Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Price, a prisoner at HMP Holme House, on 24 February 2020

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*

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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 John Price died in hospital of pneumonia on 24 February 2020 while a prisoner at HMP Holme House. He also had chronic kidney disease and Type 2 diabetes which contributed to but did not cause his death. He was 85 years old. I offer my condolences to Mr Price's family and friends.

I am not satisfied that the healthcare Mr Price received was equivalent to that he could have expected to receive in the community. I am concerned that healthcare staff did not monitor Mr Price's diabetes or weight loss in line with national guidelines. I am also concerned that they did not seek advice or escalate the situation when prison staff said they were unable to facilitate Mr Price's admission to hospital until the following day due to a lack of escort staff.

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 **October 2020**

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Summary

Events

1. On 16 May 2017, Mr John Price was sentenced to eight years and six months in prison for sexual offences and sent to HMP Holme House.

2. Mr Price had had poor health for several years, including Type 2 diabetes, kidney disease and anaemia, and had had a stroke in 1996. He was registered blind, used a cane and needed help with personal care.

3. A prison GP tasked healthcare staff to conduct regular blood tests for Mr Price., but blood tests were only completed infrequently. They indicated that he was anaemic and that his Type 2 diabetes was unstable. Prison GPs and hospital staff tried to vary Mr Price's medication to stabilise his conditions. On occasions, Mr Price refused to give any blood samples.

4. From 9 February 2020, Mr Price reported feeling unwell. On the evening of 12 February, a prison GP noted Mr Price's blood tests were abnormal, indicating that his kidneys were not working, and said he needed to go to hospital. Prison staff said there were no staff available to escort him until the next morning. Mr Price was taken to hospital on 13 February.

5. Mr Price's condition deteriorated and on 24 February, he died from pneumonia.

Findings

6. The clinical reviewer concluded that, overall, the care Mr Price received at Holme House was not equivalent to that he could have expected to receive in the community.

7. His diabetes and weight were not monitored in line with NICE guidelines. Although his kidney disease was monitored appropriately, the response to the abnormal blood test results on 12 February was not in line with national guidance. Healthcare staff should have sought advice from out of hours services when prison staff were unable to facilitate Mr Price's transfer to hospital and should have escalated the situation.

Recommendations

- The Head of Healthcare should ensure that prisoners with diabetes receive a structured annual diabetic review in line with NICE guidelines.

- The Head of Healthcare should ensure that all healthcare staff use the MUST tool, where appropriate, in line with NICE guidance.

- The Head of Healthcare should ensure that the healthcare staff are aware of the process for communicating abnormal blood test results so that any issues are dealt with in a responsive and timely manner.

- The Head of Healthcare should ensure that healthcare staff are aware of the escalation and communication procedures if prison staff are unable to facilitate a hospital transfer.

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. She obtained copies of relevant extracts from Mr Price's prison and medical records.

10. NHS England commissioned an independent clinical reviewer to review Mr Price's clinical care at the prison.

11. We informed HM Coroner for Teesside and Hartlepool of the investigation. She gave us the results of the post-mortem examination. We have sent her a copy of this report.

12. One of the Ombudsman's family liaison officers contacted Mr Price's next of kin, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She said she had none.

13. Mr Price's family received a copy of the initial report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence. They also stated that they were not kept updated about Mr Price's health situation or his death by the family liaison officers.

14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Holme House

15. HMP Holme House is a Category C training prison holding over 1,200 men. G4S provides health services at the prison. There is a 24-hour healthcare inpatient unit with 16 beds.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Holme House was in February and March 2020. Inspectors reported that prisoners' perceptions of healthcare were extremely negative. There was an appropriate range of primary care clinics, and patients with long-term conditions and complex needs were well managed. Delivery of care across the prison was well coordinated by senior nurses. The inpatient facility was well managed, but there was limited provision of therapeutic regime activities. Social care arrangements were well developed, although prisoner carers had received minimal training and there were no arrangements for their supervision.

Independent Monitoring Board

17. 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 2018, the IMB reported that the prison had seen steady and significant improvements in stability and performance. This had been achieved against a backdrop of tight staffing resources. It did not consider that healthcare services were equivalent to those in the community, citing very long GP appointment waiting lists and constant nurse shortages.

Previous deaths at HMP Holme House

18. Mr Price was the 19th prisoner to die at HMP Holme House since February 2017, and there have been two natural causes deaths at the prison since Mr Price's which are under investigation. Of the previous deaths, 12 were from natural causes, three were self-inflicted deaths and three were drug-related deaths. There are no similarities between our findings in the investigation of Mr Price's death and the other deaths.

