Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Holden, a prisoner at HMP Highpoint, on 25 December 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.

Our 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 Holden died of heart failure on 25 December 2020 in his cell at HMP Highpoint. This was caused by coronary artery atherosclerosis (blocked arteries) and cardiomegaly (an abnormal enlargement of the heart). Mr Holden was 54 years old. I offer my condolences to his family and friends.

The clinical reviewer found that the clinical care that Mr Holden received at Highpoint was equivalent to that which he could have expected to receive in the community. Mr Holden repeatedly refused to take his heart and blood pressure medication. Although it is clear that he understood the risks to his health of refusing his medication, I am concerned that his mental capacity was not formally assessed.

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 **February 2022**

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Summary

1. On 6 April 2015, Mr Stephen Holden was sentenced to six years in prison for false imprisonment and grievous bodily harm, and sent to HMP Norwich.

2. He had several chronic health conditions, including hypertension (high blood pressure) and heart failure. He also had a history of diverting medication. (This involves pretending to take tablets but keeping them to use later or to sell to other prisoners.)

3. On 10 March 2020**,** he was transferred from Norwich to HMP Highpoint. At his initial and secondary health screens, his blood pressure was high. Healthcare staff decided that he should have daily blood pressure checks. A prison GP also noted that Mr Holden was taking pregabalin (used for epilepsy or pain relief), for which there was no medical indication, and planned to reduce the prescription until it was stopped. Mr Holden was unhappy about this and said that he would refuse to take his other medication if his pregabalin was stopped.

4. Between March and December 2020, Mr Holden frequently refused to take his heart and hypertension medication and to attend appointments to monitor his blood pressure. It was clear that he knew that he was at risk of a stroke, heart attack or heart failure from not taking his medication. Healthcare staff recorded that they tried to encourage him to take his medication but he continued to refuse.

5. In October, Mr Holden experienced headaches and nausea due to his high blood pressure and on 19 October, he went to hospital. He discharged himself that day because he did not want to wait to be seen. He returned to Highpoint and refused to attend the healthcare unit for a follow-up review. He also refused to sign a disclaimer to confirm that he had refused treatment.

6. At unlock on the morning of 11 December, officers called a medical emergency code blue (used when a prisoner is unconscious or has breathing difficulties) because Mr Holden was slumped over a chair in his cell and was slurring his words. A nurse attended and advised that he should go to hospital. Mr Holden refused treatment, to go to hospital or to sign a disclaimer confirming his refusal to attend hospital. Prison staff monitored him overnight.

7. On 23 December, healthcare sent Mr Holden a letter advising him to take his medication. His blood tests from April showed that he had an increased risk of heart failure and needed further blood tests. The letter noted that he had mental capacity to understand the risks and benefits of taking his medication. However, there is no evidence that a formal assessment was completed.

8. At 8.50am on 25 December, an officer found Mr Holden lying face down in his cell. She called a code blue and together with other staff, performed cardiopulmonary resuscitation (CPR) until 9.48am, when paramedics arrived and pronounced him dead.

Findings

9. The clinical reviewer found that the care that Mr Holden received at Highpoint was of a good standard and was equivalent to that which he could have expected to receive in the community.

10. However, she concluded that healthcare staff should have formally assessed Mr Holden's mental capacity when he decided to stop taking his heart and hypertension medication in response to his pregabalin being reduced.

Recommendations

- The Head of Healthcare should ensure that healthcare staff formally assess the mental capacity of prisoners who refuse medical interventions (including prescribed medication) and record this in SystmOne.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Highpoint informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded.

12. The investigator did not visit HMP Highpoint due to the COVID-19 pandemic. She obtained copies of relevant extracts from Mr Holden's prison and medical records.

13. The investigator interviewed five members of staff and one prisoner at Highpoint on 14 January, 20 May and 25 June. All the interviews were conducted by telephone because of the restrictions in place during the COVID-19 pandemic.

14. NHS England commissioned a clinical reviewer to review Mr Holden's clinical care at the prison. The clinical reviewer conducted joint interviews with the investigator.

15. We informed HM Coroner for Suffolk of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

16. Our family liaison officer contacted Mr Holden's niece to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.

17. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies. They provided an action plan which is annexed to this report.

