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 October 2013, 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 of a man who died from a stroke at Blackpool Victoria Hospital on 5 July 2013, while in the custody of HMP Kirkham. The man was 80 years old. I offer my condolences to the man's family and friends.

An investigator was appointed and 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 2001 and moved to Kirkham in 2011. In May 2012, he suffered a stroke but recovered. The man's memory deteriorated during his time in prison and care plans were implemented to support him. He was diagnosed with probable mixed Alzheimer's disease and vascular dementia in July 2013.

On 4 October, the man collapsed in his room at Kirkham and was taken to Blackpool Victoria hospital where he was found to have suffered a massive and irreversible bleed to his brain. The man was placed on a ventilator but with the agreement of his family, life support was removed the next day and he died later that afternoon.

I consider that the man received good support at the prison as his memory and health deteriorated and I share the clinical reviewer's opinion that the standard of healthcare the man received at Kirkham was equal to that which he could have expected to receive in the community.

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

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SUMMARY

1. The man was sentenced to life imprisonment in 2001. He had a history of chronic cardiac and respiratory diseases and he suffered from memory loss. The man transferred to HMP Kirkham in April 2011. Staff at the prison noted a gradual deterioration in his memory during his time at Kirkham.

2. In May 2012, the man was admitted to hospital after his speech became slurred and he was diagnosed with a left-side stroke. He was admitted to hospital again in June with similar symptoms but recovered and was discharged.

3. Over the following months, the man's memory and mental state deteriorated further. Care plans were put in place to support him and healthcare staff reviewed him frequently. In July 2013, the man was diagnosed with probable mixed Alzheimer's disease and vascular dementia (degenerative brain syndromes).

4. At around 3.20pm on 4 October, some prisoners found the man on the floor of his room. Officers and healthcare staff attended. The man was taken to Blackpool Victoria hospital by ambulance. His condition deteriorated and he was placed on a ventilator. A scan showed that the man had suffered a massive and irreversible bleed to the brain. On 5 October, the man's family agreed that the life support should be withdrawn and he died at 5.42pm.

5. The clinical reviewer concluded that the standard of healthcare the man received at Kirkham was equivalent to that he would have received in the community. We are satisfied that there was an appropriate emergency response when the man collapsed. A medical emergency code was used correctly and an ambulance was requested quickly.

THE INVESTIGATION PROCESS

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

7. NHS England commissioned a clinical reviewer to review the man's clinical care in prison.

8. The investigator visited Kirkham on 15 October and obtained copies of the man's prison and prison medical records. He met the Governor, visited the wing where the man had lived and spoke to two prisoners who knew him. The investigator and clinical reviewer interviewed prison staff on 20 November and 4 December. The investigator gave the Governor initial feedback on the investigation, and followed this up in writing.

9. The investigator informed HM Coroner for Blackpool and Fylde of the investigation and the Coroner provided the cause of death. We have sent the Coroner a copy of this investigation report.

10. One of the Ombudsman's family liaison officers contacted the man's son, 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 son did not have any specific issues for the investigation to consider.

11. The man's family received a copy of the draft report and indicated that they were satisfied with the findings.

12. The service also received a copy of the draft report. They pointed out some factual inaccuracies. This report has been amended accordingly.

HMP KIRKHAM

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

14. Healthcare services are provided by Lancashire Care Foundation Trust. There is a dedicated healthcare unit with a part-time doctor and qualified nursing staff to provide health care for prisoners.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Kirkham was in November and December 2009. The Inspectorate found that the prison was purposeful and active, and provided a safe environment. Staff-prisoner relationships were good and healthcare provision was sound. There was a member of staff leading on older persons' issues, which ensured that their needs were identified and addressed.

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 to 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 second prisoner to die at Kirkham since 2005. The previous death also involved an emergency response by staff and prisoners. While we concluded that the response in that case was appropriate, we recommended that the prison should review their emergency medical code protocol to ensure it was fully understood and correctly used. We are satisfied in the man case that the correct emergency code and appropriate response was used.

