



**Investigation into the circumstances surrounding the
death of a man at hospital in February 2012,
while in the custody of HMP Kirkham**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

June 2012

This is the report of an investigation into the death of a man who was in the custody of HMP Kirkham when he died in February 2012. He died of a sudden heart attack. I offer my condolences to his friends and family.

The investigation was carried out by an investigator, with the full co-operation of Kirkham prison. The local Primary Care Trust (PCT) appointed a clinical reviewer to review the man's clinical care.

The man arrived at HMP Kirkham in December 2011 in apparent good health. Despite a history of alcohol misuse, he had no ongoing medical issues and he presented as fit and well at his initial and secondary health screening. He collapsed suddenly at the beginning of February 2012. He was given emergency life saving treatment at Kirkham, before being transferred by ambulance to hospital. Despite continued attempts to revive him, he was pronounced dead.

The investigation has identified some areas for improvement in the initial monitoring and review of those withdrawing from alcohol and has suggested as a precaution that it would be helpful to introduce routine reviews of those presenting with cardiovascular risk factors. Overall we found the man received good care during his time in prison and his sudden death could not have been foreseen. The emergency response was good and the clinical reviewer commended staff for their efforts when he collapsed. Supportive arrangements were put in place for his family, staff and prisoners affected by his death.

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.

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Prisons and Probation Ombudsman

June 2012

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SUMMARY

1. The man appeared at Crown Court on 5 September 2011, when he was sentenced to 12 months imprisonment and sent to HMP Altcourse. On arrival, he had a first reception health screen with a nurse who assessed that he did not have any physical or mental health issues. He said that he was dependent on alcohol.
2. During his time at Altcourse, the man was regularly prescribed antacid medication for heartburn, which was reviewed following his transfer to HMP Haverigg on 20 October. After his arrival at HMP Kirkham on 12 December, he reported as fit and well and was examined by both a nurse and doctor and his antacid medication was continued. A substance misuse worker provided him with some brief counselling for his alcohol problem, but he declined to be referred for ongoing support.
3. At the beginning of February, while working in the waste management unit, the man suddenly became unwell during the afternoon tea break which started at 3.00pm. He had left the hut where workers congregated, telling a friend that he felt unwell and wanted fresh air. He was found collapsed nearby a short while later. A prisoner quickly alerted staff who found him unconscious and unresponsive. Staff requested healthcare assistance and started cardio pulmonary resuscitation (CPR is an emergency procedure to maintain blood circulation in someone not breathing).
4. Healthcare staff arrived with emergency life saving equipment, including a defibrillator and they were quickly joined by paramedics at 3.25pm. The man was shocked by the defibrillator machine several times and, when he was transferred to the ambulance, was described by paramedics as stable, but still unconscious. Despite the response at the waste management unit, intervention by healthcare workers and the prompt attendance by paramedics, He was not revived and was pronounced dead at 5.04pm at hospital.
5. The prison contacted the man's family at the earliest opportunity after his collapse and transfer to hospital. A family liaison officer (FLO) was appointed, who immediately went to the hospital, along with the duty governor, to meet the family when they arrived. Ongoing support was offered to the family by the FLO, in line with Prison Service policy.
6. The clinical reviewer concludes that the emergency care that the man received was of a high standard. We make three recommendations as a result of this investigation concerning procedural issues relating to the monitoring of those withdrawing from alcohol, routine reviews of those known to have cardiovascular risk indicators, and a review of the emergency medical code system.

