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 January 2015 at 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, who died of a heart attack in January 2015, at HMP Holme House. I offer my condolences to the man's family and friends.

One of my investigators carried out the investigation. A clinical reviewer was, appointed to review the clinical care the man received at Holme House. The prison cooperated fully with the investigation.

The man received an 18-month prison sentence on 18 March 2014. He was released from prison on 16 December, but he breached his licence conditions and was recalled and sent to Holme House on 23 December. The man did not have any history of cardiovascular disease and, apart from one recent slightly high reading, his blood pressure was normal, as were his cholesterol levels. On 5 January, he pressed his cell bell and an officer found he was unwell. Healthcare staff attended and, while they were taking him to the prison's healthcare centre, he suffered a cardiac arrest. Staff and paramedics attempted to resuscitate him, but he had died.

I agree with the clinical reviewer that, overall, the man received an appropriate standard of care at the prison and that the emergency response when he collapsed was very well managed. The man died from a sudden heart attack, which the prison could not have predicted or prevented.

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 2015**

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SUMMARY

1. The man was convicted in 18 March 2014 and received an 18-month prison sentence. He was released on licence on 16 December. On 23 December, he breached his licence conditions and was recalled to prison. He was sent to Holme House.

2. On 23 December, the man had a reception health screen, which identified no significant physical health problems. At his second reception screen, on 30 December, a nurse found that his blood pressure was slightly high. She made an appointment for a further reading on 6 January, in line with the National Institute for Health and Care Excellence (NICE) guidelines.

3. At 5.13pm on 5 January, a prison officer responded to the man's cell bell and found he had vomited. The officer asked a nurse to assess the man.

4. A nurse assessed the man shortly afterwards. She arranged to take him to the prison's inpatient unit, as she was concerned that he might have inhaled some vomit. He stayed in his cell while the nurse went to see another prisoner. A few minutes later, an officer checked the man and found that his condition had got worse.

5. The nurse and a healthcare assistant took the man in a wheelchair to the inpatient unit. Just outside the unit, the nurse realised something was wrong with the man. His colour had changed and he was unresponsive. She radioed an emergency code at 6.15pm. The man was not breathing, and she began cardiopulmonary resuscitation. Other healthcare staff attended, including a prison GP.

6. The control room called an ambulance at 6.16pm, which arrived at 6.32pm. Prison staff and paramedics continued to attempt resuscitation, but, at 6.44pm, the doctor declared the man dead.

7. The clinical reviewer considered the man received an appropriate standard of care at Holme House and that the emergency response was very well managed. She made some recommendations for improvements, which the Head of Healthcare will need to address, but we are satisfied that staff at Holme House could not have predicted or prevented the man's death. We make no recommendations.

THE INVESTIGATION PROCESS

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

9. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. She interviewed five members of staff at Holme House in February 2015 and another by telephone.

10. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.

11. We informed HM Coroner for Teesside of the investigation, who sent us the post-mortem report. We have sent the coroner a copy of this investigation report.

12. One of the Ombudsman's family liaison officers contacted the man's nephew on 29 January, to explain the investigation. The man's nephew did not have any concerns or questions for the investigation to consider.

13. The draft report was issued for consultation with the prison service. They pointed out some factual inaccuracies. This report has been amended accordingly.

14. The man's nephew received a copy of the draft report. He did not make any comments.

HMP HOLME HOUSE

15. HMP Holme House is a local prison holding over 1200 men. Most are on remand, or recently convicted by courts in the local area. Care UK provides health services at the prison. There is a 24-hour inpatient unit with 16 beds and palliative care facilities.

HM Inspectorate of Prisons

16. The most recent inspection of Holme House was in August 2013. The Inspectorate found the overall quality of healthcare had improved and was good. Patient care was very good. There was an appropriate mix of clinics for primary care and lifelong conditions and waiting times were reasonable with low rates of non-attendance.

Independent Monitoring Board

17. Each prison in England and Wales 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 report, for the year to December 2013, the IMB considered that prisoners at Holme House received a high standard of healthcare at the prison.

Previous deaths at HMP Holme House

18. The man was the third prisoner to die from natural causes at Holme House since the start of 2014. There were no relevant similarities between these deaths.

