

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Graham Harding, a prisoner at HMP Holme House, on 21 June 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



© Crown copyright 2015

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Graham Harding died of obesity and hardening of the arteries, at HMP Holme House on 21 June 2015. He was 73 years old. I offer my condolences to Mr Harding's family and friends.

Mr Harding had a number of long-term health conditions, which appear to have been generally well managed, and I do not consider that there was anything staff at Holme House could have done to prevent his sudden and unexpected death. I am satisfied that Mr Harding received a good standard of care at the prison, equivalent to that he could have expected to receive in the community.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

January 2016

Contents

Summary	
The Investigation Process	
Background Information	
Key Events	
Findings.....	

Summary

Events

1. On 26 June 2014, Mr Graham Harding was sentenced to two years, three months in prison and arrived at HMP Holme House. Mr Harding had several complex medical conditions, including type 2 diabetes, high blood pressure, obesity, an underactive thyroid, osteoarthritis and leg ulcers. Healthcare staff admitted him to the prison's inpatient unit to assess his needs.
2. On 1 July, after nurses had implemented a care plan, Mr Harding moved to a standard prison wing. He had equipment to test his blood sugar levels and manage his diabetes. Healthcare staff monitored his leg ulcers, applied creams and changed his dressings daily. He received pain relief to ease his discomfort.
3. Mr Harding's needs continued to be managed on his wing until 18 June 2015, when a nurse admitted Mr Harding to the inpatient unit. His leg ulcers had affected his mobility and the nurse was concerned that he had not been testing his blood sugar levels regularly. Just after 7.00am on 21 June, a nurse found Mr Harding unresponsive in his cell and it was apparent that he had died.

Findings

4. The clinical reviewer concluded that the standard of care Mr Harding received at the prison was equivalent to that he might have expected to receive in the community. We are satisfied that Mr Harding received good care at Holme House and staff could not have prevented his sudden and unexpected death.

The Investigation Process

5. The investigator issued notices to staff and prisoners at HMP Holme House informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
6. The investigator obtained copies of relevant extracts from Mr Harding's prison and medical records.
7. The investigator interviewed three members of healthcare staff at Holme House in August 2015 and one by telephone in September 2015.
8. NHS England commissioned a clinical reviewer to review Mr Harding's clinical care at the prison.
9. We informed HM Coroner for Teesside of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
10. One of the Ombudsman's family liaison officers contacted Mr Harding's wife to explain the investigation. Mr Harding's wife said that she was dissatisfied with the medical treatment her husband had received at the prison and she had contacted the Governor and healthcare staff repeatedly about it. She believed that after his discharge from hospital in February 2015, his health declined.
11. Mr Harding's family received a copy of the initial report. They raised a number of issues and questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence. The prison considered our initial report and did not identify any factual inaccuracies.

Background Information

HM Prison

12. HMP Holme House is a local prison in Stockton-on Tees, holding over 1200 men, either convicted or remanded 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

13. The most recent inspection of HMP Holme House was in August 2013. Inspectors reported 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

14. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to December 2014, the IMB reported that the quality of healthcare services was good and compared very favourably to those available in the community. There had been improvements in some aspects of patient care, but there had been some difficulties caused by staff shortages and long term sick absences.

Previous deaths at HMP Holme House

15. Mr Harding was the fourth prisoner to die from natural causes at Holme House since the start of 2014. There were no significant similarities with the circumstances of the other deaths.

Key Events

16. On 26 June 2014, Mr Graham Harding was sentenced to two years, three months in prison, for sexual offences and was sent to HMP Holme House. Mr Harding had longstanding and complex health problems, including type 2 diabetes, hypothyroidism (underactive thyroid gland), osteoarthritis, leg ulcers, high blood pressure and deafness. He was severely obese, with limited mobility and used walking sticks to get around. Healthcare staff admitted Mr Harding to the prison's inpatient unit to assess his needs.
17. Nurses created care plans to manage Mr Harding's medical conditions. They gave him insulin units and a machine to check his blood sugar levels and self-administer insulin, if necessary. They took blood tests around once a month and noted that he should have a diabetic diet. He received dietary advice.
18. On 1 July, a prison GP discharged Mr Harding as an inpatient and he moved to a standard prison wing. Nurses continued to monitor Mr Harding daily, as part of his care plan.
19. Throughout his time in prison Mr Harding developed recurrent ulcers on both legs, which took time to heal. Nurses cleaned and changed his dressings, gave him creams and surgical stockings. A podiatrist visited him twice to check his wounds and advise staff on their care.
20. On 26 January 2015, at approximately 3.40pm, an officer found Mr Harding not breathing and unresponsive in his cell. A nurse and several other healthcare staff, including a prison GP, responded to an emergency call. The nurse noted that Mr Harding's eyes were open and he had no pulse or other signs of life. Healthcare staff performed cardiopulmonary resuscitation and Mr Harding began breathing again. Paramedics took Mr Harding to hospital, where he remained until 17 February. The hospital found no cause for his cardiac arrest.
21. After Mr Harding was discharged from hospital, healthcare staff prescribed salbutamol, (a medication to help open his lung airway), a nasal cannula (to deliver additional oxygen through his nose) and a Bi-level Positive Airway Pressure machine (Bi-Pap). This delivers pressurised air through a mask to prevent throat blockages and breathing difficulties when asleep. Mr Harding kept the machine until 24 April when, with his agreement, staff returned it to the hospital as he hardly used it.
22. Nurses and GPs at Holme House continued to monitor and review Mr Harding's medical conditions frequently. On 6 March, a prison GP noted that Mr Harding's blood pressure remained high and he had hardened skin on his legs, which the GP attributed to circulatory problems. He asked for a blood pressure check in one month and blood tests in three months.
23. Mr Harding's leg ulcers deteriorated and on 20 April, a nurse took swabs of the fluid for testing. The next day Mr Harding went to see a respiratory specialist, who prescribed tiotropium, a medication to prevent wheezing, shortness of breath, coughing and chest tightness.

