A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man on 12 October 2013, while in the custody of HMP Altcourse

Our Vision

‘To be a leading, independent investigatory body,
a model to others, that makes a significant contribution
to safer, fairer custody and offender supervision’

This is the investigation report into the death from an internal haemorrhage of a man on 12 October 2013, while a prisoner at HMP Altcourse. He was 20 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by a senior investigator. A doctor reviewed the clinical care the man received in prison. Altcourse cooperated fully with the investigation.

The man was arrested on 2 October and charged with offences arising from a violent incident, during which he had stabbed himself in the stomach. He was taken to hospital for an emergency operation. When he was discharged, on 10 October, he was taken into police custody and arrived at Altcourse on 11 October after being remanded to prison. Neither the discharge letter from the hospital nor the clinical records from his time in police custody arrived with the man at the prison. When he arrived at Altcourse, prison staff began suicide and self-harm monitoring and admitted him to the prison's healthcare unit. During the afternoon of 12 October the man's condition deteriorated rapidly. A prison doctor called an emergency ambulance, but the man died during surgery at hospital. A post-mortem examination found that he had died from a haemorrhage from a major artery.

The clinical reviewer has raised several concerns about the man's time at Altcourse. These included his arrival at the prison without appropriate medical information from either the hospital or police about what aftercare was necessary; the prison's failure to initiate a care plan even though he had recently had a major operation; and incomplete recording of information in the man's medical record. However, the clinical reviewer notes that the haemorrhage would have caused the man to deteriorate very quickly and I am satisfied that there was little that healthcare staff at Altcourse could have reasonably done to prevent his death.

The 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.

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

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SUMMARY

1. On 2 October, the man was arrested after allegedly attempting to assault members of the public, including an ex-girlfriend. Before he was arrested, he had stabbed himself in the stomach and neck. He was taken to hospital and had keyhole surgery to repair injuries to his stomach and aorta. The man remained in hospital until 10 October when he was discharged and taken into police custody. He still had staples in his stomach from his operation, which were due to be removed at a later date. On Friday 11 October, at a local magistrates' court, he was remanded into custody and taken to HMP Altcourse.

2. The prison began suicide and self-harm prevention procedures because of the man's self-inflicted injuries. The man was moved to the prison's healthcare inpatient unit from the induction unit during the evening of 11 October. Healthcare staff did not have a full discharge note from the hospital or medical notes from his time in police custody to inform their care and did not initiate a care plan to manage the wound from his operation. The man was placed in a care suite with a prisoner carer who remained with him all night.

3. At around 2.00pm on Saturday 12 October, the man complained of being in pain. A doctor gave him pain relief medication and healthcare staff and officers monitored him during the afternoon. At around 4.45pm, the man said that his pain had increased and a nurse asked the doctor to review him. The doctor suspected internal bleeding and an emergency ambulance was called. Five minutes before the ambulance arrived, the man became unresponsive. He was taken to hospital, but died while undergoing surgery. A post-mortem established that he had died form a haemorrhage from his supra-renal aorta, which he had damaged on 2 October.

4. We make three recommendations as a result of this investigation. The man did not arrive with full medical information and, although healthcare staff chased a discharge report from the hospital, they did not follow this up. The clinical reviewer was concerned that there was no care plan for the man even though he was recovering from an operation and still had a wound, and she was critical about the lack of entries in his the clinical record.

THE INVESTIGATION PROCESS

5. The investigator issued notices at HMP Altcourse informing staff and prisoners of the investigation and asking anyone who had relevant information to contact him. No one responded.

6. NHS England commissioned a clinical reviewer to review the man's clinical care in custody.

7. The investigator visited Altcourse, met the Director, spoke to staff and obtained copies of the man's prison and medical records. He interviewed staff and prisoners at Altcourse on 7 November. He gave initial feedback to the Head of Safer Custody at the prison, and followed this up in writing. At the draft report stage the National Offender Management Service (NOMS) responded to the recommendations. That response is included below the recommendations.

