

**Investigation into the circumstances surrounding the
death of a man at HMP Holme House in May 2012**

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

October 2012

This is the report of an investigation into the death of a man, a prisoner at HMP Holme House. He died of a heart attack in May 2012. He was 55 years old. I offer my condolences to his family and friends and all those affected by his death.

A clinical review into the standard of healthcare the man received at HMP Holme House was conducted. Holme House co-operated fully during the course of our enquiries.

The man's cell mate raised the alarm when he found him unresponsive in his bed. Healthcare staff attempted to resuscitate him but were unsuccessful.

The clinical review finds that the man's clinical care was equivalent to what he would have received in the community. However, the investigation highlighted some areas for improvement. His community GP records were not obtained, which might have provided healthcare staff with background knowledge of his general health. Arrangements for emergency ambulance access to Holme House were not in line with national guidance and there was an unacceptable delay in calling an ambulance and getting paramedics to his cell once the ambulance arrived. While these matters were unlikely to have changed the outcome for him, as he appears to have died immediately from a major heart attack, in other cases such a delay could be crucial.

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

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SUMMARY

1. The man was remanded into HMP Holme House on 21 March 2012. It was his first time in custody. He had been charged with a serious offence, but had not been convicted.
2. During his first reception health screen, the man said that he did not have any health concerns and was not taking any prescribed medications. For this reason, his community general practitioner (GP) details were not requested, which would have listed his past medical history. He was offered advice on keeping a healthy diet and was offered help to stop smoking, which he declined.
3. When the man's cell mate got up at about 7.30am on 1 May, he found him unresponsive in bed. He pressed the cell bell for help and an officer went to the cell after first checking that neither he nor his cell mate were on medication, which he said was frequently a reason why prisoners ring their bells at that time. After calming down the cell mate, the officer realised that the man needed medical assistance, so he shouted for an emergency code to be called over the radio to alert healthcare. A Senior Officer (SO) called a code blue emergency over the radio at 7.36am.
4. Two nurses went straight to the cell. They started cardiopulmonary resuscitation (CPR) and one nurse asked for a defibrillator, which the SO brought to the cell from the senior officer's office on the wing.
5. The defibrillator was attached at 7.43am and instructed that CPR should continue. Another SO arrived and was told that the nurses had asked for an ambulance to be requested. An ambulance was called at 7.44am and arrived at the prison gate four minutes later. It then took the paramedics 11 minutes to get to the cell as the ambulance was searched as it came through the gate and then driven at walking speed to the wing. When the paramedics arrived at the scene, nurses had stopped CPR as the man was not responding. The paramedics did their own checks for signs of life, but could find none and he was pronounced dead.
6. We agree with the clinical reviewer that the general care the man received while at Holme House was equivalent to that he would have received in the community. The report highlights that community GP records should always be obtained to provide staff with background knowledge of a patient's general health. There are a recommendation to help ensure that all prison staff understand the need to request an ambulance in a life threatening situation without waiting for healthcare staff and that ambulances have swifter access to patients in an emergency. Support was not offered to staff in the weeks following his death, only immediately after the incident, contrary to national guidance.

THE INVESTIGATION PROCESS

7. The Ombudsman's office was notified of the man's in May 2012. Notices were issued to staff and prisoners at HMP Holme House to inform them of the investigation and asking anyone who had information relevant to the investigation to contact the investigator. No one came forward.
8. HM Coroner for Teeside was informed of the investigation. A copy of the report will be sent to the Coroner. A copy of the post-mortem report was received on 4 July 2012 and indicated that the man died of a heart attack.
9. A clinical reviewer was appointed by Teeside PCT to conduct a clinical review of the care the man received in custody. He received copies of all the relevant medical and prison documentation. The clinical review was received on 10 July 2012.
10. The investigator visited Holme House on 8 May 2012. She met the Deputy Governor, the prison family liaison officer (FLO) and staff who had been involved in the man's care. She was shown where he lived. She received all documentation relating to his time in custody. She reviewed prison and health records and liaised with the Governor throughout the course of the investigation.
11. The investigator and her colleague interviewed the man's cell mate and two healthcare staff on 5 July. She interviewed the officer who was first on scene on 6 July and a senior officer on 16 July.
12. One of the Ombudsman's FLOs contacted the man's son shortly after his death. The FLO explained the investigation process and invited him to ask any questions about his father's care. He did not have any specific questions or concerns that he wished to be considered during the investigation.
13. The report was issued for consultation with the Prison Service. There were no factual inaccuracies. Recommendation three has been amended and the responses to the recommendations have been added to the recommendations page.