KEY EVENTS

18. The man was sentenced to life imprisonment for murder in May 2001. This was his first time in prison. The man's medical history included a number of chronic cardiac and respiratory diseases. He also suffered from Ménière's disease (an inner-ear disorder affecting hearing and balance) and memory loss.

19. In April 2011, the man transferred to HMP Kirkham. After initial health screenings, he saw healthcare staff frequently. No major concerns were recorded. In May, the man moved from the induction unit to F8 unit.

20. In the months after he arrived at Kirkham, staff noted a deterioration in the man's memory and he reported difficulty in recalling facts about his past. He sometimes behaved aggressively towards other prisoners. Healthcare staff continued to see the man frequently and supported him with his medication regime as his memory deteriorated. Tests did not indicate dementia and a mental health assessment did not identify any concerns.

21. On 3 May 2012, a prison GP reviewed the man after he became disorientated and his speech was slurred. (He had displayed similar symptoms during the previous week). The GP suspected that his symptoms could have been caused by transient ischaemic attacks. (TIA's, are small strokes causing minor and temporary symptoms). The man went to the primary care assessment unit at Royal Blackpool Victoria hospital that afternoon and was diagnosed with a viral illness and TIAs. Another prison GP saw the man the next day when he returned to the prison. She noted the man still had slurred speech and referred him back to the hospital.

22. On 8 May, the man went to the TIA clinic at Blackpool Victoria hospital. He was admitted to the stroke unit and remained in hospital until 10 May. As a category D prisoner (low security risk), the man was not restrained at any time. Healthcare staff at the prison remained in contact with the hospital during this time. A CT scan showed that the man had suffered a stroke on the left side of his brain. The consultant noted that the man had recovered well and his symptoms had improved.

23. On 11 May, the GP saw the man and noted that he was still having episodes of slurred speech and experiencing weakness in his right arm. She diagnosed a stroke and the man was readmitted to the stroke ward at Blackpool Victoria hospital. He remained there until 18 May, when he was transferred to Royal Preston hospital for further examination. The man was discharged back to the prison on 22 May. A scan had confirmed a left-side stroke, but there was no evidence of any further problems. A nurse examined the man when he returned to prison and recorded that his speech and mobility were normal.

24. The man continued to have frequent contact with healthcare staff after he returned to the prison. On 13 August, the man attended an outpatient appointment with the consultant at Royal Preston hospital. The consultant

noted that the man did not have any further symptoms of TIAs and discharged him.

25. On 15 April 2013, prison staff recorded that prisoners had said that the man had tried to leave the unit at night to collect medication. In the morning he appeared disheveled and unsteady, and had soiled his bed. Other prisoners helped to clean the man's room and he was taken to the healthcare unit. The man reported being confused, especially when alone, and said he had short term memory loss. The GP examined the man and recorded no medical concerns. Later that day, at about 3.30pm staff found that the man had locked himself in a toilet cubical on his unit. He had fallen over and was being sick. Healthcare staff were called and after around 15 minutes, the man was able to open the door. After taking medical observations, staff called an ambulance and the man was taken to Blackpool Victoria hospital.

26. The man returned to the prison the next day. His medical observations were normal and he was noted to appear well, and his memory had improved. Prison staff discussed his care needs with the man. He said that he felt appropriately supported by staff at the prison and enjoyed the regime. An Additional Support Protocol document (ASP document, a local care plan implemented when prisoners require addition support) was opened and prisoner helpers were assigned to help him with cleaning and collecting meals.

27. Healthcare staff began to review the man daily when he collected his medication. A nurse saw the man on 18 April and recorded that he was forgetting when he had eaten meals. They discussed a possible move to C1 unit for elderly and immobile prisoners where more support would be available, but the man did not want to move.