8. The post-mortem examination indicated that the cause of the man's death was related to his self-inflicted injury which incurred in Wales. HM Coroner for Liverpool therefore agreed to move jurisdiction for the death to HM Coroner for North Wales.

9. One of the Ombudsman's family liaison officers contacted the man's family to explain the purpose of the investigation and invite them to raise relevant matters for the investigation to consider. They were concerned that the man had been remanded into custody even though the hospital had advised the court that he should not go to prison and questioned whether Altcourse could have refused to take the man when he arrived. They wanted to know whether reception health screenings were adequate and about the level of care available in the healthcare unit compared to hospital. The man's family received a copy of the draft report. They pointed out some factual inaccuracies and/or omissions. This report has been amended accordingly. The man's family also raised a further matter which has been addressed through separate correspondence.

HMP ALTCOURSE

10. HMP Altcourse is a local prison in Liverpool which takes prisoners from the courts in Merseyside, Cheshire and North Wales. It is managed by G4S custodial services and holds up to 1,133 sentenced and remanded adult and young adult men. G4S runs the company that provides healthcare services at the prison. There is a 12 bed inpatient facility which provides 24 hour cover and there is a palliative care suite.

HM Inspectorate of Prisons

11. The most recent inspection of HMP Altcourse was a short, follow-up inspection in October 2012. Inspectors found that the standard of health care was reasonable, but staff shortages had affected some areas of clinical care. Not all needs were being met, partly because of a lack of nurses. Inspectors also noted that there was no health input into the induction programme.

Independent Monitoring Board

12. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recent annual report for the year ending June 2013, the IMB noted that GP services were provided by two fully qualified doctors with previous experience of prisons and prisoners. The IMB noted that a robust approach was taken regarding appropriate medical prescribing, with regular reviews of medication.

Previous deaths at HMP Altcourse

13. There have been nine deaths from natural causes at Altcourse since 2010. We have recently made a recommendation to Altcourse about medical record keeping following an investigation into another death in 2013 and we repeat that recommendation in this report. We previously made a similar recommendation about the standard of record keeping following an investigation in 2012.

Suicide and self-harm monitoring

14. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Support for prisoners includes setting a number of significant interactions with them during the day, supplemented by checks on their well-being during the times they are locked in their cell. Part of the ACCT process involves assessing immediate needs and drawing up a care-map to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the care-map have been completed, and a review should be held within a week of the ACCT being closed.

KEY EVENTS

15. The man had a history of mental health problems and had been diagnosed as having Asperger's syndrome (a form of autism).[1] He was arrested on 2 October, after allegedly being responsible for a series of violent attacks. He was armed with knives and police used a taser to subdue him. After he was arrested, the man was taken to a local hospital as he had serious self-inflicted injuries to his neck and abdomen. He underwent a laparotomy (keyhole surgery) to repair injuries to his pancreas, small intestine (duodenum) and supra-renal aorta. The man was admitted to the hospital's intensive trauma unit and given antibiotics.

16. On 9 October, Dr A reviewed the man's mental health and wrote that the man was able to converse fully and that he gave a clear account of his actions. Dr A found no evidence of psychosis and noted that the man now regretted his attempt to take his own life. However, Dr A thought that the man was still at risk of self-harm. Dr A noted that the man understood what would happen at court.

17. The man was discharged from hospital on 10 October. His wounds were closed with clips, which were due to be removed in another six days. He was described as being stable.

18. After he was discharged from hospital, the man was taken to a local police station. He told a police nurse that he had no physical health problems other than the injuries he had been treated for in hospital. He said he had been diagnosed with Asperger's syndrome and a community psychiatric nurse saw him twice a week and Dr A reviewed him every three to six months. The man said that he did not have any current thoughts of suicide or self-harm. The police nurse assessed the man as fit to be detained and he was prescribed omeprazole (for excess stomach acid) and paracetamol.

19. On Friday 11 October, the man was remanded into custody by a local magistrates' court for attempted murder and other charges. He arrived at HMP Altcourse that afternoon. This was his first time in prison. Records of his medical treatment during his time in police custody did not accompany him to Altcourse.

