

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Glenn Yates a prisoner at HMP Altcourse on 25 November 2018

A report by the Prisons and Probation Ombudsman

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 Glenn Yates died in hospital on 25 November 2018 from a pulmonary embolism (blockage of a blood vessel in the lungs), while a prisoner at HMP Altcourse. He was 46 years old. I offer my condolences to Mr Yates' family and friends.

I am satisfied that the standard of care Mr Yates received at Altcourse was equivalent to that he could have expected to receive 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.

Sue McAllister CB
Prisons and Probation Ombudsman

April 2019

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Summary

Events

1. Mr Glenn Yates was recalled to prison custody on 25 September 2018 and sent to HMP Altcourse.
2. On 12 November, Mr Yates reported right sided abdominal pain and sickness, which continued for the next few days. Blood tests showed inflammation and anaemia. The GP advised further examination at hospital but Mr Yates refused to go. The GP prescribed antibiotics and arranged more tests.
3. A second set of blood tests, taken on 21 November, identified anaemia and deteriorating kidney function. Mr Yates agreed to be taken to hospital where he was admitted. He was discharged back to Altcourse on 23 November, with medication (a final day's dose of antibiotic and folic acid) and appointments for further tests. The medication was never administered.
4. On 25 November at 8.30am, Mr Yates complained of feeling unwell and a nurse examined him and arranged a doctor's appointment for later that morning. There were no officers available to escort Mr Yates to the healthcare unit at that time.
5. At approximately 10.15am, an officer escorted Mr Yates to the healthcare unit but on the way Mr Yates became dizzy, short of breath and unable to stand without support. A second officer brought a wheelchair and they took Mr Yates to the healthcare unit where a doctor examined him. Mr Yates' blood pressure was low and his pulse fast. The doctor arranged for him to go to hospital by ambulance.
6. Mr Yates left Altcourse at 11.18am. He walked to the ambulance unassisted but during the journey, his condition deteriorated and paramedics gave him oxygen. On arrival at hospital Mr Yates was taken to the resuscitation unit where at 11.45am he had a suspected heart attack. At 12.55pm, a hospital doctor recorded that Mr Yates had died.
7. A post-mortem examination showed Mr Yates died from a pulmonary thromboembolism (a blocked blood vessel in the lung), which was caused by metastatic carcinoma of the right kidney (cancer) with inferior vena caval thrombosis (a blood clot in the major vein that carries blood from the legs).

Findings

8. The clinical reviewer found that the care Mr Yates received at HMP Altcourse was equivalent to that he could have expected to receive in the community.
9. The clinical reviewer was satisfied that the failure of the prison to administer the antibiotic and folic acid to Mr Yates when he returned from hospital did not affect the outcome.
10. We make no recommendations.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Altcourse informing them of the investigation and asking anyone with relevant information to contact him. No one responded
12. The investigator obtained copies of relevant extracts from Mr Yates' prison and medical records.
13. NHS England commissioned a clinical reviewer to review Mr Yates' clinical care at the prison.
14. We informed HM Coroner for Merseyside and Liverpool District of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
15. The investigator contacted Mr Yates' sister, 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.
16. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Altcourse

17. HMP Altcourse is a local prison in Liverpool which takes prisoners from the courts in Merseyside, Cheshire and North Wales. It is managed by G4S custodial services and holds up to 1,324 sentenced and remanded adult and young adult men. G4S runs the company that provides primary healthcare services at the prison. Prime Care provides secondary mental health services.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Altcourse was in November 2017. Inspectors noted that the provision of consistent healthcare had been problematic, though recent changes were beginning to improve patient outcomes. The healthcare environment was poor and the waiting area for vulnerable patients wholly inadequate but there was a clear commitment to health promotion activities.
19. The prison had a range of appropriate and accessible primary care services but prisoners experienced delays in obtaining routine repeat prescriptions. Men with physical health care needs received responsive care but activities and support for men with mental ill health was more limited.

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 June 2018, the IMB reported that a new GP contract had recently been agreed which they hoped would reduce the current eight week waiting time to see a doctor for non-urgent appointments. The Board highlighted the poor condition of the waiting room for vulnerable prisoners which they described as airless, cramped and generally unfit for purpose.
21. On a positive note the Board highlighted a dramatic reduction in recent months of healthcare complaints together with the introduction of a healthcare 'forum' which gave prisoners the opportunity to raise concerns. They also noted the benefits of health promotion and prevention activity, including stress awareness, HIV, blood pressure, autism and mental health awareness and bowel cancer screening.