HMP HOLME HOUSE

14. HMP Holme House detains adult males who have either been remanded into custody or convicted and hold up to 1,212 prisoners.
15. Healthcare services at the prison are commissioned by County Durham Primary Care Trust (PCT). There are GP surgeries and registers for patients with diabetes, respiratory problems and other chronic conditions. There is an inpatient healthcare centre with 28 beds, providing 24 hour nursing cover.

Her Majesty's Inspectorate of Prisons

16. HM Chief Inspector of Prisons conducted a full unannounced inspection of Holme House in 2010. Inspectors noted that prisoners were given information in reception about how to access healthcare services. About healthcare in general they commented:

"Primary care facilities were being refurbished to enable changes to the delivery of clinics and treatments. The inpatient unit was stark. Fewer prisoners than the comparator rated the quality of the service from doctors and nurses as good or very good. Primary care services and lifelong conditions support were good, although prisoners were not able to see a pharmacist."

In relation to emergency equipment inspectors noted:

"Resuscitation equipment, including external automatic defibrillators, was sited in reception, the health centre, the inpatient unit and on each house block. The equipment was checked weekly and logs were up to date. Health services staff were resuscitation trained and up to date."

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community. IMB members have full access to the prison and help to ensure that standards of care and decency are maintained. In their 2011 annual report, the IMB wrote:

"2011 has been a very challenging year for healthcare staff. The early part of the year saw the Healthcare provision continuing at the high standard the Board has come to expect. In February 2011 they were presented with an award for 'rapid improvement in performance' by North Tees and Hartlepool Foundation Trust."

Previous deaths at Holme House

18. In the two years before the man died, there have been four other deaths from natural causes at Holme House. There are no similarities between the previous deaths and that of his.

KEY EVENTS

19. The man was remanded into HMP Holme House from Crown Court on 21 March 2012. It was his first time in custody.
20. The man had a first reception health screen¹ with a nurse. He told her that he did not have any health concerns and he was not taking any prescribed medications. She recorded his height (6 foot) and weight (85 kilograms). He signed a consent form for his community general practitioner (GP) to be contacted to obtain his past medical history, but did not give an address. She told the investigator that if prisoners do not have any health concerns and are generally in good health, GP records are not routinely requested.
21. The following day, 22 March, the man had a full induction which included a gym assessment. He completed a questionnaire based on his health, and indicated that he was fit to use the gym facilities without consent from a doctor. He indicated he had not had any chest pain in the previous months, including during physical activity.
22. The man had a secondary health screen on 24 March with a nurse. She noted that he did not have any “outward signs of physical or mental health concerns”. His body mass index (BMI)² was recorded as 25.38, which indicated that he was slightly overweight for his height. He was told about the benefits of healthy eating and was offered help to stop smoking, which he declined. His blood pressure was recorded as 136/82 (within the normal range). He said that he drank two to four times per month and never drank more than six drinks on one occasion. According to his family, he was a heavy drinker in the community. The nurse told the investigator that he had no withdrawal symptoms associated with alcohol dependency and she did not have any concerns about his appearance.
23. There are no significant entries in the man’s medical record or prison documentation. Staff told the investigator that he was a polite and courteous man who raised no cause for concern. He was employed in the mail stamping workshop. He lived in a shared cell on the vulnerable prisoners’ unit (VPU)³. His cell mate said that he had shared a cell with him for about two weeks before he died. He said they got on well and talked about their lives. He said that the man had never complained of feeling unwell, but had occasionally said he felt “rough”. He said that he had never complained of chest pain.
24. During the early hours of 1 May, the cell mate got up to use the toilet. He told the investigator it was still dark outside and guessed it was around 3.00am (there was no clock in the cell). He said could not hear any snoring or heavy breathing, but this was not unusual as he was a quiet sleeper, so he was not worried.

¹ All prisoners have a health screen when entering prison to identify any immediate health concerns and to identify a prisoner’s medical history, including mental health.

² A measure used to check if a person’s weight is healthy for their height. A BMI of 25-29.9 is classed as overweight.

³ Prisoners can request segregation from the general prison population on a separate wing. This can be due to a number of reasons including: the nature of their offence, publicity surrounding their case and trouble coping with being in prison.

