Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Adrian Green, a prisoner at HMP Altcourse, on 6 May 2022

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Adrian Green died from acute myocardial insufficiency (inadequacy of the heart to pump blood around the body) on 6 May 2022 while a prisoner at HMP Altcourse. He was 48 years old. I offer my condolences to Mr Green's family and friends.

The clinical reviewer concluded that the physical healthcare that Mr Green received at Altcourse was not of the required standard and not equivalent to that which he could have been expected to receive in the wider community. The clinical reviewer made five recommendations which the Head of Healthcare will need to address, including one about the healthcare team's management of Mr Green's elevated blood pressure.

Prison staff were unclear about when routine and welfare checks were meant to be carried out, and what was required with each check. The welfare check on 6 May, the day Mr Green died, was not carried out properly.

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

Adrian Usher
Prisons and Probation Ombudsman **October 2023**

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Summary

Events

1. On 29 April 2022, Mr Adrian Green was sentenced to three months in prison for sending an offensive/menacing message, criminal damage and breaching a supervision order. He was sent to HMP Altcourse that day.

2. At 8.06am on 6 May 2022, an officer unlocked Mr Green's cell to allow him to collect his medication. As he did not respond, the officer went into the cell and shook Mr Green. When he still did not respond, the officer asked for assistance from colleagues.

3. Two officers went into Mr Green's cell. They concluded that he was not showing any signs of life and at approximately 8.09am, they called a medical emergency code blue.

4. A family liaison officer was appointed that day and Mr Green's next of kin was contacted and told that he had died.

Findings

5. Healthcare staff did not put in place an action plan to monitor or review Mr Green's high blood pressure.

6. The officer who delivered Mr Green's breakfast did not properly carry out the morning welfare check. It was also evident from the interviews with officers that there were differences in their understanding about what time routine and welfare checks were to take place and what each check entailed.

7. The prison had not kept a copy of their policy/instruction about welfare checks which had been in place at the time. They told us that new policies and procedures were being written following Sodexo taking over the management of the prison in June 2023, and there was no welfare policy currently in place.

Recommendations

- The Director should update and train against a clear welfare check policy so that staff fully understand their responsibilities.

The Investigation Process

8. The PPO was notified of Mr Green's death on 6 May 2022.

9. The investigator issued notices to staff and prisoners at HMP Altcourse informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

10. The investigator obtained copies of relevant extracts from Mr Green's prison and medical records.

11. The investigator interviewed twelve members of staff on Microsoft Teams on 26 and 29 September 2022, 4 and 7 October 2022 and 3 February 2023.

12. NHS England commissioned a clinical reviewer to review Mr Green's clinical care at the prison. The clinical reviewer and investigator jointly interviewed nine members of staff on 26 and 29 September.

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

14. The PPO family liaison officer contacted Mr Green's sister to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to the letter.

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

Background Information

HMP Altcourse

16. HMP Altcourse is a category B local prison, accommodating up to 1,164 sentenced and remanded adult male prisoners and young offenders from the Cheshire and Merseyside courts across seven houseblocks. At the time of Mr Green's death, the prison was managed by G4S. It is now managed by Sodexo.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Altcourse was in November 2021. Inspectors reported that prisoners' safety was not "sufficiently good" and had deteriorated since their last inspection in 2017. However, they reported that the prison was calm and well-ordered, with staff working hard to ensure prisoners' experience of custody was respectful.

18. Staffing challenges had a detrimental impact on the development of primary and mental health care. The inspectors noted that there was a lack of structured clinical supervision which meant that the safety and effectiveness of care was not being addressed.

19. The inspection of health services was jointly undertaken by the Care Quality Commission (CQC) and HM Inspectorate of Prisons under a memorandum of understanding agreement between the agencies. Following the inspection, the CQC issued two "requirement to improve" notices to the healthcare provider, HCRG Medical Services Ltd. These concerned delays to 48-hour mental health assessments, the quality of audits undertaken and a lack of regular clinical supervision of staff to support them with their work and patient caseloads.

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 latest annual report, for the year to June 2022, the IMB stated that overall prisoners have been fairly and humanely treated and that prisoner's health and wellbeing needs have largely been met.

21. The IMB also stated that in relation to deaths in custody, the prison and healthcare team had a robust system in place for monitoring PPO recommendations and the implementation of the associated action plans.

Previous deaths at HMP Altcourse

22. Mr Green was the twenty-second prisoner to die at Altcourse since May 2019. Of the previous deaths, fifteen were from natural causes, five were self-inflicted and one was drug-related.

23. In November 2019, following an investigation into a death from natural causes, the PPO made a recommendation about blood pressure monitoring. The circumstances

were similar to Mr Green's as in both cases, high blood pressure had been identified but follow-on actions/reviews had not been put in place.