THE INVESTIGATION PROCESS

7. The investigator visited HMP Kirkham on 7 February 2012. She met the Head of Safety, who was to act as the liaison officer for the investigation and provided all of the man's records. In addition, she met the prison's family liaison officer (FLO), visited the waste management unit where the man worked and his billet (living quarters). She met a number of staff and prisoners who worked and lived alongside him. She also met a governor. In advance of her visit, notices were issued announcing the investigation to staff and prisoners. No staff or prisoners came forward in response.
8. The local Primary Care Trust (PCT) asked a clinical reviewer to review the man's clinical care.
9. The investigator returned to Kirkham on 1 March. During this visit she interviewed five members of staff and two prisoners; one prisoner declined to be interviewed. She and the clinical reviewer jointly interviewed two healthcare staff. In addition, she met the Senior Probation Officer (SPO), Head of Healthcare and the prison FLO. She gave the Governor a preliminary feedback of the findings of her investigation, which was confirmed, in writing, on 5 March 2012.
10. The investigator contacted Her Majesty's Coroner for Blackpool and the Fylde District to inform her of the investigation and request a copy of the post-mortem report. The investigation report will be sent to the Coroner to assist her enquiries.
11. One of the office's family liaison officers contacted the man's mother on 20 February to inform her about the investigation and to allow the family to ask questions about her son's care at Kirkham. The family did not raise any issues with him.
12. We understand that the man's sister raised issues with Kirkham's family liaison officer about some trainers which went missing on transfer from a previous prison and about his application for Home Detention Curfew. Neither of these matters are directly relevant to the circumstances of his death and were not raised with us, but we understand that compensation was paid for the missing trainers. In relation to his application for release on Home Detention Curfew, this was considered and turned down at Haverigg on 5 December. The application was refused because it was not considered that he would be able to abide by the restrictions of HDC at the proposed address. His application and appeal were properly considered.
13. The man's family received a copy of the draft report. Having considered the investigation findings they provided some further written concerns. The investigator has sought to address these. Any concerns not covered in the finalised report are addressed in separate correspondence to the family.

HMP Kirkham

14. HMP Kirkham is a category D open prison in the North West area holding up to 586 adult male convicted prisoners. There are 24 billets, which provide single and double occupancy basic living accommodation. When the man was at Kirkham, healthcare was provided by North Lancashire Primary Care Trust (PCT) but from 1 March it was provided by the Lancashire Care Foundation Trust.
15. The prison has a wide range of facilities and provides work and/or education for all prisoners. Within the prison there are a number of working groups including the conservation area, farms and gardens and the recycling/waste management unit where the man was employed.

HM Inspectorate of Prisons

16. HM Chief Inspector of Prisons last conducted a full announced inspection of the prison from 30 November to 4 December 2009. The then Chief Inspector concluded:

“Kirkham is an impressive open prison ... The prison is also very purposeful and active, with a wholly appropriate focus on resettlement. The Governor and staff deserve considerable praise for what has been achieved.”

Previous deaths in custody at Kirkham

17. The man’s death was the fourth death to have occurred at Kirkham since April 2004 when the office began investigating all deaths in prison custody in England and Wales. All previous deaths were due to natural causes, the most recent of which was in June 2005. The investigator reviewed the Ombudsman’s reports into these deaths and found no issues in common with him.

Categorisation

18. 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. The man was a low risk category D prisoner, who are prisoners who can be reasonably trusted in open conditions.

KEY EVENTS

19. The man was born in June 1966. He lived in Cheshire and was unemployed, but had previously worked as a forklift truck driver. He was sentenced to 12 months imprisonment at Crown Court on 5 September 2011 for drug offences, and was taken to HMP Altcourse.
20. The Person Escort Record (PER) noted that the man said he was an alcoholic. (A PER is a form that accompanies prisoners on all journeys from and between prisons, police and hospital. It serves as a communication tool about risks a prisoner poses on escort or transfer.) A nurse recorded that he had no ongoing medical issues, but that he disclosed that he was a smoker and alcohol dependent. He was referred to a prison doctor for further assessment. A short while later he was seen by a prison doctor. His blood pressure was recorded as a little high at 149/87, and his pulse was also slightly higher than normal at 84 beats per minute (bpm). (The normal range for blood pressure is 100/70 to 140/90, although the pressure varies throughout the day depending on the individual's activities. A blood pressure reading of greater than 140/90 is classed as high. The normal range for a pulse is between 60 – 80 bpm).
21. The doctor prescribed thiamine and vitamin B compound (used in the detoxification process, to treat vitamin deficiencies that can occur in someone who is alcohol dependent). The doctor noted that the man should be reviewed by a nurse the following day to check for alcohol withdrawal symptoms, although there is no record that this happened.
22. The next day, the man was assessed as a category D prisoner. He was advised that his release date was 5 March 2012 and that his Home Detention Curfew Eligibility Date was 6 December 2011. (The HDCED is the earliest date a prisoner can be released to a suitable address and subject to an electronic tag.)
23. On 28 September, the man was seen by a nurse as he complained of heartburn. He was referred to the doctor and was seen by another prison doctor two days later. During this examination, he said he had been experiencing heartburn for two weeks and was prescribed omeprazole (used to treat excess stomach acid). The doctor noted that he should be reviewed in four weeks, or earlier if his symptoms worsened.
24. The man was transferred to Haverigg on 20 October. An initial health screen was completed the following day by a nurse. He disclosed that he had been suffering acid reflux and his omeprazole medication was continued. As a low risk prisoner he was allowed to have this medication in his possession. He was also given advice on giving up smoking.
25. There were no other significant contacts with healthcare staff at Haverigg. The man was assessed as fit to transfer to a category D establishment and moved to Kirkham on 12 December.

