

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Neil Mitchell a prisoner at HMP Holme House on 29 February 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 Neil Mitchell died of acute bronchopneumonia due to chronic obstructive pulmonary disease at HMP Holme House on 29 February 2016. He was 67 years old. I offer my condolences to Mr Mitchell's family and friends.

The severity of Mr Mitchell's condition had been diagnosed before he went into prison and his death was not unexpected. Prison healthcare staff thoroughly assessed his needs and monitored him closely. Although the prison cancelled a hospital appointment without good reason, overall, I am satisfied that Mr Mitchell received a good standard of care in prison, equivalent to that he could have expected 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

September 2016

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Summary

Events

1. On 17 September 2015, Mr Neil Mitchell was sentenced to three years in prison and sent to HMP Durham. Mr Mitchell had already been diagnosed with advanced chronic obstructive pulmonary disease (COPD - the name for a collection of progressive lung diseases, including chronic bronchitis and emphysema). He was often short of breath and needed continuous oxygen. His care was palliative, to manage his symptoms and pain.
2. On 4 January 2016, Mr Mitchell transferred to HMP Holme House. At an initial health screen, a nurse noted his medical conditions and referred him to the prison doctor, who re-prescribed his medication and admitted him to the inpatient unit for a period of assessment before he went to a standard wing. Healthcare staff created appropriate care plans and reviewed Mr Mitchell daily. They adjusted his medication as necessary and, when he was particularly frail, they monitored him in the prison's inpatient unit.
3. Just after 11.00pm on 29 February, a night patrol officer responded to Mr Mitchell's cell bell but he was unable to tell her what was wrong, as he was too breathless. The night patrol officer asked a nurse to come to the wing to assess him and went back to his cell to let him know. A few minutes later, Mr Mitchell collapsed and the night patrol officer radioed an emergency medical code. Prison staff and paramedics tried to resuscitate him, but he did not recover. At 11.40pm, paramedics pronounced him dead.

Findings

4. When Mr Mitchell arrived at Holme House, he had end stage COPD. Healthcare staff closely monitored him and were responsive to his needs. We are satisfied that Mr Mitchell received a good standard of care at HMP Holme House, at least equivalent to that he could have expected in the community.
5. For security reasons, the prison cancelled a hospital appointment due on 25 February and rebooked it for 21 March, as Mr Mitchell had been notified of the date. As Mr Mitchell was already on maximum therapy for COPD, the clinical reviewer did not consider this would have altered the outcome or the timing of his death, but we are not satisfied that the cancellation of the appointment was justified by an appropriate risk assessment.

Recommendation

- The Governor should ensure that hospital appointments are not cancelled unless there are overriding, fully justified and documented security reasons, and there is no detriment to the prisoner's health.

The Investigation Process

6. 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.
7. The investigator obtained and reviewed copies of relevant extracts from Mr Mitchell's prison and medical records.
8. NHS England commissioned a clinical reviewer to review Mr Mitchell'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 Mitchell's wife, and solicitors acting on her behalf, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Mitchell's wife had a number of concerns including that, after he arrived at Holme House, Mr Mitchell was not accommodated in the healthcare inpatient unit, as he had been at HMP Durham, and that staff had not dispensed his medication and oxygen promptly. She considered that the staff at Holme House were not supportive and that Mr Mitchell received insufficient social care.
11. Mr Mitchell's wife received a copy of the initial report. She raised a number of issues that do not impact on the factual accuracy of this report and have been addressed in correspondence.
12. The Prison Service also considered the report and found no factual inaccuracies.

Background Information

HMP Holme House

13. HMP Holme House is a local prison holding over 1200 men. Most are on remand, or recently convicted by courts in the local area. Since April 2015, G4S has provided health services at the prison. There is a 24-hour inpatient unit with 16 beds and palliative care facilities.

HM Inspectorate of Prisons

14. 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.
15. Inspectors reported that the prison planned to introduce social care and healthcare staff had started to assess prisoners' needs.

Independent Monitoring Board

16. 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 2015, the IMB reported that healthcare staff dealt with increasingly complex and challenging issues, but successfully delivered services competently. There was a high number of staff vacancies but these were filled by agency staff and had not affected the standard of service.

