PRISONS AND PROBATION
OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in February 2013 at HMP Holme House

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man at HMP Holme House in February 2013. He died from a bacterial infection of the biliary tract caused by gallstones. He was 43 years old. I offer my condolences to his family and friends.

A clinical review was carried out of the care the man received in prison. Holme House cooperated fully with the investigation.

The man died just a week after moving from HMP Frankland to Holme House. He had reported no concerns at the time of his transfer and was happy about the move. He had a history of abdominal pain and gallstones which had been explored and treated in the past, although he was often uncooperative and frequently declined treatment or to attend medical appointments. In 2011, he refused to have surgery to remove his gallbladder. Two days after he arrived at Holme House, he began to report chest pain. Doctors did not regard the pain as resulting from cardiac problems but, when he died suddenly in February, it was thought that he might have had a heart attack. The clinical reviewer had some concerns that few healthcare staff seemed to be aware of their protocol on dealing with chest pain. While this was not the cause of his death, this is a concern for future cases.

The clinical reviewer concludes that the man's care was equivalent to that he could have expected in the community. He had the capacity to make decisions about his treatment and exercised his right not to have surgery. I am satisfied that he received appropriate clinical care in prison.

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 **October 2013**

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SUMMARY

1. The man was sentenced to 14 years imprisonment in 2005, for serious offences. He transferred to Frankland prison later that year.

2. The man had a history of abdominal and chest pain. In 2008, he was found to have a number of gallstones. He was advised to have his gallbladder removed, but he refused to attend two medical appointments to discuss this.

3. In 2009, the man refused to attend a gastroscopy and, in 2011, he refused to take cholesterol medication. He told the doctor he would take his chances without medication or treatment. In September 2011, he again refused to contemplate having surgery to remove his gallbladder.

4. The man transferred to Holme House on 18 February 2013. Four days after arriving at the prison, he was admitted to the prison's inpatient unit in the healthcare centre for observation after complaining of chest pain. The prison doctor diagnosed indigestion. Subsequently, another doctor considered he might have gastritis - an inflammation of the stomach lining.

5. A few days later the man told staff he did not want to take a shower or any exercise and did not want lunch. A nurse persuaded him to eat something. Staff noted that he had spent most of the day lying on his bed watching television.

6. Just before 4 o'clock that day, the man collected his tea. An officer noticed that he appeared unwell and unsteady on his feet when he was returning to his cell. The officer assisted him back to his cell and carried his tray for him. Almost immediately, he slumped on his bed and quickly became unresponsive. Staff attempted to resuscitate him, and the efforts continued when paramedics arrived shortly after, but resuscitation was not possible and he was pronounced dead at 4.30pm.

7. This report makes three recommendations about the chest pain protocol, access to medication out of hours and informing families about a prisoner's death.

THE INVESTIGATION PROCESS

8. The Ombudsman was notified of the man's death on 25 February 2013. The investigator issued notices informing staff and prisoners at Holme House about the investigation and asking anyone who had relevant information to contact her. No responses were received. Holme House forwarded his prison and medical records to the investigator.

9. The investigator informed Her Majesty's Coroner for Teeside about the investigation. The Coroner has been sent a copy of the report to assist with enquiries.

10. The local PCT commissioned a clinical reviewer to review the man's clinical care. The clinical reviewer and the investigator carried out joint interviews on 9 April 2013. The investigator provided written feedback to the Governor about the preliminary findings of the investigation.

11. One of the Ombudsman's family liaison officers contacted the man's family to explain the purpose and scope of the investigation. They raised no specific issues for the investigation to consider but wondered whether transferring from Frankland prison to Holme House had affected the man's health. They were very positive about the support they had received from the prison's family liaison officers. They received a copy of the draft report but made no further comments.

12. The post-mortem report was not received in this office until 28 May. Until that time it seemed likely that the man had suffered a heart attack. On receiving the post-mortem report, which noted the cause of death as ascending cholangitis due to gallstones[1], the clinical reviewer added an addendum to the report, but noted that this did not change his findings or recommendations.

