

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Craig Price a prisoner at HMP Northumberland on 22 August 2016

**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*



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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 Craig Price died in hospital on 22 August 2016 of heart disease, while at HMP Northumberland. Mr Price was 34 years old. I offer my condolences to Mr Price's family and friends.

I am satisfied that Mr Price received a generally good standard of clinical care for the short time he was at Northumberland. The post-mortem report found that Mr Price died of heart disease caused by blocked arteries. Five months earlier, hospital specialists assessed Mr Price as at low risk of having a heart attack. He declined a full health screening when he arrived at Northumberland and, while there was some confusion over his anti-depressant medication and disability assessment, I am satisfied there was nothing healthcare or prison staff could have done to predict or prevent his death. I am also satisfied that staff acted appropriately during the emergency response.

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**

**March 2017**

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# Summary

## Events

1. On 12 December 2013, Mr Craig Price was remanded to HMP Durham for sexual offences. On 10 October 2014, he was convicted and sentenced to 10 years imprisonment. He was transferred to HMP Northumberland on 4 August 2016.
2. Mr Price was HIV positive and, while at Durham, attended hospital every six weeks for a check-up. During these appointments, his blood pressure and risk of suffering a heart attack or stroke was assessed. In March 2016, his risk of suffering a heart attack or stroke was calculated at 7.7% (a calculation lower than 10% is considered low risk). In June 2016, his blood pressure reading was 124/87 (a blood pressure reading lower than 140/90 is considered normal).
3. When Mr Price arrived at Northumberland, a nurse noted that he was HIV positive. Mr Price already had a six-month supply of atripla to manage his HIV. Mr Price denied taking any medication for mental health problems despite being on sertraline (an anti-depressant). Healthcare staff did not notice this for two weeks.
4. A nurse noted that Mr Price was within a normal weight range and had no concerns over his physical or mental health. He declined smoking cessation advice, and also declined a second health screening where blood pressure and routine blood tests take place.
5. While in the community before he came to prison, Mr Price had two operations on his skull to reduce swelling caused by an epileptic fit. The surgery caused brain damage and reduced mobility. Mr Price wore a splint on his left arm and leg but he was able to use the stairs. He was allocated a cell on the first floor of the vulnerable prisoners' wing. An officer asked a member of healthcare staff to arrange an assessment of Mr Price to see if he needed any adaptations to help him mobilise. The assessment did not take place.
6. On 22 August, at approximately 8.10am, Mr Price collapsed on the stairs while on his way to work. He said he felt unwell. An officer and prisoner took him back to his cell where nurses, who were already on the wing, treated him. Mr Price started vomiting and his breathing became shallow. An officer called a code blue at 8.17am while a nurse carried out cardiopulmonary resuscitation (CPR). An ambulance arrived at 8.38am and paramedics continued CPR and took Mr Price to hospital. Mr Price died in hospital at 10.24am.

## Findings

7. We are satisfied that Mr Price received an appropriate standard of care at Northumberland, particularly during the emergency response, which was equivalent to that he could have expected to receive in the community. However, we are not satisfied that it took two weeks for a member of healthcare staff to notice that Mr Price should have been taking anti-depressants and that Mr Price was not referred for a disability assessment during his reception health screening, and later when an officer requested it.

## Recommendations

- The Governor should ensure that all prisoners with limited mobility are offered an assessment by the disability liaison officer.

## The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Northumberland informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
9. The investigator obtained copies of relevant extracts from Mr Price's prison and medical records.
10. NHS England commissioned a clinical reviewer to review Mr Price's clinical care at the prison.
11. We informed HM Coroner for Northumberland South of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
12. One of the Ombudsman's family liaison officers contacted Mr Price's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She raised questions about the appropriateness of his location and having medication in his possession.
13. Mr Price's mother received a copy of the initial report. His father pointed out some factual inaccuracies. This report has been amended accordingly. Mr Price's father also raised questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.
14. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly.

