Investigation into the circumstances surrounding the death of a prisoner at HMP & YOI Altcourse, at Fazakerley Hospital in May 2011

Report by the Prisons and Probation Ombudsman for England and Wales

April 2012

This is the report of an investigation into the death of a man, a prisoner at HMP and YOI Altcourse, who died unexpectedly in May 2011, after suffering from a cerebral aneurysm. I offer my condolences to his family for their sudden loss.

The investigation was undertaken by one of our senior investigators. A clinical review of the healthcare provided to the man was commissioned by Liverpool Primary Care Trust (PCT), and was completed by a Clinical Reviewer. I would like to express my thanks to the Director of Altcourse and his staff for their co-operation. I apologise for the delay in completing this report.

The man arrived in Altcourse in April 2011 and this was his first time in prison. When he was examined at his first healthscreen, he was diagnosed having hypertension (high blood pressure). He had previously been diagnosed within the community but told staff that he had not been taking medication because he could not afford the prescriptions. He was prescribed bendroflumethiazide, a medication for high blood pressure, but on 3 May he told the prison doctor that he had stopped taking it because it made him feel light headed and dizzy. He was then prescribed a different medication for high blood pressure; ramipril.

On 6 May, he was found in a collapsed state in his cell. When he was found he was responsive and healthcare staff were called. However, he rapidly deteriorated and he was taken to Fazakerley Hospital by emergency ambulance. On arrival, he was taken for an immediate computed tomography (CT) scan. This indicated that he had suffered from a cerebral aneurysm. (A cerebral aneurysm is a bulge in the wall of an artery in the brain and is due to a weakness in the wall of the artery.) Hospital staff informed the prison staff that he was in a critical condition and there was no treatment that could be given. Prison staff informed the man's next of kin and organised transport for his mother and a friend to go to the hospital. Sadly the next day, he died at 9.20pm.

The investigation concludes that he received an adequate standard of health care and that the prison could not reasonably have foreseen his death. However, the clinical reviewer believes that his treatment for high blood pressure might have been improved and a recommendation is made regarding appropriate medication. I am also pleased to commend the actions of a Senior Officer, for his care and support to the man's family.

Nigel Newcomen CBE
Prison and Probation Ombudsman **April 2012**

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SUMMARY

1. The man died in May 2011, in Fazakerley Hospital, Liverpool. He was sent to prison in April 2011 and received at HMP Altcourse. During a routine healthscreen, it was confirmed he was suffering from high blood pressure. Although prescribed medication for this in the community, he was not taking it.

2. Whilst in prison, he was prescribed medication for his blood pressure, which the clinical reviewer considered to be "not ideal but not useless." However, his medication was changed shortly after he told healthcare staff that he was experiencing side effects.

3. On 6 May, he was found in a collapsed state in his cell. Emergency care was given to him and he was subsequently taken to hospital by ambulance. His next of kin were immediately contacted and transport was provided to take them to the hospital.

4. Unfortunately, he had suffered a cerebral aneurysm and staff at the hospital said that there was no treatment available for his condition. He sadly died in May and his family were with him at the time.

5. We make one recommendation in this report relating to the chronic disease management team at Altcourse adhering to NICE guidelines regarding prisoners with high blood pressure. We also make one commendation regarding the actions of an SO, who acted as the prison family liaison officer as his willingness to provide transport for the man's next of kin was over and above that which would be expected.

THE INVESTIGATION PROCESS

6. The man died in May 2011. A senior Investigator , opened the investigation when she visited HMP Altcourse on 13 May. She spoke to two members of the Independent Monitoring Board and was shown around the prison. She was given copies of his prison and clinical records. She gave feedback to a Governor after the interviews had taken place, and would like to thank him for his assistance during this visit.

7. Notices were issued to staff and prisoners informing them of the investigation and inviting anyone who had any relevant information to contact the investigator. No responses were received. The senior investigator carried out interviews with staff on 8 July.

8. A clinical review of the healthcare received by the man was commissioned by Liverpool PCT. This was completed by a Clinical Reviewer. The review was not received by our office until 6 November and this impacted on the delay in issuing this report, as did the ill health of the investigator.