20. The man told reception staff about his recent self-harm. Officer B opened an ACCT document at around 2.10pm and noted that the man had stabbed himself with a samurai sword, had cut his throat and had been on drugs at the time of his alleged offences. Court staff had completed a Suicide and Self-Harm warning form to alert prison staff to his risk. Officer B completed an immediate action plan, and set the level of observations at five per hour. The man was referred to a nurse, and was given access to a telephone and a prisoner carer (peer supporter) to support him.

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[1] Asperger syndrome is a form of autism, which is a lifelong disability that affects how a person makes sense of the world, processes information and relates to other people. Autism is often described as a 'spectrum disorder' because the condition affects people in many different ways and to varying degrees

21. Nurse C conducted a routine reception healthscreen at 2.30pm. (Every prisoner receives a reception healthscreen to determine any immediate physical or mental health needs, any substance misuse issues and any risk of suicide or self-harm.) She noted that the man had a history of drug abuse and had been diagnosed with Asperger's syndrome. She recorded that he was due to return to hospital on 18 November for surgical follow up and made an appointment for him to see the prison doctor.

22. The man then moved to a cell in the prison's induction unit. In a statement for the investigator, Officer D said that, at around 4.00pm, she found the man lying "crunched up" on the bed in his cell. He explained his injuries and told her he was in pain. Officer D contacted the healthcare unit and a nurse agreed to see the man after she had finished issuing medication.

23. Nurse E examined the man at around 4.45pm. He told her that he had just eaten two chocolate bars and this had made him feel sick. His temperature was 36 degrees, blood pressure 130/80 and pulse 73 beats per minute (bpm), all within the normal range.[2] Nurse E gave him two ibuprofen tablets and advised him to discuss his symptoms with the prison GP, at his evening surgery with whom an appointment had been arranged that evening.

24. Officer D remained concerned about the man and the induction unit manager arranged for him to be transferred to the prison's healthcare inpatient unit. Officer D took the man to the healthcare centre at 7.30pm and he was located in the care suite in the inpatient unit with a trained peer supporter.

25. The prison GP saw the man at around 7.45pm, who told him that he had taken MCAT (mephedrone – a synthetic stimulant drug) and cocaine before his alleged offences. The prison GP wrote in his police statement that he saw a discharge note from the hospital which he described as poor quality. The prison GP examined the man and prescribed omeprazole (20 milligrams to be taken once a day) and paracetamol (500 milligrams to be taken six times a day). At around 9.00pm, healthcare staff contacted the hospital for more information, but were asked to call back the next day when the consultant would be available. There is no record that healthcare staff contacted the hospital again.

26. Nurse F was on duty that night. At around 5.45am on Saturday 12 October, she noted in the medical record that the man had appeared slightly unsettled during the night and had tried to sleep on the floor before getting back into his bed. The peer supporter told the investigator that the man had complained that he was in pain, but he appeared to be able to handle it. He said that the man had tried to lie on the floor of the cell as he felt uncomfortable on the bed, but that he had convinced the man to return to his bed.

[2] Blood pressure and pulse - most adults in the UK have blood pressure readings in the range from 120/80 to 140/90 and normal pulse rate is between 60 and 100 beats per minute.

27. Officer G saw the man at around 10.20am to explain what was expected of him in prison and to show him the facilities in the inpatient unit. He wrote that the man felt bad about his offence and regretted what he had done. He told Officer G that he felt much better and had been surprised by how approachable staff were at the prison. The man was given his lunch at around 11.30am. At around 12.20pm, Nurse H recorded that the man had accepted fluids and his medication.

28. Officer G conducted an ACCT assessment at 1.30pm. The man said that after taking drugs he had wanted to kill people starting with his ex-girlfriend. After failing to do so, he decided to go after the people he hated. When he could not find anyone he began attacking random members of the public. The man said he had not wanted to spend his life in a mental health unit, so he had turned his sword on himself, cutting his throat and his stomach.