Previous deaths at HMP Holme House

17. Mr Mitchell was the sixth prisoner to die at Holme House since the beginning of 2014. There were no significant similarities with the circumstances of the previous deaths.

Key Events

18. On 17 September 2015, Mr Neil Mitchell was sentenced to three years in prison for sexual offences and sent to HMP Durham.
19. At initial health assessments, healthcare staff noted that Mr Mitchell had advanced COPD. He said that this had been diagnosed in 2013 and his community GP had said that he could die imminently. Healthcare staff noted that he was frail, had difficulty breathing and used oxygen 24 hours a day. He was a heavy smoker. Throughout his time at Durham, Mr Mitchell lived in the prison's inpatient unit, which did not allow smoking so he was given a nicotine patch.
20. Healthcare staff referred Mr Mitchell to a Macmillan specialist palliative care nurse, with responsibility for overseeing the care of prisoners in the North East with life-limiting conditions. On 5 October, she visited him to assess his condition and needs. Mr Mitchell told her that he had been on his GP's palliative care register since February 2015 and had agreed that he did not want to be resuscitated if his heart or breathing stopped. However, he said he had changed his mind. She noted this, but explained that because of his clinical condition, if staff attempted to resuscitate him it would not necessarily be successful. She visited Mr Mitchell several times at Durham.
21. On 7 October, Mr Mitchell went to a routine respiratory appointment at a local hospital. Doctors revised his medication to include seretide (a steroid to help prevent breathlessness). On 12 October, Mr Mitchell said that he did not want to go to hospital again, as he did not want to be handcuffed.
22. On 31 December, the healthcare team held a multidisciplinary meeting, including the palliative care nurse, to plan Mr Mitchell's transfer to HMP Holme House. They noted that Mr Mitchell was able to care for himself and did not need nursing assistance, but a recent occupational health assessment had noted that he needed a shower chair and grab rails.
23. On 4 January 2016, Mr Mitchell transferred to HMP Holme House. At an initial health screen, a nurse noted that he needed oxygen 24 hours a day and was using a bottle of portable oxygen until healthcare staff could set up the concentrator machine that he normally used. A prison GP re-prescribed his medications and Mr Mitchell was admitted to the healthcare inpatient unit for assessment.
24. On the morning of 5 January, a prison GP examined Mr Mitchell, who was short of breath. The doctor increased his prescription of oxygen from 1 litre to 2 litres and arranged for him to use a nebuliser (a machine that delivers high doses of medication as a mist to be inhaled). He instructed the nurses to check Mr Mitchell's concentrator and his oxygen saturation level every day, to ensure it was between 88% and 92% and planned to review him daily. A nurse created a care plan.
25. A prison GP reviewed Mr Mitchell again in the afternoon. Although Mr Mitchell said he felt better, the GP diagnosed a chest infection. He prescribed steroids and antibiotics and said he would consider whether Mr Mitchell needed steroids long-term. The GP advised the nurses to call a doctor if his oxygen level

dropped below 90, or if they were concerned about a reduced level of consciousness.

