Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Pearson a prisoner at HMP Holme House on 28 September 2017

A report by the Prisons and Probation Ombudsman

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*

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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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr David Pearson died on 28 September 2017 of liver failure in his cell at HMP Holme House. He was 54 years old. We offer our condolences to those who knew him.

Overall, Mr Pearson received a good standard of care at Holme House, equivalent to that which he could have expected to receive in the community. The investigation did, though, identify some specific concerns about which we make recommendations, although these concerns did not contribute to Mr Pearson's 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.

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

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Summary

Events

1. On 19 June 2015, Mr David Pearson was sentenced to nine years and six months in prison for sexual offences. He had been at HMP Holme House since 17 January 2017. He had a number of chronic health conditions for which prison GPs prescribed a large number of medications and he often went to hospital because of illness. Healthcare staff implemented care plans for him.

2. Hospital liver specialists reviewed Mr Pearson on several occasions and from July 2017, they said that he should receive palliative treatment only. Mr Pearson told medical staff that he was tired, did not want any further emergency treatment and that he wanted to die in prison.

3. Specialist palliative care nurses co-ordinated his care and he was nursed with open door arrangements in place which meant that his cell door was not locked. Nurses made Mr Pearson comfortable and monitored him. His condition deteriorated and, after becoming unresponsive, Mr Pearson died on the morning of 28 August.

Findings

4. We agree with the clinical reviewer that, overall, Mr Pearson received a good standard of care at Holme House, equivalent to that which he could have expected to receive in the community. However, the clinical reviewer found that staff did not formally assess Mr Pearson's risk of falls despite his poor mobility and even after he fell in his cell, or assess fully the risk posed to his skin by his diabetes.

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 Head of Healthcare should ensure that prisoners at risk of a breakdown of skin integrity should have an appropriate risk assessment and that staff take appropriate action as a result of the assessment.

The Investigation Process

5. 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.

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

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

8. We informed HM Coroner for Teesside of the investigation, who gave us the cause of death. We have sent the Coroner a copy of this report.

Background Information

HMP Holme House

9. 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

10. The most recent inspection of HMP Holme House was in July 2017. Inspectors reported that, overall, their inspection was disappointing as they found a greater need for safety, decency and prisoner rehabilitation. They said that many recommendations from deaths in custody had not been implemented.

11. Inspectors also found that health services had deteriorated since their previous inspection, mainly due to chronic staff shortages. They noted that the range of primary care services was good, but waiting times for some services, including routine GP appointments, were very long. Inspectors found that healthcare staff provided compassionate care to patients with complex needs in the inpatient unit but their efforts were undermined by frequent lock-downs and an impoverished regime. They said that pharmacy and dental services were generally good and prisoners with social care needs were identified promptly and received good support.

Independent Monitoring Board

12. 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 their 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

13. Mr Pearson was the fourth prisoner to die of natural causes at Holme House since January 2016. We have consistently found that Holme House has provided good palliative and end of life care. However, we previously identified that staff needed to ensure the risk of falls assessment is completed. In August 2017, HMPPS accepted our recommendation and said that there was a routine audit of clinical notes and practice to ensure staff were completing holistic patient assessments, including risk assessments of slips, trips or falls occurring, and that any concerns were escalated to the Regional Operations Manager.

Key events

14. On 19 June 2015, Mr David Pearson was sentenced to nine years and six months in prison for sexual offences. He was sent to HMP Holme House on 17 January 2017. He had a number of chronic health conditions, including diabetes, epilepsy, impaired vision, hearing loss, reduced mobility, liver problems, osteoarthritis and slurred speech due to a stroke. Prison GPs prescribed a large number of medications and he often went to hospital because of illness.

15. Healthcare staff implemented care plans to manage Mr Pearson's conditions. He was admitted to the inpatient unit so that healthcare staff could review him frequently and, primarily, to try to stabilise his diabetes.

16. On 27 January 2017, Mr Pearson told a prison GP that his stomach was swollen. The GP prescribed medication for fluid retention caused by liver cirrhosis. He reviewed Mr Pearson three days later as his stomach was still swollen. He prescribed further medication to help with the fluid retention and recommended that healthcare staff check his weight and measure his stomach in one week.

17. Nurses checked Mr Pearson's measurements and as his stomach remained unchanged, the prison GP increased the prescribed medication on 2 February.

18. On 5 February, Mr Pearson told a nurse that he felt dizzy, tired, had stomach pain and he felt breathless. She checked his blood pressure, oxygen saturation level and pulse, which were within normal ranges. Later that evening, she checked his observations again. They remained in the normal range, but his stomach was "grossly distended up to the diaphragm". She arranged for Mr Pearson to go to hospital. In hospital, Mr Pearson's abdomen was drained of fluid and hospital staff discharged him on 8 February.

19. On 26 February, a nurse noted that Mr Pearson fell in his cell. She examined him and noted that he was at risk of falls and had a small graze on his left arm. She found no other injuries.

