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 December 2013 while in the custody of HMP Holme House

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 in December 2013, while a prisoner at HMP Holme House. The man died of complications relating to liver disease. He was 46 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. A clinical reviewer reviewed the clinical care the man received at Holme House. The prison cooperated fully with the investigation.

The man was sentenced to seven years in prison on 5 July 2013 and sent to Holme House. He had been diagnosed with liver disease before his sentence and was under the care of a consultant. On 23 August, the man was diagnosed with decompensated liver disease (when the body can no longer compensate for the damaged liver). On 24 September, further medical investigations revealed the man was suffering from oesophageal varacies (dilated blood vessels in the throat or stomach) associated with his liver disease.

On 25 December, the man became very unwell and was admitted to the University Hospital of North Tees where his condition deteriorated quickly. He was placed in a medically induced coma and transferred to the intensive care ward on 27 December. The man died two days later.

I agree with the clinical reviewer, that the standard of healthcare the man received at Holme House was equivalent to that he could have expected in the community. However, I am concerned that the use of restraints when the man was taken to hospital just before his death was not justified by fully considered risk assessments which took into account his poor health and mobility. This is a matter I have raised with the Holme House before and it does not appear that lessons are being learned.

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

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SUMMARY

1. The man was sentenced to seven years in prison for sexual offences on 5 July 2013. He was sent to HMP Holme House. Before his sentence he had been diagnosed with cirrhosis of the liver from excessive alcohol consumption. He was under the care of a liver specialist at University of North Tees Hospital.

2. On 23 August, the man was unwell and admitted to hospital. Tests revealed he had developed decompensated liver disease. He returned to Holme House on 31 August and was admitted to the prison's inpatient unit. The man was aware he had a life limiting condition that could not be cured. He remained in the inpatient unit and was nursed palliatively.

3. A CT scan on 24 September, showed the man had oesophageal varacies, arising from his liver disease. An MRI scan on 27 September identified a narrowing of the pancreas which was causing jaundice. At his request, the man moved back to a residential houseblock on 11 October.

4. The man remained on the houseblock where, because of his poor mobility, other prisoners assisted him. Healthcare staff reviewed him at least twice a day. On 25 December, the man became unwell and vomited blood. He was admitted to University Hospital North Tees and the next day tests indicated a significant amount of internal bleeding. On 27 December, the man was moved to the intensive care unit and placed in a medically induced coma and on a ventilator. The man's condition continued to deteriorate and he died at 10.40am on 29 December.

5. The clinical reviewer is satisfied that the man received good quality care and support while at Holme House which was equivalent to that he could have expected in the community. However, we are not satisfied that the risk assessments when the man was taken to hospital just before his death fully took into account his state of health and mobility. We make one recommendation about this.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at HMP Holme House informing them of the investigation and inviting anyone who had relevant information to contact her. No one responded.

7. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. NHS England appointed a clinical reviewer to review the man's clinical care at the prison. The investigator informed the Governor in writing of the preliminary findings of the investigation.

8. We informed HM Coroner for Teesside of the investigation, who provided the cause of death. We have sent the Coroner a copy of this investigation report.

9. One of the Ombudsman's family liaison officers contacted the man's father, his nominated next of kin, to explain the investigation. The man's father said he had had little contact with his son, but wanted to know how he had died.

10. The investigation has assessed the main issues involved in the man's care, including his diagnosis and treatment, whether appropriate care was provided, his location, security arrangements for escorts, liaison with his family, and whether compassionate release was considered.

11. The man's next of kin was provided with a copy of the draft report. They did not make any comment on the factual accuracy of the report. The prison considered our draft report and recommendation, which it accepted. The prison has also submitted an action plan detailing what they have done to address the issue we raised and this is included at the end of the report.

HMP HOLME HOUSE

12. Holme House is a local prison for up to 1,212 men. The majority of its prisoners are remanded into custody or recently convicted by courts in the local area. Care UK provides health services at Holme House. There is an inpatient unit with 18 beds and 24 hour nursing care.

HM Inspectorate of Prisons

13. The most recent inspection of HMP Holme House was in August 2013. Inspectors found that the overall standard of healthcare was good. There was a reasonable skills mix of healthcare staff, with 10 nurse prescribers. Health services were delivered from a health centre and wing based rooms, which were generally of a reasonable standard. The Inspectorate described palliative care at the prison as excellent, with multi-departmental care based on best practice from Macmillan Cancer Support.

Independent Monitoring Board (IMB)

14. 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 recently published annual report for the year to December 2012, the IMB said that healthcare services were delivered to a high standard at least equivalent to services offered in the community. The IMB noted that a new palliative care suite was about to be opened.

Previous deaths at HMP Holme House

15. The man's death was one of seven natural cause deaths at Holme House in 2013. We have made recommendations about the use of restraints in a number of these previous investigations.

