The clinical review states that the prisoner was well monitored at Holme House and received the appropriate medication for his conditions.

At about 11.10am in early July, healthcare staff and the prison doctor entered the prisoner's cell in order to assess him, following some concern from staff that he was not too well. The man was lying on his bed, not breathing and unresponsive. Cardio Pulmonary Resuscitation (CPR) was started. Despite resuscitation attempts, the doctor pronounced him dead at about 11.20am.

THE INVESTIGATION PROCESS

1. The investigation into the circumstances surrounding the prisoner's death was opened by one of my investigators, when he visited HMP Holme House on 27 July. My investigator spoke to healthcare staff and a prisoner who knew the prisoner. Notices had been issued to staff and prisoners informing them of the investigation and giving them the opportunity to speak with my investigator. No prisoners or staff came forward in response to my notices.
2. The Governor and his staff produced the prisoner's core record, his medical record and a number of other documents for review.
3. North Tees Primary Care Trust were commissioned to conduct a clinical review into the care and treatment that he received whilst at Holme House. This is attached to this report as an annex.
4. One of my Family Liaison Officers contacted the man's daughter in law (the family's representative) on 13 July, to offer the family the opportunity to meet with him and the investigator to discuss the purpose of the investigation, and to raise any concerns they would like addressed. The family raised no issues concerning the prisoner and were complimentary in regard to the way in which the prison and, in particular, the prison's family liaison officer had dealt with them.
5. My investigator contacted Her Majesty's Coroner by letter to inform him of the nature and scope of the investigation and to request a copy of the post mortem report. My final report will be sent to the Coroner to assist him with the inquest into the prisoner's death.

HMP HOLME HOUSE

6. Holme House is a purpose built local Category B prison, which opened in May 1992. It holds unconvicted and convicted male adult prisoners and unconvicted young male 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.
7. The prison was most recently inspected by HM Chief Inspector of Prisons, Ms Anne Owers, in April 2005. Holme House was deemed to be a largely safe and well-ordered establishment, and suicide and self-harm prevention was found to be well managed. Many of the prisoners most likely to be at risk of self-harm were diverted to beds in the healthcare centre upon reception.
8. The healthcare centre has 28 in-patient beds, approximately half of which are occupied by prisoners undergoing detoxification. Ms Owers noted in her 2005 report that there was a good range of clinical services at Holme House delivered by a well qualified, experienced and committed healthcare team.

KEY EVENTS

9. On 8 June 2006, the man was remanded into custody at Holme House. On reception he went through the standard induction procedure for new prisoners, which included an initial health screen interview. This established that prior to his arrest he had been a voluntary in-patient in a local Mental Health Unit for approximately 12 months. The health screen also established that he suffered with chronic obstructive pulmonary disease, type two diabetes, and ischaemic heart disease, for which he had been on appropriate medication. The prisoner had use of a subutamol inhaler to relieve breathlessness. Whilst in custody, he continued to receive his medication. In light of his age and clinical needs, the man was placed and monitored on the prison's Chronic Disease Management Register.
10. It was also noted during reception that in June 2005, the prisoner might have attempted to hang himself. He denied any present thoughts of self-harm, and was not considered to need a regime designed to support those prisoners who are in crisis and who may injure themselves. As a consequence, he was not the subject of any formal mental health observations whilst in healthcare.
11. During his reception, the prisoner submitted an application under Prison Rule 45. Because of the nature of his alleged offences, he wanted to be managed as a vulnerable prisoner. (Vulnerable prisoners are those whose offences or behaviour are such that they may need to be segregated from other prisoners for their own safety and protection.) His application was approved on the basis that he would have been moved to a residential block after discharge from the healthcare centre. However, due to his clinical needs, the prisoner was never discharged to a residential block.
12. A nurse told my investigator that on reception the prisoner looked underweight, dishevelled and frail in appearance. My investigator also learnt that he was the oldest prisoner that Holme House have had to manage and care for. Because of his age and medical needs, it was decided by the healthcare manager to continue to monitor him in healthcare. The prisoner was located in a relatively spacious single cell in the in-patient facility.
13. On 9 June, the medical record notes that he was only eating small amounts of food and needed prompting with his personal hygiene. At the initial health screen, the prisoner had told staff that he was incontinent at night and appropriate protective measures and monitoring was put in place. The man was also referred for a mental health assessment following the information that he had been an in-patient at a local Mental Health Unit.

