Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Powell a prisoner at HMP Altcourse on 6 January 2018

A report by the Prisons and Probation Ombudsman

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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 Michael Powell died in hospital of pneumonia on 6 January 2018, while a prisoner at HMP Altcourse. He was 80 years old. I offer my condolences to Mr Powell's family and friends.

I am satisfied that Mr Powell received a good standard of care at Altcourse, at least equivalent to that which he could have expected to receive in the community and that healthcare staff responded quickly and appropriately to the sudden deterioration in his health.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **June 2018**

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Summary

Events

1. On 13 October 2017, Mr Michael Powell was sentenced to 11 years imprisonment, for sexual offences and sent to HMP Altcourse.

2. Mr Powell was elderly and frail when he arrived at Altcourse. Initial health screens identified that he had several longstanding medical conditions, including heart problems, high blood pressure, anaemia and kidney disease.

3. Over the following weeks, nurses conducted physical and mental health assessments and created care plans to manage Mr Powell's illnesses. Prison GPs requested tests and prescribed medication. Mr Powell spent periods in the inpatient unit when he required closer monitoring.

4. On 19 December, Mr Powell fell in his cell and fractured his hip. He spent a day in hospital and returned to Altcourse on 20 December. On 21 December, he became unwell, with symptoms of drowsiness and a poor appetite. On 23 December, a nurse found Mr Powell pale, breathing noisily, with an irregular pulse and pinpoint pupils. He was admitted to hospital, where he was diagnosed with pneumonia and given antibiotics. Mr Powell did not respond to treatment and died on 6 January 2018.

Findings

5. The investigation found that throughout Mr Powell's time at Altcourse, he received a good standard of clinical care, which was responsive to his needs and at least equivalent to that which he could have expected to receive in the community. When he became unwell, healthcare staff monitored him closely and referred him to hospital quickly when his condition deteriorated.

6. We are satisfied that Mr Powell's overall management was appropriate and that staff supported his next of kin during his illness and after his death.

The Investigation Process

7. 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.

8. The investigator obtained copies of relevant extracts from Mr Powell's prison and medical records.

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

10. We informed HM Coroner for Liverpool and Wirral of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

11. The investigator wrote to Mr Powell's sister, his next of kin, to explain the investigation and to ask if she had any matters for the investigation to consider. She did not respond to our letter.

12. We shared the initial report with HM Prison and Probation Service and they found no factual inaccuracies.

Background Information

HMP Altcourse

13. HMP Altcourse is a local prison in Liverpool, which takes prisoners from courts in Merseyside, Cheshire and North Wales. It holds up to 1,324 remanded and sentenced adults and young men. G4S manages the prison and provides primary healthcare services. There is an inpatient unit with 12 beds and 24-hour healthcare cover.

HM Inspectorate of Prisons

14. The most recent inspection of HMP Altcourse was in November 2017. Inspectors reported that there was a range of appropriate primary care services, prisoners received responsive care and staffing levels were satisfactory. Continuity of care had been adversely affected after the termination of the previous GP contract and the use of locum cover, but this had recently improved with use of a regular agency. Care plans were in place for prisoners with long term conditions, but they were sometimes inadequately reviewed. The inpatient unit required improvement.

Independent Monitoring Board

15. 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 June 2017, the IMB reported that the role of Healthcare Manager had been reintroduced to help improve the service to prisoners. Assessments for prisoners with social care needs were prompt and there were good links with Lancashire Social Services.

Previous deaths at HMP Altcourse

16. Mr Powell was the ninth prisoner to die from natural causes at Altcourse since January 2016. There were no significant similarities between the circumstances of his death and those previously investigated.

Key Events

17. On 13 October 2017, Mr Michael Powell was sentenced to 11 years in prison, for sexual offences. He arrived at HMP Altcourse the same day. It was his first time in prison.

18. At Mr Powell's initial health screen, a nurse recorded he had been diagnosed with heart problems, high blood pressure and failing hearing. (It was subsequently noted that he had a history of anaemia, chronic kidney disease and heart failure.) The nurse also noted Mr Powell's advanced age and that he used a walking aid due to reduced mobility. He referred him to the prison GP because of his frailty.

19. Mr Powell was immediately admitted to the healthcare inpatient unit. Staff managed him under the suicide and self-harm prevention procedures (until 24 October), as he had attempted suicide before entering prison.