24. On 17 June, a nurse admitted Mr Harding to the inpatient unit for observation, as she was concerned that he was not monitoring his sugar levels sufficiently regularly and that his leg ulcers, although healing slowly, were weeping fluid. On 18 June, a nurse noted Mr Harding was breathless. She encouraged him to use a walking frame to get to the shower.
25. On 19 June, while checking his blood glucose levels, a nurse told Mr Harding to use his cell bell if he felt unwell. On 20 June, she noted in Mr Harding's medical record that he appeared to sleep for long periods. In the evening, another nurse noted that Mr Harding said he felt faint, but he appeared alert and orientated and became verbally aggressive. He was able to move from a wheelchair to a chair.

Events on 21 June 2015

26. On 21 June, a nurse recorded that Mr Harding appeared to have slept well overnight and had not reported any concerns. She told the investigator that, although she had recorded this at 6.27am, she thought that she had last checked him at about 5.00am.
27. At 7.05am, a nurse looked into Mr Harding's cell through the observation hatch. Mr Harding was lying on the bed but the nurse could not see any chest movements. Mr Harding did not reply when he called his name. He called for assistance. Another nurse came but was also unable to get a response so he called an emergency code blue (used in circumstances such as when a prisoner is unconscious or has breathing difficulties).
28. The nurses went into the cell and a nurse immediately began cardiopulmonary resuscitation. Another nurse attached a defibrillator to Mr Harding, which found no shockable heart rhythm. Mr Harding's body was cold and rigid with no signs of life, so the nurses considered it would be inappropriate to continue with resuscitation. At 7.50am, paramedics recorded that Mr Harding had died.

Contact with Mr Harding's family

29. At 10.15 am on 21 June, a prison family liaison officer visited Mr Harding's wife, informed her of his death and offered condolences. She visited Mr Harding's wife again the next day, when other family members relatives were present, to give further information and support. Mr Harding's funeral was on 24 July 2015. In line with national policy, the prison contributed to the costs of the funeral

Support for prisoners and staff

30. After Mr Harding's death a prison manager debriefed the staff involved in the emergency response and offered his support and that of the staff care team.
31. The prison posted notices informing staff and prisoners of Mr Harding's death, and offering support to those who needed it. Staff reviewed all prisoners assessed as at risk of suicide and self-harm in case they had been adversely affected by Mr Harding's death.

Post-mortem report

32. A post-mortem examination concluded that the cause of Mr Harding's death was obesity and coronary artery atheroma.

Findings

Clinical Care

33. When Mr Harding arrived at Holme House, a nurse quickly identified that he had complex medical needs and admitted him to the healthcare unit for assessment. Healthcare staff liaised effectively with the hospital about his care and there were good, clear, holistic care plans, which were well communicated and discussed with Mr Harding.
34. The clinical reviewer commented that staff should be commended for successfully resuscitating Mr Harding on 26 January 2015, when he was found unresponsive.
35. The clinical reviewer has made some recommendations for improving the delivery of aspects of healthcare at Holme House including screening, management of infections, and medical record keeping, which the Head of Healthcare will need to address. As these were not directly related to the circumstances of Mr Harding's death, we do not repeat them in this report.
36. The clinical reviewer concluded that Mr Harding's care and treatment in prison were of a high standard and equivalent to that he could have expected to receive in the community. We are satisfied that Mr Harding received appropriate care at Holme House and staff could not have anticipated or prevented his sudden death.

**Prisons &
Probation**

Ombudsman
Independent Investigations