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 January 2014, while in the custody of HMP Kirkham

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, from a stroke, of a man in January 2014, while a prisoner at HMP Kirkham. The man was 71 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. A clinical reviewer reviewed the clinical care the man received at Kirkham. The prison cooperated fully with the investigation.

The man had been in prison since 2004 and at Kirkham since 2012. His initial health screen indicated that he suffered from high blood pressure and had mobility problems due to an accident 30 years previously. However, he was active and enjoyed working in one of the prison workshops. Healthcare staff monitored his blood pressure regularly, but otherwise the man had little contact with them.

On 20 January 2014, the man reported to the prison's healthcare unit as he was feeling unwell. His blood pressure was low and he had a very fast heart rate. He was taken to Blackpool Victoria Hospital and admitted for observation. The next morning, the man became unconscious and was found to have suffered a stroke. The man died at 12.35am on 27 January. His family were with him at the time.

I am satisfied that the man's death could not have been foreseen or prevented. The man received good support at the prison and the standard of healthcare he received at Kirkham was equal to that which he could have expected to receive in the community.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **June 2014**

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SUMMARY

1. The man was sentenced to life imprisonment on 21 June 2004 and sent to HMP Altcourse. An initial health screen indicated a history of high blood pressure (hypertension) and limited mobility due to a motor bike accident 30 years before. The man served his sentence at several prisons, and transferred to HMP Kirkham in September 2012. Healthcare staff reviewed the man regularly in the prison's hypertension clinic and prescribed medication to control his blood pressure. Despite his health problems and age, the man maintained a job in one of the workshops at Kirkham.

2. On 20 January 2014, the man felt unwell and reported to the prison's healthcare unit. A nurse examined him and found that his heart rate was rapid and his blood pressure was low. She called an ambulance and the man was taken to Blackpool Victoria Hospital and was admitted for observation.

3. The man was released on temporary licence and a prison officer remained with him to provide support.

4. On 21 January, the man had a stroke and the hospital said his prognosis was poor. A sister and nurse from the prison's healthcare team, went to the hospital to see the man and the prison's family liaison officer contacted his family. The man's daughter and son went to the hospital to be with their father.

5. A prison manager visited the man on 22 January and spoke to his family. They said they preferred to be alone with their father so the accompanying prison officer was withdrawn. The man died at 12.35am on 27 January with his family at his bedside.

6. The clinical reviewer concluded that the standard of healthcare the man received at Kirkham was equivalent to that he could have expected to receive in the community. We are satisfied that the man received good care and make no recommendations.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Kirkham informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.

8. NHS England commissioned a clinical review into the man's clinical care in prison.

9. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. The investigator gave the Governor initial feedback in writing.

10. We informed HM Coroner for Blackpool and Fylde of the investigation, who provided the cause of death. We have sent the Coroner a copy of this investigation report.

11. One of the Ombudsman's family liaison officers contacted the man's daughter, his nominated next of kin, to explain the purpose of the investigation and invite his family to identify any relevant matters for the investigation to consider. The man's daughter did not have any specific issues for the investigation to consider and nor did his son.

12. The man's next of kin were informed the draft report was available, and they did not make any comment. The prison considered our draft report and identified a factual inaccuracy. The report has been amended accordingly.

HMP KIRKHAM

13. HMP Kirkham is an open prison in the North West holding over 600 men. There are 24 living units with single rooms and an admissions unit with double rooms for new arrivals.

14. Lancashire Care Foundation Trust provides healthcare services at the prison. There is a healthcare unit with a part-time doctor and qualified nursing staff.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Kirkham was in November 2013. The Inspectorate found that the healthcare services had improved since their last inspection in 2009. Waiting time to see doctors and nurses were short and medicines management was good.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure prisoners are treated fairly and decently. In its most recently published report for the year ending December 2012, the IMB said that Kirkham provided a safe and decent environment and that prisoners were treated fairly. The IMB noted that older prisoners made up almost nine percent of the prison's population.

Previous deaths at Kirkham

17. The man was the third prisoner to die at Kirkham since 2005. One of the previous deaths also involved a man who died of a stroke, but there were no other similarities.