20. Each day, nurses helped Mr Pearson to shower, dress and they monitored his food and fluid intake. He was nursed with open door arrangements in place. (This meant that his cell door was not locked.)

21. On 3 June, hospital doctors discussed with Mr Pearson whether he wanted anyone to try to resuscitate him if his heart or breathing stopped. Mr Pearson decided that he did not want to be resuscitated, and this was formally recorded in his medical record.

22. On 26 July, a nurse added Mr Pearson to the palliative care register as his prognosis was poor. A palliative care specialist was appointed as Mr Pearson's key palliative nurse. Another palliative care nurse completed a summary and said that the plan was for Mr Pearson to be made as comfortable as possible. She noted that Mr Pearson asked for a review of his pain management as he had chronic and constant stomach pain. He was aware of his liver failure. Staff arranged for him to have access to 24-hour nursing cover. A prison GP completed a medication review and changed his pain relief from nefopam to naproxen.

23. On 10 August, Mr Pearson discussed with the palliative care specialist his wishes for his advanced care planning. He said that he wanted pain relief and to remain at Holme House for his end of life care. He also said that he did not want to attend hospital for further treatment and he wanted to include in his advance care plan his Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form as immediate guidance to healthcare professionals if he had a cardiac arrest. She told him that she would arrange for his advance care plan to be witnessed.

24. A nurse saw Mr Pearson later that day. Mr Pearson confirmed his wishes to her and she told him he could change them at any time. He was concerned about problems with using a commode and she arranged with a nurse in the inpatient unit for a continence assessment to be completed. When Mr Pearson was unable to get out of bed, nurses gave him urine bottles to use. They helped him to wash, dress and use a commode.

25. When a healthcare assistant checked on Mr Pearson at 9.00am on 28 August, he told her that he was having difficulty breathing. She asked two senior nurses to assist her. One senior nurse noted that Mr Pearson was deteriorating. Mr Pearson told the other senior nurse that he felt "rotten". She noted that his breathing was laboured. Nursing staff stayed with him and made sure he was comfortable. The staff at Holme House were fully aware of the DNACPR and did not attempt resuscitation when they found him unresponsive. Nurses contacted the duty manager, the chaplaincy team and the prison managers. A senior nurse certified Mr Pearson's death at 11.10am.

Contact with Mr Pearson's family

26. Mr Pearson's family told prison staff that they did not want any contact or any information about him.

27. The prison arranged and paid for Mr Pearson's funeral, which was held on 13 October 2017.

Support for prisoners and staff

28. After Mr Pearson's death, a prison manager debriefed the healthcare staff who were with Mr Pearson when he died to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

29. The prison posted notices informing other prisoners of Mr Pearson'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 Pearson's death.

Cause of death

30. The Coroner confirmed that the cause of Mr Pearson's death was end stage liver failure.

Findings

Clinical care

31. The clinical reviewer said that the care that Mr Pearson received was of a reasonable standard and equivalent to that which he could have expected to receive in the community. She said that there was evidence of good practice in the way that clinical staff supported Mr Pearson with his changing clinical needs. They frequently checked his observations and identified at an early stage that his health was deteriorating. The clinical reviewer said that healthcare staff created care plans to meet Mr Pearson's health and social needs, and reviewed them regularly as his needs changed.

Healthcare risk assessments

32. While the clinical reviewer recognised that Mr Pearson had care plans, she was concerned that healthcare staff did not monitor his diet, skin integrity and risk of falls using validated assessment tools.

33. Although healthcare staff acknowledged that Mr Pearson was at risk of falls and arranged for him to be referred to a physiotherapist and occupational therapist for advice, the care plans to assess his mobility and risk of falls did not comply with the clinical guidance produced by the National Institute for Health and Care Excellence (NICE). Had they done, this would have enabled staff to identify and assess Mr Pearson's visual impairment and mobility limitations. In August 2017, Holme House agreed to implement a previous recommendation we made about this issue. We repeat that recommendation in this report:

    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.

34. The clinical reviewer said that Mr Pearson's diabetes put him at risk of a breakdown of skin integrity. She said that staff should have used another assessment tool such as Waterlow, Norton or Braden to assess Mr Pearson's risk. We agree and make the following recommendation:

    The Head of Healthcare should ensure that prisoners at risk of a breakdown of skin integrity should have an appropriate risk assessment and that staff take appropriate action as a result of the assessment.

35. The clinical reviewer said that healthcare staff monitored Mr Pearson's glucose levels a number of times a day and checked that he had adequate meals, snacks and fluids. She considered that as his diabetes was unstable, staff should have used the Malnutrition Universal Screening Tool (MUST) to identify, assess and monitor Mr Pearson's risk for potential malnutrition and help in managing his care plan.

36. However, we found that healthcare staff monitored his eating and drinking and the palliative care nurses created a care plan using the MUST which healthcare staff subsequently used to monitor his nutrition and hydration levels. We therefore make no recommendation.

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