25. At approximately 7.25am, the cell mate got up to make a cup of tea for them both. He said that he tried to make conversation with the man, but he did not respond. He was lying in bed and the cell mate felt for a pulse, but he could not find one. He could not see any signs of breathing and the man was cold to touch. He pressed the emergency cell bell⁴ for help at 7.30am.
26. An officer had just started his shift and was in the wing office. He told the investigator that night staff handed over to the early shift staff member who started around 7.00am. Any issues concerning prisoners during the night would have been written in the wing observation book. There were no entries in the wing observation book relating to the man. When the cell bell was activated, he checked to see if the man or his cell mate were on the list of prisoners that needed morning medication as they often want their medications when they wake up instead of waiting for the nurse to come round. Neither of them were on the medication list, and he went to the cell to see what they wanted.
27. Once he left the office, the officer could hear the cell mate shouting “he’s dead” at the top of his voice and banging the cell door, so he quickened his pace. The officer said it took between thirty seconds and a minute to get from the wing office to the cell. He opened the cell door and found him crying, in an agitated state. The officer told the investigator that at that point he was not sure what was going on and he first tried to calm the cell mate down. He then saw the man lying on his back on the bottom bunk covered with a blanket. He checked him but he could not find a pulse or any signs of breathing. He described his face as “stone cold”.
28. The officer shouted to other staff on the landing that there was a “code blue” emergency⁵. (He said that he did not have a radio so could not call a code blue himself.) The officer checked the man again for signs of life, but could find none. Senior Officer (SO) 1 heard the emergency code being shouted and called a code blue over the radio to let healthcare staff know there was an emergency at 7.36am. He said he got to the cell a couple of minutes later and found the cell mate very upset and asked an officer to take him away from the scene.
29. The officer told the investigator that they did not start CPR before the nurses arrived as the nurses got there so quickly. Two nurses came from the treatment room on a nearby wing and arrived at the cell at the same time as the SO (about two minutes after the code blue). One nurse had brought the emergency bag with her, which contained equipment to assist with CPR, such as oxygen. She shook the man and tried to get a response but could not. The nurses slid him onto the floor with help from an officer. The nurse said that he was pale in colour and had a purple discolouration to his neck and shins. The nurse said that his body was warm, but she thought that was because of the temperature of the cell.

⁴ A bell used to alert the attention of wing officers in an emergency. The bell sounds until the officer attends the cell and re-sets it. At Home House cell bell activations are logged electronically and show the time of the cell bell and the time it was re-set.

⁵ An emergency code that signifies a cardiac or respiratory arrest, severe breathing difficulties or any event considered as life threatening.

She started chest compressions and the other nurse administered rescue breaths.

30. The SO said that the nurse asked for a defibrillator⁶. Defibrillators are kept in the healthcare centre and in the senior officer's office on every houseblock. He got the defibrillator from the office and returned to the scene. A senior nurse came from the healthcare centre and took over compressions. The defibrillator was attached at 7.43am and it instructed staff to continue with CPR.
31. SO 2 arrived at the cell about two minutes later. SO 1 told him that the nurses had asked for an ambulance to be called. SO 1 said that SO 2 radioed the communications department and requested an ambulance, (although SO 2 said that he could not remember if he had called the ambulance). The ambulance log shows that an ambulance was requested at 7.44am.
32. An ambulance was dispatched straight away and arrived at Holme House four minutes later, at 7.48am. At 7.50am, after three cycles of CPR, the nurses agreed to stop because the man was not responding. At 7.56am, the ambulance arrived outside the houseblock. Three minutes later, at 7.59am (11 minutes after the ambulance got to the prison) the paramedics reached the cell. The paramedics did their own checks for signs of life, but found none and he was pronounced dead.

Post-mortem report

33. The post-mortem report recorded that the man died of a heart attack, which was caused by heart disease. The extent of heart disease meant that he was at increased risk of a sudden and unexpected death at any time.

Support for prisoners

34. After the emergency the officer took the cell mate to the wing office for a cup of tea and to try and calm him down. They talked about what had happened and he was then taken to healthcare for support and observation. He stayed in healthcare overnight before moving back to a different cell on the wing the next day. He said he had been offered support from the Listeners, but felt he needed more support. He was referred to a bereavement counsellor.
35. The Governor issued a notice to all prisoners that the man had died. The notice indicated the support that was available, including Listeners. Prisoners who were subject to self harm monitoring procedures were reviewed. A memorial service was not held, which would have provided prisoners with an opportunity to pay their respects.

⁶ A machine that gives the heart an electric shock in some cases of cardiac arrest. Pads are attached to a patient's chest and the machine monitors the heart's electrical output. It will then advise if a shock needs to be administered. CPR is carried out while the defibrillator is attached (but will stop if the machine needs to shock).

