Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Holt a prisoner at HMP Wakefield on 3 May 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*

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 Stephen Holt died on 3 May at HMP Wakefield from bacterial meningitis. He was 53 years old. I offer my condolences to Mr Holt's family and friends.

We found that overall, the healthcare received by Mr Holt was equivalent to that he might have expected to receive in the community. However, guidance on the administration of medication without prescription was not adhered to as Mr Holt was given paracetamol on 74 days between January and May 2020 without review.

Bacterial meningitis is rare in adults over 50 and many of the symptoms occur frequently in a range of common conditions, making it difficult to spot. We cannot say whether investigation of Mr Holt's frequent requests for paracetamol would have affected the outcome for him. We make a recommendation to put structures in place to ensure compliance with guidance on this in future.

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 **November 2020**

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Summary

Events

1. Mr Stephen Holt was sentenced to an indeterminate sentence for public protection (IPP) in 1988. He first transferred to Wakefield in 2003 and returned there in 2006 after a period in secure mental hospital.

2. Mr Holt did not have any long-term physical health conditions but had a long history of mental illness including dissocial personality disorder and learning difficulties.

3. Mr Holt did not show signs of ill-health in the days leading up to his death. The day before he died his friend and neighbour noticed him looking pale and Mr Holt told him he had a headache and stiff neck. The healthcare staff who dispensed evening medication also noticed he did not seem himself. Mr Holt told them he had a headache and accepted their offer of paracetamol.

4. Mr Holt was discovered dead in his cell the next morning at early morning roll count. There were signs of rigor mortis and, appropriately, staff did not attempt resuscitation. A post-mortem showed that he had died from bacterial meningitis.

Findings

5. The clinical reviewer concluded that Mr Holt's healthcare was equivalent to that he might have expected to receive in the community.

6. Although there was no obvious indication that Mr Holt might have meningitis, he was dispensed paracetamol on 74 days between 1 January and 2 May 2020, including more than three days consecutively on seven occasions without review. This was contrary to Care UK's minor ailments protocol and NICE guidance. We cannot say whether a review would have affected the outcome for Mr Holt.

7. The clinical reviewer identified additional learning for the prison on risk assessments for in-possession medication, cardio metabolic monitoring for side effects of anti-psychotic medication and weight monitoring after starting new anti-psychotic medication.

Recommendations

- The Head of Healthcare at HMP Wakefield should ensure adherence to Care UK guidance for administering medication under patient group directions (PGD) and provide an auditable trail to demonstrate compliance.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Wakefield 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 Holt's prison records and body-worn camera footage from 3 May 2019.

10. NHS England commissioned an independent clinical reviewer to review Mr Holt's clinical care at the prison. Due to restrictions in place during the Covid-19 pandemic, the investigator interviewed five members of staff and one prisoner by telephone in May, June and July 2020. The clinical reviewer also spoke to the deputy head of healthcare. Further information was obtained by email.

11. We informed HM Coroner for West Yorkshire of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

12. The PPO's family liaison officer wrote to Mr Holt's next of kin, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They did not have any specific questions. We have sent them a copy of this report.

Background Information

HMP Wakefield

13. HMP Wakefield is a high security prison and holds up to 750 men. There are four main residential wings, a healthcare centre, a segregation unit and a close supervision centre (a small unit aiming to provide a supportive, safe, structured and consistent environment for some of the most challenging offenders).

14. Care UK provides healthcare at Wakefield. Service provision for psychiatry, recovery and psychology services are contracted from the Midlands Partnership Foundation Trust.

HM Inspectorate of Prisons

15. The most recent full inspection of HMP Wakefield was in June 2018. HMIP found a respectful prison with good staff/prisoner relationships and many good initiatives in train to improve life there. Clinical governance had improved since the last inspection. A health needs analysis informed the service and a comprehensive health improvement plan supported development. Serious incidents had been properly investigated and lessons learned were shared with staff and underpinned development. Healthcare staffing levels were reasonable. Psychiatry input was good but there was not enough psychology input.