ISSUES

The diagnosis of the man's terminal illness and informing him of his condition

16. On 5 July 2013, the man was sentenced to seven years imprisonment for and sent to HMP Holme House. When he arrived, a prison GP noted that the man had liver disease, pancreatitis (inflammation of the pancreas) and diabetes mellitius. He recorded that the man had jaundice in his eyes. The man had a history of excessive alcohol use and smoked cigarettes.

17. On 12 July, a prison GP, examined the man and noted that he was under the care of the liver specialist, a liver specialist at University Hospital North Tees. The GP asked healthcare administration to obtain the man's medical notes from his community GP and referred the man for a blood test.

18. The GP reviewed the man's GP records on 19 July and noted a letter from the liver specialist informing the man that the hospital would be unable to treat him until he stopped drinking. The GP referred the man to the Telemed service to ensure his outpatient appointments with the liver specialist could continue effectively.

19. On 23 August, a prison GP, examined the man who was short of breath and had swollen ankles. The doctor noted he was jaundiced, his abdomen was swollen and his bowel was distended. The man was taken to University Hospital North Tees, where tests revealed he had developed decompensated liver disease, where the body is no longer able to compensate for the effect of the liver damage. Hospital staff informed him that this was a life limiting condition and there was no cure. He returned to Holme House on 31 August.

20. The man was aware of his diagnosis of chronic liver disease before he arrived at Holme House. We are satisfied that healthcare staff at the prison took appropriate steps to confirm this diagnosis and maintained follow up communication with the hospital and liver specialist. The man was appropriately sent to hospital when his condition worsened and further diagnosed with decompensated liver disease. Hospital staff told the man that there was no curative treatment, although the prognosis was unclear.

The man's medical treatment

21. Once it becomes evident that a serious medical condition will not be responsive to active treatment, it is appropriate that a palliative care plan is put in place. The NHS document 'The route to success in end of life care – achieving quality in prisons and for prisoners' sets out how palliative and end of life plans might be implemented in prisons. Palliative care is longer term care that is not curative, but may extend life. It includes treatment such as chemotherapy and pain relief, and includes planning for all care needs, including pastoral and spiritual. Regular care planning meetings should include the patient and any family, and the patient's wishes regarding resuscitation should be considered.

22. The GP met with the man on 2 September to explain the diagnosis of decompensated liver disease. The man said he wanted to be resuscitated if he had a cardiac or respiratory arrest and this was recorded in his medical notes.

23. On 12 September, a nurse spoke to the man about his diagnosis and the aggressive nature of his illness. The man was tearful and aware he might be dying. His main concern was that he should be pain free. The man told the nurse that he had no contact with any of his family.

24. The nurse completed a care plan to ensure the man's palliative and diabetic care was managed appropriately. The plan included nursing care, observations and medication. The man received pain relief and medication for liver disease and diabetes. The palliative care lead nurse attended regular multidisciplinary team meetings about the man's ongoing care and nurses reviewed the man daily to monitor and manage his pain, diabetes and liver condition in line with his care plan.

25. The man attended University Hospital of North Tees on 24 September for a CT scan. This showed he had developed oesophageal varacies (dilated blood vessels usually in the throat or stomach), arising from liver disease. On 27 September, the man had an MRI scan which indicated narrowing of the pancreas. The liver specialist (the liver specialist) said this explained why the man's jaundice had worsened. The man's case was to be discussed at the next hospital multidisciplinary meeting.

26. The liver specialist wrote to the GPs at Holme House on 11 November and said that the man was suffering from chronic pancreatitis, alcohol related liver disease, raised blood pressure in the veins around the liver and some narrowing of the structure that carries bile from the liver to the small intestine. The liver specialist referred the man for a further CT scan. (This had not been carried out by the time the man died).

27. At 1.50pm on 25 December, the nurse saw the man after he had vomited blood and passed black faeces. She decided that he needed to go to hospital. Prison staff took him to University Hospital North Tees at 2.00pm by car which, because it was Christmas Day, they thought would be quicker than an ambulance.

28. The man was admitted to hospital and the next day an endoscopy showed that his oesophageal varacies were bleeding. On 27 December, due to continued serious bleeding, the man was moved to the intensive care unit. He was placed in an induced coma and on a ventilator.

29. The man's condition deteriorated and doctors removed the ventilator at 10.05am on 29 December. The man died at 10.40am

30. The clinical reviewer concluded that the man's care at Holme House was equivalent to that he could have expected in the community. His medications were prescribed appropriately and his pain relief was reviewed and increased

when necessary. The man was able to attend outside hospital appointments without problems. The clinical reviewer noted that discussions with the man about his palliative care suggested that he was entering the final stage of his life, although the hospital was still planning investigations into his condition and management. Although there was no curative treatment, the prognosis was unclear at the time. Nevertheless, the clinical reviewer is satisfied that his palliative care needs were appropriately discussed and assessed. We are satisfied that the man's care was well managed at Holme House.