Background Information

HMP Highpoint

18. HMP Highpoint is a Category C prison in Suffolk, holding up to 1,319 men across two sites (North and South). Care UK provides general and mental health services at the prison seven days a week between 7.45am and 6.15pm from Monday to Friday and 8.00am to 6.00pm at weekends. NHS 111 and emergency services are used out of hours, if required.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Highpoint was in August 2019. Inspectors reported that healthcare services were good overall. Partnership working was effective and governance arrangements were well developed and robust. Primary care services were delivered by a skilled and well-led team, and patients with long-term conditions had their needs met. Waiting times for most clinics were reasonable but prisoners waited too long to see the doctor. Social care arrangements were working well and there was no evidence of any unmet needs.

Independent Monitoring Board

20. 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 report for the year to 31 December 2020, the Board reported the Governor and staff had made every attempt to reduce the stress on prisoners during the pandemic and time out of cell had been curtailed as little as possible. GP and nurse-led services had continued, but with some limitations on the number of patients seen in clinic.

Previous deaths at HMP Highpoint

21. Mr Holden was the second prisoner to die at Highpoint since September 2018. The other death was also from natural causes. There are no similarities between our findings in the investigation of Mr Holden's death and the other death at Highpoint.

Key Events

22. On 6 April 2015, Mr Stephen Holden was sentenced to six years in prison for false imprisonment and grievous bodily harm, and sent to HMP Norwich.

23. Mr Holden had a number of chronic health conditions, including hypertension (high blood pressure), asthma, liver failure due to cirrhosis (scarring of the liver), heart failure, chronic low back pain, atrial fibrillation (abnormal beating of the heart), a vocal cord nodule (a lump found on the vocal cords). He reported that he had been coughing up blood. He had a history of substance misuse and of diverting his prescribed pregabalin medication. (Pregabalin is prescribed for epilepsy, nerve pain and anxiety, but is also widely abused for its euphoric effects.)

24. On 10 March 2020, Mr Holden was transferred from Norwich to HMP Highpoint. A nurse completed his initial health screen and recorded that his blood pressure was high. Mr Holden said that he was anxious about his medication and was advised to bring it to his secondary health screen to discuss with nurses. The next day, a medical technical officer completed his secondary health screen and recorded that his blood pressure was high. Mr Holden was assessed as suitable to have his medication in his cell with him.

25. On 13 March, a prison GP saw Mr Holden and took his blood pressure again. It was very high. The prison GP discussed with Mr Holden his medication, the dangers of pregabalin and the need to reduce and stop its use. He noted Mr Holden's history of substance misuse and his history of diverting medication. Mr Holden was unhappy about this decision and said that he would be left in pain. The prison GP told Mr Holden that he was already taking three types of pain medication and that he needed to take medication to control his hypertension. The prison GP arranged a six week medication review and reduced Mr Holden's pregabalin gradually each week until it was stopped. Mr Holden was prescribed amlodipine for his blood pressure.

26. On 14, 15, 18 and 19 March, Mr Holden did not attend the medication hatch for his medication.

27. On 20 March, the prison GP saw Mr Holden and further reduced his pregabalin dosage. Mr Holden did not attend the medication hatch on 20 or 21 March.

28. On 22 March, Mr Holden's blood pressure was checked and was still high. A plan was made to monitor Mr Holden's blood pressure daily. Mr Holden did not attend the medication hatch for his medication for the following three days.

29. On 10 April, Mr Holden attended the medication hatch and handed in all the medication that he had in his cell as his medication was to be dispensed at the hatch in future.

30. On 22 May, the prison GP reviewed Mr Holden's medication. Mr Holden said that he would stop all his medication once his prescription for pregabalin was finished. He said that his pain increased as the pregabalin was reduced. The prison GP said that there was no medical need for him to take pregabalin and offered him paracetamol, which he declined.

31. On 29 May, the prison GP stopped Mr Holden's baclofen and fefopam (pain relief medication) because he said that he did not want to take this medication again. From this appointment onwards, Mr Holden refused to attend the medication hatch for his medication.