29. The man said at the time he had wanted to be dead but that he was not thinking straight because he was under the influence of drugs. He said he was now glad to be alive and had much to live for. The man said that he had not attempted suicide before, but often self-harmed. Officer G recorded that the man suffered from Asperger's syndrome and he claimed that this might have contributed to his offence as he said that he got fixated with things and the drugs compounded this. The man said that he could not contemplate suicide as, because of his injuries, he was in too much pain to do anything. Officer G noted that the man had eaten brunch and drank milk and coffee. He recorded the man's issues as drug use and the seriousness of the charges he was facing.

30. At around 2.00pm, the man asked for some pain relief for stomach pain and Nurse H gave him some paracetamol. At around 2.25pm, the prison GP examined the man. He found no signs of infection around the wound site and asked that the man should continue to receive fluids and paracetamol.

31. At 2.30pm, Nurse J decided that the man was not fit enough to attend an ACCT case review. Nurse J wrote in the ACCT record that she had tried to ask him some questions in his cell, but he had said that he was in too much pain. Officer G agreed to delay the first case review until the next day to see if the man was fit enough to attend. Nurse J also arranged for a mental health nurse to see the man. The level of observations remained the same.

32. At 3.50pm, the man told a healthcare assistant that the pains in his stomach were easing off, but at 4.45pm Officer G recorded that the man was still in pain. Officer G spoke to a nurse, who asked the prison GP to see the man. At around 5.00pm, the prison GP recorded that the man's pulse was relatively high at 100 bpm and his blood pressure was quite low at 117/64. The prison GP gave the man oxygen and adrenaline. He then suspected internal bleeding and decided to send the man to hospital. According to the control room records, an ambulance was called at around 5.35pm. The prison GP also contacted the Accident and Emergency Department at the local hospital to explain the man's condition.

33. At 5.40pm, the prison GP recorded that the man was unresponsive and that his pupils were dilated. Paramedics arrived at his cell at around 5.45pm and took the man to hospital at 5.50pm. The man was accompanied by two officers and restraints were not used. The ambulance arrived at hospital at 5.55pm.

34. The prison's family liaison officer contacted the man's parents as soon as he knew that the man would be going to hospital and arranged to meet the man's parents at the hospital.

35. The escort staff telephoned the prison at 6.25pm to inform the duty director that hospital staff had told them that the man's heart had stopped twice. At around 6.45pm, the man was taken into an operating theatre for surgery.

36. The prison's family liaison officer met the man's family at 7.15pm and waited in a relatives' room while the man was in theatre. At 8.10pm, a nurse and two surgeons came to speak to the man's family and the prison's family liaison officer left the room to give them privacy. The nurse told him that the man had died at 7.54pm. The prison's family liaison officer expressed his condolences to the man's family and outlined the help the prison could give them.

37. Notices were issued to staff and prisoners informing them of the man's death. Prisoners subject to suicide and self-harm monitoring were reviewed in case they had been affected by the man's death.

38. The prison's family liaison officer maintained contact with the man's family, offered support and arranged to return his belongings. In line with national policy, the prison offered financial assistance towards the cost of the man's funeral, which took place on 31 October 2013.

39. A pathologist conducted a post-mortem examination and recorded the cause of the man's death as a haemorrhage due to a stab wound to the abdomen. After the cause of death was confirmed, it was agreed that the jurisdiction for the death would move to HM Coroner for North Wales as this was the area where he had been initially treated after he had stabbed himself.

ISSUES

Medical care

40. The clinical reviewer considered the man's healthcare in prison, including the management of his clinical care and risk of self-harm. The clinical reviewer made several recommendations in her review which is annexed to this report and which the Head of Healthcare and Director of Altcourse will need to address.

Arrival at Altcourse

41. The clinical reviewer has established that healthcare staff at Altcourse was not fully aware of the man's history when he arrived there on 11 October. The nurse who completed the reception health screen did not have a copy of the discharge letter from hospital (which was finally located at the prison on 15 October) or the man's medical records from police custody. The prison GP asked nursing staff to obtain further information from the hospital on 11 October, but the consultant was not available and no one followed this up the next day as the hospital had suggested.