Support for staff

36. When a prisoner dies in custody, the Prison Service requires a 'hot debrief' to be held to ensure staff involved have an opportunity to discuss any issues arising, and for support to be made available. An operational manager held a hot debrief at 9.30am on 1 May. Staff were reminded about the care and welfare team during the debrief. The officer said that he had been sent home and did not return to work for a few days. He said that a staff welfare officer had telephoned him at home and offered him support. After he returned to work, he said that senior staff did not check to see how he was and he considered that the level of support was not sufficient (although he could have contacted the care team at any time). The nurse said that she returned to her duties after the incident. She said she felt that the prison had offered her appropriate support, but she did not feel she had been supported by her employer (the PCT provide the healthcare services). We are satisfied that staff were offered sufficient support.

Support for family

37. A prison family liaison officer (FLO) was appointed. The man had listed his two sons as his next of kin. The FLO and the deputy FLO and one of the prison managers went to the recorded address and arrived at 9.00am. The man's ex-wife was there and she telephoned his sons to ask them to come home. When they arrived the FLO explained to them that their father had died. She explained the FLO role and provided her contact details.

38. The FLO provided support to the man's family when they identified his body, during the opening of the inquest and helped to arrange the funeral. On the prison's behalf, she offered a financial contribution towards the funeral costs. She returned his property on 10 May and reiterated that the family could call her at any time. The man's son gave her a bunch of flowers and a card to thank her for her help and described the support and advice his family had received from the prison FLO as excellent. The funeral was held on 16 May. Both she and Governor attended the funeral, and flowers were sent on behalf of the prison.

ISSUES

Clinical care

39. The man did not mention any health concerns during his first reception health screen and had no contact with healthcare staff during his time at Holme House. The clinical reviewer finds that healthcare staff made reasonable efforts to address risk factors that would have increased the risk of heart disease in his lifestyle, such as his weight and being a smoker. He was advised how to maintain a healthy diet and was offered help to stop smoking, which he declined.
40. The clinical reviewer suggests that it would have been best practice for him to have been offered a blood lipid screening⁷ test because he was slightly overweight but overall he concludes that the care the man received was equivalent to what he might have expected in the community.

Obtaining GP records

41. Prison Service Order (PSO) 3050, continuity of healthcare for prisoners, instructs “efforts should be made to retrieve any information required from the prisoners GP or other relevant service he/she has recently been in contact with”. As the man did not have any health concerns and did not mention a family history of significant illness, his medical records were not requested from his community GP.
42. A nurse said that GP records are usually requested when a prisoner has health concerns or says they are receiving prescribed medication. The post-mortem examination found that the man had a history of a rapid heart beat and renal failure, and was a heavy drinker and smoker. We consider it is good practice to obtain GP records whenever possible so that healthcare staff in prisons have a full picture of a prisoner’s medical history which is not always volunteered and can then refer the prisoner to any necessary secondary services. His medical records should have been retrieved in line with the PSO to confirm his medical needs.

The Head of Healthcare should ensure that community GP records are routinely requested for all prisoners following the first reception health screen.

Emergency response

43. The clinical reviewer comments that staff should record if they were able to feel a “central pulse”, as opposed to if they could “feel a pulse”. The nurse agreed that she had not specified where she had checked for a pulse. Otherwise, the clinical reviewer concludes that the resuscitation attempt by healthcare staff was prompt and appropriate. While healthcare staff did not bring a defibrillator to the

⁷ A test that determines cholesterol level. Cholesterol is a major contributing factor in the progression of heart disease.

emergency there is one on each of the houseblocks at Holme House so one was readily available.