Previous deaths at HMP Altcourse

22. Mr Yates' death was the 17th at Altcourse since November 2015. Of the previous deaths, 11 were from natural causes and five were self-inflicted. There have been two deaths since, both from natural causes. There were no similarities between Mr Yates' death and the previous deaths.

Key Events

23. On 25 September 2009, Mr Glenn Yates was given an indeterminate prison sentence for public protection, with a minimum term of two years and 14 days, for sexual offences. On 6 November 2015, he was released on licence.
24. On 25 September 2018, Mr Yates was recalled to prison after breaching the conditions of his licence. He was taken to HMP Altcourse.
25. At his initial health screen, Mr Yates told a nurse that he was not taking any medication, had not seen a doctor for several months and had no outstanding hospital appointments.
26. On 5 November, a nurse examined Mr Yates after he reported intermittent left sided abdominal pain. He had no swelling or bruising and no problems passing urine or stools. He said he was eating and drinking well with no nausea. The nurse gave him ibuprofen and Mr Yates put in an application to see the doctor.
27. On 12 November, a nurse examined Mr Yates in his cell after he was sent back from work complaining of right sided abdominal pain. Mr Yates said the pain was worse when breathing in and that he felt sick after eating. Mr Yates took ibuprofen and paracetamol to control the pain. The nurse noted in Mr Yates' medical record that he would seek advice from the senior nurse but there is no record of the outcome.
28. On 15 November, a nurse examined Mr Yates at 10.25am, after he said he felt dizzy. He was pale but alert and talking in full sentences with no chest pain or nausea. Mr Yates told the nurse that he had been suffering from chronic abdominal pain for four to five weeks and had requested a doctor's appointment but was still waiting. She took Mr Yates' clinical observations, which were all within normal range. Mr Yates said he felt much better and returned to his cell to rest. She told him to contact healthcare if his symptoms returned and made an appointment for a doctor to see him later that day.
29. A prison GP reviewed Mr Yates at 2.35pm. Mr Yates told the doctor that he had felt unwell for some time. He said he felt increasingly thirsty and nauseous, with intermittent abdominal pain. The prison GP prescribed metoclopramide (used to treat and prevent nausea and vomiting) and arranged blood tests. He told Mr Yates that he would see him again in one week with the results of the blood tests.
30. However, a prison GP saw Mr Yates the next day to take blood samples after nursing staff had been unable to do so. Mr Yates also had an electrocardiogram (ECG - a test to check the heart's rhythm and electrical activity). The results were recorded as satisfactory with no acute changes. Mr Yates appeared lethargic and the prison GP advised that he go to the healthcare wing for observation. Mr Yates declined.
31. On 17 November at 2.28pm, a prison GP saw Mr Yates to discuss his blood test results which showed a raised C-reactive protein (a blood test marker for inflammation in the body) and moderate anaemia (a lack of red blood cells which carry oxygen around the body). He suggested Mr Yates go to hospital for further examination but he refused. He also refused to go to the healthcare wing for

observations and signed a disclaimer to that effect. He explained the consequences of his decision which included sepsis and possible death.

