Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Allan Brown a prisoner at HMP Holme House on 7 January 2017

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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*

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 Allan Brown died on 7 January 2017, from heart failure and a fractured hip while a prisoner at HMP Holme House. He was 74 years old. I offer my condolences to Mr Brown's family and friends.

I consider that overall Mr Brown received a good standard of care at Holme House, equivalent to that he would have received in the wider community. However, there was no formal falls risk assessment despite Mr Brown's poor mobility and it was wholly inappropriate that Mr Brown was restrained when he was sent to hospital.

I am also concerned that there was an unsatisfactory level of care and support given to a member of staff heavily involved in Mr Brown's care following his death.

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 **August 2017**

Contents

Summary

Events

1. On 7 April 2015, Mr Allan Brown was sentenced to five years imprisonment for sexual offences and was sent to HMP Holme House. He had significant health problems, including Type 2 diabetes, high blood pressure, poor mobility and depression. In 2006, Mr Brown had a lung removed as a treatment for cancer. He was prescribed numerous medications.

2. On 17 December, a doctor reviewed Mr Brown and noted that he had lost 16kgs weight in eight months. The doctor referred him to hospital for specialist advice, but considered that a lack of appetite and not eating lunch were the likely cause of the weight loss. Specialists requested various medical investigations, which did not find any cause for concern.

3. In April 2016, Mr Brown suffered from increasing angina attacks. A doctor referred him for further cardiac medical investigations and prescribed an increase in atenolol (used to treat angina).

4. On 10 June, a doctor discussed with Mr Brown the results of the cardiac tests, which indicated he had heart failure. The doctor explained there was no cure but that his symptoms could be controlled through medication. The doctor placed Mr Brown on the palliative care register. Mr Brown's key worker created a full care plan, which included the support of Macmillan nurses.

5. Between June and January 2017, healthcare staff regularly reviewed Mr Brown to ensure that his physical and social care needs were met.

6. On 4 January 2017, Mr Brown fell in his cell and healthcare staff sent him to hospital with a suspected fractured hip. Following surgery, Mr Brown's condition deteriorated and he died on 7 January 2017.

Findings

7. The clinical reviewer noted that Mr Brown had a history of poor health. Healthcare staff implemented care plans to care for Mr Brown, which increased as his condition deteriorated, though there was no record that a formal falls risk assessment was undertaken. In spite of this, the clinical reviewer concluded that, overall, the clinical care Mr Brown received at Holme House was of a good standard and equivalent to that he would have received in the wider community.

8. When Mr Brown was taken to hospital on 4 January, officers restrained him with an escort chain even though he had broken his hip and in contravention of a local prison protocol that prisoners on the palliative care register should not be restrained.

9. We are also concerned that Mr Brown's key nurse was not informed of his death in person and found out about his death from a notice at the prison gate. She was also not offered any support following his death.

Recommendations

- The Head of Healthcare should ensure that prisoners at risk of falls have an appropriate risk assessment in line with NICE guidelines and the assessment is recorded and acted on.
- The Governor and Head of Healthcare should ensure all staff, including healthcare staff, are offered appropriate and timely support after a death in custody.
- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints 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.

The Investigation Process

10. 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. One member of staff responded to the notice with information about Mr Brown.

11. The investigator obtained copies of relevant extracts from Mr Brown's prison and medical records. She interviewed three members of staff at HMP Holme House on 28 February 2017.

12. NHS England commissioned a clinical reviewer to review Mr Brown's clinical care at the prison.

13. We informed HM Coroner for Teesside of the investigation who gave us the cause of Mr Brown's death. We have sent the coroner a copy of this report.

14. The investigator wrote to Mr Brown's next of kin, his wife, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.

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

16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Holme House

17. HMP Holme House is a local prison holding over 1,200 men. Most are on remand, or recently convicted by courts in the local area. G4S provides health services at the prison. There is a 24-hour inpatient unit with 16 beds and palliative care facilities.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Holme House was in August 2013. Inspectors reported that the overall quality of health care had improved and was good. They found that patient care was very good, with an appropriate mix of clinics for primary care and lifelong conditions. Waiting times were reasonable and non-attendance rates low. Inpatient care had improved, but the shower and bathing facilities were poor.

19. Inspectors reported that the prison planned to introduce social care and healthcare staff had started to assess prisoners' social care needs.

Independent Monitoring Board

20. 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 2016, the IMB reported that they were concerned about the healthcare unit's staffing levels, the waiting times for primary care appointments, the ability of the healthcare provider to meet the needs of prisoners and the ability of the prison to escort prisoners to outside appointments.

Previous deaths at HMP Holme House

21. Mr Brown was the sixth person to die of natural causes at Holme House since January 2015. We have consistently found that Holme House has provided good palliative and end of life care.

Findings

The diagnosis of Mr Brown's terminal illness and informing him of his condition

22. On 7 April 2015, Mr Allan Brown was sentenced to five years imprisonment for sexual offences and was sent to HMP Holme House. He had significant health problems, including Type 2 diabetes, high blood pressure, poor mobility and depression. In 2006, Mr Brown had a lung removed as a treatment for cancer. He was prescribed numerous medications, including glyceryl trinitrate spray, amlodipine, enalapril, atenolol and bendroflumethiazide (all prescribed to treat heart conditions).

