Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Richard Mook a prisoner at HMP Holme House on 21 May 2018

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.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.

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 Richard Mook died on 21 May 2018 of multiple organ failure caused by severe septicaemia (blood poisoning), which in turn was caused by an extensive chest infection while a prisoner at HMP Holme House. He was 46 years old. I offer my condolences to his family and friends.

Healthcare staff provided good care to Mr Mook to support him with his mental health and try to address his drug problems. However, there were some shortcomings before his death in changing his dressings regularly and taking his clinical observations when his health deteriorated.

I am also concerned that when Mr Mook went to hospital, the use of restraints was not justified by a fully considered risk assessment which took into account his poor 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
Deputy Prisons and Probation Ombudsman **November 2018**

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Summary

Events

1. Mr Richard Mook was sentenced to life imprisonment on 13 July 1995. He had been at HMP Holme House since 18 October 2016. He had a complex medical history of schizophrenia, anxiety, depression, a personality disorder, self-harm, drug use and epilepsy. He was a smoker who accepted help to try to stop smoking.

2. Healthcare staff developed care plans to manage his conditions. They reviewed him frequently and adjusted his medication as necessary. When Mr Mook felt stressed, he would self-harm. These episodes were monitored and he was offered support from staff.

3. In May 2018, after a self-harm episode, Mr Mook's wound dressings were not checked or changed for four days. On 12 May, healthcare staff found him unwell and breathless and treated him for low oxygen saturation levels. An ambulance was called and paramedics took him to hospital. Two officers escorted him and used handcuffs for the journey.

4. Mr Mook's condition did not improve and he remained in hospital. He deteriorated further and, on 21 May, he died from multiple organ failure due to severe septicaemia caused by an extensive chest infection. His family were present when he died.

Findings

5. The clinical reviewer concluded that Mr Mook's care was of a good standard and, in some areas, was equivalent to that he could have expected to receive in the community. We found that Mr Mook received good support from the mental health team and the substance misuse team at Holme House, and staff frequently offered him support.

6. However, the clinical reviewer identified areas where Mr Mook's care was not equivalent, namely the delays in changing his wound dressing and in completing his clinical observations. (We note, however, that a hospital doctor said that Mr Mook's wounds were not the source of the sepsis that killed him.)

7. On 12 May, Mr Mook was initially restrained with double handcuffs when he was taken to hospital by ambulance as an emergency. We are not satisfied that the prison fully took into account Mr Mook's medical condition and lack of mobility when assessing his risk.

Recommendations

- The Head of Healthcare should ensure that there is a clear and audited process for wound management so that healthcare staff prioritise treating, monitoring and changing the dressing of wounds, as required.

- The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Investigation Process

8. 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.

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

10. The investigator interviewed one member of staff by telephone on 20 August 2018.

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

12. 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.

13. The investigator wrote to Mr Mook's family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They did not respond to our letter.

14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy and this report has been amended accordingly.

Background Information

HMP Holme House

15. HMP Holme House is a medium security training prison holding over 1,200 men. Until May 2017, it was a local prison, holding men on remand or who had recently been convicted by courts in the local area. G4S provides health services at the prison. There is a 24-hour healthcare unit with 16 beds and palliative care facilities.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Holme House was in July 2017 and took place when Holme House was being transformed from a local prison (holding mainly prisoners on remand) to a training prison (for convicted prisoners). Inspectors reported that the healthcare interactions that they observed between staff and prisoners were very good but they noted that chronic staff shortages in the primary care nursing team had affected service delivery. In their survey, only 22 per cent of prisoners said that the quality of health services was good. Many prisoners complained about long waiting times, and inspectors found that prisoners waited up to five weeks for routine doctor and nurse practitioner appointments. However, they found that patients with urgent needs were seen quickly.

17. Inspectors reported that the quality of care reflected in ACCT documentation varied widely. They found that some were completed well but in most cases, there was little continuity of case management, many case reviews were not multidisciplinary, observations were often perfunctory and some risk assessments were very poor. Inspectors found that there was a wide range of integrated mental health services, but high demand and staff shortages affected their provision and waiting times.

Independent Monitoring Board

18. 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 31 December 2017, the IMB reported that plans were in place to restructure the delivery of primary care but that the plans had been compromised by significant staff shortages, including difficulties in the recruitment and retention of healthcare staff.

Previous deaths at HMP Holme House

19. Mr Mook’s death was the seventeenth death at Holme House since January 2015. Of those deaths, twelve were from natural causes. There are no similarities between this and the previous deaths.

Assessment, Care in Custody and Teamwork

20. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system used to support prisoners at risk of suicide and self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

21. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

22. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction 64/2011 on safer custody.

Psychoactive Substances (PS)

23. PS (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

24. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS, the need for more effective drug supply reduction strategies, better monitoring by drug treatment services and effective violence reduction strategies.