20. During his ward round on 14 October, a prison GP assessed Mr Powell. He instructed staff to monitor his blood pressure daily and refer him for a GP review if it was persistently raised. In the following days, healthcare staff conducted further physical and mental health assessments. They created several care plans and closely monitored Mr Powell. They also provided a soft diet, a hospital bed and made a social care referral for help with personal care. (A subsequent assessment identified no social care needs.)

21. At a review on 20 October, a prison GP noted possible anaemia and a mass in Mr Powell's abdomen. The GP requested blood tests and an ultrasound scan (which took place on 4 December). On 23 October, the GP prescribed antibiotics for a suspected urinary tract infection.

22. On 1 December, Mr Powell moved to a cell in the vulnerable prisoners' wing. On 9 December, he became unwell and was readmitted to the inpatient unit for closer monitoring. Staff implemented care plans, including one for risk of falls.

23. At around 9.30pm on 19 December, Mr Powell told a nurse he was in pain after slipping on the floor of his cell and hitting his left hip. He could not remember when he had fallen. The nurse arranged for the GP to review him. A prison GP examined Mr Powell and sent him to hospital for an X-ray. After an overnight stay, Mr Powell returned to Altcourse on 20 December. The hospital discharge letter noted that he had fractured his pelvis and that the fracture clinic should review him in a week.

24. On 21 December, healthcare staff became concerned that Mr Powell appeared drowsy and had not eaten that day. He normally had a good appetite. A prison GP assessed him and prescribed pain relief. Nurses gave Mr Powell oxygen, conducted frequent clinical observations and created a food and fluid refusal care plan. Over the next day, there appeared to be some improvement.

25. At 6.40am on 23 December, a nurse checked Mr Powell through the observation panel of his cell. He was concerned as he was lying flat on his bed and breathing noisily and asked for permission to enter the cell. On examination, the nurse found that Mr Powell was pale, with an irregular pulse and pinpoint pupils.

There was also vomit on his pillow. Healthcare nurses gave him oxygen and called an ambulance.

26. The ambulance crew took Mr Powell to Aintree University Hospital, with two escort officers. No restraints were used.

27. Hospital doctors diagnosed pneumonia. They treated Mr Powell with antibiotics and he agreed that he did not want to be resuscitated if his heart or breathing stopped. Prison healthcare staff obtained regular updates on his condition.

28. Mr Powell did not respond to treatment and remained unwell. During the afternoon of 5 January, the hospital stopped active treatment and began palliative care, as he had not improved. Mr Powell died at 2.30am on 6 January 2018.

Contact with Mr Powell's family

29. Shortly after Mr Powell went to hospital on 23 December, the prison assigned a prison manager as the prison's family liaison officer. Later that day, the family liaison officer informed Mr Powell's sister, his next of kin, that he had been admitted to hospital and gave details of his diagnosis and treatment. He also arranged for her to visit on 28 December, either in hospital or at the prison if he was discharged before then. This was brought forward to 26 December, at the request of the doctor treating Mr Powell. The family liaison officer arranged a further visit for his sister on 5 January 2018, to enable Mr Powell's consultant to discuss end of life care.

30. At around 9.30am on 6 January, the family liaison officer telephoned Mr Powell's sister to break the news of his death. He offered support and advised her of the procedures to be followed. He kept in touch with Mr Powell's sister over the following weeks.

31. In line with national policy, the prison offered to contribute to the cost of Mr Powell's funeral, which was held on 8 February. However, his sister declined as Mr Powell had made full provision for this.

Support for prisoners and staff

32. After Mr Powell's death, the Head of Safer Custody debriefed the escort staff to ensure they had the opportunity to discuss any issues arising and to offer support.

33. The prison posted notices informing staff and other prisoners of Mr Powell's death and offering support.

Cause of death

34. An inquest concluded that the cause of Mr Powell's death was 1a) pneumonia, 2) heart failure.

Findings

Mr Powell's clinical care and management

35. When Mr Powell went into prison, he was elderly and frail with reduced mobility. Healthcare staff assessed his health needs and created appropriate care plans, which were implemented and reviewed promptly. They nursed him in the inpatient unit when he needed additional monitoring and made timely referrals to hospital, when he became seriously unwell.

36. The clinical reviewer concluded that Mr Powell's health needs were appropriately assessed and reviewed and he was referred promptly for hospital investigations. We agree with the clinical reviewer that Mr Powell's healthcare at Altcourse was of a good standard, responsive to his needs and at least equivalent to that which he could have expected to receive in the community.

37. We are satisfied that Mr Powell was managed appropriately throughout his time at Altcourse and that there was prompt and effective communication with his next of kin during his illness and after his death.

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