14. The medical record notes that, on 11 June, the man was eating and drinking reasonably well and was checked frequently by nursing staff for incontinence. No problem was reported. It was also determined that, whilst he had experienced some breathlessness on effort, he had the use of his inhaler at all times. My investigator was also told by a prisoner that he was given assistance with his personal hygiene and cleaning.
15. On 13 June, the man's property from the local Mental Health Unit was received by Holme House. The medical record notes that the nurse in charge at the unit, stated that the prisoner had been at the hospital since June 2005, following an incident whereby he had suffered injuries to his neck that were not necessarily self-inflicted. During his stay at the unit, the prisoner was not diagnosed with a mental illness, but he had been a very problematic resident and a very difficult man to manage. The medical record notes that, whilst at the Mental Health Unit, he was incontinent of faeces and urine as a form of protest rather than due to any medical problem. The nurse in charge of the unit also told a nurse at Holme House that the prisoner had recently attacked a member of staff as well as another resident, and that he would openly masturbate in front of female staff. The nurse at Holme House told my investigator that the prisoner continued to do this whilst in healthcare. In effect, the man was considered to be a threat to female staff. Following the disclosure from the nurse at the Mental Health Unit, healthcare staff (who were predominantly female) were more wary of dealing with the prisoner. My investigator also established that previous attempts to obtain information from the Mental Health Unit at an earlier stage were unsuccessful.
16. The medical record notes that, on 16 June, a letter was sent to the prisoner's doctor requesting details of his chronic disease management, mental health history, hospital consultations and operations. A response to the letter giving a comprehensive clinical history was received at Holme House on 22 June.
17. On 18 June, the man was prescribed Ensure protein drinks by the doctor in order to build up his strength. The medical record also notes that he had to be continually prompted to shower and clean his cell. On 19 June, the medical record notes that the prisoner was covered in excrement and refused to clean his cell.
18. On 20 June, the man was assessed by a Registered Mental Nurse (RMN). She told my investigator that the prisoner told her to 'F*** off'. She could not find any evidence that the man was suffering from a mental illness and told my investigator that he could be a 'manipulative and obnoxious man'.
19. By 23 June, the medical record notes that the prisoner was being encouraged by staff to eat and drink more, but would not speak to staff. My investigator spoke to a wing cleaner who said that the man did not really associate and would spend a lot of time in his cell. The medical record notes that whilst the prisoner had a degree of mobility and could do

things for himself, he would often pretend that he could not do anything at all.

20. On 1 July, the prisoner had an electrocardiogram (ECG), (this is used to monitor the electrical activities of the heart). The clinical review was unable to establish why he needed an ECG, but following the ECG reading the medical record notes that consideration would be given to referring him to a cardiologist.
21. At about 3.15pm on 1 July, the medical record notes that the prisoner was found sitting on the floor of his cell. He had sustained bruising to the left side of his forehead. The man said he had slipped off his bed. He was assessed by healthcare staff who recorded that he was alert and orientated.
22. At about 8.10am on 2 July, the prisoner was given breakfast and medications at his cell door. Breakfast things were collected from his cell at about 8.40am by officers and a wing orderly. No concerns were raised.
23. At 10am, the medical record notes that a nurse offered the prisoner a shower, but he grunted in response which was not considered out of the ordinary. At about 11am, the medical record notes that he was encouraged in regard to his food and fluid intake. The nurse also told my investigator that at this time she was slightly concerned about him as he did not look well. She asked the doctor to see him later on that morning.
24. At 11.10am, a nurse and the doctor entered the prisoner's cell in order to assess his needs. The man was lying on his bed unconscious, not breathing and unresponsive. There were no vital signs. The nursing staff commenced cardio pulmonary resuscitation (CPR) whilst a defibrillator was brought by another member of the nursing staff to the cell. My investigator established that nursing staff were up to date with their CPR. Despite their efforts to resuscitate the prisoner, he was pronounced dead by the doctor at 11.20am.

EVENTS AFTER THE PRISONER'S DEATH

25. Following the prisoner's death, Holme House implemented their contingency plan in the event of a death in custody. This included notifying the Area Manager, the Prison Service's National Operations Unit, the Independent Monitoring Board and the police. A nurse notified North Tees Primary Care Trust of a Sudden Untoward Incident by telephone. My investigator subsequently contacted Cleveland Constabulary who have confirmed that the prisoner's death was not suspicious and not the subject of a criminal investigation.
26. A Principal Officer (PO) the prison's family liaison officer, was contacted at home and told of the man's death. The PO then attended the establishment (on his day off) in order to prepare to break the news of the prisoner's death to his family. However, it was established that the prisoner had not provided a contact number or address for his next of kin. In light of the nature of the man's offences, Durham Constabulary were contacted for their advice. An officer from Durham Constabulary, who was aware of the case and family sensitivities, accompanied the PO to the next of kin's home address and other members of his immediate family to break the news. The family were made aware that a Prisons and Probation Ombudsman's investigation into the prisoner's death would take place.
27. The man's daughter in law subsequently told my family liaison officer that the PO was sensitive and very considerate in dealing with the family, and that the prison had offered to pay for travel to the chapel of rest and funeral expenses. The family were aware that the prisoner was not a well man and have not raised any issues in regard to his care or treatment whilst in prison.
28. Staff were told of the prisoner's death by a notice from the Governor. My investigator also spoke to a prisoner on the healthcare centre who confirmed that an officer informed prisoners on the wing of the man's death later that day.
29. Because of other operational matters, a 'hot debrief' for staff who had been involved in the care and resuscitation attempts on the prisoner could not be held. My investigator was told by a nurse that, whilst care and support was available to staff, she felt a timely debrief of events soon after the prisoner's death would have been useful and reassuring to her - especially as she was worried that she had not referred the man sooner to the doctor that morning. My investigator noted that a letter had been sent by the duty governor acknowledging and thanking her for her efforts.

