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 at HMP Altcourse in May 2014

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 on 25 May 2014, while in the custody of HMP Altcourse. The man was 51 years old and died from a variceal haemorrhage (bleeding in the oesophagus or stomach) as a result of undiagnosed liver cancer. I offer my condolences to his family and friends.

The investigator carried out the investigation. A clinical reviewer reviewed the man's clinical care at Altcourse. The prison cooperated fully with the investigation.

The man was sentenced to four and a half years in prison in May 2013, and sent to HMP Altcourse. Blood tests showed he was positive for hepatitis C. Healthcare staff did not refer him for any treatment and did not record his condition on the front of his medical record, in line with good practice. This meant that a prison GP, a year later, who had not read his full medical record, was not aware the man had hepatitis C when he reviewed abnormal liver function results. The GP did not refer the man for further investigation.

On 24 May 2014, a prisoner found the man collapsed in his cell and alerted officers who called an emergency response code. Control room staff did not call an ambulance automatically as they should have done, but waited until a doctor requested one twenty minutes later. The man was taken to hospital where his condition deteriorated rapidly and he died the next evening. His family were with him at the time.

I agree with the clinical reviewer that the clinical care the man received at Altcourse was not satisfactory. A nurse and a prison GP discussed the man's hepatitis C with him in March 2013, but did not refer him for further investigation or treatment. The man had abnormal liver function tests in 2013 and 2014, but prison GPs did not take any further action. A referral to a liver specialist might not have prevented the man's death, but opportunities to detect his liver cancer and its consequences, were missed. Healthcare staff at the prison also need to ensure that medical records easily identify prisoners with chronic conditions and that they take appropriate action whenever abnormal test results are received.

Nigel Newcomen CBE **April 2015**
Prisons and Probation Ombudsman

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SUMMARY

1. The man left prison on conditional licence in March 2012, but was recalled to prison in December after breaching his licence conditions. He was sent to HMP Altcourse. The man had a history of drug misuse and said he had hepatitis C. Blood tests confirmed this. On 24 May 2013, a court sentenced the man to four and a half years in prison for drugs offences.

2. In March 2013, a nurse talked about the man's positive hepatitis C status with him. The same month, a prison GP discussed with the man blood test results, which showed abnormal liver function, and his hepatitis C condition. They did not refer him to a specialist or an appropriate chronic disease management clinic.

3. On 18 April 2014, a prison GP examined the man after he had complained of stomach pains. Blood tests showed abnormal liver function, but the GP took no further action.

4. On the morning of 24 May 2014, a nurse examined the man who had been vomiting during the night. She took routine clinical observations, but did not record his blood pressure. The nurse took a sputum sample and consulted a prison GP. The GP said he did not need to see the man until after the results of the sputum sample, or if he felt worse.

5. At approximately 1.50pm, another prisoner found the man collapsed in his cell. Officers called an emergency code, but the control room did not call an ambulance. Healthcare staff arrived and requested an ambulance at 2.10pm when the man's condition deteriorated. The man died in hospital at 9.35pm on 25 May. His family were with him at the time. He had been suffering from liver cancer and died from a variceal haemorrhage.

6. The clinical reviewer found that the man's medical care was not satisfactory. In March 2013, healthcare staff did not refer him for treatment for hepatitis C and abnormal liver function tests were not followed up. In April 2014, a GP did not fully review the man's medical record and no one had highlighted his condition on the front of the record. As a result, the GP was not aware that the man was positive for hepatitis C when he reviewed his abnormal liver function tests.

7. The man was very ill, yet he was restrained when taken to hospital. We are not satisfied that the risk assessment fully took into account his health and mobility to justify the use of restraints. We make four recommendations.

THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at HMP Altcourse informing them of the investigation and asking 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 record. She visited Altcourse on 6 June 2014 and spoke to the Head of Healthcare and a member of the Independent Monitoring Board. The investigator interviewed four members of staff at Altcourse on 15 August. She informed the Director of the initial findings of the investigation.

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

11. We informed HM Coroner for Liverpool of the investigation who gave us the cause of death and have sent him a copy of this investigation report.

12. One of the Ombudsman's family liaison officers contacted the man's sister to explain the investigation. She did not have any specific concerns for the investigation to consider. The man's sister said the prison's family liaison officer and the chaplaincy had been helpful.

13. The draft report was shared with the Prison Service. There were no factual inaccuracies and the action plan has been added to the end of the report.