26. On 6 January, Mr Mitchell moved to a standard residential cell in Houseblock 3. A healthcare assistant accompanied him to help settle him and set up his equipment. On 11 January, a prison GP noted that he had improved and was not short of breath, but decided that he should continue to take steroid medication.
27. On 15 January, a nurse drew up a social care plan for Mr Mitchell. Actions included daily checks by the nurse on his houseblock; weekly reviews by his named nurse, who should report changes to a senior nurse; medications to be taken to his cell daily; supplying an oxygen cylinder; a wheelchair for moving longer distances; assistance when using the stairs; and help with personal hygiene, as required. On 21 January, Mr Mitchell was admitted to the inpatient unit again. (The records do not show when he was discharged.)
28. On 29 January, the palliative care nurse the clinical lead at Holme House reviewed Mr Mitchell and noted that his breathlessness had got worse since he had arrived at Holme House; he used a nebuliser throughout the meeting. He was no longer able to manage his personal care and relied on prisoner carers to help him. In view of his deterioration, he was admitted to the inpatient unit. A prison GP prescribed one dose of prednisolone, a steroid.
29. A nurse noted that healthcare staff should wash and dress Mr Mitchell; change his bed linen, make his bed and clean his cell; deliver his meals and cut his food to prevent choking; and offer drinks at appropriate intervals, cooling hot drinks to avoid scalding. She obtained permission from prison managers for Mr Mitchell's cell to be kept open at all times to allow healthcare staff easy access and they checked him at least hourly during the night.
30. On 2 February, Mr Mitchell complained to a nurse that he had not received his medication. The nurse explained that his nebuliser was issued as and when he needed it, not at set times. He had received his prescribed antidepressant but Mr Mitchell denied receiving this. A few days later, another nurse advised Mr Mitchell to press his cell bell if he felt he needed his nebuliser.
31. On 3 February, the palliative care nurse reviewed Mr Mitchell, who said that he felt better and his breathlessness had improved since moving back to the inpatient unit. However, he was anxious that he could not keep the medication for his nebuliser in his cell. She discussed his management with the nursing team, to ensure he did not have to wait too long for his medication. They later arranged for his night time nebuliser medication to be delivered with his afternoon dose, for him to administer when he felt he needed it. Mr Mitchell was discharged from the healthcare unit on 5 February and returned to his houseblock.
32. On 8 February, the prison cancelled a routine respiratory appointment arranged for 25 February and rebooked it for 21 March, as the letter had been sent directly to Mr Mitchell, so he knew the date. (For security reasons, prisons prefer prisoners not to know about hospital appointments in advance.)

33. At 2.30pm on 15 February, a prison officer reported that Mr Mitchell's oxygen compressor was not working. Healthcare staff contacted the manufacturer and arranged for it to be repaired at 8.00am the next morning. In the meantime, Mr Mitchell had a 40 litre emergency tank.
34. On 26 February, Mr Mitchell told a prison GP that he did not want to go to hospital appointments, as he was concerned about confidentiality if officers were present and he did not want to be handcuffed. No decision had been made about whether Mr Mitchell would need to be handcuffed and the GP said he would raise this at the next palliative care meeting. The doctor assured Mr Mitchell that prison healthcare staff would continue to treat him and try to resuscitate him if necessary, but explained that hospital doctors' decisions about resuscitation might be based on his clinical condition and whether they thought resuscitation would be feasible.
35. In the early hours of 28 February, Mr Mitchell complained of a pain in his right lung and a nurse examined him. She found his blood pressure was normal, but his heart rate was slightly raised. She did not record his oxygen level as the machine did not give a reading, but she was not concerned about his oxygen level as he was not breathless and his colour was normal. She gave him antibiotics for a possible chest infection. Later, he said that he felt better.
36. At 4.10am on 29 February, Mr Mitchell rang his cell bell and asked to see a nurse, as he wanted more medication. The officer telephoned a nurse, who said that Mr Mitchell had received all his medication for the day and had his inhalers and nebulisers in his cell. She said he was not due to receive any more until 8.00am but would come to see him if he was unwell or if it was an emergency. Later that morning, Mr Mitchell said he felt unwell and had no energy. Nurses checked him throughout the day.
37. At 11.01pm on 29 February, Mr Mitchell pressed his cell bell. Electronic records show that a night patrol officer answered his call within one minute. She said that Mr Mitchell was sitting on the toilet using his nebuliser. She asked if he was all right, but he could not speak as he was short of breath. Around 11.05pm, she phoned a nurse, explained Mr Mitchell's symptoms and asked the nurse to examine him. The nurse phoned the night manager and asked him to meet her and unlock the entrance to Houseblock 3.
38. In the meantime, the night patrol officer went back to Mr Mitchell's cell to reassure him that the nurse was on her way. Shortly afterwards, Mr Mitchell collapsed to the floor, so she radioed a code blue emergency (this indicates circumstances such as when a prisoner is unconscious or not breathing). Control room staff received the code blue call at 11.10pm and called an ambulance very quickly.
39. The night manager and the nurse were already on their way to Mr Mitchell's cell, when they heard the code blue call and arrived at 11.16pm. They immediately started cardiopulmonary resuscitation (CPR). Shortly afterwards, another nurse and several other prison staff joined them. The nurses used a defibrillator, which found no shockable heart rhythm, so they continued CPR. Three paramedics arrived at the cell at 11.30pm and took over emergency treatment. Mr Mitchell

did not respond and, at 11.40pm, the paramedics recorded that Mr Mitchell had died.