23. On 24 April, Mr Brown had a full health assessment and weighed 94 kgs.

24. Due to Mr Brown's poor mobility, a nurse carried out a health and social assessment with him on 21 June. The prison gave Mr Brown a chair and a walking frame to increase his comfort and a plan was created to assist Mr Brown with his day to day activities. This plan did not assess Mr Brown's risk of a fall. A prisoner helped Mr Brown by collecting meals and cleaning his cell.

25. On 30 November, a healthcare care assistant introduced herself to Mr Brown as his keyworker. She initially gave him weekly personal care, which progressively increased to day to day care in 2016.

26. On 17 December, a prison GP reviewed Mr Brown and noted that he had lost 16 kgs of weight in eight months. Mr Brown told the doctor that his appetite was poor, that he was not eating lunch and that he disliked prison food. The GP felt that this was the likely cause of the weight loss but arranged for blood tests and an x-ray to be sure. The results of those tests did not raise any serious concerns. However, on 24 December, a GP referred Mr Brown to hospital for specialist advice and investigations but noted that he did not meet the criteria for a two week referral for patients with suspected cancer.

27. On 11 March 2016, Mr Brown was seen at the hospital and referred for a CT scan. After delays on the part of the hospital and the prison, the hospital performed a CT scan on 23 June that did not show any evidence of cancer.

28. On 15 March, a nurse created a number of care plans for Mr Brown. They included assessing his mobility and risk of falls, his personal hygiene and his level of pain.

29. In late March, Mr Brown began to suffer with increased angina attacks. On 1 April, a prison GP reviewed Mr Brown, increased his atenolol dose (used to treat angina) and referred him to a specialist for cardiac investigations. On 31 May, Mr Brown saw a specialist at the hospital and underwent various cardiac tests.

30. On 10 June, a prison GP discussed the results of the cardiac tests with Mr Brown, which indicated that he was now in heart failure (a long-term condition that cannot be cured though the symptoms can be controlled). He placed Mr Brown on the palliative care register as his condition was terminal, though there was no current prognosis. Mr Brown's key worker and other healthcare staff continued to offer Mr Brown support along with his day to day nursing care.

31. On 23 August, a prison GP reviewed Mr Brown because he felt unwell, weak and dizzy. He explained that Mr Brown had severe hypertension (high blood pressure) and heart failure, and that he was on the optimum treatment. He also recommended that staff should not attempt to resuscitate Mr Brown if his heart or breathing stopped, but Mr Brown refused this, as he wanted to discuss the matter with his specialist. There was no record that anyone discussed resuscitation with Mr Brown again.

32. The clinical reviewer noted that Mr Brown had significant medical conditions and mobility problems, and that healthcare staff appropriately supported him as his health deteriorated. Healthcare staff implemented appropriate care plans to support him for his day to day living.

33. The clinical reviewer noted that the GP's referral in December 2015 was not an urgent referral and Mr Brown was seen within 18 weeks, in line with national guidelines for an outpatient appointment. The clinical reviewer also noted that both the hospital and the prison cancelled appointments for the CT scan. As the missed appointments related to investigations to determine whether Mr Brown had cancer and were not related to the condition that caused his death, we do not repeat the clinical reviewer's recommendation here. However, we draw the Governor's and the Head of Healthcare's attention to it and the need to maintain an appropriate balance between the demands of patient care and security.

Mr Brown's clinical care

34. On 31 August 2016, a nurse and a pharmacy technician became Mr Brown's allocated keyworkers. Following a full assessment, healthcare staff implemented care plans to ensure that Mr Brown received daily nursing care and a social care package to assist him with his personal hygiene and daily living activities. A Macmillan nurse made regular visits to support Mr Brown and the healthcare staff.

35. Between August and January 2017, healthcare staff regularly reviewed Mr Brown to ensure that his physical and social care needs were met.

36. Around 8.00pm on 4 January, an officer responded to Mr Brown's cell bell. He found Mr Brown on the floor, next to his toilet conscious but in pain. He radioed for the night orderly officer and healthcare to attend and asked for an emergency ambulance. At 8.10pm, the communications room rang for an emergency ambulance.

37. Two nurses and the night orderly officer gained access into Mr Brown's cell at around 8.20pm. The nurses took Mr Brown's observations and from the position of his legs assessed that he might have fractured his hip. Although in pain, Mr Brown was conscious and able to speak to the nurses. A nurse remained with Mr Brown until the ambulance arrived, and made him comfortable using a blanket, pillow and oxygen to help his breathing.

38. At 9.30pm, an ambulance crew arrived at Mr Brown's cell. The Ambulance Service had experienced a high number of priority calls and they knew that Mr Brown had qualified healthcare staff attending to him. Paramedics took over the care of Mr Brown from the nurse and used GTN spray (used to treat angina) after

he complained of chest pain. The paramedics took Mr Brown to hospital at 10.20pm.