32. On 10 June, a nurse saw Mr Holden in the healthcare unit and discussed with him his refusal to take his hypertension and heart medication. A plan was made to keep him on the list of prisoners who received medication at the medication hatch twice daily in order to allow him access to his medication if he changed his mind and wanted to start taking it again.

33. On 1 July, Mr Holden told healthcare staff that he would not attend the medication hatch for his medication and would not attend for blood pressure readings.

34. On 19 October, a nurse saw Mr Holden as he had complained of headaches, nausea and feeling unwell for the past three weeks (all symptoms of high blood pressure). His blood pressure was taken and found to be very high. His heart rate was recorded as abnormal and he had atrial fibrillation (an irregular heartbeat). He was taken to hospital for further investigation. Two prison officers escorted him and used a single cuff and an escort chain. After he arrived at hospital, Mr Holden discharged himself because of the waiting time. Later that day, after he returned to Highpoint, he refused to attend the healthcare unit for a follow-up consultation.

35. On 22 October, a nurse checked Mr Holden's blood pressure and Mr Holden agreed to restart his hypertension medication. She made an appointment for him to see a prison GP the following week.

36. On 27 October, he saw a prison GP and said that he wanted to be prescribed pregabalin again.

37. On 29 October, Mr Holden saw a nurse and repeated that he only wanted to restart pregabalin. She told him that his blood pressure was rising and explained the risks involved. Mr Holden walked out of the consultation.

38. On 19 November, Mr Holden asked Nurse Hill for pain relief for muscle cramps. They discussed his medication which he continued to refuse to take.

39. On 25 November, a nurse saw Mr Holden as he complained of numbness down his right side and headaches over the last few days. She advised him strongly to take his medication. He raised his voice in response, asked again for pregabalin and refused to take his medication.

40. On 27 November, Mr Holden told the prison GP that it would be his fault if he had a heart attack because he refused to give him pregabalin and without it, he would not take his medication.

41. On 6 December, a nurse saw Mr Holden as he had upper chest pain which had started that morning. His blood pressure reading was extremely high. The next day, Mr Holden's blood pressure was even higher. However, he refused to have his blood pressure monitored, to attend hospital or to take his medication.

42. On 9 December, it was recorded in Mr Holden's medical record that his blood pressure was extremely high but that he refused to sign a disclaimer. He said that if he died, it would be the fault of healthcare staff.

43. Throughout December, he refused to sign a disclaimer eight times. Healthcare staff saw Mr Holden several times and explained to him the risks he faced by not taking his medication. His refusal to take medication was discussed at weekly multidisciplinary team meetings. (Actions from these meetings included asking him to sign a disclaimer to confirm that he understood the risks posed to his health, writing to him setting out the clinical risks to his health, reviewing his care plan, continuing to invite him to weekly blood pressure checks to monitor him, continuing to offer him the opportunity to collect his medication at the medication hatch, reviewing his medication and him, as required, despite his continued refusal to take his medication and attend blood pressure monitoring.) Healthcare staff saw him regularly when they visited his wing and gave him the chance to have his blood pressure monitored and to take his medications.

44. At 3.15pm on 11 December, an officer unlocked Mr Holden's cell and found him slumped over a chair. Mr Holden told the officer that he was having a stroke and that he had had one before. The officer noted his words were slurred and called a medical emergency code blue. A nurse attended and advised Mr Holden that he should go to hospital. He refused. The nurse noted that prison staff would observe him overnight. The prison GP reviewed Mr Holden's medical records and noted that Mr Holden was aware that there was a risk of heart attack if he continued to refuse his medication.

45. On 23 December, healthcare staff wrote to Mr Holden to advise him to take his medication to prevent a heart attack or stroke. They noted that he had the mental capacity to understand the health risks and benefits that these would provide. He was advised that his blood tests to detect for heart failure showed that he was at very high risk of having a heart attack or cardiac arrest. Healthcare staff advised him that they would continue to book him in for his blood tests and blood pressure readings.