26. At Kirkham the man underwent another reception health screen with a nurse. His blood pressure and pulse were normal (118/84 and 58 bpm). He was examined the following day by a prison doctor and his omeprazole medication was continued. He was also assessed by a nurse. He agreed to have hepatitis injections (to prevent disease of the liver) and told the nurse that he had been experiencing a pain in his left calf. There is no indication that he received any treatment for this, and he did not seek any further medical advice about his leg.
27. On 15 December, a substance misuse worker completed an alcohol assessment with him. He said that he had not consumed alcohol since he was sentenced and that he had often experienced heartburn as a consequence of his excessive drinking. He was counselled about his level of alcohol use but he declined to be referred for additional group work. He was provided with written information about alcohol misuse and details of how to access the substance misuse team if he wanted further help.
28. On 5 January a prison doctor authorised a repeat prescription for omeprazole and a nurse administered the man's final hepatitis B vaccination. The next day he was treated with olive oil ear drops by the nurse. This condition was reviewed on 13 January and a prison doctor prescribed a stronger medication to soften the ear wax. He did not collect this prescription.
29. A nurse reviewed the man's ear condition on 20 January. He was encouraged to collect and use the prescribed medication to help alleviate his symptoms. A nurse examined him on 26 January and noted that there had been some improvement, but that he needed to continue using the ear drops. This was the last contact he had with healthcare staff.

Events in February

30. The man was working in the waste management unit, his regular place of employment. At some point during the afternoon tea break, which began at 3.00pm, he went outside into the yard. In a written statement for the Governor, a prisoner who worked with him wrote:

“I could tell he wasn't feeling well, he went outside to get some fresh air”.
31. Another prisoner who worked with the man said in his written statement:

“I was at work about 3.10/20 [3.10pm or 3.20pm] and me and a prisoner went outside to clear some of the work we had, once we'd finished I set off to go back inside and as I did I heard a funny noise and checked to see what was wrong and he was on the floor so I shouted the other prisoner and he instantly ran for help I then called for help off the other lads inside”.
32. The man was found lying between some wooden pallets and the fence surrounding the waste management unit and several witnesses stated that he

had been sick. The instructional officer arrived and removed some of the pallets to ensure that he could be moved easily and safely. He was placed in the recovery position [to prevent suffocation or obstruction of the airway in an unconscious person]. He was unresponsive and appeared to be turning blue. The officer and his work colleague checked to see if he was breathing and decided to start CPR.

33. An officer contacted the healthcare centre by telephone to request assistance. Two nurses went directly to the waste management unit, along with a healthcare orderly (a prisoner). The officer also contacted the prison's Central Control Room to ask for an emergency ambulance as he was aware that the man's condition was serious. The Control Room received this request at 3.25pm and immediately requested an ambulance.
34. When healthcare staff got to the waste management unit they were told that CPR had been attempted. They observed that the man was not breathing and was turning blue. The senior nurse said she thought he was dead. The healthcare staff, with the assistance of a works instructor and a prisoner continued CPR and gave him oxygen. The other nurse attached a defibrillator machine [a portable electronic device that diagnosis heart rhythms] to him. The machine indicated he should be shocked and the first shock was administered by the machine, without effect. CPR continued and a further two shocks were administered by the defibrillator. On the third shock he began to breathe.
35. The ambulance arrived at 3.31pm and, while prison staff continued with CPR, they assessed the man and attached their own defibrillator that provided a print out of his heart rhythm. A further shock was administered by the machine and his heart started beating and he started breathing again, although remained unconscious.
36. An officer had been instructed to attend the scene to accompany the man to hospital. While he was receiving treatment, the officer was given an accompanied release on temporary licence authorising that he could leave the prison. No restraints were used and there was no delay in him being taken to hospital because of this process.
37. Once his condition was stabilised, the man was transferred to the ambulance where paramedics continued to treat him. The paramedics told the senior nurse that he had probably suffered "a massive infarct [heart attack]". The ambulance arrived at hospital at 4.15pm and he was taken directly into an emergency room. The officer remained outside the room and was later told by doctors that he had been pronounced dead at 5.04pm.