## Background Information

### HMP Northumberland

15. HMP Northumberland can hold more than 1,300 men. Sodexo Justice Services manages the prison and G4S provide the healthcare services. Healthcare staff are on duty from 7.30am to 7.30pm, Monday to Thursday and from 7.30am to 6.00pm on Friday. At the weekend and on Bank Holidays, healthcare staff are on duty from 8.00am to 6.00pm. Northern Doctors provide an out of hours service at other times.

### HM Inspectorate of Prisons

16. The most recent inspection of HMP Northumberland was in September 2014. The report was critical of many aspects of the prison but found that the quality of healthcare was generally good and appreciated by prisoners. There was an appropriate range of clinics to meet prisoners' needs.

### 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 report for the year to December 2015, the IMB noted that despite a challenging year in which the healthcare provider had changed, standards of care had been maintained overall and in some areas improved. Locum arrangements had resulted in some lack of continuity, and lack of familiarity with the protocols in a prison environment and this had an impact on both the patient experience and the wider operation of the prison.

### Previous deaths at HMP Northumberland

18. Mr Price was the fifth prisoner to die from natural causes at Northumberland since January 2015. There have been no deaths since. There are no significant similarities with the circumstances of the previous deaths.

## Key Events

19. On 12 December 2013, Mr Craig Price was remanded to HMP Durham charged with sexual offences. On 10 October 2014, he was convicted and sentenced to 10 years imprisonment and was moved to HMP Northumberland on 4 August 2016.
20. In the community, Mr Price had surgery on his skull to reduce swelling caused by an epileptic seizure in 2004. This caused mild brain damage and weakness to the left side of his body. In November 2015, a nurse at Durham assessed Mr Price's cognitive function and noted that his short-term memory was "a little deficient, though not sufficiently for there to be any concerns, objectively he functions well". While at Durham, Mr Price was prescribed sertraline to treat depression, for almost two years.
21. Mr Price attended hospital appointments every six months to monitor his HIV, blood pressure and risk of suffering a heart attack or stroke. In March 2016, Mr Price's risk of suffering a heart attack or stroke was calculated at 7.7% (a calculation lower than 10% is considered low risk). In June 2016, his blood pressure reading was 124/87 (a blood pressure reading lower than 140/90 is considered normal).
22. Mr Price was transferred to HMP Northumberland on 4 August 2016. A nurse assessed Mr Price at his reception health screening. She noted that Mr Price had HIV. A Durham GP had already prescribed a six-month supply of atripla (anti-viral medication). She noted that he had weakness to the left side of his body and reduced mobility due to a brain injury. He had a splint on his left leg and arm. Mr Price told her that he did not take any medication for mental health problems. He told her that he had not experienced any chest pain and he had no concerns about his physical health. She noted that his weight was within normal range. Mr Price was a heavy smoker of cigarettes and declined smoking cessation advice. He also declined a second health screening, which includes a blood pressure reading, and routine blood tests. He was located on the first floor of the vulnerable prisoner's wing.
23. The showers were located on the same floor as Mr Price's cell and prisoners collected his meals for him. When he arrived, an officer noted that although slower than other prisoners, Mr Price managed on the wing. However, on 8 August, she spoke with a member of healthcare staff and asked for an assessment of his location, to see if he required any adaptations. The member of healthcare staff told her it would happen the next day. The assessment did not take place, and healthcare staff did not record her request. She also recorded that Mr Price told her that he preferred to remain where he was, with prisoners he knew.
24. On 18 August, a nurse noticed on his medical record that Mr Price had not been prescribed any sertraline at Northumberland. She re-prescribed it. Mr Price had been risk assessed by a GP as being allowed to have his medication in his possession. She noted that this would not happen until his current prescription ended. Mr Price died before he finished his prescription and therefore had no in possession medication. There were no other entries in his medical record.