Independent Monitoring Board

16. 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 April 2019, the IMB noted that the prison continued to face challenges over the provision of psychology services. There had been 24 prisoners on the Improving Access to Psychological Therapy (IAPT) waiting list, awaiting the arrival in post of an assistant psychologist.

Previous deaths at HMP Wakefield

17. Mr Holt was the 21st prisoner to die at Wakefield since May 2018. Eighteen out of the 20 previous deaths were from natural causes. There are no direct similarities between Mr Holt's death and the previous deaths.

Patient group directions (PGDs)

18. Patient group directions (PGDs) allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription. According to NICE guidance, medicines should not be given under a PGD for more than three consecutive days (72 hours) without review.

Key Events

19. Mr Stephen Holt was sentenced to an indeterminate sentence for public protection (IPP) for rape in July 1988. He was given a minimum time to serve of seven years however the Parole Board did not conclude that his risk to the public ever reduced sufficiently for him to be released.

20. Mr Holt suffered from a number of mental health issues including dissocial personality disorder and learning difficulties. He spent two periods in secure mental hospital in 1995 and between 2001 and 2006.

21. Mr Holt suffered from hypertension (high blood pressure), depression, gastro-oesophageal reflux and back pain. He was prescribed propanolol (to treat anxiety), chlorpromazine (to treat psychosis), escitalopram (for depression), esomeprazole (for gastric reflux) and cholecalciferol (to treat a vitamin D deficiency). None of his medication was in possession and he collected it twice daily from staff in the medication hatch.

22. Mr Holt had a history of self-harm by strangulation and cutting and was periodically managed under Prison Service suicide and self-harm monitoring procedures (known as ACCT). He was also under the care of the prison psychiatrist.

23. On 18 September 2019, blood tests showed Mr Holt had slightly raised cholesterol and triglycerides (different types of fat in the blood that can increase the risk of heart disease and stroke). Mr Holt was referred to healthcare for lifestyle advice but declined this.

24. Also in September 2019, Mr Holt referred himself to the mental health team because he said he was hearing voices that told him to harm himself. ACCT procedures were started. Mr Holt said he was having violent fantasies of a sexually inappropriate nature.

25. Mr Holt saw the prison psychiatrist on 30 September, he said the voices were getting worse and asked for a change in medication. The psychiatrist agreed to replace his prescription for chlorpromazine with aripiprazole (to treat auditory hallucinations).

2020

26. The prison psychiatrist reviewed Mr Holt on 27 January 2020. Mr Holt said he was feeling better since the change of medication. The voices were still present but were less intrusive. The psychiatrist planned to review Mr Holt in six months.

27. On 28 January 2020, Mr Holt saw a nurse about dry skin and was prescribed an emollient cream. This was his last contact with the primary care team. Mr Holt was not seen again by the mental health team either. A restricted regime was put in place from 24 March as part of lockdown procedures necessary during the Covid-19 pandemic.

28. Mr Holt was dispensed paracetamol under a patient group direction (PGD) on 74 days between 1 January and 2 May 2020, including consecutively for over three days on seven occasions without review.

2 May 2020

29. At about 4.00pm, a nurse and a pharmacy technician dispensed afternoon medication. The nurse said that Mr Holt arrived straight from the exercise yard pushing another prisoner in a wheelchair. Both told the investigator that Mr Holt was unusually quiet and did not greet them in his usual way. The nurse asked Mr Holt if he was ok, and he replied that he was but that he had a bit of a headache.

30. The nurse said Mr Holt did not look unwell, or pale and he had been out on exercise. He did not have a rash or any other sign of clinical illness. The pharmacy technician asked him if he wanted two paracetamol and Mr Holt said he did. She dispensed him a single dose of two 500mg tablets under a PGD.

31. The prisoner who had lived in the cell next door to Mr Holt for about two years said that Mr Holt was not a talkative man, but they got on well. He said he was the same age as Mr Holt and regarded him as fit for his age. Mr Holt was able to play table tennis pretty well and did not seem unhealthy.