KEY EVENTS

18. On 21 June 2004, the man was sentenced to life imprisonment and sent to HMP Altcourse. It was noted that his medical history included hypertension, limited mobility due to an accident 30 years before, arthritis in his right knee, and that he had undergone a gastric bypass procedure in 2000.

19. The man served his sentence in a number of prisons and transferred to HMP Kirkham from HMP Wymott on 19 September 2012. He had a full health screen when he arrived, including blood tests and a medication review. The man attended the hypertension clinic for a blood pressure check every two months.

20. An orthopaedic surgeon saw the man on 23 April 2013, about his knee pain, for which he was referred for physiotherapy. The man settled into the regime at Kirkham and worked in the workshops. He was granted regular release on temporary licence to attend services at a local church and sing in the choir.

21. On 25 November 2013, the man attended the hypertension clinic and his blood pressure reading was 140/60, within normal limits. The next day, he saw a doctor who noted that, despite a chesty cough, the man's chest was clinically clear with a good air entry. The man's next hypertension review was due in two months. Over the next six weeks, the man had no interaction with healthcare staff.

22. The man went to the healthcare unit at 11.44am on 20 January 2014 as he was feeling unwell with a pain in the left side of his chest. A nurse took a pulse reading which was irregular and rapid. The man's blood pressure reading was 108/60, which was below normal range.

23. The nurse called for an emergency ambulance, which arrived at 12.05pm. The man was released on temporary licence and accompanied by an officer for support.

24. The man was admitted to Blackpool Victoria Hospital and the officer remained with him. At 3.15pm, a nurse from Kirkham contacted the hospital for an update on the man's condition. Hospital staff told her that he had been diagnosed with atrial fibrillation (a fast irregular heartbeat) and was being treated with medication.

25. Around 10.15am on 21 January, a member of hospital staff informed a nurse that the man was being treated for a suspected stroke and was being transferred to the hospital's stroke unit for further tests. Later that morning, the hospital informed the prison that the man had become unresponsive and requested that his next of kin should be informed. The nurse and sister went to the hospital to ensure the man had support and to liaise with hospital staff.

26. The prison's family liaison officer attempted to contact the man's next of kin, his daughter, but at first was unable to do so as the telephone numbers on record were unobtainable. The family liaison officer then examined the man's prison telephone log to establish the correct contact numbers for his daughter and son. At 10.40am, he left a voice message for the man's daughter. He spoke to the man's son, told him of his father's serious medical condition and advised that his family should go to the hospital.

27. Hospital staff informed the sister and nurse that the man had suffered a stroke; the next 72 hours would be crucial but his prognosis was poor. The nurses spent some time at the man's bedside, but had left before the man's family arrived at the hospital.

28. On 22 January, prison manager visited the man. She also met his daughter and son at the hospital. At the request of the man's daughter, it was agreed that the presence of the supporting prison officer was no longer needed.

29. Later that day, after discussion with hospital staff, the man's family signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order. (This means that in the event of cardiac or respiratory arrest no attempt at resuscitation will be made, but all other appropriate treatment and care will continue to be provided).

30. On 25 January, the family liaison officer visited the man's family to offer his support. The man died at 12.35am on 27 January, with his family at his bedside.

31. The family liaison officer remained in contact with the man's family to offer continued support. A funeral service was held on 4 February and attended by the Governor. The prison offered a contribution towards funeral expenses in line with national policy.

Support for staff and prisoners

32. The Governor issued a notice informing staff and prisoners of the man's death and informing them of the support available.

Post-mortem report

33. A post-mortem examination concluded that the man died from a left sided haemorrhagic cerebral infarct (a stroke).

ISSUES

Clinical Care

34. The clinical reviewer concluded that the standard of healthcare the man received at HMP Kirkham was good. The man arrived at Kirkham in September 2012 and had good quality and timely health assessments. He regularly attended the hypertension clinic for blood pressure checks and his blood pressure was well controlled using appropriately prescribed medication.

35. The clinical reviewer noted that the actions taken by the healthcare team on 20 January were appropriate and the man's stroke and consequent death could not have been foreseen or prevented. We agree with the clinical reviewer, that the man received healthcare equivalent to that he could have expected in the community. We make no recommendations.