28. On 22 April, officers recorded that the man had started to behave aggressively towards his helpers and was making false accusations against them (symptomatic of dementia). A healthcare manager produced a draft care plan with multi-disciplinary input to formalise the man's care arrangements.

29. On 30 April, the healthcare manager examined the man and diagnosed possible early stage dementia caused by vascular disease (hardened arteries). The Head of Healthcare noted that it was becoming difficult to manage the man at Kirkham because of his behaviour and the lack of 24-hour care at the prison. The Head of Healthcare referred the man to the Memory Assessment Service at Lytham hospital the next day to assess if the man had early-stage dementia.

30. A mutli-discliplinary care planning meeting was held on 2 May to discuss the man's future health and social care in prison, and possible support from outside agencies. Staff decided to move the man to a room on C1 unit to safeguard himself and other prisoners because of his recent behaviour. Other prisoners on C1 were asked to report any concerns they had about the man to staff.

31. On 9 May, staff from the memory clinic at Lytham hospital assessed the man and noted some evidence of paranoia and scheduled an appointment at the clinic. The man attended the clinic on 22 July and a consultant psychiatrist diagnosed probable mixed Alzheimer's disease and vascular dementia (degenerative brain syndromes). She noted that the man's dementia was still at an early stage and recommended memantine (medication to treat the symptoms of Alzheimer's disease). The psychiatrist asked the prison to provide the clinic with weekly medical updates. The man was started on memantine on 5 August, but this was stopped on 19 August on the advice of the clinic as the man's blood pressure was low. On 27 August, the psychiatrist told the nurse that she was sending the man's medical observations to a cardiologist. The nurse noted that there would be no further action taken until the cardiologist had replied.

32. Over the following weeks, healthcare staff saw the man frequently when he collected his medication and no concerns were recorded. Prison staff said that the man was becoming more confused but noted that he was being closely monitored by the healthcare team.

Events on 4 October

33. On the morning of 4 October, the man went to the healthcare unit to collect his medication and have his clinical observations taken. The nurse said he appeared well and talked to staff. The Head of Healthcare saw the man around lunchtime walking back to his living unit and said he appeared well. The man had a parole hearing scheduled for 1.30pm that day to consider his suitability for release from prison. The hearing was adjourned for the man's Offender Manager to obtain further information.

34. At around 3.20pm, an officer heard an assistance alarm bell sounding while walking past C1 unit. He went to the entrance and a prisoner told him that the man had collapsed. He went to the man's room and found him on the bed and said that he seemed incoherent. A prisoner told him that the man had fallen to the floor and hit his head. Two prisoners had picked the man up and put him in the recovery position on his bed. The officer did not have a radio and went to get assistance from healthcare staff.

35. The officer met an Operational Support Grade (OSG) and another officer outside the building. They had been in the F unit office nearby and were responding to a radio message from the control room stating that an emergency bell had been activated. The officer told them that the man had collapsed. The OSG radioed a code blue emergency call (which indicates when a prisoner is unconscious or has respiratory problems) to summon medical help. The control room log shows that an ambulance was called immediately and healthcare assistance was requested. The OSG and one of the officers went to the man's room.

36. Two nurses arrived at the man's room with emergency equipment and a wheelchair shortly after the prison staff. A nurse told us that a prisoner had

run from C1 unit to the healthcare unit to get help and the nurse had heard the code blue call her radio while on the way to attend to the man. When they arrived at the man's room, prison staff told them that he had hit his head (the nurse later told us that there was no evidence that the man had hit his head). The nurse took the man's medical observations, which were normal, but was unable to record his blood pressure. The nurse administered oxygen because he appeared pale, but he started to vomit. The nurse continued to talk to the man and maintained his airway. She said that he was conscious and responded to them.