Key Events

19. On 16 May 2017, Mr Price was sentenced to eight years and six months in prison for sexual offences and sent to HMP Holme House.

20. Mr Price had had poor health for several years and had a history of Type 2 diabetes, hypertension (high blood pressure), kidney disease and anaemia, and had had a stroke in 1996. He was registered blind and used a cane.

21. Healthcare staff completed reception screens and prison GPs prescribed appropriate medications. Healthcare assistants visited Mr Price daily to help him with his social care.

22. In September, a prison GP asked for routine blood tests to be arranged. A nurse noted she was unable to obtain a blood sample. There is no record of further attempts.

2018

23. In April 2018, a nurse checked Mr Price's blood glucose level and it was low. He gave Mr Price dextrose tablets to increase his glucose level.

24. In May, a prison GP completed a medication review and noted that Mr Price's blood pressure was "well controlled". He noted that no blood tests had been arranged as he had requested several months earlier, and repeated the request. However, there is no record of blood tests being taken until December.

25. In September, nurses noted that Mr Price had lost two stones in weight since his arrival at Holme House, but they did not use a malnutrition scoring tool (MUST) to monitor any further weight changes.

26. In December, Mr Price had blood tests which showed that he was anaemic. A prison GP prescribed vitamin B12 and iron tablets and made a two-week referral for investigations into the possibility of urological cancer. Subsequent tests found Mr Price did not have cancer but had anaemia and was B12 deficient.

27. On 24 December, Mr Price was moved to the prison's inpatient unit, where he remained.

2019

28. A prison GP arranged Mr Price's first diabetic blood check in January 2019. As the result was abnormal, he referred him to the diabetic nurse, who concluded the result was satisfactory for Mr Price and that no further action was necessary.

29. Mr Price was admitted to hospital twice briefly in April (once following a 'vacant episode' and once for a suspected deep vein thrombosis). The hospital reported that Mr Price's kidney function was abnormal and recommended an adjustment to his medication. Mr Price was taken to hospital again in May as an emergency with a hypoglycaemic (low blood sugar) episode.

30. Mr Price had several periods where his blood tests indicated he was anaemic that his diabetes was unstable. Prison GPs tried to discover why. They

monitored and altered Mr Price's medications to try to stabilise his condition. In June, healthcare staff arranged for Mr Price to have six monthly diabetic blood tests.

31. Mr Price frequently refused to have any blood tests. From September until the end of October he declined six times and in December once. No reason was noted or whether this was escalated and what the plan was to encourage Mr Price to have his bloods taken.

2020

32. From 21 January onwards, Mr Price repeatedly asked if he could receive liquid medication as he was having difficulty swallowing tablets.

33. On 31 January Mr Price again refused to have any blood tests. No reasons or follow up action were noted.

34. On the morning of 9 February, Mr Price reported feeling unwell and was seen by a nurse. On the morning of 10 February, Mr Price was seen by a nurse again after he vomited. The nurse took his clinical observations (which were normal) but a blood test showed high ketones (acids that build up in the blood in diabetes). The nurse informed a prison GP who asked for Mr Price's observations, blood sugar and ketones to be monitored.

35. The prison GP saw Mr Price that afternoon. She prescribed anti-sickness medication as he was still feeling nauseous, and asked staff to continue monitoring his bloods. A nurse checked Mr Price that evening and recorded that he seemed to be asleep. There is no record that any formal observations, blood sugar or ketones were taken as the prison GP had requested.

36. On the morning of 11 February, a nurse saw Mr Price who reported feeling sick. The nurse encouraged him to eat and drink but he said he could not. A health care assistant took his observations (which were normal) but there is no record that his blood sugar or ketones were tested. He was seen three hours later by the nurse who recorded that he was lethargic and felt nauseous. Mr Price had not eaten any food but had taken fluids.

37. Later that afternoon, the hospital telephoned the healthcare department and reported that Mr Price's blood test results were abnormal. (The clinical reviewer said that the results indicated that Mr Price had an acute kidney injury stage 3, meaning that his kidneys had suddenly stopped working). There is no record that the results were communicated to a GP or out of hours doctor for advice.

38. The following morning, 12 February, Mr Price continued to present as lethargic and nauseous. The nurse recorded that the plan was for the GP to review the blood results. There is no record that any formal observations, blood sugar or ketones were taken.