25. HM Prisons and Probation Service now has in place provisions that enable prisoners to be tested for specified non-controlled PS as part of established mandatory drugs testing arrangements.

Key Events

26. On 13 July 1995, Mr Richard Mook was sentenced to life imprisonment for murder. He had a complex medical history of schizophrenia, anxiety, depression, a personality disorder, self-harm, drug use and epilepsy. He was a smoker who accepted help to try to stop smoking.

27. On 18 October 2016, Mr Mook was transferred to HMP Holme House. A nurse completed his reception screening. She noted that while he denied thoughts of self-harm, his behaviour was bizarre as he avoided all eye contact and mumbled responses. She noted that he should be allocated a cell in the healthcare unit. She noted recent episodes of self-harm and of behaviour related to his personality disorder and psychosis at his previous prison, HMP Durham. ACCT monitoring was started and Mr Mook was placed under constant watch.

28. Mr Mook was appropriately referred to the mental health team who identified that he had mental health issues. The mental health team frequently reviewed him and offered him support.

29. On 25 October, Mr Mook told an officer that he did not have any thoughts of self-harm and wanted to leave the healthcare unit and live on a standard wing. Staff arranged this after they stopped ACCT procedures.

30. There were a number of recorded incidents when Mr Mook banged his head and cut his arms when he felt stressed or angry. He was monitored under ACCT procedures after these incidents.

2017

31. In 2017, Mr Mook had at least 10 ACCT reviews. Records show that he engaged with the reviews and there was a pattern of self-harming when he felt stressed. Staff offered support and encouragement.

32. On 25 May, Mr Mook told his offender supervisor that he had recently seen a psychiatrist, who had changed his medication from tablets to injections as he had been trading his medication with other prisoners.

33. On 28 June, Mr Mook confided in a nurse that he had started using psychoactive substances (PS) in October 2016 and was using them daily. He said that PS made him feel lethargic, anxious and paranoid, which affected his mental health. She referred him to the mental health team and the Drug and Alcohol Recovery Team (DART, which provides treatment options for prisoners with substance misuse issues). Mr Mook had an appointment with a mental health nurse the next day. He also engaged with DART workers. Specialists concluded that Mr Mook’s thoughts about his offence details and anniversary were triggers for increased substance misuse and mental health decline. Specialists continued to offer him support as and when needed.

34. On 21 October, Mr Mook tested positive for PS. He told an officer that other smokers gave him cigarettes and that he had not intentionally smoked PS. She reminded him about the support mechanisms available if he felt stressed.

2018

35. On 6 January, Mr Mook tested positive for benzodiazepines, PS and opiates. During an ACCT review on 30 January, Mr Mook told an officer that he had used PS for at least one month and it was affecting his mood and self-harming behaviour. He remained subject to ACCT procedures. On 1 February, Mr Mook appeared under the influence of PS, so was unable to receive his prescribed medication. He was advised that his medication would be stopped if this behaviour continued.

36. On 9 February, Mr Mook felt angry and frustrated after meeting an independent psychiatrist about his Parole Board application. He self-harmed and told the Residential Supervising Officer that he had done so out of frustration.

37. On 5 April, Mr Mook cut his arms. He told an officer that he did not know why he had done so, but it might be connected to the stress of his parole hearing.

38. On 11 April, Mr Mook cut his left arm. He told the Residential Supervising Officer that he was under threat from other prisoners and that he did not want to stay in the house blocks. A nurse examined Mr Mook and noted that he had made numerous deep lacerations to his forearm. She arranged for an ambulance to attend to take him to hospital, where the wound was dressed and he returned to Holme House. ACCT monitoring began again and Mr Mook attended the reviews.

39. Mr Mook returned to hospital the next day when the wound started to bleed extensively. He remained in hospital overnight and then returned to Holme House on 13 April but returned to hospital again when his arm started bleeding again. During this time, healthcare staff did not record any clinical observations. Hospital doctors gave him antibiotics and washed his wound on his forearm.

40. Mr Mook was scheduled to attend hospital appointments for plastic surgeons to examine his arm but, after he was mistakenly told the dates of the appointments, the appointments were cancelled for security reasons and rescheduled.

41. On 4 May, a prison pharmacy technician noted that when Mr Mook collected his medication, his dressing was soaked in blood. She booked an appointment for the next day for a nurse to reassess his wound and change the dressing. However, this did not happen until 8 May when a nurse changed the dressing and noted that the wound was leaking, had an odour and unusual colour. She took swabs to check for infection.

42. On 9 May, staff stopped ACCT monitoring.

43. On 12 May, Mr Mook collected his medication from a nurse and told her that he felt unwell. She noted that he was breathless and she asked the duty nurse to check him. The duty nurse checked him and noted his oxygen saturation level was 72% (normal is over 94%) and he was very anxious. She administered oxygen, which increased his saturation level to 84% and requested an emergency ambulance. Two officers escorted Mr Mook to hospital, and he was handcuffed for the journey. In hospital escorting staff restrained Mr Mook using an escort chain (one hand is handcuffed to an officer using a chain). When hospital staff completed their assessments, the handcuffs were removed and never reapplied.