46. At 8.50am on 25 December, while unlocking cells and conducting welfare checks, an officer looked through Mr Holden's cell door observation panel and saw him lying face down on the floor. She opened the cell door and tried to rouse him, shouting his name. He did not respond and she called a medical emergency code blue. A second officer arrived and together, they moved Mr Holden into the recovery position because he was not breathing. A third officer then arrived and together, they moved him onto his back and started CPR. Healthcare staff arrived and helped with resuscitation efforts. At 9.48am, paramedics arrived and pronounced that Mr Holden had died.

Contact with Mr Holden's family

47. On 25 December, an officer was appointed as the prison's family liaison officer (FLO). At 12.17pm, the FLO telephoned Mr Holden's sister and broke the news of Mr Holden's death. Later that day, Mr Holden's niece contacted the FLO and asked to act as next of kin. This was agreed and the FLO remained in contact

with her. Highpoint contributed to the cost of the funeral in line with national instructions.

Support for prisoners and staff

48. After Mr Holden's death, the Head of Security, 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.

49. The prison posted notices informing other prisoners of Mr Holden'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 Holden's death.

Post-mortem report

50. The Coroner concluded that Mr Holden died of acute heart failure, caused by coronary artery atherosclerosis (blockage of the coronary arteries) and cardiomegaly (an abnormal enlargement of the heart).

51. A consultant histopathologist provided a supplementary post-mortem report which identified sub-therapeutic amounts of prescribed amitriptyline (used to treat Mr Holden's back pain) and quetiapine (an antipsychotic) which he was not prescribed. The histopathologist found that it was likely that Mr Holden's non-compliance with his prescribed amlodipine (hypertension medication) could have precipitated an acute terminal cardiac arrhythmia. However, there is no evidence of illicit drug use or drug overdose and therefore, in his opinion, Mr Holden's death was due to natural causes.

Findings

Clinical care and Mr Holden's refusal of medication

52. The clinical reviewer considered that the care that Mr Holden received was of a good standard and was equivalent to that which he could have expected to receive in the community. Mr Holden had poor health and frequently refused to take his heart and blood pressure medication because his pregabalin, which was not medically indicated for him, was reduced and then stopped. She found that healthcare staff tried to encourage him to take his blood pressure medication many times and that they outlined the life-threatening risks which he understood.

53. PSI 16/2015 on adult safeguarding in prison states that, "Neglect is a failure to identify and meet the needs of a prisoner, for example by ignoring medical…or physical care needs, failing to provide access to appropriate health, care and support or withholding…medication…Neglect also includes self-neglect, which covers a wide range of behaviour such as neglecting to care for one's personal…health...It also states that when a prisoner neglects his own welfare, it is the responsibility of staff to take action to meet his needs."

54. Highpoint's operational policy on managing omitted doses of medication sets out that if prisoners refuse to take their prescribed medication, healthcare staff should record their mental capacity. It states that if a patient is deemed not to have capacity, an urgent appointment with the psychiatrist should take place, and that concerns should be raised at multidisciplinary team meetings.

55. Mr Holden neglected his health needs when he refused to take his medication. He failed to attend the medication hatch 34 times to take his medication and he refused to sign a disclaimer eight times. Healthcare staff recorded this in his electronic medical records and that he had capacity when refusing his medication. They ensured that he had every opportunity to take his medication and continued to invite him to weekly blood pressure monitoring clinics and to discuss him at weekly multidisciplinary team meetings (the actions of these meetings demonstrates that staff prioritised Mr Holden's health and meet his needs).

56. The Mental Capacity Act 2005 is designed to protect people who lack capacity to make decisions about their care. It should be assumed that a person has the capacity to make a decision himself unless it is proven otherwise. The clinical reviewer found that although Mr Holden refused to take his medication and considered that he was well aware of the clinical dangers of not doing so, there was no evidence that healthcare staff completed a formal assessment of his mental capacity to test his ability to understand the risks to his health if he did not take his prescribed medication.

57. At the time of Mr Holden's death, Highpoint had not conducted a formal assessment of his mental capacity and recorded it in his medical records. Although we were pleased to learn that Highpoint now assess and log prisoners' mental capacity in their medical records, we have not yet seen evidence of this and therefore recommend that:

The Head of Healthcare should ensure that healthcare staff formally assess the mental capacity of prisoners who refuse medical interventions (including prescribed medication) and record this in SystmOne.

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