42. The clinical reviewer believes that this lack of information was a root cause for the events of 12 October and that this led to significant clinical risk for the man. As the man had recently undergone a serious operation from which he was still recovering, we agree that having proper discharge information was an essential prerequisite for providing appropriate care for him at Altcourse.

43. Although it is not clear that this would have affected the outcome for the man, we consider that further discharge information should have been obtained from the hospital on 12 October. It is also a concern that information about his medical treatment during his time in police custody was not received when the man arrived at Altcourse. Prison Service Order 3500 (continuity of healthcare) states that efforts should be made to retrieve any information required from the prisoner's GP or other relevant service he has recently been in contact with and emphasises the importance of continuity in the success of clinical interventions. More priority should have been given to ensuring that the information was received as soon as possible in case there was important detail about his ongoing care. We make the following recommendation:

The Head of Healthcare should ensure that all relevant medical records are requested promptly for newly-arrived prisoners, particularly those with ongoing health problems

44. Altcourse has a policy that, when a prisoner is admitted to the inpatient unit, a care plan should be initiated within 24 hours and a named healthcare worker identified to implement and review the plan. The man had been admitted to the healthcare centre more out of concern about his possible mental state given his serious self-harm and the charges he was facing, rather than because it was considered his physical health needed inpatient care. Nevertheless, he had physical health needs. Although the man had been in the inpatient unit just

less than 24 hours when he was admitted to hospital, the clinical reviewer did not find any evidence that a care plan had been implemented or even considered, although the wound from the man's operation and his pain relief both needed to be monitored. We make the following recommendation:

The Head of Healthcare should ensure that appropriate care plans are initiated as soon as possible when a prisoner is admitted to the inpatient unit.

Record keeping and clinical observations

45. According to the NHS Code of Practice, the primary function of clinical records is to support patient care. The clinical reviewer considered that the record keeping at Altcourse was sporadic and did not meet the expected requirements of clinicians. In particular, healthcare staff did not always note both the electronic medical record (SystmOne) and the ACCT document as they should have done. The clinical reviewer also considered that some nursing interventions were not recorded as they should have been.

46. The clinical reviewer found that, during the man's stay in the healthcare unit, more priority was given to his mental health needs and ACCT observations rather than monitoring his physical health. His clinical observations were not taken and monitored frequently and there was no plan to identify and escalate action if the man's condition deteriorated. In particular, few observations were taken between 2.00pm on 12 October and 5.00pm, when the prison GP saw him. The observations that were carried out were recorded retrospectively so were not part of an ongoing review of his condition. We have recently made a recommendation to Altcourse about record keeping which the prison has said will result in a new process being introduced. In the man's case, few observations were completed and records of these were made retrospectively. We therefore repeat our previous recommendation:

The Head of Healthcare should ensure that all results of diagnostic investigations and previous medical history should be documented in the prisoner's medical record.

Concerns raised by the man's family

47. The man's parents wanted to know whether Altcourse could have refused to accept the man when he arrived at the prison due to his health problems. The prison is obliged to accept prisoners remanded on legal warrants from the courts so had no discretion about whether to accept the man into its custody. The man could then have been taken to hospital if healthcare staff did not think that he was fit enough to remain in prison, but at the time he arrived there was no reason to consider he required acute hospital care. The hospital had assessed the man as fit to be discharged from hospital care the day before he arrived at Altcourse and a nurse in the police custody suite had also assessed the man as being fit to be detained on 10 October.

48. The man’s parents asked whether the health screening process at Altcourse was adequate. As noted earlier, the clinical reviewer found that the health screen would have been better had full discharge information from the hospital been available, although there is no information to show that this would have altered his subsequent management. The man was also reviewed by a prison doctor during the evening on the day he arrived at Altcourse as part of his reception process. The doctor assessed the man as fit to be at Altcourse and requested his past medical history including fuller discharge information from the hospital. Apart from the concern that full information did not arrive at the prison with the man, we are satisfied that reception health screen was adequate.

