Investigation into the circumstances surrounding the death of a prisoner at HMP Holme House in November 2007

Report by the Prisons and Probation Ombudsman for England and Wales

July 2008

This is the report into the death of a remand prisoner at HMP Holme House, who died in November 2007. A post mortem examination concluded that the man had died as a result of coronary heart disease and chronic bronchitis/emphysema. I would like to offer my sincere condolences to the man's family and friends for their loss.

One of my colleagues, conducted the investigation. In addition, North Tees Primary Care Trust conducted a clinical review into the man's healthcare at Holme House.

I would like to thank the Governor of Holme House, and his staff for their co-operation and assistance with the investigation. I am particularly indebted to the prison liaison, who ensured the relevant documentation was made available to my investigator. Thanks also go to the Principal Officer and Senior Officer who took on the role of Prison Family Liaison Officers, who have been supportive and helpful to the man's family throughout.

The man had been in custody for just 11 days. He was not a healthy man and had a history of chronic illness. Accordingly, throughout his time at Holme House he was located in the healthcare wing. On the morning of his death, he was unlocked to collect his breakfast meal and receive his medication. As he approached the treatment room where the medication was dispensed, the man appeared to have difficulties and then collapsed to the floor. Officers and nursing staff quickly attended and attempted to gain a response from him. He was taken by wheelchair back to his cell where attempts to revive him continued until the arrival of ambulance staff. Sadly, he never regained consciousness and was pronounced dead by paramedics at approximately 8.15am.

I have identified three areas of good practice and make three recommendations as a result of my investigation into the man's death. The Prison service has accepted these recommendations.

Stephen Shaw CBE
Prisons and Probation Ombudsman **July 2008**

CONTENTS

Summary	4
The investigation process	5
HMP Holme House	7
Key findings	8
Issues	10
Recommendations and good practice	12

SUMMARY

The man was remanded into custody in November 2007. He had been suffering for some time from a number of chronic illnesses which were being treated with medication from his local General Practitioner (GP).

On his arrival at HMP Holme House, a nurse saw him and completed a health screen in which his ongoing medical problems were revealed. The nurse made arrangements for the man to be located in the healthcare wing to allow a more detailed assessment of his medical needs to be conducted. Arrangements were also made for him to be seen and assessed by a physiotherapist in relation to his mobility, but this did not take place before he died.

On the morning of his death, he was unlocked to collect his medication and breakfast. The servery and treatment area was a short walk from his cell. As he approached the treatment room door, a member of staff observed him lean forward onto the wall before collapsing onto the floor. Staff were quick to respond and it was immediately clear that the man was unconscious. Following immediate efforts to gain a response, staff moved him back to his cell where nursing staff administered cardio pulmonary resuscitation (CPR). These efforts, continued until the arrival of ambulance staff who took over from the nursing staff in administering treatment. Despite their best efforts he failed to respond to treatment and he was confirmed dead at 8.15am.

THE INVESTIGATION PROCESS

1. The investigation was opened at HMP Holme House in November 2007. Notices were issued, informing staff and prisoners of the investigation and inviting anyone who had relevant information to come forward. There were no responses to the notices.

2. The investigator visited the prison in January 2008. He met with the appointed liaison, visited the healthcare wing and talked to staff. The investigator subsequently liaised with the prison to clarify information about the man's healthcare needs and his prison life. The investigator also obtained relevant documentation, including the man's medical record.

3. One of my Family Liaison Officers (FLOs), contacted the man's wife. The FLO explained the role of the Ombudsman and asked about any concerns the family had about the man's care. The family had been very shocked by his death, but his widow told the FLO that they were very pleased with the way the prison had dealt with them. Her only concern was that she had been unable to speak with her husband during the short time he had been in custody. She told the FLO that she felt that confusion had led to her husband being unable to use the phone, and this she felt was regrettable. I have looked into this matter during the investigation and have made a recommendation. However, my investigator was provided with documents that suggest the man was given access to a phone on at least one occasion.

4. I am grateful to HM Coroner for providing the post mortem results. The report records the cause of death as coronary heart disease and chronic bronchitis/ emphysema. A copy of my report will be sent to the Coroner to assist with the inquest.

HMP HOLME HOUSE

5. HMP Holme House is a category B prison for adult males, opened in May 1992. The prison primarily serves the communities of the Tees valley, South West Durham, East Durham and North Yorkshire. The accommodation comprises six self-contained house blocks with a mixture of single and double cells.

6. Holme House offers a variety of employment opportunities within a modern workshop complex. These are complemented and supported by a purpose-built education department that offers both part-time and full-time classes.

7. HM Chief Inspector of Prisons, Ms Anne Owers, conducted an announced inspection of Holme House in April 2005. Following the inspection, Ms Owers said of Holme House:

> "This inspection recorded some extremely good work in detoxification and healthcare, where uniformed and specialist staff were working together to produce excellent outcomes. Suicide and self-harm prevention was well managed, and more prisoners told us that they felt safe in Holme House than in comparable establishments. They also reported better than average relationships with staff."