9. One of our family liaison officers wrote to his family to explain the investigation process and ask if they had any questions that they wanted the investigator to consider. At the time they raised no concerns. His family were offered an opportunity to receive and comment on the draft version of the report and identified an inaccuracy relating to his family being present when he died. This has been amended.'

The Inquest

10. The HM Coroner for the City of Liverpool, held the inquest into the man's death in July. The jury concluded that he died from natural causes.

The Man

11. This was his first conviction and his first time in prison. However, staff said that he had settled into the regime well.

HMP ALTCOURSE

12. HMP Altcourse is located on the outskirts of Liverpool. It opened in December 1997 and is privately managed under contract by G4S custodial services. Altcourse was restructured from a category A to a category B local prison in June 2003. (Prisoners are risk assessed when they come into prison and given a category based on their offence and the risk that they pose to the public should they escape. Prisoners whose escape would be highly dangerous to the public are held in category A conditions. Those who do not require the highest security conditions but for whom escape must be made very difficult are held in category B prisons.)

13. Altcourse receives both sentenced and remand prisoners from the courts in Merseyside, Cheshire and North Wales. It also takes young offenders on remand. Young offenders reside alongside adults on all units except the vulnerable prisoners' unit. There is an operational capacity of 1324 prisoners, including 90 spaces on the vulnerable prisoners' unit, where the man lived. There are seven houseblocks which are colour coded and each is named after one of the fences in the Grand National steeplechase course.

14. Healthcare is provided by a multidisciplinary team of registered general nurses, mental health nurses, healthcare assistants as well as two general practitioners (GPs) and visiting specialists. Nursing staff are on site 24 hours a day and doctors' surgeries are held every morning, Monday to Friday.

15. The last unannounced full inspection by Her Majesty's Chief Inspector of Prisons (HMCIP) took place in January 2010. In their report, inspectors said:

> "Altcourse is a local prison in Liverpool, run by G4S. It has always had good inspection reports, and this report, following a full unannounced inspection, is no exception. Levels of activity in particular remained exceptionally good for a local prison.
>
> "Healthcare was adequate, but staff shortages and a recent lack of leadership had impacted on services."

Independent Monitoring Board (IMB)

16. The IMB is a board made up of independent, unpaid volunteers appointed by the Secretary of State. They monitor the day to day life in the prison and ensure that proper standards of care and decency are maintained. The most recent annual report by the IMB at Altcourse is from 2009 to 2010 and, in respect of healthcare, the board said:

> "The partnership arrangement with the local Primary Care Trust has continued to develop and strengthen during the reporting year through a positive and open culture of trust. There is also a clear vision and strategy to deliver a quality service and drive improvements in all aspects of prisoner healthcare and, as required, facilitate a seamless service on release for prisoners requiring continued health treatment."

There have been 21 previous deaths at Altcourse since the Ombudsman began investigating deaths in custody in 2004. There were no overt similarities with the man's death.

KEY EVENTS

17. The man was convicted and sentenced to two years' imprisonment in April 2011. On arrival at Altcourse, he had a healthscreen where he told staff that he suffered from high blood pressure. His blood pressure was recorded as 230/157mm/Hg at this time. This is considered to be very high. He told staff that whilst he had been prescribed medication for high blood pressure in the community, he did not take it because he could not afford it. He was subsequently examined by a prison doctor, and was prescribed bendroflumethiazide, a drug which lowers blood pressure. There were no other illnesses or medical conditions of note.

18. He was consequently assessed as being fit to work in the prison. Due to the nature of his offence, he was given a cell in the vulnerable prisoners' unit, on Reynoldstown block. He shared the cell with another prisoner. He was again examined for a follow up healthscreen on 26 April, when he told staff that he did not drink or smoke. At this healthscreen, he also said that other family members had high blood pressure and both his grandmother and mother had previously had strokes.

19. His personal officer, Prison Custody Officer (PCO), introduced herself to him on 29 April. She noted in the records that, although this was his first time in prison, he "appears to have settled well on the unit" and no concerns were raised. He attended daily education classes.