14. The man's family received a copy of the draft report. They raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

HMP ALTCOURSE

15. 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 1,324 sentenced and remanded adult and young adult men. G4S runs the company that provides primary healthcare services at the prison. Prime Care provides secondary mental health services.

HM Inspectorate of Prisons

16. The report of the most recent inspection of HMP Altcourse in June 2014 has not yet been published. Initial feedback from inspectors was that healthcare provision was generally good, but they were concerned about the waiting time to see a GP. The previous inspection of Altcourse was in October 2012. Inspectors found that healthcare was reasonable, but there were problems with staff shortages which affected some areas of clinical care.

Independent Monitoring Board

17. 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 June 2013, the IMB commented that GP services were provided by two fully qualified doctors with previous experience of prisons and prisoners. The IMB noted that there was a robust approach to ensure appropriate prescribing, with regular medication reviews.

Previous deaths at Altcourse

18. The man was the fourth prisoner to die from natural causes at Altcourse since the start of 2013. There has been one death since his. We have raised the issue of effective record keeping before.

KEY EVENTS

19. The man left prison on licence in March 2012, but was returned to prison in December for breaching his licence. He was sent to HMP Altcourse. On 24 May 2013, a judge sentenced the man to four and a half years in prison for drugs offences.

20. When the man first arrived at Altcourse in December 2012, he had an ongoing ear condition (which had been treated in hospital) and had symptoms of opiate withdrawal. He said he had hepatitis C The prison's drug treatment intervention scheme prescribed methadone and the man had blood tests for hepatitis B, C and HIV. The results showed he was positive for hepatitis C.

21. On 1 March 2013, the nurse discussed the man's positive hepatitis C result him. There is no record of any discussion before then. He said he had been diagnosed 20 years before, but had not received any treatment. The man said he was not an alcoholic. The nurse arranged for the man to have blood tests and a liver function test. The man told the nurse he was keen to have treatment for hepatitis C.

22. On 6 March, a prison GP discussed the man's blood test results with him. His liver function test was abnormal. The GP said this was to be expected, as the man was positive for hepatitis C. She did not refer him for any further tests or treatment.

23. Throughout the rest of 2013, healthcare staff saw the man frequently in relation to his ear condition. A GP prescribed propranolol (a beta-blocker used to treat tremors and heart conditions) for a tremor in his hands and he continued to take this until he died. Because he was overweight, healthcare staff referred him to the gym. Tests for cholesterol level and for diabetes were normal.

24. On 18 April 2014, a prison GP referred the man for a blood test, after he complained of abdominal pains. On 23 April, another prison GP received the results. The results of a liver function test were abnormal, but the GP took no further action.

25. Between 8.00am and 9.00am on 24 May, a nurse examined the man because he had been vomiting during the night. The man said that there had been some blood in the vomit. She recorded his temperature at 36 degrees (slightly low), pulse 93 (which is high) and an oxygen saturation level of 98 % (within normal range). She did not record his blood pressure. A nurse took a sputum sample. The GP advised her that he did not need to assess the man at the time, but would do so when they received the sputum results, or if the man felt worse. .

26. At approximately 1.50pm that day, a prisoner found the man collapsed in his cell. The prisoner immediately informed the officer. Two officers went to the man's cell and they found him lying on the floor, but conscious. The man told the officer he did not remember how he had ended up on the floor. The

officer called a code 1 (an emergency medical code indicating a prisoner has breathing difficulties or a serious medical condition). Control room staff asked The officer if an ambulance was required. She said that one was not needed, because the man was conscious and responding to questions.

27. A few minutes later, a nurse and doctor arrived. They moved the man to a wheelchair to take him to the healthcare centre for further observation but, very shortly after, he started to vomit blood. Staff moved him back to the floor and the doctor attempted to insert a cannula (a small tube inserted into the vein to administer medicines directly), but was unable to do so. The nurse gave the man oxygen and doctor asked the officer to request an ambulance. The control room log shows that they called an ambulance at 2.10pm.

28. Paramedics arrived at the prison at 2.15pm and took over the man's care. The log shows that he went to Aintree Hospital, in an ambulance, at 2.50pm. Two officers escorted the man and restrained him with an escort chain. (A long chain with a handcuff at each end, one end is attached to the prisoner and the other to an officer).