44. Hospital staff diagnosed suspected sepsis and acute pneumonia. Mr Mook's condition deteriorated and he died in hospital on 21 May.

Contact with Mr Mook's family

45. When Mr Mook was admitted to hospital with breathing difficulties on 12 May, the prison appointed family liaison officers. Prison staff contacted his mother to tell her that he was seriously ill in hospital but she said that she was unable to visit him and staff should contact his sister. One family liaison officer telephoned his sister and arranged for her to visit him.

46. On 21 May, hospital staff told prison staff that Mr Mook was deteriorating and they had contacted his family to return to the hospital. A family liaison officer met Mr Mook's family at the hospital and offered support. Mr Mook died at 6.50pm with his family present.

47. Mr Mook's funeral was on 13 June. Two prison staff attended. The prison offered a financial contribution in line with national instructions.

Support for prisoners and staff

48. After Mr Mook's death, a prison manager debriefed the staff who had been the escorts in hospital to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

49. The prison posted notices informing other prisoners of Mr Mook's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide and self-harm in case they had been adversely affected by Mr Mook's death.

Cause of death

50. The Coroner gave the cause of death as multiple organ failure caused by severe septicaemia which in turn was caused by an extensive chest infection.

51. The Coroner provided information from a consultant anaesthetist in the Critical Care Team who said that there was no connection between Mr Mook's death and any wound he had inflicted.

Findings

Clinical review

52. The clinical reviewer concluded that Mr Mook's care was of a good standard and, in some areas, was equivalent to that which he could have received in the community. She said that his mental health care and supportive therapies were very good. She noted that Mr Mook had said that he felt well supported when other prisoners bullied him. However, she said that there were areas which were not equivalent.

53. The clinical reviewer was critical of the missed opportunity on 4 May 2018 for staff to replace a blood-soaked dressing which covered a serious self-harm wound. She noted that the four-day delay potentially led to the wound becoming infected. Mr Mook's clinical observations were not noted and the pathology laboratory had no record of receiving the swab for testing. However, she said that Mr Mook had capacity to request a dressing change and the wound was not the source of the sepsis which led to his death.

54. The clinical reviewer was also critical of the lack of any record of the clinical observations and National Early Warning Score (NEWS, a clinical assessment to monitor unwell patients) on 12 May when Mr Mook was breathless.

55. We consider that Mr Mook's mental health care and medication were appropriately managed. Mr Mook had a known history of substance misuse and he met members of the DART several times to review his substance misuse plan. He engaged with them consistently.

56. The clinical reviewer made a number of recommendations about Mr Mook's clinical care which were unlikely to have changed the outcome for him but which the Head of Healthcare will need to address. However, we agree and note that there were missed opportunities to monitor Mr Mook's self-harm wounds. We make the following recommendation:

    The Head of Healthcare should ensure that there is a clear and audited process for wound management so that healthcare staff prioritise treating, monitoring and changing the dressings of wounds, as required.

Restraints

57. 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.

58. A judgment in the High Court in 2007, made it clear that prison staff need to distinguish between the prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when he has a serious medical condition. The judgement indicated that prison staff must take into

account medical opinion about the prisoner’s ability to escape and keep this under review as circumstances change.

59. The emergency risk assessment for his hospital admission on 12 May 2018 noted that he was a Category C prisoner who was having breathing difficulties, there were no medical objections to the use of restraints, there was an unquantified risk that he could escape unaided, he was not subject to ACCT procedures and he had a recent self-harm history. Two officers accompanied him, using double handcuffs to restrain him.

60. When interviewed, the prison manager who made the decision to use double handcuffs said that he noted Mr Mook’s sentence details. He placed more emphasis on the conviction and sentence details than on Mr Mook’s health condition when the ambulance was requested.

61. Public protection is critical, but security measures must be proportionate to a prisoner’s individual circumstances and the provisions set out by the High Court are clear.

62. We are concerned that it was considered appropriate to use double handcuffs for Mr Mook. Double cuffing is usually required for moving Category A or Category B prisoners in good health. Mr Mook was a Category C prisoner. When, exceptionally, double cuffs are used for a Category C prisoner like Mr Mook, the National Security Framework requires that reasons should be recorded in writing. It is difficult to see how the assessment concluded that a seriously ill man had the ability to escape unaided from two escort officers.

63. The Prison Service has a responsibility to protect the public, but security must be balanced with humanity and measures must be proportionate to a prisoner’s individual circumstances. We are not satisfied that managers appropriately considered his condition at the time and how this affected his risk. We make the following recommendation:

The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

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