8. The most recent report by the prison's Independent Monitoring Board (IMB) was issued in 2005. The report commented generally well on all areas of the prison and the following comments were made of reception and healthcare:

> "The staff working within reception have to deal with some very difficult prisoners either arriving from court or from other prisons. They work very well under pressure and make a good team. They treat all prisoners with courtesy and respect and often work beyond their shifts to accommodate late arrivals from court."

> "There are concerns by nursing staff due to the rapid turnover of staff. The perception is that qualified staff appointments within the prison are merely as a stop-gap or stepping stone jobs. The unit has benefited from inclusion in the roster of two officers easing safety and security issues."

Most of the concerns raised by the IMB have since been addressed.

9. There have been four other deaths from natural causes at Holme House since I took over responsibility for investigating all deaths in custody in 2004. I repeat some earlier recommendations that I have made in relation to medical record keeping in this report.

KEY FINDINGS

Events leading up to the man's death.

10. In November 2007, the man was remanded into custody to HMP Holme House. On arrival, a member of the healthcare team assessed him and it became clear that he had a number of chronic illnesses. In view of this, a nurse decided that he should be located in the healthcare wing to enable better management of his condition.

11. While in the reception area, he was asked to provide a contact number for his wife so that she could be informed that he was alright. The man provided two numbers but no answer was obtained from either. However, the following day a member of the healthcare staff gave him access to an office telephone and he was then able to speak to his wife.

12. The nurses and prison officers who had contact with him during his time in the wing described him as a polite man who just seemed to get on with things. There is mention of him getting irate on one occasion. Staff told my investigator that this was due to him finding it difficult to collect his own meals and medication owing to his use of crutches. Staff would therefore help by carrying his meals back to his cell for him.

13. The man had been identified as having 70 per cent disability due to chronic obstructive pulmonary disease (COPD). An appointment was made for him to be seen by a physiotherapist to assess his physical health. In the meantime, staff continued to encourage him to collect his meals and medication. Nursing staff told my investigator that, whenever possible, patients in healthcare are encouraged to keep mobile to aid their recovery, unless it is physically impossible for them to do so. His cell was a short walk from the servery and medication dispensary area.

14. On the morning of his death at about 7.45am, his cell was unlocked so he could collect his breakfast and medication. As he approached the door of the treatment room, a member of staff saw him lean forward onto the gate before sliding down onto the floor. An Officer, who was one of the prison officers on duty, supported the man and laid him onto the floor. A nurse, who was in the treatment room, called to him to try and gain a response. Another nurse, who was in the office, heard the raised voices and came out. On seeing the man on the floor, she also attempted to get a response from him. He failed to respond, so she went to request an ambulance. Staff moved the man away from the treatment room gate allowing the nurse in the treatment room to get out.

15. An officer and nurse lifted him into a wheelchair. An oxygen mask was applied to the man while checking for a pulse. A nurse said she detected a very weak pulse, about four beats per minute. Together the staff moved him back to his cell where the officer and nurse lifted him onto his bed. The Senior Nurse asked her colleague to collect a defibrillator machine (a device which delivers a measured electrical shock to arrest fibrillation of the heart). While this was being collected, the Senior Nurse continued to check but could find no pulse.

With the assistance of another nurse, she began to perform cardio pulmonary resuscitation (CPR). When the defibrillator arrived, the machine was attached to the man and it indicated that there was no output. The nursing staff then took it in turns to continue CPR until the arrival of paramedics.

16. The paramedics arrived at 8.05am. They took over from the nursing staff and continued to administer first aid to the man. At 8.15am, the paramedics confirmed that he was dead.

Events following the man's death.

17. At 10.00am on the morning of the man's death, the Duty Governor contacted a Principal Officer (PO) at HMP Deerbolt and asked him to take on the role of Family Liaison Officer (FLO) as the FLO at Holme House was unavailable.

18. When the PO arrived at Holme House, the Duty Governor, and another Governor informed him about the circumstances of the man's death. Following this, the PO and another Governor left the prison to visit the man's wife at her home to tell her what had happened. They arrived at around midday. After breaking the sad news, the PO and Governor remained with her to await the arrival of her son and his partner.

19. The man's family was informed of the role of the prison FLO and the post mortem process. After providing the family with contact details, the PO and Governor left the family home at 2.00pm and returned to Holme House.

20. The PO kept in regular contact with the family during the week after the man's death. He returned the property and went along to the mortuary to offer support. He also attended the opening of the inquest and arranged transport for the family. Together with a Governor, the PO attended the funeral in December. The prison offered to pay the full funeral costs.

21. On 12 December, the PO went to see the man's wife and introduced the Senior Officer (SO) from Holme House, who was to take over as FLO. The SO continued to liaise with the family until 22 December, when she wrote to the man's wife to tell her that she would no longer be acting in this capacity. The SO explained to her the role of the Ombudsman's FLO and assured her that, although she would no longer be acting as a Family Liaison Officer herself, she could still be contacted if necessary.