32. The prison GP recorded Mr Yates' vital signs which were within normal range. He also gave him a physical examination which was satisfactory and did not raise concerns. Mr Yates said he felt stronger. He arranged for Mr Yates' vital signs to be recorded twice a day, for a chest X-Ray and repeat blood tests. He prescribed a seven-day course of amoxicillin (antibiotics).
33. On 21 November at 11.46am, a prison GP took blood samples from Mr Yates. The results showed low haemoglobin levels (indicating anaemia) and deteriorating kidney function. At 4.36pm, a prison GP examined him. Mr Yates was pale and short of breath and a physical examination identified 'crackles' at the base of his right lung. The prison GP convinced Mr Yates that he needed to go to hospital and arranged his transfer to hospital where he was admitted to the medical assessment unit.
34. Mr Yates was taken to hospital in prison transport escorted by two officers. He was handcuffed to an officer but later, when it became apparent that he would be in hospital overnight, the handcuff was removed and replaced 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.)
35. Prison healthcare staff stayed in regular contact with the hospital until Mr Yates' discharge and return to Altcourse on 23 November. His discharge summary indicated sinus tachycardia (a faster than usual heart rhythm), microcytic anaemia (iron deficiency in the blood), low iron and folate (vitamin B12) levels and a low thyroid stimulating hormone (indicating thyroid disease). Mr Yates' discharge plan included a colonoscopy and gastroscopy (to examine his colon, stomach and intestine), to eat an iron rich diet and to return to hospital in a week's time for further treatment and test results. He was discharged with his final day's dose of amoxicillin and folic acid.
36. A nurse saw Mr Yates on his return at 3.36pm. He said he felt better in himself. Escort staff took his discharge letter and medication to the healthcare wing. At 4.32pm, a prison GP noted Mr Yates' return to Altcourse in the medical record and wrote his prescription in line with the discharge summary. However, due to an administrative error Mr Yates did not receive his medication despite repeatedly asking for it.

Events of 25 November

37. On 25 November at 8.30am, Mr Yates approached an officer and told her he felt unwell, was in pain and had still not received the medication prescribed to him at hospital. The officer contacted a nurse who was on the unit dispensing medication.
38. The nurse examined Mr Yates in his cell a short while later. He recorded that Mr Yates was pale and lethargic, but his vital signs were within normal limits. Due to his symptoms, recent blood results and hospital admission, he advised Mr Yates to go to the healthcare unit and made an appointment for him to see a doctor.

39. There were no officers available to escort Mr Yates to the healthcare unit and as his condition worsened the officer became more concerned. At 9.40am, she radioed for medical assistance and a nurse attended about five minutes later. She assured the officer that someone would be there soon to escort Mr Yates to the healthcare unit, but there is nothing in the medical record to indicate that a nurse to see Mr Yates.
40. The officer remained concerned about the delay and contacted the duty director. He told her that an officer would be there immediately.
41. An officer arrived at approximately 10.15am, to escort Mr Yates and two other prisoners to the healthcare unit. Mr Yates walked from his cell unaided but was pale and appeared out of breath. While walking over to the healthcare unit Mr Yates began to fall behind and when he caught up asked if he could stop to catch his breath. He was bent over with his hands on his knees. Mr Yates then dropped to the floor onto his hands and knees. The officer told him to get up and tried to assist him but Mr Yates did not respond. After five to ten seconds, Mr Yates started to speak and tried to stand. The officer and one of the prisoners assisted him and supported him once he was upright.
42. Initially the officer thought Mr Yates was messing around but once he realised that this was not the case he radioed for medical assistance. Another officer joined him almost immediately with a wheelchair and they helped Mr Yates into it and took him to the healthcare unit.
43. A prison GP, saw Mr Yates at 10.19am. He complained of feeling dizzy. He recorded Mr Yates' vital signs, noting his blood pressure was low at 90/57mmHg while his pulse was fast at 130 beats per minute. Mr Yates did not have chest or abdominal pain but, because the cause of his symptoms was unknown, He arranged for him to go to hospital for further examination. Control room staff called an ambulance.
44. Mr Yates remained in the healthcare inpatient unit under observation. He told a nurse that he was cold and she gave him a blanket. Paramedics arrived at 11.00am and were with Mr Yates shortly after. At 11.18am, after examination, Mr Yates was taken by ambulance to hospital. Two prison officers accompanied him and he was restrained with an escort chain.
45. Mr Yates walked unaided to the ambulance but on the way to hospital his condition deteriorated and paramedics gave him oxygen. On arrival he was taken immediately to the resuscitation department for assessment but at 11.45am, he had a suspected heart attack. The escort chain was removed immediately.
46. At 12.55pm, despite the efforts of hospital staff, a doctor pronounced that Mr Yates had died.

Contact with Mr Yates' family

47. On 25 November at 1.10pm, the prison appointed, a prison chaplain, as the family liaison officer (FLO). Mr Yates had named his sister as his next of kin and at 1.30pm the FLO and a prison manager left Altcourse to visit her.