KEY EVENTS

19. On 18 March 2014, the man received an 18-month prison sentence. He arrived at Holme House the same day.

20. At a reception health screen, Nurse A recorded no major problems and the man's blood pressure was within the normal range. The man declined help to stop smoking.

21. Healthcare staff monitored the man as they had concerns about his mental health and deteriorating physical health, including his mobility and ability to care for himself. The man had no history of heart disease and blood tests on 25 April and 28 May, showed that his cholesterol levels were within the normal range.

22. On 5 June, the man was transferred to HMP Northumberland and, on 18 September, he was moved to HMP Forest Bank. Reception health screens at both prisons noted that he had problems with his mobility and that his blood pressure readings were within the normal range.

23. On 30 October, Nurse B examined the man, after he complained of chest pain and was short of breath. She noted he was wheezing and coughing, had congested chest sounds and was unable to talk in full sentences. The nurse gave him two salbutamol nebulisers (a treatment for asthma) and took him to the healthcare unit.

24. Dr A, a prison GP, assessed the man later that day. She prescribed a course of antibiotics and steroids to reduce inflammation in the airways. She also referred him to a chronic obstructive pulmonary disease (COPD – a lung disease) clinic for a spirometry test to measure his lung capacity.

25. On 16 December, the man was released from prison on licence. However, on 23 December, he was recalled to prison for breaching his licence conditions and sent to Holme House. At a reception health screen, Nurse C noted no significant health problems.

26. On 30 December, at a second health screen, Nurse D noted the man's blood pressure was slightly high. National guidelines require that when a blood pressure reading is high, three further readings should be taken before the patient is referred to a GP. The nurse made an appointment to take the man's blood pressure again, on 6 January.

27. At 5.13pm on 5 January, the man rang his cell bell. A minute later, Officer A, responded and found the man retching, with vomit on his beard and sweatshirt. The officer agreed to get a nurse to come and see him and asked the man to sit on his bed. The officer telephoned the healthcare unit and spoke to Nurse E, who said she was going to see a prisoner on another houseblock and would see the man afterwards.

28. At approximately 5.45pm, Officer A took Nurse E to the man's cell. The man was shaking and making a very loud wheezing sound. Neither Nurse E nor the officer knew if the man's breathing was usually wheezy, but they asked another prisoner, who said he did not suffer from breathing problems. The man told the nurse that he did not feel unwell. He was oriented and able to tell her where he was. The nurse was concerned that the man might have inhaled some vomit, so she began to arrange for him to be admitted to the prison's inpatient unit.

29. Nurse E asked Nurse A, who was in charge of the inpatient unit, to arrange for a healthcare assistant to bring a wheelchair to help her take the man to the unit, for the doctor to assess him. As a precaution, she also asked for an emergency trolley, with oxygen equipment.

30. Nurse E then went to see a prisoner on another landing, and Officer A and other officers supervised the prisoners' association period. A few minutes later, the officer checked the man. She was concerned that he had a white liquid, similar to vomit, coming from his nose and he was shaking a lot. She called the nurse who thought that the man had vomit in his lungs, which meant that the need to move him to the healthcare unit had become more urgent, though his breathing had improved and the initial wheeze had gone.

31. Shortly afterwards, Healthcare Assistant A arrived with a wheelchair. The man was able to put on his shoes and, with help from Healthcare Assistant A and Nurse E, he walked out of his cell and down some steps in the houseblock and got into the wheelchair.

32. On the way to the inpatient unit, the man told Nurse E that he felt okay. When they arrived near one of the entrances to the inpatient unit, she looked at him again. He was a poor colour and did not respond to her. At 6.15pm, the nurse radioed a code blue (indicating an emergency such as when someone is not breathing) and asked a passing officer for help to get the man out of the wheelchair so she could assess his pulse and breathing.

33. At 6.16pm, a control room operator called an ambulance. He told the emergency service operator that the man was elderly and had breathing problems. The emergency services advised that an ambulance would not be able to attend for 30 minutes.

34. Nurse E asked Healthcare Assistant A to bring a defibrillator from the inpatient unit and inform other healthcare staff that the man had collapsed. The nurse listened to the man's breathing and opened his airways. She could hear some agonal breathing (gasping breathing, common in those suffering a cardiac arrest) but could not find a pulse in his neck.

