Investigation into the circumstances surrounding the death of a man, a prisoner at HMP Acklington, in January 2009

Report by the Prisons and Probation Ombudsman for England and Wales

August 2009

This is a report into the death of a man at HMP Acklington in January 2009. The man died from natural causes. He was 69 years old, but frail and appeared older than his years. A post mortem showed that the man died from a coronary artery atheroma.

I offer my sincere condolences to the man's family and friends for their loss. One of my Family Liaison Officers contacted his family at the start of the investigation.

The investigation was carried out on my behalf by my colleague. Both he and I would like to thank the Governor and all of his staff for their full and ready co-operation during the course of our enquiries. I also thank the local Primary Care Trust for the appointment of a clinical reviewer.

As the man died from natural causes, the findings of the clinical review play an essential part in my report. The review shows that he received generally good care whilst in custody, although there were some shortcomings that should be addressed.

I make two recommendations: one about medical and risk assessments being conducted at HMP Holme House before prisoners are transferred, the other about obtaining medical information from the community. I also recognise the good practice in family liaison demonstrated both by Acklington and HMYOI Lancaster Farms.

The man died just three days after his transfer to Acklington from HMP Holme House. It was his first time in prison and he had only been in custody for a month.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Stephen Shaw CBE
Prisons and Probation Ombudsman **August 2009**

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SUMMARY

The man appeared at Teesside Crown Court in December 2008 and was sentenced to six years in prison for sex offences. He was sent to HMP Holme House where an Initial Reception Healthcare assessment was undertaken. He suffered from anxiety, chronic obstructive pulmonary disease (COPD) (narrowing of the airways causing shortness of breath), and gout (inflammation of joints, tendons and surrounding tissues caused by excess uric acid in the blood), and was prescribed many medications. During his time at Holme House, the man saw the prison doctors on four separate occasions when his medication was reviewed and repeat prescriptions were given

In January 2009, the man transferred to HMP Acklington. Another Initial Reception Healthcare Assessment confirmed his medical conditions and medication. The nurse noticed his frailty and that he was unable to negotiate stairs. The following day, the prison doctor confirmed his medication and that he appeared much older than his actual age.

Three days afterwards, an Officer Support Grade (OSG) conducted the early morning roll check at 5.45am on H wing. When he came to check on the man in cell H1-16, he looked through the observation hatch and was unable to see him on his bed. The OSG called for assistance and an Officer responded.

At 5.52am, both members of staff went into the cell and found the man sitting on the toilet in a slumped position. The Officer checked for vital signs in his neck and wrist but there was no pulse, he was cold to the touch and his body was stiff and rigid. It was the Officer's opinion that he had been dead for some time and that commencing resuscitation was inappropriate. The Night Orderly Officer arrived shortly afterwards and also concluded that the man had been dead for some time.

The man's next of kin was recorded as being his brother who lived some considerable way away. Due to the distance involved it was decided to ask HMYOI Lancaster Farms to tell the family of his death. The duty Governor and prison chaplain visited his family at 10.30am that morning. The man's family had contacted the Prison Service when he was convicted to say that they did not want any contact with him, and they reiterated that they did not want any contact with Acklington.

In accordance with the family's wishes, the Governor from Acklington made the arrangements for the man's funeral and disposal of his property and belongings. The Governor from Acklington maintained formal contact with the family by letter to inform them of the actions the prison had taken. The man's funeral took place on 23 January and was conducted by the prison chaplain.

Two principal issues arise from this investigation. I emphasise that prisoners' medical records, where appropriate, should be obtained from community practitioners and recommend that the processes for prisoner transfers should be reviewed. I also commend the Governor for his work at HMP Acklington.

THE INVESTIGATION PROCESS

1. The investigation was opened on 10 January 2009 when my investigator issued notices announcing the investigation to staff and prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to my investigator. No prisoners came forward as a result.

2. The investigator visited HMP Acklington on 26 January. During his visit he was also given copies of all documentation relating to the man. My investigator returned on 23 February and interviewed eight members of staff. The investigator also visited HMP Holme House on 5 March and interviewed four members of staff.