Contact with Mr Mitchell's family

40. One of the prison's family liaison officers was called to the prison and at 3.30am she and a Senior Officer set off to inform Mr Mitchell's wife of his death. When they arrived at the address listed in his records, a neighbour told them that Mr Mitchell's wife had moved home a few weeks before. The family liaison officer obtained the address of a friend listed in Mr Mitchell's prison records and they went to see her. Mr Mitchell's friend explained that she acted as an informal carer for Mr Mitchell's wife and had a key to her home. She went with the officers to notify Mr Mitchell's wife and they arrived around 5.15am.
41. The family liaison officer informed Mr Mitchell's wife of her husband's death and offered condolences and support. They agreed that all further contact with Mr Mitchell's wife would be through her friend. In line with national policy, the prison contributed towards the cost of Mr Mitchell's funeral, which was held on 14 March.

Support for prisoners and staff

42. The Governor was informed of Mr Mitchell's death and went to the prison and debriefed the staff involved in the emergency response. He offered his support and that of the staff care team.
43. The prison posted notices informing other prisoners of Mr Mitchell's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Mitchell's death.

Post-mortem report

44. The report of the post-mortem examination concluded that Mr Mitchell's cause of death was bronchopneumonia (inflammation of the lungs) due to chronic obstructive pulmonary disorder.

Findings

Clinical care

45. When Mr Mitchell arrived at Holme House, he had severe end stage COPD and needed constant oxygen. Prison healthcare staff created a detailed care plan and checked him daily. When his condition deteriorated, they admitted him to the inpatient unit to monitor him more closely and we are satisfied he was appropriately located throughout his illness. A specialist palliative care nurse discussed Mr Mitchell's care with him and attended multidisciplinary team meeting about his care. The clinical reviewer concluded that Mr Mitchell's care at Holme House was generally very good and we are satisfied that he received an appropriate standard of care.

Hospital appointments

46. Mr Mitchell did not attend any hospital appointments while he was at Holme House. A few days before his death, he told a prison GP that he did not want to go to hospital, as he was concerned about the use of handcuffs and privacy if prison escort officers were present. At the time, no decision had been made about whether Mr Mitchell needed to be restrained for hospital appointments and the doctor agreed to discuss the issue at the next multidisciplinary meeting about Mr Mitchell's care.
47. The prison cancelled a hospital appointment arranged for 25 February, apparently for security reasons because Mr Mitchell was aware of the date. Mr Mitchell died before the rescheduled date of 21 March. The Prison Service's National Security Framework does not require hospital appointments to be cancelled automatically when prisoners become aware of the time and date, although our experience is that prisons often do this without sufficient reason. The clinical reviewer did not consider that this would have affected the timing of his death as Mr Mitchell was already on maximum therapy for COPD, however, there is no record of any risk assessment to justify cancelling the original appointment or any security intelligence to indicate Mr Mitchell was at risk of escape. We make the following recommendation:

The Governor should ensure that hospital appointments are not cancelled unless there are overriding, fully justified and documented security reasons, and there is no detriment to the prisoner's health.

Emergency response

48. Prison Service Instruction (PSI) 03/2013 requires prisons to have a medical emergency response code protocol, which ensures an ambulance is called automatically in a life-threatening emergency. The protocol should give guidance on efficiently communicating the nature of a medical emergency, ensuring that staff take the correct equipment to the incident and that there are no delays in calling an ambulance. The PSI and the prison's protocol indicates difficulty in breathing as an example of symptoms when staff should use an emergency medical code.

49. A key symptom of Mr Mitchell's condition was breathlessness and he often had breathing difficulties. It would therefore have been difficult for night patrol officer to decide whether to use an emergency medical code when she first answered Mr Mitchell's cell bell on the night of 29 February, as it would not have been obvious that this episode was unusual. We are satisfied that she acted reasonably when she initially called a nurse to examine Mr Mitchell and that she correctly radioed a code blue emergency immediately when Mr Mitchell's condition deteriorated.

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