32. The prisoner said that in the few days leading up to his death, he thought Mr Holt looked grey. He last saw Mr Holt at about 4.30pm on 2 May at dinner time. He said Mr Holt looked white and not at all himself, as if he was "in another world". He asked Mr Holt if he was okay and Mr Holt complained of a stiff neck and chest pain. He did not tell staff.

3 May 2020

33. An officer began the early morning roll count at about 5.15am. At about 5.20am he turned Mr Holt's cell night light on and saw him lying on his floor on his front. He shouted to Mr Holt and kicked his door but received no response. The officer radioed a code blue emergency and waited for other officers to arrive.

34. A supervising officer (SO) and several other officers arrived very quickly. The SO opened Mr Holt's cell and checked for a pulse. She said Mr Holt was cold and stiff and she thought he had been dead for some time.

35. The emergency response nurse that night said he heard radio traffic on the way to Mr Holt's cell that indicated he had died. He examined Mr Holt as soon as he arrived at the cell. Mr Holt was lying face down on the floor. His hips were twisted around and his legs were still under his table. His chair was lying on its side. The nurse said Mr Holt was waxy, his limbs were stiff, there was post-mortem pooling of blood in his arms and neck and he had no pulse. The nurse used his stethoscope but could not detect a heartbeat. He said Mr Holt appeared to have been dead for some time and so he did not attempt resuscitation.

36. Ambulance records showed the 999 call was received at 5.25am. Paramedics arrived at the prison at 5.31am and were with Mr Holt at about 5.35am. They gave Mr Holt an electrocardiogram (ECG) that showed no activity in the heart. At 5.48am, they confirmed Mr Holt had died.

Contact with Mr Holt's family

37. At 8.30am, the prison appointed a family liaison officer (FLO). Mr Holt had not registered a next of kin. His record showed that he had last contacted his family in 2018. The FLO did not travel to their home because of Covid-19 social distancing measures. He rang numerous times but was unable to make contact. At 3.25pm, an operational manager decided to ask the local police to inform Mr Holt's next of kin that he had died. The FLO spoke to the next of kin later the same afternoon.

38. Mr Holt's family did not want to be involved with funeral arrangements. The prison organised and paid for Mr Holt's funeral in line with national guidance.

Support for prisoners and staff

39. After Mr Holt's death, the duty governor 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.

40. The prison posted notices informing other prisoners of Mr Holt's death, and to offer support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Holt's death. The prisoner who lived next door to Mr Holt confirmed staff had asked him if he was alright after Mr Holt died.

Post-mortem report

41. The pathologist concluded Mr Holt died from bacterial meningitis with an associated cerebral abscess. Toxicology tests showed no illicit substances.

Findings

Clinical care

42. The clinical reviewer found that overall the healthcare received by Mr Holt at HMP Wakefield was equivalent to that he might have expected to receive in the community.

43. She identified some deficiencies in the review and monitoring of in-possession medication and the cardio-metabolic monitoring of patients taking anti-psychotics, that the head of healthcare will want to address.

Paracetamol issued under a PGD without review

44. Care UK's Health in Justice minor ailments protocol covers the administration of pain relief for headache. It reflects current NICE guidelines that medication, such as paracetamol, should not be given for three consecutive days (72 hours) without review. Mr Holt was dispensed paracetamol on 74 days out of 122 between 1 January and 2 May 2020, including for seven periods of over 72 hours without review.

45. Bacterial meningitis is rare in adults over 50 and many of the classic symptoms occur frequently in other common conditions, so it is difficult to spot. Fatality rates are high and urgent hospital referral is mandatory in suspected cases because of the incidence of rapid deterioration. We cannot say whether investigation into Mr Holt's frequent use of paracetamol would have led staff to suspect meningitis, or whether it would have affected the outcome for Mr Holt, but it might do in future cases.

46. This issue was identified in Care UK's 72-hour review and we understand that measures have been taken to ensure ongoing compliance with guidance. Nevertheless, we make the following recommendation:

The Head of Healthcare at Wakefield should ensure adherence to Care UK guidance for administering medication under patient group directions (PGDs) and provide an auditable trail to demonstrate compliance.

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