The man's location

31. On 31 August, the man returned from hospital to Holme House and was admitted to the prison's inpatient unit for nursing care. Despite being unwell and having limited mobility, the man was able to look after himself.

32. On 30 September, the man told healthcare staff he would like to return to his houseblock. A week later, the GP discussed this with nurses and wing staff and the man returned to a shared cell on his houseblock on 11 October. Prisoner 'buddies' and prison staff helped him with daily tasks. (Buddies are specially selected prisoners who help disabled, infirm and elderly prisoners with day to day living). His care plan remained in place and nurses visited him at least twice a day.

33. We are satisfied that staff at Holme House appropriately considered the man's preferences about his place of care. The clinical reviewer was satisfied that the man was appropriately located.

Restraints, security and escorts

34. The Prison Service has a duty to protect the public when escorting prisoners to hospital, and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process. It deemed that restraining by handcuffs of a prisoner receiving chemotherapy (and by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.

35. When the man was taken to hospital on 25 December, a nurse completed the medical section of the escort risk assessment and noted that there were no healthcare objections to the use of restraints. The nurse did not comment on the man's medical condition and whether or how this impacted on his risk of escape. There was little other information on the risk assessment apart from

a reference to the man's offence. The man was accompanied by two officers and restrained by an escort chain. (An escort chain is a length of chain with one cuff attached to an officer and the second cuff attached to the prisoner.)

36. On 26 December, the security department completed another risk assessment. A nurse completed the healthcare section but again there was no reference to the man's medical condition and whether this impacted on his risk of escape. The security manager, completed the security section and noted that he was a low risk of escape. The head of security authorised the use of restraints and stated they could be removed for medical treatment or tests, but should be reapplied as soon as possible afterwards.

37. When the man was transferred to the intensive care unit (ICU) on 27 December, he was on a ventilator and unconscious, but still restrained. At the request of a hospital consultant, the head of residential services reviewed the risk assessment. She authorised the removal of restraints while the man was unconscious, but noted that the restraints should be reapplied if he regained consciousness.

38. In response to our initial feedback the Governor of Holme House, responded to justify the decision about the use of restraints and said that while the man was obviously ill he was mobile and it was known that he presented a risk to women. She did not explain why the risk assessments completed at the time of the man's hospitalisation did not contain medical opinion about how his health and mobility impacted on his risk of escape or why it would be necessary to use restraints again simply because a very ill prisoner regained consciousness.

39. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances which must be fully considered, taken into account and balanced against the actual security risks based on the prisoner's condition at the time. We are not satisfied that the decisions taken were justified by fully considered risk assessments that took into account the man's medical condition as required by the 2007 High Court judgement. This is a matter we have raised with Holme House before. We make the following recommendation:

The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Liaison with the man's family

40. The man had little contact with his family. A family liaison officer and an operational manager visited the man's father, his nominated next of kin, at 3.00pm on 27 December. They informed him that the man was in intensive care and his prognosis was poor. The man's father told the family liaison officer he had had only very limited contact with his son for many years. He

did not want to visit him, but asked the family liaison officer to telephone him when his son died.

41. The family liaison officer and manager went to two different addresses to try to find the man's mother, but were unable to locate her.

42. At 11.30am on 29 December, the family liaison officer telephoned the man's father to tell him that his son had died. The family liaison officer and manager visited the man later that day. The man's sister was also present and said she had contacted the man's mother and told her that he had died.

43. Holme House arranged and paid for the funeral. The service was conducted by the prison chaplain on 16 January 2014. Senior prison staff attended.

Compassionate release

44. Prisoners can be released from custody on compassionate grounds before their sentence has expired. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.

45. Although the man was terminally ill, he did not have a clear prognosis and an application for compassionate release was not started. We are satisfied that he would not have met the criteria for an earlier application and his sudden decline in December was too rapid for such an application to be feasible.

RECOMMENDATION

The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response
1	The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.	Accepted	The Prison and Probation Ombudsman's learning lessons update from February 2013 was re-circulated to all Duty Governors and Custodial Managers in February 2014, who have been reminded that risk assessments f prisoners taken to hospital are based on a consideration of the individual's health circumstances and the actual risk the prison presents at the time. Extracts from the PPO update were highlighted to remind staff of th legal obligations. This update is now on a circulation list to be reissued annually. The Holme House escort risk assessment document has now been redesigned to highlight to both healthcare staff and Duty Governors that the present health condition each prisoner must be considered and any u of restraints must be proportionate to their current security risks.