Liaison with the man's family

38. The Decency Manager was appointed as the prison FLO. An attempt was made to contact the man's mother, who was his nominated next of kin, to advise that he was being taken to hospital. Unfortunately, her telephone was out of order, but an officer went to the man's room to try and find an

alternative contact. The officer found a letter from the man's sister, explaining that their mother's telephone was not working and providing a mobile contact number. The FLO then contacted the man's mother at 5.00pm, to let her know that he had collapsed and been taken to hospital. The family said that they would go to the hospital.

39. Following notification of his death, the FLO and the duty governor travelled to the hospital to wait for the man's family to arrive. Hospital staff broke the news to the family over the telephone before they reached the hospital. The prison FLO spent time with them and explained the events of the afternoon. She provided the family with her contact details and explained that she would be their point of contact at Kirkham.
40. The FLO maintained regular contact with the family. On 3 February, she visited them at home, answered many of their questions and provided details of what to expect following his death. In line with Prison Service guidance a contribution towards funeral expenses was offered.
41. Over the next week, the FLO continued to provide support to the family. The prison provided transport for them to visit Kirkham, on 10 February. During this visit, they visited his room and, at their request, packed up his belongings. They also attended a memorial service for the man that day, which was sensitively managed, reflecting both his and his mother's religious preference.
42. The funeral was held on 15 February and was attended by the FLO and the Duty Governor. The prison FLO maintained contact with the man's mother over the next few weeks. The Duty Governor wrote two letters to the family expressing his and the prison's condolences, and offering ongoing support. Family liaison following the man's death was exemplary.

Support for prisoners

43. A notice to prisoners was issued on 2 February by the Governor which announced the death of the man and expressed condolences. This notice reminded them of the available support, via staff, the prison chaplaincy and Listeners (prisoners trained by Samaritans to offer confidential support). The Governor wrote an individual letter to each prisoner present when the man collapsed, thanking them for their assistance and acknowledging the impact of his death.
44. There was one prisoner on an open ACCT (Assessment, Care in Custody and Teamwork; procedures for those identified as at risk to themselves) and the care plan was reviewed and the individual was closely monitored and offered additional support.
45. Prisoners were invited to attend the memorial service, which gave the man's family the opportunity to meet his friends and those who had tried to revive him. During the interviews, prisoners told the investigator that they felt well supported by Kirkham and that their attendance and involvement at the memorial service had assisted them in coming to terms with his death.

46. On 29 February, the prison FLO contacted the chaplain at Kirkham and provided her with a list of those prisoners present when the man collapsed, to invite them to a bereavement support group the following week. We consider that the level of support to prisoners after his death was excellent.

Support for staff

47. The Duty Governor, along with the prison FLO, travelled to the hospital when they received the news of the man's death, enabling them to support the officer who had gone to the hospital with him.
48. The next day the Head of Safety held a hot debrief (a meeting immediately after an incident which focuses on reassurance, information sharing and how staff can support each other) with all staff that were involved, along with members of the care team (staff specially trained to provide support to their peers).
49. A notice to staff was issued on 2 February by the Governor announcing the man's death and reminding them of the available support, through the care team. His probation office was also contacted and informed of his death. The Duty Governor wrote an individual letter to every member of staff present when he collapsed, acknowledging the efforts they made when trying to revive him.

Post-mortem examination

50. A post-mortem examination was undertaken on 6 February and concluded the cause of death was due to coronary artery atheroma (narrowing of the arteries to the heart resulting in reduced blood flow and causing a heart attack). A toxicological analysis of blood and urine was requested, although the report has not yet been made available.

ISSUES

Clinical care

51. A clinical reviewer was appointed by the local Primary Care Trust (PCT) to review the medical care that the man received while in prison custody. Her clinical review looks at his treatment and considers whether it was appropriate and equivalent to that which is available in the community.
52. The man classed himself as alcohol dependent, and healthcare staff in reception at Altcourse correctly identified that he should be monitored for symptoms of alcohol withdrawal. He was prescribed thiamine and vitamin B. However there is no evidence that he was subsequently monitored or reviewed as requested by the doctor. Following his transfer to Haverigg prison, there is no record of treatment for excessive alcohol consumption or continuation of the previous medication or that his condition was reviewed.

The Heads of Healthcare at Altcourse and Haverigg should ensure that all prisoners who are withdrawing from alcohol are appropriately reviewed.

