Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Andrew Atkinson, a prisoner at HMP Garth, on 23 October 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*

Summary

1. 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.

2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

3. Mr Andrew Atkinson, who was 55 years old, died of heart failure caused by heart disease and blood clots in his heart on 23 October 2020 at Royal Preston Hospital.

4. The clinical reviewer concluded that the clinical care Mr Atkinson received was equivalent to that which he could have expected to receive in the community. The clinical reviewer commented on some good practice by healthcare staff and made two recommendations not linked directly to Mr Atkinson's death.

5. We did not find any non-clinical issues of concern.

Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Atkinson's clinical care at HMP Garth.

7. The PPO has investigated the non-clinical issues in Mr Atkinson's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

8. Despite the prison and the coroner's office's extensive efforts, no next of kin has been found.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Garth

10. Mr Atkinson was the 12th prisoner to die at Garth since October 2018, and the third death due to natural causes in that time. Three more prisoners have died from natural causes at the prison since Mr Atkinson and there has been another apparently self-inflicted death. There were no significant similarities between the circumstances of Mr Atkinson's death and the previous deaths.

Key Events

11. On 4 December 2006, Mr Andrew Atkinson was given an indeterminate sentence for possessing an imitation firearm with intent to cause fear of violence. He had several health conditions, mostly heart-related, including heart disease, blood clots and he had had multiple heart attacks. Mr Atkinson also had a history of non-compliance with treatment, including refusing to go to hospital appointments and appointments with the prison GP.

12. In June 2020, Mr Atkinson agreed that a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) should be put in place due to his severe heart disease. This was regularly reviewed and was discussed with Mr Atkinson before his most recent admission to hospital.

13. On 8 October, healthcare staff persuaded Mr Atkinson to go to hospital as he had chest pains. Mr Atkinson was restrained on his journey into hospital, after a full risk assessment that took into account his physical deterioration.

14. The prison considered applying for Mr Atkinson's early release on compassionate grounds, however he did not meet the criteria. He did not have a terminal illness and his condition was critical because he would not take his medication. If Mr Atkinson was released, then started taking his medication, his life expectancy would have dramatically improved. The mental health team assessed his capacity and it was agreed that he had the mental capacity to refuse his medications.

15. Mr Atkinson had always made clear that he did not want to notify anyone of his poor health. On his last admission into hospital, the prison tried to find his next of kin as his health started to decline. Mr Atkinson had no named next of kin and had not had any correspondence with anyone for over six years. Unfortunately, after a concerted effort by prison staff and then the coroner's office, no one found next of kin for Mr Atkinson.

16. Mr Atkinson died at Royal Preston Hospital on 23 October at 11.00pm.

17. The post-mortem examination confirmed that Mr Atkinson died from end-stage heart failure, with heart disease and clots in his heart listed as contributory factors.

18. Mr Atkinson tested positive for COVID-19 while in hospital, however this was not recorded as a contributing factor to his death.

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Assistant Ombudsman

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