ISSUES

Immediate clinical needs and aftercare

22. A clinical review of the man's medical care was conducted by Hartlepool Primary Care Trust and North Tees Primary Care Trust. The review identified that Holme House had recently moved to a computerised system for recording medical information. In respect of this, the review contains one recommendation about developing an audit tool, which I support. However, the absence of such a tool had no bearing on the care given to the man.

    I recommend that the Governor implements an audit tool to undertake record keeping audits of the clinical system.

    The Prison Service accepted this and said:

    > *The PCT and Head of Healthcare to devise an audit system for record keeping on the new clinical system.*

23. Although he had not been in custody for very long, the medical screening process in place at Holme House ensured that the man's continuing chronic health problems were documented. My investigator was told that, on reception into custody, all prisoners suffering from chronic illnesses or going through alcohol or drug detoxification are offered the opportunity to be located on the healthcare wing for at least the first 24 hours. The clinical reviewers also mention this process and say that they found the first and second health screenings complete and conducted within the prescribed timescales. The record identified the man's past and current health problems.

    I commend the procedures for screening prisoners which enabled the man's chronic health problems to be immediately identified and treatment arranged promptly.

24. The healthcare wing at Holme House often has between ten and 17 in-patients. Like the deceased, some of these prisoners are there because of ongoing physical health problems, but a large majority have mental health issues. During the investigation, my investigator was told that those prisoners with mental health problems can sometimes be disruptive when located in the residential wings. Unfortunately, due to their behaviour some find themselves being moved between the segregation unit and healthcare. The staffing of the healthcare wing is made up of both nursing and discipline staff. The discipline staff are part of the selected segregation unit team and work across both departments. The practice of using segregation unit staff to work in healthcare ensures continuity of care for those prisoners who find themselves moving between the two areas on a regular basis. My investigator was told by nursing staff that they felt the assistance that the discipline staff provided was invaluable. Discipline staff said that, since working in healthcare, they had a better understanding of the pressures faced by the nursing staff.

Although not directly linked to the care provided to the man, the staffing arrangements within the healthcare wing at Holme House offer good continuity of care which I regard as good practice.

25. The clinical review says that the man was only held in the healthcare wing on his first night. However, my investigator established that he was in fact located in healthcare throughout the entire period that he was at Holme House and never moved to any residential wing.

26. The clinical reviewers identified that a care plan for the man was in place and that referrals had been made to appropriate practitioners. The care plan pathway was complete and very clear. The clinical reviewers consider the care provided to him was of an appropriate level. Further, the standard of record keeping was good and ensured effective communication. There were no delays in him receiving his medication and all his clinical needs were met.

27. Following the man's collapse in the healthcare wing, both nursing and discipline staff quickly tried to assist him and the efforts of all concerned should be recognised. I should be grateful if the Governor could share this and my other observations with his staff.

Maintaining family ties

28. Following his death, the man's wife mentioned to my Family Liaison Officer her concern that he had been unable to contact her while he was in custody. It would appear that there was some confusion regarding his ability to access the PIN phone system (this allows prisoners to purchase call credits and make telephone calls by using a unique access code). It is recorded that he was given access to an internal phone in order to contact his wife, but this appears to have happened only once. The confusion over use of the PIN phone might have arisen as a result of him being sent directly to the healthcare wing after reception.

The Governor should ensure that new prisoners located in the healthcare wing immediately after reception should have the same opportunity to participate in the induction process as other new prisoners.

The Prison Service accepted this and said:

> *All prisoners not located on the First Night Centre are seen by the induction officer the next day. A new Induction package is currently under review which, on implementation, will ensure all new prisoners not located on the First Night Centre will be seen and given the full induction package.*

All prisoners should be given the opportunity of a telephone call within 24 hours of reception.

The Prison Service accepted this and said:

All new prisoners on arrival receive application to input their telephone numbers on the pin phone system within 24 hours. For those potentially subject to public protection measures, this can be up to three days.

Family liaison and support

29. The prison acted quickly to appoint a Principal Officer as Family Liaison Officer to notify the next of kin. The support given to the family by the PO during this very difficult period was carried out in a very professional and caring manner. The prison ensured that the family's questions and concerns were answered, and they were not left to deal with difficult matters alone. The family recognised the support they were given and were very grateful for it.

I commend the Principal Officer (FLO) for the considerable help and support he provided to the man's family.

RECOMMENDATIONS

1. **I recommend that the Governor implements an audit tool to undertake record keeping audits of the clinical system.**

2. **The governor should ensure that new prisoners located in the healthcare wing immediately after reception should have the same opportunity to participate in the induction process as other new prisoners.**

3. **All prisoners should be given the opportunity of a telephone call within 24 hours of reception.**

GOOD PRACTICE

1. **I commend the procedures for screening prisoners which enabled the man's chronic health problems to be immediately identified and treatment arranged promptly.**

2. **Although not directly linked to the care provided to the man, the staffing arrangements within the healthcare wing at Holme House offer good continuity of care which I regard as good practice.**

3. **I commend the Principal Officer (FLO) for the considerable help and support he provided to the man's family.**