3. The local Primary Care Trust asked a clinical reviewer to carry out a review of the man's clinical care. My investigator and the clinical reviewer jointly discussed aspects of his treatment with healthcare staff at Acklington and Holme House.

4. My investigator contacted Her Majesty's Coroner for North Northumberland to inform him of the nature and scope of my investigation and request a copy of the Post Mortem report. Upon completion, my report will be sent to the Coroner to assist his enquiries into the man's death.

5. One of my Family Liaison Officers contacted the man's family about the investigation but they did not wish to participate in the process.

HMP ACKLINGTON

6. HMP Acklington opened in 1972 as a category C prison. The prison is situated on a former RAF station near Amble in Northumberland and has the capacity to house 946 prisoners.

7. Healthcare is provided by the local Primary Care Trust. Nurses and a prison doctor (provided through a local practice) deliver primary healthcare during the daytime, seven days a week. There is no out of hours medical cover at the prison, although a doctor can be contacted by prison staff over the telephone after 6.00pm. Prisoners who require inpatient nursing care are transferred to an outside hospital or another prison.

8. Her Majesty's Chief Inspector of Prisons last reported on Acklington following an announced inspection in December 2006. The Chief Inspector was disappointed at what she found at Acklington, and concluded that it did not provide a safe and decent environment. However, she did consider that healthcare had improved in recent years, although there was still room for further improvement.

9. The Independent Monitoring Board Annual Report for 2006-07 strongly criticised the standard of accommodation on several wings at Acklington.

10. Since April 2004 when I began investigating all deaths in prison custody in England and Wales, 17 prisoners have died in Acklington including the man. Of the 16 previous cases that I have investigated, ten were due to natural causes.

HMP HOLME HOUSE

11. Holme House is a purpose built local Category B prison, which opened in May 1992. It primarily serves the Tees Valley, South West Durham, East Durham and North Yorkshire. It has the capacity for 994 prisoners, who are housed in a total of six residential units known as house blocks one to six.

12. The local Primary Care Trust is the provider of healthcare services at Holme House. There is an inpatient unit with 28 beds and 24 hour nursing care. An out of hours doctor's service is covered by the prison doctor with help from an emergency medical service.

13. HM Chief Inspector of Prisons conducted an announced inspection of Holme House in April 2005. Following the inspection, she said of Holme House:

> "There was no evidence of disrespectful treatment of prisoners, although there were some instances of staff dealing with prisoners in a superficial manner or without regard to their individual needs. The healthcare department provided a good range of clinical services, although in our survey prisoner perceptions of the quality of healthcare were below the benchmark. There had been problems in the recruitment of GPs but this was being addressed. Inpatient care was provided in decent, clean surroundings but there was limited opportunity for patients to associate. The mental health in-reach service provided a good service to prisoners in the house blocks."

14. The most recent report by the prison's Independent Monitoring Board (IMB) was issued in 2005. This presented a generally favourable view of all areas of the prison. The following comment was made of healthcare:

> "There are concerns by nursing staff due to the rapid turnover of staff. The perception is that qualified staff appointments within the prison are merely as a stop-gap or stepping stone jobs. The unit has benefited from inclusion in the roster of two officers easing safety and security issues."

KEY FINDINGS

15. The man was born in October 1939, and lived in the Cleveland area prior to his conviction. He had been married but divorced some 30 years previously. Due to the nature of his conviction, members of his family decided not to maintain contact with him after he was sentenced, and had made this known to the Prison Service.

16. In December 2008, the man appeared at Teesside Crown Court and was sentenced to six years in prison for sex offences. He was sent to HMP Holme House where an Initial Reception Healthcare assessment was undertaken by the reception nurse. This was the man's first time in prison, and he said that he had no thoughts of self harm but did suffer from anxiety. He told the reception nurse that he felt quite unwell.

17. The man told the nurse that he had been treated in James Cook Hospital eight weeks earlier, and had been diagnosed as suffering from chronic obstructive pulmonary disease (COPD) and gout. He said he had also seen his doctor the week before attending court as he had a chest complaint.