20. He returned to the healthcare centre on 3 May, where he was reviewed by the prison doctor. He told the doctor that he had stopped taking the bendroflumethiazide because it made him feel light headed and dizzy. However, the doctor recorded his blood pressure as 170/110mmHg and it was thought that the cause of his symptoms were side effects of the medication. (one of the three prison doctors subsequently told the investigator that this could have been caused by side effects of the drug or if the man's blood pressure had dropped too low.) The doctor subsequently changed his prescription to ramipril, a different type of medication to lower the blood pressure and, in the opinion of the clinical reviewer, a more effective treatment.

21. In May, he was expected in the education block but did not arrive. At around 9.20am, two PCOs went to his cell to find him. When one of the PCO's opened the observation panel in the door of the cell, he saw the man sitting on the toilet, but bending forward with his head almost touching the floor. The officers entered the cell. They moved him to the floor and tried to put him in the recovery position. The PCO told my investigator that he had recently completed a three day refresher first aid course and was fully qualified in first aid.

22. The PCO described him as conscious, but said his speech was slurred and he felt clammy with saliva in the corners of his mouth. The told the other PCO that he had "blacked out" on the toilet and that this had happened on other occasions when he was living at home. The officers called a level three

emergency over the prison radio. (A level three code is used when someone has had a seizure but is conscious.)

23. A Nurse responded to the emergency call. She arrived at the cell approximately two minutes later, with another nurse and an oxygen tank and rebreather mask (to raise oxygen levels). She told the investigator that on entering the cell, she saw the man lying on his side in the middle of the floor. She gave him some oxygen and carried out a number of assessments. At that time, he was responsive. He knew the time, day and where he was. She then noticed that he quickly started to deteriorate. His body started to shake and she noticed a left sided weakness. His eyes were pinpointed, his blood pressure was 220/160 and his pulse rate was 130 beats per minute. The nurse then asked for a level one emergency alarm to be called and an emergency ambulance to be summoned. (A level one code is used when a prisoner's condition is considered to be life threatening.)

24. One of the prison doctors and other healthcare staff attended the cell within minutes. They brought the emergency treatment bag and defibrillator. (A defibrillator is an electronic device which measures electrical activity in the body and advises on action to be taken. It can deliver a brief electric shock to the heart to enable its natural pacemaker to regain control and establish a normal heart rhythm.) At this stage, he was unconscious and no longer responsive to verbal commands. His eyes were still pinpointed and his breathing was slightly laboured. He was still shaking and twitching, mainly on the left side. The doctor examined his heart but concluded that there was no evidence of a heart attack.

25. At interview, the doctor explained to the investigator that he was considering two causes for his condition at that stage. His symptoms indicated either a stroke or a possible overdose of opiates. He decided to give him a drug called nalexone, which reverses the symptoms of an overdose, although it is not harmful if the patient has not taken an overdose. He did not respond to the treatment and remained unconscious. The nurse put the defibrillator pads on his body as a precaution and so that they were fully prepared to use the machine if he had a heart attack. An ambulance arrived shortly afterwards and he was taken to hospital as an emergency. A risk assessment was carried out and staff were advised that no restraints were to be used whilst he was unconscious.

26. When he was taken to hospital, prison staff telephoned his mother, his nominated next of kin. She had no transport to get to Fazakerley Hospital, so, the prison family liaison officer, drove to her house in Crewe and then took her and a friend to the hospital in Liverpool.

27. On arrival at the hospital, he was immediately taken for a computed tomography (CT) scan, a special x-ray which shows cross section images of the body. Hospital staff diagnosed a cerebral aneurysm, which was not treatable because his brain was not showing any activity. (A cerebral aneurysm is a weakness in either a vein or an artery in the brain. The weakness causes the vein or artery to enlarge and possibly rupture which

subsequently leads to either pressure or bleeding in the brain.) He was then taken to the Intensive Care Unit and on the following day, the prison escort was reduced to one officer.

28. He did not regain consciousness and died at 9.20pm . The prison provided his family with financial assistance for his funeral and offered to provide transport to the inquest. The staff who were involved in the his care and treatment were offered counselling and staff care following his death.