48. They arrived at Mr Yates' sister's address at 2.05pm. They told her of Mr Yates' sudden death and offered their condolences. The FLO outlined his role as the family liaison officer. He explained that the prison would support Mr Yates' sister with the funeral costs.
49. On 28 November, the FLO telephoned Mr Yates' sister but her son told him that she had been admitted to hospital and that Mr Yates' brother would be arranging the funeral.
50. Mr Yates' funeral was held on 20 December 2018. The prison contributed towards the cost in line with Prison Service instructions.

Support for prisoners and staff

51. After Mr Yates' death, the duty director debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. Healthcare staff were not present but held their own review of Mr Yates' care.
52. The prison posted notices informing other prisoners of Mr Yates' 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 Yates' death.

Post-mortem report

53. A post-mortem examination showed that the primary cause of Mr Yates' death was a pulmonary thromboembolism (a blockage in one of the pulmonary arteries in the lungs). This was caused by metastatic carcinoma of the right kidney (cancer) with inferior vena caval thrombosis (the inferior vena cava is the major vein that returns blood to the right side of the heart).

Findings

Clinical care

54. The clinical reviewer was satisfied that the care Mr Yates received at Altcourse was at least equivalent to that he could have expected to receive in the community.
55. Long term health conditions were managed appropriately and in line with national guidance and when Mr Yates' health deteriorated he was assessed appropriately and referred correctly to secondary care.
56. When Mr Yates returned to Altcourse from hospital on 23 November, a doctor prescribed but did not administer his discharge medication (folic acid, used to treat anaemia, and his final dose of antibiotics). Despite telling staff that he had not had his medication, Mr Yates did not receive it before his death.
57. Healthcare staff at Altcourse identified this omission when completing the 72-hour review of Mr Yates' care and produced an action plan to prevent such an omission in the future.
58. The clinical reviewer was satisfied that the omission did not affect the outcome for Mr Yates.
59. We do not make a recommendation about the missed medication but the Head of Healthcare will need to ensure that the measures in the action plan are implemented immediately.

Emergency response

60. Prison Service Instruction (PSI) 3/2013 'Medical Emergency Response Codes', contains instructions for Governors/Directors of all prisons to ensure that a Medical Emergency Response Code protocol exists that enables staff discovering a prisoner exhibiting certain symptoms to clearly and concisely convey the nature of the medical emergency to all interested parties.
61. Local protocols must clearly define the nature of the medical emergency with the use of a two-level code system that differentiates between a blood injury and all other injuries. It is recommended that 'Code Red' is used for blood/burns and 'Code Blue' for breathing/collapse. Altcourse has an appropriate local protocol (Notice to Staff 07/2018) issued 18 January 2018.
62. On 25 November, two officers independently requested 'medical assistance' when they became concerned about Mr Yates' medical condition. The Safer Custody Manager explained that a request for medical assistance is used when an officer needs medical help but which is not an emergency and not serious enough to warrant a Code Red/Blue, which when called requires the control room to call an ambulance immediately.
63. The two officers said that though they were concerned about Mr Yates' condition, neither considered the situation to be an emergency that necessitated calling a medical emergency code. Both officers explained that although Mr Yates looked unwell, was short of breath and in some discomfort, they were aware medical

staff had seen him that morning and that he had an urgent appointment to see a doctor. We are satisfied that under the circumstances the officers acted appropriately.

Restraints, security and escorts

64. 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.
65. On 21 November at 5.40pm, Mr Yates was taken to hospital in prison transport accompanied by two officers. A risk assessment was completed that said Mr Yates was fully mobile and his illness had only limited impact on his ability to escape. This was Mr Yates' first escort from Altcourse and although he was generally considered low risk, he had recently been recalled to prison for breach of a Sexual Offences Prevention Order. The Head of Security authorised the use of a single handcuff meaning Mr Yates was handcuffed by the wrist to the wrist of a prison officer.
66. Mr Yates remained handcuffed in hospital until 8.15pm, when it became apparent that he would be kept in overnight for further treatment. The Head of Security authorised the handcuff to be removed and replaced with an escort chain.
67. On 25 November, Mr Yates was taken to hospital by ambulance. He was mobile and walked to the ambulance unassisted. A risk assessment was completed by the duty operations manager. The duty director authorised the use of an escort chain. On arrival at hospital when Mr Yates' condition deteriorated, the escort chain was removed immediately.
68. We are satisfied that on both occasions the use of restraints was correct and appropriately reviewed.

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