39. On 5 January, Mr Brown had surgery to repair his fractured hip. The following day, his condition deteriorated so hospital staff moved him to the intensive care unit and placed him on a life support machine.

40. Mr Brown's condition continued to deteriorate and, at 3.00pm on 7 January, hospital doctors decided to switch off Mr Brown's life support machine. A post-mortem reported confirmed that Mr Brown died from multi organ failure caused by hypertensive heart disease and the effects of fractures of the right elbow and hip.

41. As Mr Brown's health deteriorated his care plans were re-assessed and updated to reflect his physical condition. This included medical reviews, interventions and investigations by both the prison doctors and hospital staff. Overall, we agree with the clinical reviewer that the clinical care Mr Brown received was of a good standard and equivalent to that he would have received in the wider community.

42. The clinical reviewer noted that the two nurses responded to Mr Brown's fall in a timely manner, and provided appropriate medical care and support while waiting for the ambulance. We are satisfied that despite delays in the arrival of an ambulance, a nurse remained with Mr Brown and ensured that he was not on his own at any time.

43. While, overall, Mr Brown's care was equivalent, the clinical reviewer noted that Mr Brown's considerable medical conditions and mobility problems put him at risk of falling. The care plans that were implemented to assess his mobility and risk of falls were not compliant with National Institute for Health and Care Excellence (NICE) clinical guidance (CG161 assessing risk and prevention of falls in older people). We make the following recommendation:

The Head of Healthcare should ensure that prisoners at risk of falls have an appropriate risk assessment in line with NICE guidelines and the assessment is recorded and acted on.

44. At interview, a nurse told the investigator that after taking annual leave, which coincided with Mr Brown's death, she learned of Mr Brown's death via a notice at the prison gate. She also said she had not been offered any care, support or welfare services from healthcare management.

45. As Mr Brown's keyworker we consider that she should have been notified of his death in person rather than reading a notice. We are also concerned that she was not offered any support following his death. We make the following recommendation:

The Governor and Head of Healthcare should ensure all staff, including healthcare staff, are offered appropriate and timely support after a death in custody.

Mr Brown's location

46. During much of his time at Holme House, Mr Brown was located in house block three, the vulnerable prisoner unit. A buddy carer assisted him with collecting his meals and cleaning his cell.

47. In October 2016, he moved to house block seven into a cell appropriate for his medical needs. In December, following a period of poor health, Mr Brown spent three days in the prison's palliative care suite on the inpatient unit for respite care, before returning to house block seven.

48. We are satisfied that Mr Brown was appropriately located throughout his time at Holme House.

Restraints, security and escorts

49. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. 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 takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

50. On 4 January, when Mr Brown was taken to hospital, a custodial manager authorised two officers to accompany him and restrain him with an escort chain (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). He reached this decision despite Mr Brown having significantly limited mobility and a suspected broken hip. He was also a palliative care prisoner and the prison has a protocol that all registered palliative care prisoners should not be restrained on transfer to hospital. A list of registered palliative care prisoners was situated in the cuffing room, where restraints are kept.

51. The custodial manager told the investigator that he had authorised officers to restrain Mr Brown as it was an exceptionally busy night with emergencies and incidents triggering a staff shortage. He completed an emergency hospital risk assessment but did not collect the restraints from the cuffing room so did not see the palliative care register.

52. The duty governor told the investigator that later that evening Mr Brown's escort contacted her and queried the use of the restraints. She authorised him to remove the restraint. However, there is no written information or evidence about this conversation and no evidence that the restraints were actually removed.

53. At 8.00am on 5 January, the bed watch notes record that one of the escorting officers spoke to a custodial manager, who authorised the escort chain to be removed due to Mr Brown's poor medical condition.

54. While we understand that another custodial manager decided that Mr Brown should be restrained on the basis of the limited information available to him, we consider that this decision was unjustifiable given Mr Brown's health and mobility at that time. His risk of escape was negligible given his suspected hip fracture and we consider that the prison did not reach the appropriate balance between security and dignity for Mr Brown. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints 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 Mr Brown's family

55. On 17 September 2016, an officer was appointed as Mr Brown's family liaison officer and spoke to Mr Brown about the help and support he would be able to offer him and his family. The next day, he introduced himself to Mr Brown's family during a visit and advised them of his support. He kept in regular contact with Mr Brown's family.

56. At 8.45am on 5 January 2017, the officer telephoned Mr Brown's wife to inform her that her husband had been taken into hospital. Later that morning, he collected Mr Brown's wife from her home and took her to see her husband.

57. On 7 January, the duty governor arranged for a taxi to take Mr Brown's wife to the hospital when doctors made the decision to withdraw Mr Brown's life support. She met with Mr Brown's wife at the hospital and offered her condolences and support.

58. Mr Brown's funeral was held on 25 January and the prison contributed to the costs of the funeral in line with national instructions.

Compassionate release

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

60. Mr Brown was added to the palliative care register in June 2015. While he was terminally ill through heart failure, there was no prognosis. Following his fall on 4 January 2017, and subsequent surgery, his health did not deteriorate until 24 hours before his death.

61. As a result, we are satisfied that Holme House did not proceed with a compassionate release application.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141