39. At 5.20pm, a prison GP recorded that Mr Price was to go to hospital because of the abnormal blood results. She arranged an ambulance which would arrive within one to four hours. However, at 8.20pm, a nurse recorded that the Night Orderly Officer had said there were no staff available to escort Mr Price that night and that priority would be given for the escort the next morning. A nurse checked

Mr Price at 10.15pm that night and again at just after midnight, at about 2.00am and at 6.00am. There is no record that any formal observations were taken to check his vital signs.

40. On the morning of 13 February, Mr Price went to hospital, escorted by two staff. He was not restrained. Mr Price's condition deteriorated in hospital and he developed pneumonia. He died on 24 February.

Contact with Mr Price's family

41. On 30 April 2019, the prison appointed two prison officers as the prison's family liaison officers (FLOs). Mr Price had named his next of kin. As Mr Price's health declined, both FLOs contacted Mr Price's next of kin to update her. When Mr Price died, a FLO telephoned her as arranged, to inform her of her father's death. The prison arranged and paid for Mr Price's funeral in line with national instructions.

Support for prisoners and staff

42. After Mr Price's death, a prison manager, debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

43. The prison posted notices informing other prisoners of Mr Price'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 Price's death.

Post-mortem report

44. The Coroner established that Mr Price had died of pneumonia. He also had chronic kidney disease, Type 2 diabetes and age-related frailty which contributed to but did not cause his death.

Findings

Clinical care

45. Mr Price had complex medical needs. The clinical reviewer concluded that some areas of Mr Price's care were good. Healthcare staff created a comprehensive care package and created appropriate care plans. He lived in the prison's inpatient unit from the end of December 2019 and had nurse and social care visits two or three times a day. Prison GPs prescribed appropriate medication.

46. However, the clinical reviewer found that the management of Mr Price's diabetes, acute kidney disease and dietary care were not equivalent to that he could have expected in the community. The clinical reviewer concluded that the overall care received was not equivalent to that expected in the community due to the mixed and varying care standards.

Diabetes care

47. National Institute for Health and Clinical Excellence (NICE) Clinical Guidance NG28 states that adults with Type 2 diabetes should have annual checks and reviews. The clinical reviewer noted that Mr Price did not have a structured annual review. She said this element of his diabetes care was not equivalent to the care he could have expected in the community.

48. NICE guidance also states that blood sugar levels should be checked over the past two to six months to establish a stable level. The first time Mr Price had a test was on 17 January 2019, some 20 months after he arrived at Holme House. The diabetic nurse reviewed the test and decided it was in a normal range and made no plans for further monitoring. Healthcare staff only began frequent monitoring after June 2019.

49. We therefore recommend:

The Head of Healthcare should ensure that prisoners with diabetes receive a structured annual diabetic review in line with NICE guidelines.

Dietary care

50. NICE guidance on nutritional support for adults states that MUST (Malnutrition Universal Screening Tool) should be used to identify adults who are malnourished or at risk of malnutrition. The clinical reviewer noted that healthcare staff monitored, supported and encouraged Mr Price with his nutritional needs, but did not use the MUST tool which could have prompted regular reviews and a referral to a dietician. In January 2019, his weight loss went unnoticed and he was not referred to a dietician as he should have been. The clinical reviewer found that this aspect of Mr Price's care was not equivalent to that he could have expected in the community. We therefore recommend:

The Head of Healthcare should ensure that all healthcare staff use the MUST tool, where appropriate, in line with NICE guidance.

Kidney disease care

51. The clinical reviewer found that Mr Price was monitored in line with NICE Clinical Guidance CG182 on chronic kidney disease in adults, which says that the annual monitoring of bloods is sufficient.

52. However, she found that the response to Mr Price's abnormal blood test results on 11 and 12 February (which she said indicated an acute kidney injury stage 3) was not in line with the national guidance and was not equivalent to the care he would have received in the community. She was concerned that healthcare staff did not communicate the abnormal blood tests promptly on 11 February and did not take advice from the sources of out of hours advice available to them. She also considered that healthcare staff should have escalated their concerns when prison staff said he could not be taken to hospital on the night of 12 February as the GP had requested.

53. We therefore recommend:

The Head of Healthcare should ensure that the healthcare staffs are aware of the process for communicating abnormal bloods so that any issues are dealt with in a responsive and timely manner.

The Head of Healthcare should ensure that healthcare staff are aware of the escalation and communication procedures if prison staff are unable to facilitate a hospital transfer.

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