29. A hot debrief was held where staff were reassured. The debrief focussed on how staff felt the incident went and they were able to openly discuss any difficulties they may have encountered and support was offered. Prisoners on the wing were notified of his death and offered support from staff.

ISSUES

Health

30. The clinical reviewer, commented that, in general, the man's care was "reasonable and safe" and "of an adequate standard." However, he commented on the treatment provided for his high blood pressure. As stated in this report, he was suffering from untreated high blood pressure when he went into Altcourse. He was immediately prescribed medication to lower his blood pressure and was reviewed two weeks afterwards.

31. The clinical reviewer said that the first medication which he was prescribed, bendroflumethiazide, was not the most suitable medication for his age and ethnicity. He believes that ACE inhibitors (for example ramipril) would have been a more effective long term medication. However, he stated that "One can say that here the doctor chose a medication which was less than ideal but not useless." He was changed to an ACE inhibitor [ramipril] a few days later.

32. The clinical reviewer also commented that, for a patient like the man, he would have expected a follow up blood pressure reading to take place after three or four days treatment, rather than waiting for two weeks. However, he qualifies this by saying that he was in a prison setting and could have reported any problems to the prison staff and thus been seen by the medical staff. We agree with the clinical reviewer's conclusion and recognise that he had some responsibility to discuss any concerns he might have had regarding his medication and had ample opportunity to do so.

33. He comments that the emergency response was "satisfactory". We concur with him and find no shortcomings from the actions of the staff who provided the emergency response.

34. He did not make any recommendations but he suggested that the Head of Healthcare at Altcourse notes his comments in relation to the management of hypertension when the man entered the prison. He also asked that clear instructions relating to the management of hypertension be given to the chronic disease management team and suggests that the prison take reasonable steps to keep themselves appraised of the relevant National Institute of Clinical Excellence guidance. We agree with his comments and make one recommendation based on his findings. Although we make this recommendation we are assured that these slight failings did not contribute to the untimely death.

    The Head of Healthcare should ensure that the chronic disease management team and healthcare staff keep up to date with NICE guidelines when treating prisoners with high blood pressure.

Family Liaison

35. When he was taken to hospital, staff immediately contacted his next of kin by telephone. On finding that his mother was without transport, the prison family liaison officer (FLO), drove to Cheshire and transported his mother and a friend to the hospital in Liverpool. He also offered to take the man's mother to the Inquest but due to ill health she declined.

36. We are particularly pleased to note this level of care and support which we consider to be over and above that required. We therefore commend him for his actions and ask that the Director passes on our commendation to him

CONCLUSION

37. When the man went into prison he was suffering from untreated high blood pressure. He was given medication to reduce his blood pressure, although the clinical reviewer believed that this was not the best type of medication for someone of his age and ethnicity. However he added that whilst not the best medication it did reduce his blood pressure. He attended healthcare for a follow up appointment two weeks after his first healthscreen and the clinical reviewer believed this to be unacceptable for someone with such a high reading. Nevertheless, he concluded that the treatment of the man was "of an adequate standard."

38. He died of a rupture of a silent cerebral aneurysm. The clinical reviewer said that whilst high blood pressure would increase the risk of a rupture, such an aneurysm can also occur in the absence of high blood pressure. As he did not present with any other symptoms to suggest that he had a silent aneurysm, we believe the prison healthcare could not have foreseen his death. However, we note that the management of prisoners with high blood pressure should conform to NICE guidelines.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that staff keep up to date with NICE guidelines when treating prisoners with high blood pressure.

The prison has accepted this recommendation and says:

> "Lead nurses have been identified to conduct CHD and hypertension clinics and are currently trying to secure training to assist with this process.
>
> The Head of Healthcare now ensures that staff and other relevant staff are familiar and work to the NICE guidelines.
>
> Altcourse currently has a CHD/hypertension list and medical staff are briefed about the importance that offenders are put on this list and monitored.accordingly."

GOOD PRACTICE

We are particularly pleased to note the level of care and support given by the family liaison officer, which we consider to be over and above that required. We therefore commend him for his actions and ask that the Director passes on our commendation to him.