18. The reception nurse confirmed that the man was prescribed multiple medication for chest and breathing problems. The medication he had been prescribed was Phyllocontin (treatment of COPD), Ventolin inhaler (treatment of asthma), Allopurinol (treatment of gout), Clenil Modulite inhaler (treatment for asthma), Salmeterol xinafoate accuhaler (long acting drug for treatment of COPD and asthma), Prednisolone (anti-inflammatory medication), Diazepam (treatment for anxiety), Tiotropium (inhaled medication for treatment of COPD) and Co-codamol (combination of codeine and paracetamol for moderate pain relief).

19. On 15 December, the man had a review of his medication with the duty doctor. In addition to his existing medication the doctor prescribed cod liver oil capsules. Four days later, the duty doctor saw him again as he was complaining of acute swelling of his right knee. The doctor prescribed Colchicine (treatment for gout) and gave him a Methylprednisolone acetate injection (anti-inflammatory steroid injection).

20. A healthcare nurse saw the man on 25 December as he was experiencing pain in his groin. The healthcare nurse gave him a urine sample bottle and said that, if the pain continued over the next few days, he should provide a sample so that tests could be completed.

21. The man was next seen by a second duty doctor five days later and the doctor authorised a repeat prescription of Clenil Modulite and the Salmeterol inhaler. On 5 January 2009, the second duty doctor saw the man again and completed a urine sample test to check his potassium levels. The test was necessary because of the amount of medication the man was taking, and especially the Phyllocontin. The results were recorded as being within normal limits. The second duty doctor authorised a repeat prescription of Allopurinol and Phyllocontin.

22. The next day (6 January 2009), the man was transferred to HMP Acklington as that establishment has a vulnerable prisoners unit which runs the sex offender treatment programme. Prisoners should be assessed as fit before they are transferred, but there is no record to confirm that the man was fit for transfer and no risks were identified. He arrived at the prison at 12.10pm and had another Initial Reception Healthcare Assessment by a nurse which confirmed his conditions and medication. The nurse recorded how frail the man was and that he was unable to negotiate stairs. Later that day, he was seen by a second nurse in the doctor's surgery. The second nurse recorded that he looked very frail, pale and was shaking. It also appeared that he suffered from dribbling incontinence. He was referred to see the doctor the next day.

23. The following day, the prison doctor reviewed the man's medication. The prison doctor also recorded how frail he was, and that he appeared much older than his actual age. The man was also seen by the second nurse who asked about any incontinence problems. He denied that he had any bladder or bowel problems. He told the second nurse that he could manage his own personal hygiene, but only had a shower about twice a month. He was given advice about the importance of personal hygiene. The second nurse also recorded that he appeared to be feeling low, confused, and had a marked tremor.

24. Just two days afterwards, the OSG conducted the early morning roll check on H wing at 5.15am. When he came to check on the man in cell H1-16, he looked through the observation hatch and was unable to see him on his bed. The OSG went to the wing office to call for assistance. An Officer responded and joined the OSG outside the man's cell. At 5.52am, they both entered the cell and found him sitting on the toilet in a slumped position. The Officer checked his neck and wrist but there was no pulse, he was cold to the touch, and his body was stiff and rigid. It was the Officer's opinion that he had been dead for some time and that commencing resuscitation was inappropriate. The OSG had previously worked for a funeral director and, based on his experience, he agreed with the Officer's assessment of him.

25. The Officer and the OSG locked the cell and went to the wing office to call the Night Orderly Officer. The Officer opened a death in custody log to record events. The Night Orderly Officer arrived on H wing shortly after 6.00am and went with the Officer and OSG to the man's cell. The Night Orderly Officer concurred with the decision not to attempt resuscitation. He sealed the man's cell and then contacted the on call doctor the duty governor. The on call doctor pronounced the man dead at 7.10am.

Events following the man's death

26. The man's next of kin was recorded as his brother who lived some considerable distance away. Due to the distance involved, the decision was taken to contact the nearest establishment to the family, HMYOI Lancaster Farms, to request the assistance of the Family Liaison Officer. Lancaster Farms were happy to assist and the Governor and prison chaplain went to visit the man's family.