## Events of 22 August

25. At approximately 8.10am on 22 August, a prisoner alerted an officer that Mr Price had collapsed on the stairs on his way to work. As the officer went to help Mr Price, two nurses entered the wing and saw Mr Price was unwell. Mr Price was hot and clammy and said he felt unwell. With the help of two prisoners, the officer took Mr Price back to his cell. Both nurses joined immediately to assess Mr Price, along with another officer.
26. When Mr Price returned to his cell, he started vomiting. One of the nurses attempted to take his observations (temperature, respiratory rate, pulse and blood pressure), but he became very agitated, sitting up then lying down. His skin began to turn blue in appearance, his left pupil became dilated, he started frothing at the mouth and his breathing became shallow.
27. The nurse instructed an officer to call a code blue, recorded at 8.17am, which prompted the control room to request an emergency ambulance. She began cardiopulmonary resuscitation (CPR) and asked a prison officer to get the defibrillator located on the landing below. Both nurses continued CPR. Mr Price did not respond and they could not detect a pulse. The defibrillator advised to shock Mr Price three times, but there was still no pulse.
28. At 8.38am, an ambulance arrived at the prison. Paramedics took over CPR and, at 9.50am, took Mr Price to hospital. The prison Director authorised that Mr Price not be restrained. Mr Price arrived at hospital at 10.18am and doctors pronounced him dead at 10.24am.

## Contact with Price's family

29. On 22 August, a senior manager telephoned Mr Price's mother and told her that Mr Price had been taken to hospital. She then appointed an officer and another senior manager as family liaison officers.
30. The officer and senior manager went to the home of Mr Price's mother. They arrived at 12.12pm. The officer told Mr Price's mother that her son had died and offered her condolences and support. She maintained contact with Mr Price's mother.
31. The family arranged the funeral, which was held on 5 September. The prison contributed towards the costs in line with national policy.

## Support for prisoners and staff

32. After Mr Price's death, a senior manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
33. The prison posted notices informing other prisoners of Mr Price's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Price's death.

## Post-mortem report

34. The post mortem concluded that Mr Price died of heart disease caused by blocked arteries.

# Findings

## Clinical care

35. Mr Price had been at Northumberland less than a month when he died. During his reception health screening, a nurse established that he had a six-month supply of HIV medication from Durham. Despite also being prescribed sertraline at Durham, which was recorded in his medical records, Mr Price denied taking medication for mental health problems. Healthcare staff at Northumberland should have cross-referenced his medical record which would have identified that he was on sertraline. The clinical reviewer made a recommendation to review the current medicine reconciliation process. This did not affect the outcome for Mr Price, and we do not repeat the recommendation here. However, the Head of Healthcare will need to address this.
36. During his reception health screening, Mr Price declined a more comprehensive, second health screening with blood tests and a blood pressure reading. However, his blood pressure reading two months earlier was normal. The clinical reviewer considered that Mr Price had high levels of fat in his blood and was a smoker, but that his risk of having a heart attack or stroke was low, and he did not need preventative medication.
37. We agree with the clinical reviewer that Mr Price's care was equivalent to that he could have expected to receive in the community. We are satisfied that when Mr Price collapsed, prison officers and nurses responded immediately, and appropriately called an ambulance when his condition suddenly declined.

## Location and referral to the disability liaison officer

38. When Mr Price arrived at Northumberland, a nurse recorded that a splint on his arm and leg restricted his mobility. This did not prevent Mr Price from using the stairs and he was placed in a first floor cell. The showers were located on the same floor, and prisoners collected his meals from the ground floor to save him using the stairs. Mr Price reported to be happy, located on the first floor with the prisoners he knew.
39. Four days after he arrived, an officer asked a member of healthcare staff to carry out a disability assessment to identify whether Mr Price required any adaptations. She was told an assessment would be carried out the next day. There is no record of who she spoke to. The member of healthcare staff did not record the request and the assessment did not take place.
40. All prisons are required to appoint a disability liaison officer (DLO). The role of the DLO is to help ensure that disabled prisoners have equal access to the prison regime and facilities. Northumberland has two disability liaison officers. Requests for an assessment are received either on a general application form or from a member of healthcare staff. Neither officer received a request to assess Mr Price during his three weeks at Northumberland. There were two missed opportunities when Mr Price could have been officially referred, firstly at the reception health screen and secondly by healthcare staff when the officer requested an assessment. Therefore, it cannot be known how well Mr Price

coped with the regime and this is not acceptable. We therefore make the following recommendation:

**The Governor should ensure that all prisoners with limited mobility are offered an assessment by the disability liaison officer.**

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