29. At hospital, the man received six units of blood. He was able to talk to hospital staff. At 9.40pm, the man's condition deteriorated. A hospital doctor told the escorting officers that his condition was now life threatening and he needed to go to theatre for surgery. The duty director agreed that the officers should remove the man's restraints, which they did, at 9.45pm.

30. The man came back to the ward from the operating theatre at approximately 12.00am on 25 May. His condition deteriorated further and he had to be taken back to the operating theatre at 2.42am to try and stabilise the bleeding. He moved to the critical care unit at 5.00am. Healthcare staff from the prison kept in contact with the hospital for information about the man's condition. Hospital staff said that further investigations showed that the man was suffering from a liver tumour and extensive bleeding from his oesophagus. The man did not recover and died in hospital at 9.35pm on 25 May.

Liaison with the man's family

31. At 4.45pm on 24 May, the duty director had attempted to contact the man's brother to let him know his brother was seriously ill. He left a message for him to contact the prison urgently, which he did shortly afterwards. The man's family arrived at the hospital in the early hours of 25 May. The prison's family liaison officer arrived at the hospital at 7.30am and supported the man's family. His family were with him when he died.

32. The family liaison officer remained in contact with the man's family. His funeral took place on 9 June and Altcourse contributed to the costs in line with national guidance. A memorial service took place at the prison on 12 June.

Care for staff and prisoners

33. A Director's notice informed prisoners and staff that the man had died. The duty director held a debrief on 25 May for the staff who were with the man at the hospital when he died and offered them the support of the prison's care team. Staff reviewed prisoners being monitored as at risk of suicide and self-harm, in case they had been adversely affected by the man's death. Staff also offered other prisoners additional support.

Cause of death

34. The Coroner decided that a post-mortem examination was not necessary. He informed us that the cause of the man's death was a variceal haemorrhage. (This occurs from dilated veins in the stomach and/or oesophagus and can be as a result of chronic liver disease.) The man had hepatocellular carcinoma (liver cancer).

ISSUES

Clinical care

35. The clinical reviewer concluded that the man's standard of healthcare at the prison was not satisfactory. The man's death was caused by ruptured oesophageal varices as a result of undiagnosed liver cancer. Although a nurse and doctor discussed the man's hepatitis C with him in March 2013, they did not refer him for treatment by the hepatitis specialist service or at a chronic disease management clinic. This was a missed opportunity to diagnose his serious liver condition. There is nothing in his prison medical record to explain this.

36. The clinical reviewer noted that, on 23 April 2014, the doctor missed a further opportunity to diagnose the man when a liver function test was abnormal, but the doctor took no further action. The clinical reviewer considered that the doctor should have referred the man urgently to a liver specialist for suspected liver cancer. While a referral at this stage might not have prevented the man's death, it is possible that the hospital could have detected the oesophageal varices and assessed them for treatment.

37. The doctor told us he did not know that the man was positive for hepatitis C as this was not indicated on the front of his record and he had not read his full history. As a result, he did not relate the man's abnormal liver function test results to his hepatitis C status. It is concerning that the GP did not read the medical records fully when he received the abnormal liver function results. Although this can be time consuming, it would have informed him that the man was hepatitis C positive and should have prompted a referral to a specialist. However, it is possible for medical conditions to be highlighted on the front page of a prisoner's medical record. This would have ensured that all healthcare staff were aware that the man was positive for hepatitis C.

38. The clinical reviewer considers that healthcare staff should refer prisoners who test positive for hepatitis C, for further investigation and treatment at the earliest opportunity to help prevent future deaths. We make the following recommendations:

    The Head of Healthcare should ensure that prisoners with chronic conditions, such as hepatitis C, are appropriately assessed and monitored by GPs or trained nurses in regular chronic disease management clinics and referred to specialist services when appropriate.

    The Head of Healthcare should ensure that healthcare staff used the front page of the electronic medical record effectively to highlight chronic and serious medical conditions and that GPs review all relevant records when test results indicate a concern.

Emergency response

39. The officer called a code one (emergency code) at 1.50pm, but the control room staff did not call an ambulance until the doctor asked for one at 2.10pm. Altcourse's local instruction requires that the control room should call an ambulance automatically as soon as staff call an emergency medical code. This is in line with national instructions. It should be not be necessary for control room staff to check this first. In this case, further confusion was caused as an officer at the scene effectively withdrew the emergency code. It was clear from our interviews, that staff at Altcourse do not follow the procedure in their local instruction. The delay in calling an ambulance is unlikely to have changed the outcome for the man, but in other circumstances it could be crucial. We make the following recommendation:

The Director should ensure that the control room calls an ambulance immediately they receive an emergency medical code call.