53. During his time in prison, the man did not present with any symptoms that would indicate that he had a heart condition and he did not complain of feeling unwell. The clinical reviewer has noted that at the three prisons where he was located, there was no evidence of a review of cardiovascular (heart and blood vessels) risk factors (which include those with a high alcohol intake), although she has concluded that “it is very unlikely this would have made any difference to the care afforded to him, or unfortunately his death”. The clinical reviewer has made a recommendation that we endorse.

The Heads of Healthcare at Altcourse, Haverigg and Kirkham should introduce a routine review of cardiovascular risk factors during the reception health screen process for prisoners with known risk factors, including high levels of alcohol intake.

54. We are satisfied that there was an appropriate emergency response when the man collapsed. The officers who responded told the investigator that they were experienced in administering first aid. The clinical reviewer concluded that “the staff should be commended for their handling of his collapse and their attempt to save him”. Healthcare staff arrived quickly and continued CPR. There was no delay in taking him by ambulance to the hospital.

Emergency code system

55. Healthcare staff were alerted to the man’s collapse by telephone, although they were not given specific information about the nature of the incident. In many prisons a specific ‘red’ (for emergency blood injuries) or ‘blue’ (for emergency breathing difficulties) code system via radio is used when requesting healthcare assistance so that staff know what they are attending and therefore what equipment they need to bring.

56. Following the investigator's initial feedback on 7 February, the Governor introduced a new radio code system to all staff at a full staff meeting on 28 February. Three codes were introduced, red and blue as outlined, with an additional 'code black – for any other serious condition'. We welcomed the introduction of the code system but were concerned that the code black might be over-used by staff.
57. The Prison Service is reviewing the need for a national uniform emergency code system but has not yet reached agreement. Until that is done we recommend:

The Governor of HMP Kirkham should review the introduction of the new emergency medical codes by 30 August 2012 (six months after introduction) to establish if the new system is understood and used correctly in emergency medical situations.

CONCLUSION

58. We are satisfied that the man was treated appropriately during the time he was at Kirkham. We agree with the clinical reviewer's conclusions that he received care while he was in custody which was the equivalent to that which he could have expected in the community. His collapse and death could not have been foreseen. The emergency response was swift and appropriate. Good support was provided to his family, prisoners and staff after his death.

RECOMMENDATIONS

1. The Head of Healthcare at Altcourse and Haverigg should ensure that all prisoners who are identified as at risk from alcohol withdrawal are appropriately observed and reviewed.

Accepted:

Altcourse

Offenders who are withdrawing from alcohol are housed on the 5 day assessment unit within Healthcare for observation for a minimum of 5 days. They can remain on there longer, dependent on individual needs, and all have an initial assessment by a Doctor and IDTS staff. If there were any ongoing concerns then the Offender would be moved to the Inpatient Unit for closer monitoring. Target date for completion: In place

Haverigg

The Deputy Governor will be meeting with the NHS Cumbria Commissioner of Health Services in June 2012 to discuss this recommendation and they will work together to agree the implementation of appropriate processes. Target date for completion: June 2012

2. The Head of Healthcare at Altcourse, Haverigg and Kirkham should introduce a systematic review of cardiovascular risk factors during the reception health screen process for prisoners with known risk factors, including high levels of alcohol intake.

Accepted:

Altcourse

An initial reception is completed including blood pressure checks and a medical history is documented. All prisoners are also seen by a Doctor who completes another blood pressure and history check. Offenders housed on the 5 day assessment unit undertake on-going alcohol assessments using relevant tools and protocols including blood pressure checks. Target date for completion: In place

Haverigg

The Deputy Governor will be meeting with the NHS Cumbria Commissioner of Health Services in June 2012 to discuss this recommendation and they will work together to agree the implementation of appropriate processes. Target date for completion: June 2012

Kirkham

It has been agreed that the Head of Healthcare will introduce a systematic review of cardiovascular risk factors during the reception health screen for prisoners with known risk factors. Target date for completion 31.08.12

3. The Governor of Kirkham should review the introduction of the new emergency medical codes by 30 August 2012 (six months after introduction) to establish if the new system is understood and used correctly in emergency medical situations.

Accepted: *New emergency medical codes have been introduced and used correctly in emergency medical situations as follows:*

Red – Bleeding

Blue- not breathing

Black- other

Review to take place. Target date for completion: 29.06.12