35. The Healthcare Assistant A went to the inpatient unit and asked Nurse A to assist Nurse E and a Healthcare Assistant B, went to collect the defibrillator and emergency bag. Nurse A began to administer chest compressions, while Nurse E inserted an airway, attached an ambu-bag, a manual resuscitator to

provide pressure ventilation. The nurse asked someone to bring the suction machine, to remove vomit from the man's mouth.

36. Nurse F, who had responded to the code blue, brought the suction machine from the outpatient unit. On her way back, she told prison GP B what had happened and he came with her. The nurses suctioned the man's mouth, but he was not breathing and showed no signs of life. The doctor requested a nasopharyngeal tube to help maintain a clear airway. The nurse got one and it helped improve the man's ventilated breaths. The healthcare staff continued cardiopulmonary resuscitation.

37. Healthcare Assistant B arrived with the defibrillator and Nurse A attached it to the man. However, it did not detect a shockable heart rhythm. Staff continued to attempt resuscitation and used the suction machine, as there was a large amount of vomit in the man's mouth.

38. A radio message announced that the ambulance would not arrive for 30 minutes. Dr B and Nurse E then asked staff to tell the ambulance service that the man was in full cardiac arrest and they needed an ambulance immediately.

39. At 6.24pm, the prison control room called the emergency services again to inform them that the man was in cardiac arrest. The emergency service operator upgraded the ambulance priority and the ambulance arrived at Holme House at 6.32pm.

40. Paramedics noted that the man was unresponsive, had no pulse and was not breathing. A paramedic attached a cardiac monitor, which confirmed that the man was asystole (showing no signs of cardiac electrical activity). His pupils were fixed and dilated. Dr B briefed the paramedics and said that the man had no significant past cardiac history. He advised them to continue cardiopulmonary resuscitation for another five minutes. The man remained unresponsive and they agreed to stop at 6.40pm. At 6.44pm, the doctor pronounced the man dead.

Support for prisoners and staff

41. The prison issued notices to prisoners and staff, informing them of the man's death and offering appropriate support. A manager debriefed the staff involved in the emergency response and offered support if they needed it.

42. Prison staff checked prisoners considered at risk of suicide or self-harm in case they had been adversely affected by the man's death. The chaplain visited the houseblock and offered to speak to any of the man's friends, if they wanted further support.

Post-mortem

43. A post-mortem examination concluded that the cause of the man's death was:

i. cardiac arrest;
ii. and cardiac dysrhythmia (when electrical activity of the heart is irregular and the heart stops pumping blood around the body);
iii. acute coronary occlusion (an obstruction of an artery that supplies the heart muscle);
iv. ruptured plaque of coronary atherosclerosis (plaque that allows blood to clot inside an artery and;
v. atherosclerosis (hardening and narrowing of the arteries).

Liaison with the man's family

44. The man's records had no details of any family or anyone he wanted to be contacted in an emergency. The Head of Safer Custody and the prison's family liaison officer, contacted the man's solicitor, who in turn informed his next of kin, who lived overseas. The prison arranged and paid for the man's funeral, in consultation with his next of kin and in line with Prison Service guidelines.

ISSUES

Clinical care

45. The man's records did not show any history of cardiovascular disease. The major risk factors for developing cardiovascular disease are smoking, high blood pressure, high cholesterol, ethnicity, age, family history and smoking. The man was a heavy smoker. However, his blood pressure was within the normal range on most occasions, with the exception of the last reading. Blood tests in 2014 showed his cholesterol level was within an acceptable range.

46. On 30 December, the man's blood pressure was 168/108 (an abnormal measurement is any recording over 140/90). Nurse D recognised this was a little high and, in line with the National Institute for Health and Care Excellence guidelines, booked an appointment to take a second reading on 6 January.

47. The clinical reviewer noted that all people between the ages of 40 and 85 should be offered an NHS Health Check, which includes determining the risk of heart disease. There is no record that the man was offered one. However, we recognise that since his recall, the man had been at Holme House for only a very short time over the Christmas period. The clinical reviewer has made a recommendation about this and other matters, not directly related to the cause of the man's death, which the Head of Healthcare will need to address.

48. Overall, the clinical reviewer considered that the man received a reasonable standard of healthcare at Holme House, equivalent to that he could have expected to receive in the community, and that the emergency response was very well managed. We are satisfied that there was nothing the prison could have done to prevent the man's death and that he received appropriate care.