Ambulance delays

44. The Director of Offender Health and Chief Executive Officer National Offender Management Service wrote to all prison Governors and Directors and prison healthcare managers on 17 February 2011 to reiterate previous guidance about the importance of calling an ambulance as soon as possible in an emergency. Any delays can have a significant impact on the patient's chances of survival, so staff should not wait for healthcare to attend.
45. A protocol between Holme House and North East Ambulance Service was agreed in December 2006. The protocol states that a full assessment of the prisoner will be done by a qualified nurse and then the duty governor must be consulted before an ambulance can be called. Where necessary, prison healthcare staff can instruct the control room to request an emergency ambulance. The guidance in the February 2011 letter makes it clear that "it should not, for example, be a requirement in every case for a member of the prison healthcare team to attend the scene before emergency services are called". It makes it clear that internal procedures should not waste time in summoning emergency assistance and that the most important aspect of emergency care is that an ambulance is called in all cases where there are grave concerns about the immediate health of a prisoner. Where after assessment it is decided an ambulance is not required it is preferable to cancel an ambulance rather than to wait. The February 2011 letter required existing protocols to be immediately reviewed in light of the letter. It does not appear that this was done at Holme House.
46. An emergency ambulance was not called for the man until 7.44am, 14 minutes after the cell mate pressed the cell bell for help. This is a delay of about ten minutes after all staff had responded to the code blue. Officers waited for healthcare staff before an ambulance was called. A code blue emergency is used to signify a life threatening situation, so an ambulance should be called following any code blue.
47. The letter from the Director of Offender Health and the Chief Executive Officer also emphasised that there should be no unnecessary delays access for ambulances and for paramedics getting to the patient. The protocol at Holme House says that the ambulance will be subject to a visual search on arrival at the establishment, although other instructions for vehicle escorts contradict this and exempts emergency vehicles from searches when entering the prison. The gate action sheet (which sets out actions for the gate staff) notes that in an emergency the ambulance should reach the patient without any undue delays. However, we were told the ambulance was held up for a search. The gate action sheet also indicated that the gate officer might have to override the gates to the vehicle lock (where the ambulance comes into the prison) and it is acceptable for the escort officer to ride in the ambulance to speed up its arrival to the scene.
48. The ambulance arrived at the prison at 7.48am, and it took the paramedics another 11 minutes to get to the man. It took the investigator five minutes to walk

the route the ambulance took through the prison grounds to his cell. SO 2 told the investigator that it could have taken some time for the ambulance to get from the prison gate to the houseblock as the ambulance would have had to be searched and then would have to go through about six gates, which would all have to be locked behind the ambulance. Despite the instruction to gate staff, the SO said the ambulance could only be driven at walking speed behind the escort officer. This is an unacceptable delay for an ambulance to reach a patient, not helped by inconsistencies in staff instructions.

The Governor should ensure that, in line with national instructions, an ambulance is called immediately in an emergency and that ambulances have speedy access to prisoners in all parts of the prison.

Support for prisoners

49. The cell mate told the investigator that he had not been invited to a memorial service and we understand that no memorial service was held. Memorial services provide prisoners with an opportunity to pay their respects and try to come to terms with a death in custody. Prison Service Instruction (PSI)⁸ 64/2011, Safer Custody, stipulates that the Governor should:

“Arrange for the chaplain or other religious leader to offer to hold a memorial service for the family, other prisoners and staff.”

The Governor should ensure that memorial services are held after every death in custody, in line with PSI 64/2011.

⁸ Prison guidelines containing mandatory instructions, which are written in italics.

CONCLUSION

50. The care that the man received was equivalent to what he would have received in the community. He did not have any health concerns and did not complain of feeling unwell. His sudden death could not have been foreseen or prevented by staff at the prison.
51. Nevertheless, we consider it is good practice for GP records to be called. There was an unacceptable delay in calling an ambulance and a further delay in the paramedics getting from the prison gate to the man. The delay is unlikely to have changed the outcome on this occasion as it appears he died immediately from a major heart attack, but in future this could be crucial.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that community GP records are routinely requested for all prisoners following the first reception health screen.

Partially accepted - GP records are requested for all prisoners with specific medical conditions and or prescribed medication. Also, to confirm any outstanding hospital appointments.

2. The Governor should ensure that, in line with national instructions, an ambulance is called immediately in an emergency and that ambulances have speedy access to prisoners in all parts of the prison.

Accepted - A new call sign Code One (*followed by either red or blue depending on the nature of the injury to ensure our healthcare arrive with the right medical kit*) will now be used - this will be appropriate when a member of staff finds a prisoner and they have grave concerns about the immediate health of that prisoner e.g. serious blood loss and/or he is unconscious. On receipt of the Code One control room staff will make a 999 call for an ambulance immediately and inform the gate of the imminent arrival of the ambulance. The Orderly Officer must ensure that they deploy enough staff to assist with the swift egress of the ambulance into the prison and then to the scene of the incident.

3. The Governor should offer to hold a memorial service after every death in custody, in line with PSI 64/2011.

Accepted - The Governor of HMP & YOI Holme House will offer to hold a memorial service after every death in custody. The offer will take specific faith considerations and the views of the family of the deceased, staff and prisoners into consideration when made. If the offer of a memorial service is accepted the chaplain or other religious leader will arrange and conduct the service.