Restraints, security and escorts

40. 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 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.

41. The man was a Category C prisoner who had been fully compliant on previous escorts. Before he left for hospital on 24 May, prison staff completed a risk assessment which concluded they should use an escort chain to restrain the man. The assessment did not include any information about the man's risk of escape or risk to hospital staff. There was no healthcare input about the man's condition or whether this would impact on his risk of escape as the 2007 High Court judgement requires. We understand that this was an emergency, but a doctor and a nurse were with the man and could have contributed to the assessment. We are not satisfied that the risk assessment fully justified the use restraints for the journey or during his initial stay in hospital. We make the following recommendation:

The Director and Head of Healthcare should ensure that risk assessments for journeys to hospital and for hospital stays fully take into account individual circumstances, including how the prisoner's health and mobility impacts on his risk of escape, and are based on the actual risk the prisoner presents at the time.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that prisoners with chronic conditions, such as hepatitis C, are appropriately assessed and monitored by GPs or trained nurses in regular chronic disease management clinics and referred to specialist services when appropriate.

2. The Head of Healthcare should ensure that healthcare staff used the front page of the electronic medical record effectively to highlight chronic and serious medical conditions and that GPs review all relevant records when test results indicate a concern.

3. The Director should ensure that the control room calls an ambulance immediately they receive an emergency medical code call.

4. The Director and Head of Healthcare should ensure that risk assessments for journeys to hospital and for hospital stays fully take into account individual circumstances, including how the prisoner's health and mobility impacts on his risk of escape, and are based on the actual risk the prisoner presents at the time.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible
1	The Head of Healthcare should ensure that prisoners with chronic conditions, such as hepatitis C, are appropriately assessed and monitored by GPs or trained nurses in regular chronic disease management clinics and referred to specialist services when appropriate.	Accepted	A review of the allocation process for clinics took place in August 2014. Regular clinics in the management of chronic diseases now take place. There are now staff trained in the management of chronic diseases, in particular hepatitis C. All registered general nurses oversee an allocated chronic disease clinic and there is a specialist nurse from the Royal Hospital that attends weekly. The Head of Healthcare will ensure that all GPs make referrals to outside services for chronic diseases, if deemed appropriate. GPs will be advised of this requirement by the Head of Healthcare, as well as a notice displayed in the GP surgery. Referrals for outside services will be recorded on SystmOne and a *tasking request* will be submitted for the healthcare administrator to make the relevant appointment.	Completed and ongoing Head of Healthcare
2	The Head of Healthcare should ensure that healthcare staff used the front page of the electronic medical record effectively to highlight chronic and serious medical conditions and that GPs review all relevant	Accepted	All clinical staff will receive additional training on the use of SystmOne. A log will be kept to record all staff who have been trained. All test results that indicate a concern will be automatically reviewed by the GP.	31 January 2015 Head of Healthcare

	records when test results indicate a concern.			
3	The Director should ensure that the control room calls an ambulance immediately they receive an emergency medical code call.	Accepted	Control room staff have been briefed and will automatically request an ambulance when a code one or two is called. Gatehouse staff have also been briefed on the procedure to be adopted for ambulances in order to expedite entry and exit from the prison. A notice to staff from the Director has been issued to further reinforce the requirements. All operational staff have been briefed on the appropriate use of emergency codes. This is also covered in annual training delivered to all staff.	Completed and ongoing Heads of Security, Healthcare and Safer Custody
4	The Director and Head of Healthcare should ensure that risk assessments for journeys to hospital and for hospital stays fully take into account individual circumstances, including how the prisoner's health and mobility impacts on his risk of escape, and are based on the actual risk the prisoner presents at the time.	Accepted	Risk assessments for prisoners attending or staying in hospital have been amended to reflect individual circumstances, including how the prisoner's health and mobility impacts on his risk of escape and the actual risk the prisoner presents at the time. Risk assessments cover the appropriateness of restraints and staffing levels for escorts and hospital stays. All Duty Directors have been issued guidance to ensure that each escort is risk assessed according to the risk actually posed at the time.	Completed and ongoing Head of Security