[1] An infection of the bile duct caused by an obstruction

HMP HOLME HOUSE

13. Holme House, near Stockton-on-Tees, is a local prison primarily serving the community of Tees Valley, South West Durham, East Durham and North Yorkshire. It holds up to 1212 prisoners with a mixture of young adult offenders and adult males either on remand and sentenced. Healthcare services are commissioned by the NHS and provided by a private healthcare company.

HM Inspectorate of Prisons (HMIP)

14. HMIP conducted a full unannounced inspection of Holme House in July 2010 and reported that health services were undergoing substantial change and improving. HMIP found that admissions to the inpatient unit were clinically appropriate. The unit was described as stark but functionally adequate. There was a range of clinics for primary care and lifelong conditions and reasonable access to a doctor.

Independent Monitoring Board (IMB)

15. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure proper standards of care and decency. In their 2012 annual report, the IMB reported that healthcare services

> "are now delivered to a high standard with at least equivalence or better compared to services offered in the community. This is attributable to a great deal of hard work by the Healthcare Manager and her team. This is not to say there have not been problems or areas for improvement but any issues have been addressed promptly when identified and remedial action put in place."

Previous deaths at HMP Holme House

16. Six prisoners have died at Holme House since 2012, including the man. Two of the deaths were self-inflicted. There are no similarities between his death and the other natural cause deaths.

KEY EVENTS

2005-2007

17. The man was sentenced to 14 years for serious sexual offences at Crown Court in 2005. He moved to HMP Frankland shortly after sentencing in July 2005.

18. On 5 May 2006, the man was taken to hospital after an episode of chest pain, but he did not require any treatment. In April 2007, he had an episode of abdominal pain and had an electrocardiogram (ECG)[2]. It found nothing abnormal and he was treated for indigestion.

2008

19. On 29 February 2008, the man complained of chest pain, which was attributed to the epigastrum - the upper region of the abdomen. He was advised to take pain relief. No further problems were recorded.

20. On 2 March, the man noticed that there was blood in his urine and reported pain in his left side. He was diagnosed with a urine infection for which he was prescribed medication. Two days later, following blood tests, a doctor noted that it was likely that he had a gallstone and requested further blood tests.

21. On 7 March, the man had more blood tests. On 13 March, the doctor wrote that he seemed to have improved which could be attributed to a gallstone removing itself. He referred him for an ultrasound investigation. The ultrasound showed that he had signs of a fatty liver and that his gallbladder was "packed with calculi" (gallstones) and that he would need his gallbladder removed.

22. On 28 April, the man complained of severe abdominal pain, which he said was probably indigestion as he had experienced it before. A prison doctor reviewed his medical notes and concluded he had gallbladder and liver problems. He refused to attend two doctor's appointments, which were made for him.

23. Throughout July to September, the man failed to attend appointments to have blood taken on four occasions. At the end of September, he saw a consultant at hospital, who recorded that he suspected he had had an "episode of CBD stones which spontaneously cleared". He advised further investigation and said that he might require surgery. In October and November, he continued to refuse to attend healthcare appointments for blood tests. Eventually, on 10 November, a blood test was taken and a doctor at Frankland noted that he had raised cholesterol and needed dietary advice. He did not attend an appointment on 19 November. On 24 November, he signed a disclaimer to say he did not want to attend hospital for a diagnostic gastroscopy (stomach)

[2] An ECG machine records electrical impulses from the body to identify abnormal heart rhythms or signs of a heart attack.

examination. He refused to attend the healthcare centre for blood tests on 5 and 9 December.

2009 - 2010

24. On 13 February 2009, the man refused to attend a rescheduled gastroscopy examination at hospital. He said it was "a waste of time". He again refused to attend on 13 March. It was noted that no further appointments would be offered to him. There were no other significant interactions with healthcare staff during this time.

2011

25. The man discussed his cholesterol levels with a doctor on 4 April 2011. She offered him medication but he refused it. He said he wanted to take his chances and that he did not have a lot to live for. They discussed his decision in depth and he said he understood the implications of refusing the medication. He agreed to continue to have blood tests.

26. On 3 August, the man had another episode of epigastric pain. On this occasion he agreed to be re-referred to the consultant at hospital. A prison doctor sent a referral letter the same day. On 16 August, he had a procedure to remove a gallstone. He was referred for an endoscopy in relation to possible cholesterol deposits. He refused to attend this appointment on 13 September and no further appointments were offered.