37. The control room log shows that an ambulance arrived at the prison at approximately 3.35pm. Paramedics assisted with the man's care and took his blood pressure, which was within normal range. The nurses provided details of the man's medical observations, medication and history. The paramedics took the man to the ambulance where they continued to treat him and the ambulance left the prison at 4.30pm. The man was released on temporary licence for treatment in hospital and staff accompanied him to provide support.

38. The man was taken to Blackpool Victoria hospital and placed on a ventilator (a machine to support breathing). A CT scan later that day showed that the man had suffered a massive and irreversible cerebral bleed (stroke).

39. After some initial difficulty the Family Liaison Officer contacted the man's son, his next of kin, and informed him of the man's condition.

40. The Family Liaison Officer met the man's niece and other family members, who were at the hospital with prison staff, at around 1.00pm on 5 October. The man's son and other children arrived shortly afterwards. At 4.57pm, the man's family agreed that the ventilator should be switched off and he died at 5.42pm.

41. After the man's death, prison staff activated contingency plans and informed all relevant agencies. Notices were issued to all prisoners informing them of the man's death and offering support.

42. On 7 October, operational managers at Kirkham held a debrief meeting for all staff who were involved in the emergency response to provide support and discuss learning points.

43. The Family Liaison Officer continued contact with the man family after his death. In line with national guidance, the prison contributed to the funeral costs. A memorial service was held at the prison.

44. The Coroner gave the cause of death as a heart attack (left main coronary artery).

ISSUES

Clinical Care

45. The man arrived at Kirkham in April 2011 and had timely health assessments. He had frequent contact with medical staff, which increased as his health and memory deteriorated. The clinical reviewer concluded that the man's standard of health care in prison was equivalent to that he could have expected to receive in the community.

46. The clinical reviewer notes that the man was referred to a GP promptly when he was unwell and healthcare staff reviewed him when he returned from hospital visits. The reviewer concluded that the care plan implemented to support the man with his memory loss was comprehensive and allowed him to maintain his independence as far as possible. He was referred to secondary healthcare services quickly when stoke symptoms were identified.

47. We agree with the clinical reviewer's assessment of the standard of the man's healthcare in prison and are satisfied that he received appropriate support.

Emergency response

48. The prisoners who found the man told us there seemed to be a long time between them finding him and staff getting to his room. We cannot know exactly when the man was found (prisoners told us this was between 2.45pm and 3.30pm), but we are satisfied that staff arrived and helped the man quickly once the alarm was raised. When the officer left the man to get assistance, the OSG and other officer had already arrived, as they heard by the radio that an emergency bell had been activated. Records show that bell was activated at 3.34pm. (When the investigator tested the system, the time was found to be 10 minutes fast, which the prison has now arranged to have corrected). The control room recorded the code blue request for assistance from the OSG at 3.25pm, so the actual time of the bell was likely to have been 3.24pm. Healthcare staff arrived shortly after the officers. We are satisfied that staff attended promptly after prisoners had raised the alarm.

49. In a previous investigation into the death of a Kirkham prisoner in 2012 we were concerned that the prison did not have an appropriate medical emergency response code system. We are satisfied that the prison now has a suitable emergency protocol reflecting current Prison Service requirements.

50. The OSG used a code blue which ensured that an emergency ambulance was called automatically and arrived quickly. The staff we interviewed had a good awareness of the protocol.

51. As well as two emergency bells which are linked to the control room, there is a local alarm system on the unit where the man lived. This alarm is activated by a number of points around the building and is intended to be used by prisoners who need help. When this alarm is used, a local bell sounds on the unit and a strobe light flashes at the entrance of the building.

52. The prisoners who found the man activated both the emergency bell and the local alarm to request assistance. When we spoke to them, they were unaware that the local alarm system was not linked to the control room or the healthcare unit, and would not automatically alert staff to an incident. We were concerned that in another emergency, prisoners might just use the local alarm believing that this would automatically alert staff. We are satisfied that the Governor has now taken action to ensure prisoners are aware of this and is investigating the possibility of linking the local alarm to the control room.