49. The man’s parents queried the level of care available in the healthcare centre at Altcourse compared to a hospital in the community. The care provided in the inpatient unit was primary care for observation and treatment and it is not an acute (hospital) setting. The man had been discharged from hospital and in the community would have been recovering from his operation at home. Although it is possible that more structured care plans and monitoring might have detected a decline in his condition sooner, the man was taken to hospital quickly once his clinical deterioration was noted. Although the clinical reviewer was concerned about the lack of care plans, she noted that a haemorrhage from the aorta would have resulted in a dramatic and instant decline in the man’s presentation with minimal chance of survival.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that all relevant medical records are requested promptly for newly-arrived prisoners, particularly those with ongoing health problems.

2. The Head of Healthcare should ensure that appropriate care plans are initiated as soon as possible when a prisoner is admitted to the inpatient unit.

3. The Head of Healthcare should ensure that all results of diagnostic investigations and previous medical history should be documented in the prisoner's medical record.

ACTION PLAN: The man at HMP Altcourse on 12 October 2013

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that all relevant medical records are requested promptly for newly-arrived prisoners, particularly those with on-going health problems.	Accepted	• The Head of Security will inform the Admissions staff via an email notice that PER's must be forwarded to the nurse on reception to highlight any medical information. • The Head of Security will inform Admissions staff via email that they must forward any medical documents received at reception to the nurse on duty. • Prisoners with on-going health problems will be identified during the reception screening process in reception by Healthcare staff. • The prisoner consent form will be amended to include details of GP and recent on-going hospital treatment. • Nursing staff on reception will ensure the consent forms are placed into the 'pending' tray in the administration room for administrators to chase up details. The Practice Manager will ensure all consent forms have been actioned and scanned onto the medical record within 24 hours of reception. • On reception GP's will request urgent information at time of consultation. The Practice Manager will ensure all locum Doctors are aware of the procedure, via a notice in the GP's surgery. This will be also located in the formulary guide. During out of hours where follow ups are required, nurses will document in the senior nurses handover books for them to action (evenings/weekends). • Staff will be reminded that any actions completed or required MUST be documented in the medical records. A full staff meeting and notice to staff will be initiated to ensure all staff are aware and adhere to the procedure.	23rd May2014 23rd May 2014 23rd May 2014 19th May2014 1st June 2014 1st June 2014 23rd May 2014 22nd May 2014	

ACTION PLAN: The man at HMP Altcourse on 12 October 2013

2	The Head of Healthcare should ensure that appropriate care plans are initiated as soon as possible when a prisoner is admitted to the inpatient unit.	Accepted	• An enhanced care plan will be devised that will clearly identify the clinician initiating the care plan, reason for admission and individual care needs/monitoring. • The enhanced care plan will be implemented and initiated during the cell allocation process upon admission by the nurse on duty. • NHS England will be consulted so that the new care plan can be placed onto the clinical tree within system-one. • A full staff meeting and notice to staff will be initiated to ensure all staff are aware and adhere to the procedure. • Management checks will be implemented. Senior nurses will check care plans daily and this will be recorded in the Managers Compliance check document.	1st June 2014 16th May 2014 22nd May 2014 2nd June 2014 8th June 2014	
3	The Head of Healthcare should ensure that all results of diagnostic investigations and previous medical history should be documented in the prisoner's medical record.	Accepted	• The medical record will now be updated in reception with any medical information received during the reception process. • Any further information will be documented at the time it is received. • The Lead administrator will conduct a daily check of all information received in and daily requests from GP's. All outstanding requests will be followed up on a daily basis by admin staff (out of hours/weekends – senior nurses will chase information) • All external contact will be documented on system-one. • A full staff meeting and notice to staff will be initiated to ensure all staff are aware and adhere to the procedure.	1st June 2014 1st June 2014 6th June 2014 1st June 2014 22nd May 2014	