27. The Governor and prison chaplain arrived at the man's brother's house at 10.30am. They spoke to his sister-in-law, and informed her of his death. She said that she and her husband did not want anything to do with him. She said that her husband had contacted the Prison Service when the man was convicted to say that they did not want any contact and this remained the case. This included any involvement with the funeral and his personal property.

28. The man's sister-in-law became upset and the prison chaplain offered support, and he and the Governor stayed at her request. The Governor advised the man's sister-in-law that the Prisons and Probation Ombudsman would be in contact at some point in the near future.

29. As a result of the family's wishes, another Governor acted as a liaison point at Acklington. He made the arrangements for the man's funeral and disposal of his property and belongings. This included contact with all known financial institutions and the Department for Work and Pensions to cease payments of any state benefits. The prison's liaison officer wrote to the family to inform them of the actions the prison had taken. The man's funeral took place on 23 January and was conducted by the prison chaplain.

ISSUES

Clinical care

30. The clinical review makes the following comments concerning the clinical care that the man received whilst in prison:

> "On his admission to prison the man presented as a chronically ill man with severe breathing problems. There is a lack of clarity in his record from HMP Holme House as to when he was discharged from healthcare to a normal wing and on whose authority.
>
> The man's blood pressure was high on admission but this was never followed up. It is not recorded when or if secondary screening took place. There is no record as to whether his GP or James Cook Hospital were contacted for further clinical information. Valuable information can be gained by obtaining a copy of a prisoner's GP medical records particularly in cases where there is a large amount of prescribed medication."

31. The clinical reviewer concludes that Holme House provided "appropriate medical care" and that the care provided by Acklington appeared "exemplary".

The Head of Healthcare at Holme House should review the administrative processes to ensure that medical records are obtained for prisoners who have known medical interventions in the community prior to coming into prison.

Transfer from Holme House to Acklington

32. Holme House transfers many prisoners to jails within its geographical area. In the man's case, due to his age and offences, he was transferred to Acklington which has a vulnerable prisoners unit. However, unlike Holme House, Acklington does not have a 24 hour healthcare.

33. The clinical review comments that:

> "It is not recorded in the medical record if healthcare advice was obtained before the man was transferred to HMP Acklington but it is clear from the entries in his medical record that he was in a poor physical state on his arrival."

34. It is clear that the man was poorly when he was transferred from Holme House. From the evidence in the records, it is not possible to make any comment as to whether his transfer to Acklington was appropriate or not.

The Governor and Head of Healthcare at Holme House should review the transfer process to ensure that full medical and risk assessments are completed prior to prisoner transfer.

Family Liaison

35. Acklington appropriately followed the guidance given in PSO 2710, “Follow up to death in custody”. As the man’s next of kin lived in Cumbria it was sensible to ask Lancaster Farm to provide a prompt face to face visit to break the sad news to his family.

36. A debrief was held for all the staff involved later on the morning of 9 January. Each member of staff was informed that support was available both whilst at work and when off duty. Contact numbers were given for the care team and for the prison’s liaison officer. All the staff who spoke to my investigator said that they had nothing but praise for the care team, specifically mentioning the prison’s liaison officer.

37. Extra work was also done by the prison’s liaison officer in arranging the man’s funeral and handling all external communications. This was because the man’s next of kin did not want to have any involvement with him or the prison. The prison’s liaison officer maintained contact with the family by letter to inform them of the date of the funeral and to obtain permission to dispose of the man’s property.

    I commend the work carried out by the prison’s liaison officer in following the best practice in PSO 2710 and undertaking additional work on the man’s behalf.

RECOMMENDATIONS

1. The Head of Healthcare at Holme House should review the administrative processes to ensure that medical records are obtained for prisoners who have known medical interventions in the community prior to coming into prison.

2. The Governor and Head of Healthcare at Holme House should review the transfer process to ensure that full medical and risk assessments are completed prior to prisoner transfer.

3. I commend the work carried out by the prison's liaison officer in following best practice in PSO 2710 and undertaking additional work on the man's behalf.

At the time of issuing this report there had been no comments or agreed actions to the recommendations.