27. A consultant colorectal surgeon visited the prison to see the man on 13 September to discuss removal of his gallbladder, but he refused to see him. The consultant wrote to a prison doctor that day explaining that the man had some residue gallstones in his gallbladder and recommended that he have his gallbladder removed. The consultant was concerned that further stones might pass out of his gallbladder and cause a blockage. He said if the man changed his mind, he would be happy to see him.

2012

28. In October 2012, prison staff told the man they were intending to transfer him from Frankland to help prepare him for release the next year. He said he was happy with this and had no questions.

2013

29. On 18 February, the man transferred to Holme House. On 20 February, after an initial reception screen, he attended a second health screen assessment completed by a nurse. She noted that he was overweight and his blood pressure was on the high side of normal. He said he took no exercise and she reminded him of the importance of keeping fit in prison. She also gave him dietary advice.

30. Two days later, on 22 February, a nurse went to see the man on the wing as he felt unwell. He said he had chest pain which had started the night before. He said the pain was central to his chest but was getting worse and radiating to his jaw and arm. She referred him to the doctor.

31. A doctor examined the man 45 minutes later. He said he had experienced chest pain since 7.00pm the night before and the pain had kept him awake all night. He said that he had had similar pain in the past, but had been told that it was indigestion. The doctor noted that his mother had had a heart attack and that he had suffered from gallstones in the past. The doctor noted that he looked in pain, had a tender epigastric area and appeared pale. He prescribed him 30mg MAALOX (an antacid) and 1gm of paracetamol. He admitted him to the prison's inpatient unit for observation.

32. When interviewed for the investigation, the doctor said that he remembered not finding much of concern when he examined the man and thought he might be displaying heartburn or gastric symptoms. The doctor said he did not think that he required an ECG at that point, because he said he had not been eating much and had gallbladder symptoms in the past. The doctor also noted that he had tenderness in the gastric area and thought it best to monitor his symptoms.

33. A nurse noted in the medical records that the man had been admitted to the healthcare centre with chest pain and was being treated for dyspepsia (indigestion). There were no further healthcare notes that day.

34. On 23 February, at 1.04am a nurse saw the man. He said he still had pain in his chest and she gave him 1gm of paracetamol. The nurse told him to alert staff if his pain got worse. At 5.54am, he complained of pain again and the nurse gave him 15mls of MAALOX and 1gm of paracetamol.

35. A nurse saw the man at 10.33am and referred him to the doctor as he was still complaining of chest pains. A doctor queried why paramedics had not been called if he had repeated severe chest pain. The nurse explained that another doctor had seen him the previous afternoon, so the doctor checked the other doctor's notes and then went to see the man.

36. The doctor said that the man did not look unwell or appear to be in significant pain. He clearly identified his upper abdomen when asked where the pain was. He said he felt slightly nauseous but had not vomited. She examined his abdomen and noted it was tender around the epigastric area. She

diagnosed gastritis, an inflammation of the lining of the stomach. He was to remain in the healthcare centre until his symptoms had settled and he was given 30mg of lansoprazole for stomach acidity. Later, a nurse noted that he had had a settled day and there were no concerns.

Day of the incident

37. At 00.12am a nurse noted that the man had just started his prescription of lansoprazole, which he had not been given when it was prescribed by a doctor earlier. No reason was given. At 3.50am and 6.18am, the nurse observed that he was asleep and seemed settled.

38. An officer, who was on duty in the healthcare centre on 24 February, recalled offering the man the opportunity to take a shower at approximately 9.30am, but he declined. He was offered the opportunity to go outside in the open air 45 minutes later, but again declined. The officer said that he was lying on his bed watching television.

39. The officer next saw the man when he unlocked him to collect his lunch, but he said he did not feel like eating. A healthcare assistant (HCA) was nearby and persuaded him to eat some lunch. He did not want to come out of his cell at 1.50pm to socialise with other prisoners on the unit and also declined an afternoon period in the open air at 3.00pm.