30. The prisoner's funeral took place in July. It was paid for by the prison. His family chose not to attend. The PO and another representative from Holme House were present.

CLINICAL REVIEW AND POST MORTEM REPORT

31. The clinical review concludes that the man was an 82 year old diabetic with a history of IHD and COPD, who was monitored well during his stay at HMP Holme House. He had regular access to nursing and medical staff as required and was given appropriate medications for his conditions. The record keeping was of good standard, but all entries should be timed and the reason why investigations were undertaken should be recorded.
32. A post mortem was carried out in July. It indicates that the prisoner was an elderly man who died as a result of the acute effects of an infection involving the air passages within the lungs and the substance of the lungs themselves. The infection was regarded as a complication of his chronic chest problems, and which the examination defined as the underlying cause of the man's death.

ISSUES

Security

33. The prisoner was an unknown quantity when he was received on 8 June. Indeed, he was unique in the sense that he was the oldest prisoner that Holme House had ever had to manage and care for. He was described as a frail man and dishevelled in appearance. The clinical review establishes that he received appropriate care and treatment for his health, although it emerged that the reasoning behind some clinical investigations in respect of the prisoner's heart condition were not timed or fully recorded.
34. It was established on reception that the man had been a voluntary in-patient in a mental health unit for the preceding 12 months, although information regarding his mental health status could not be obtained until 13 June. It was not until that date that information concerning the prisoner's behaviour was disclosed that indicated that he could still be a threat to female staff. The delay in obtaining this information from the mental health unit could have had serious consequences for staff dealing with him.

The Governor and the Healthcare Manager, in conjunction with the North Tees Primary Care Trust, should continue in their efforts to obtain information at the earliest possible opportunity regarding a prisoner who may have mental health problems to ensure that the appropriate security precautions are put in place.

Family Liaison

35. Details of the man's next of kin were incomplete, but the prison's family liaison officer was quick to establish that there might have been sensitivities in telling the family of his death because of the nature of his alleged offences. In liaison with an officer from Durham Constabulary who was supporting the victims, the PO attended the next of kin's address and broke the news in a sensitive and very professional manner. This has been the subject of praise and comment from the prisoner's family and I am pleased to record that. It also highlights the challenging, but essential and rewarding, role of the family liaison officer in such circumstances.

The Governor should commend the Family Liaison Officer, for the way in which he broke the news of the death of the man to his family, and for the high level of sensitivity, professionalism and compassion that has been displayed.

Post incident debrief

36. The investigation highlighted the need to provide adequate debriefing to staff following a death in custody in line with Prison Service Order 2710. This enables timely discussion and early identification of potential learning opportunities. Whilst it was clear that care and support was available to staff affected by the prisoner's death, and that other operational matters took precedence, a hot debrief would have been useful, particularly to the nurse who treated the prisoner.

The Governor should remind senior colleagues of the importance of a timely formal debrief of key staff following a death in custody in accordance with Prison Service Order 2710.

37. The clinical review was unable to establish the reasons why the prisoner needed an ECG, as this was not recorded in the prisoner's medical record.

All entries in the medical record should be timed and the reasons why investigations were undertaken should be recorded

RECOMMENDATIONS

- 1. The Governor and the Healthcare Manager, in conjunction with the North Tees Primary Care Trust, should continue in their efforts to obtain information at the earliest possible opportunity regarding a prisoner who may have mental health problems to ensure that the appropriate security precautions are put in place.**

This recommendation has been accepted by the Prison Service

- 2. The Governor should remind senior colleagues of the importance of a timely formal debrief of key staff following a death in custody in accordance with Prison Service Order 2710.**

This recommendation has been accepted by the Prison Service

- 3. All entries in the medical record should be timed and the reasons why investigations were undertaken should be recorded.**

This recommendation has been accepted by the Prison Service

GOOD PRACTICE

- 4. The Governor should commend the Family Liaison Officer, for the way in which he broke the news of the death of the man's next of kin and the high level of sensitivity, professionalism and compassion that has been displayed.**

This recommendation has been accepted by the Prison Service

ANNEXES

Documents considered during the investigation

- A The prisoner's medical record.
- B Statements from staff who discovered the prisoner on 2 July 2006
- C Clinical review commissioned by the North Tees Primary Care Trust