40. At 3.50pm, the man went to collect his tea. The officer noticed that he seemed unsteady on his feet and appeared to be sweating. The officer said he thought he was going to drop his tray, so carried it for him. The officer said that he told him he was okay.

41. When the man got back to his cell he sat on the bed, the officer said he was sweaty and shaky and his breathing seemed shallow. At this point, the HCA came to the cell as she had also been concerned about him. She asked him if he had taken any drugs, but he seemed unable to respond. She called a nurse, who came immediately. As soon as the nurse saw him she asked for an ambulance to be called. An officer radioed an emergency Code Blue at 3.51pm and requested an ambulance. The nurse asked for a defibrillator to be brought.

42. The nurse and HCA moved the man to the floor. By this time two more nurses had joined them in the cell. One nurse checked for vital signs but found none, so another nurse began chest compressions. These were administered continuously and in rotation by different nurses. An oral airway device was inserted to keep the man's airway open and a bag valve mask used to administer breaths.

43. An automatic external defibrillator was attached to the man but it advised not to administer a shock. Healthcare staff took turns to give cardio-pulmonary resuscitation until paramedics arrived at 4.05pm. A nurse briefed the paramedics and they assessed him and administered emergency treatment

and continued to attempt resuscitation until 4.30pm, when they concluded that he had died.

Family liaison

44. At 5.00pm the prison contacted their family liaison officer (FLO), who was at home. She arrived at the prison at 6.00pm and obtained the man's mother's details. His mother lived in Sheffield, so it was agreed with the deputy governor that a FLO from a prison nearer to Sheffield should visit the family. Initially an officer from Moorland prison was identified, but at 7.30pm the FLO was told this person could not attend. It was then agreed by the FLO that South Yorkshire Police would contact the family.

45. At 9.30pm the man's brother telephoned the FLO. She explained what had happened and apologised for the police breaking the news to his family. She asked if she could visit the next day and this was agreed.

46. The FLO and another member of staff visited the man's family the next day. They explained what would happen next and discussed the funeral arrangements and the return of his property.

47. The funeral was held on 6 March and the prison contributed fully towards the cost in line with Prison Service Instructions. A memorial service was also held at the prison.

Support for staff and prisoners

48. A debrief was held for staff involved in the man's death and support offered to any member of staff who considered they needed it. Prisoners in the inpatient unit were offered the opportunity to speak to staff, Listeners[3] or Samaritans. All prisoners on suicide and self-harm monitoring were reviewed in case they had been adversely affected by his death.

[3] prisoners trained by the Samaritans to speak to vulnerable or distressed other prisoners

ISSUES

Clinical care

49. The clinical reviewer concludes that the care the man received in prison was equivalent to that which he could have expected in the community.

50. The clinical reviewer considers that there was a possibility of an underlying abdominal condition, although the man's consistent refusal to have treatment meant this remained undiagnosed. In the absence of any evidence of mental illness, he had the capacity to refuse treatment if he wished to do so.

51. The clinical reviewer explains that ascending cholangitis is a bacterial infection of the biliary tract which secretes bile to the liver. It results from stoppage due to a chronic obstruction, usually by gallstones. Usually, with such an acute infection, the symptoms include a raised temperature and fever, abdominal pain and signs of jaundice. In more severe cases the person would appear confused and have lowered blood pressure.

52. Once the post-mortem report had been received, the clinical reviewer reviewed the case notes. He concludes that none of those symptoms were observed apart from abdominal pain. The man had eaten lunch a few hours before he collapsed and at the time said he felt fine. The clinical reviewer notes that he previously declined to have his gallbladder removed and refused to see a surgeon to discuss this in 2011.

53. Until the post-mortem report it was presumed that the man had suffered a heart attack. On that basis the investigator and clinical reviewer explored the chest pain protocol and use of the ECG machine at Holme House. While eventually found not causative to his death, they remain an issue and there are lessons for future cases.

Responding to chest pain

54. A doctor said that she did not consider an ECG when she examined the man as he clearly identified pain in his upper abdomen; the area was consistent with an abdominal cause for his pain. Also, his observations were stable and he did not look unwell. The clinical reviewer agrees that this was a reasonable conclusion.

55. Another doctor held the same view. However, he was concerned that it took some time to receive results from the prisons ECG machine, as they now use a telemed machine[4]. He suggested that this had had an impact on his decision not to perform an ECG as the results took too long.

56. All clinical staff interviewed had experience of dealing with acute heart problems where an ambulance is called and an ECG performed. They said

[4] Telemedicine is the use of telecommunication and information technologies in order to provide clinical health care at a distance.

that Holme House has its own telemed ECG machine, but it is only used for routine cases as it takes some days for the results to be provided to the prison. If heart problems are suspected, an ambulance is called. The clinical reviewer notes that the telemed ECG is a useful tool, if the results are emailed or faxed within minutes. He sought information about the specification and contract for the telemed machine but, at the time of writing, the reviewer had received no response. He has suggested in his review that that the Head of Healthcare should clarify the situation.

57. A doctor said that the chest pain protocol at Holme House is the same as for patients in the community. If a prisoner complains of chest pain, an ambulance should be requested. However, no other healthcare staff were aware of a protocol.

The Head of Healthcare should ensure that all staff are aware of the chest pain protocol and that an ambulance is called when prisoners report severe chest pain.

Receiving medication out of hours

58. The man was prescribed lansoprozole, which he was to start immediately on the morning of 23 February. However, he did not receive his first dose until 12 hours later as it was the weekend and the pharmacy was closed. An out of hours store of medication is used, which should contain lansoprozole, but none was available. The clinical reviewer does not conclude that the delay in receiving this medication was a contributory factor in his death, but there is a need to ensure access to an appropriate range of medication at all times.

The Head of Healthcare should ensure clinical staff are aware of, and have access to an appropriate range of medications for out of hours use.

Family Liaison

59. Prison Service Instruction 64/2011 says that the family liaison officer and another member of staff should visit the next of kin in person to break the news of a death. Where the prison is a long distance from the next of kin, consideration can be given to asking a family liaison officer from a nearer prison to inform them to avoid undue delay. The deputy governor agreed with the family liaison officer that a member of staff at a prison near the man's family should be asked. Unfortunately, those arrangements fell through, so the local police were asked to break the news instead. We understand that the prison was trying to avoid delay, but as Holme House is less than two hours drive from Sheffield where his family lived, we consider it would have been preferable for staff from the prison to have gone themselves. Subsequent to that, the family liaison appears to have been of a good standard. The family said they found the prison's family liaison officers very supportive and wanted them recognised for their impressive work and assistance at a difficult time.

The Governor should ensure that, where practicable, the news of a prisoner's death is given to the next of kin promptly and in person by someone from the prison.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that all staff are aware of the chest pain protocol and that an ambulance is called when prisoners report severe chest pain.

   Accepted – There is currently no formal 'Chest Pain Protocol' at Holme House. This is currently under consideration by the regional medical director for the private healthcare company. All prisoners who present with chest pain will be assessed taking all other signs/symptoms and previous medical history into account and treated accordingly. If staff are unsure of the causative factor they will call for an ambulance. An emergency ambulance is always requested for any prisoner who presents with severe central chest pain.

2. The Head of Healthcare should ensure clinical staff are aware of, and have access to an appropriate range of medications for out of hours use.

   Accepted – All clinical staff are aware of and can access the Out of Hours drug cupboard located in the Inpatient Unit. A comprehensive range of medications are available and pharmacy checks stock availability on a weekly basis.

3. The Governor should ensure that, where practicable, the news of a prisoner's death is given to the next of kin promptly and in person by someone from the prison.

   Accepted – Procedures are in place to ensure prisoners families are notified promptly following the death of their next of kin member.

   Where a prisoner's next of kin is located out of the immediate area, a decision will always have to be taken on the best means of informing the next of kin. The benefits of someone attending from the prison must be weighed against the risk of the family finding out by other means.

   A mutual support network of Family Liaison staff is in operation for prisoners out of our immediate area. In this case the mutual help organised was unable to fulfil their promise to inform the man's family.

   Given the delay caused by the lack of mutual support and the estimated two hours to reach the man's next of kin address in Sheffield a decision was made to use the police.

   Staff from HMP Holme House attended the family home the next morning and the man's family were grateful for the level of support they received.