Key Events

24. On 29 April 2022, Mr Adrian Green was sentenced to three months in prison for sending an offensive/menacing message to emergency services, criminal damage and breaching a supervision order. He was transferred to HMP Altcourse that day.

25. Mr Green had extensive physical health issues, including ischaemic heart disease (reduced blood supply to the heart), hypertension (high blood pressure), type 2 diabetes mellitus (when the level of sugar in the blood is too high) and liver cirrhosis (damage to the liver due to hepatitis and alcohol).

26. Mr Green lived in a single person cell on Bechers Blue wing.

Events of 5 May

27. At approximately 2.08pm on 5 May 2022, a nurse saw Mr Green for his weekly weight check and to undertake a full set of physical observations because of his complex health needs.

28. It was recorded that Mr Green's blood pressure was slightly elevated and his oxygen saturations were slightly below the acceptable level. His National Early Warning Score (NEWS2, a tool to detect and respond to clinical deterioration) was one. (A NEWS2 score of one to four is considered low risk and can be dealt with by a nurse).

29. The nurse told us that during this consultation, Mr Green complained that his leg was swollen and painful, so she raised an electronic task for a senior nurse to see Mr Green.

30. At approximately 5.00pm, the nurse gave Mr Green his medications. She told the investigator that she did not undertake any physical observations at this time.

31. At approximately 6.00pm, the nurse went to Mr Green's cell to administer some medication that had been missed earlier. Officer A accompanied the nurse into the cell. She said that Mr Green sat up on his bed to take his medication and she observed no change in him from when she had seen him earlier. According to the CCTV footage, she was in Mr Green's cell for approximately 26 seconds.

32. Officer A told the investigator that she thought Mr Green looked unwell and he was slurring his words. She said that Mr Green had told her that there was something wrong with his leg and she described his leg as swollen and blistered. She said that she told the nurse about Mr Green's slurred speech and sore leg, and the nurse had said that they had taken a blood sample which had been sent off and "no-one had been in touch about them". The officer said that the nurse carried out physical observation checks, making a note of the results on her glove, and told her that there was nothing alarming and she would put Mr Green down for a GP review in the morning.

33. Officer A said that despite her conversation with the nurse, she remained concerned about Mr Green's leg, so she took a pen and drew around the affected

area. She said that she told Mr Green to let the night staff know if the size of the affected area increased.

34. According to CCTV footage, Officer A was with Mr Green for approximately two minutes and 30 seconds. She told us that she had told Officer B, who was working the night shift, about her concerns for Mr Green.

35. CCTV footage shows that Officer A conducted a routine roll check (primarily to check that all prisoners are accounted for) at 7.30pm.

36. Officer B told the investigator that he started his shift on the wing at 8.00pm and he began by checking that all the cell doors were locked.

37. Officer B said that Officer A did not speak to him about Mr Green. He told the investigator that as a matter of course, there was always a verbal handover between staff when there was a shift change and that anything important would be logged in the wing observation book.

38. There are no entries recorded in the wing observation book for Mr Green on 5 May.

Events of 6 May

39. It is recorded that a roll check was undertaken on 6 May at 12.30am.

40. At 5.11am, Officer B conducted a welfare check. He explained that the purpose of a welfare check was to make sure that the prisoner was okay, and the purpose of a roll check was to make sure that there was a prisoner in the cell. He said that roll checks were undertaken at 6.00am, 12.30pm, 5.30pm and 7.30pm and there was only one welfare check which took place at 5.00am.

41. It is recorded that a roll check was undertaken at 6.00am. (At this point, Mr Green had been checked at 12.30am, 5.11am and 6.00am. None of the staff undertaking the checks raised any concerns about Mr Green.)

42. At 7.58am, Officer C opened Mr Green's door and placed his breakfast in the sink inside his cell. He told the investigator that he said, *"good morning",* but Mr Green did not respond. He said that he believed Mr Green was awake and so he continued to the next cell.

43. Officer C said that officers were meant to undertake a welfare check when they handed out breakfast. He explained that a welfare check meant that he checked to see that the prisoner was okay, but prisoners did not always respond.

44. In his statement to the police, Officer C said that Mr Green appeared to be sleeping and because he was running behind schedule, he continued with his welfare checks.

45. Officer C said that roll checks were undertaken at 6.00am, midday, 5.00pm and 7.00pm.

46. Officer D told the investigator that officers undertake a welfare check at 5.00am to check the prisoner is okay and in bed sleeping. He said that they did not expect to

receive a response at that time of day. He stated that a further check was conducted at 7.00am and a second one was done at 7.30am when breakfast was handed out. He stated that during the 7.30am check, a response should be obtained from the prisoner. He said that that roll checks were done at 1.00pm, 5.00pm and around 7.00pm.

47. At 8:06am, Officer D unlocked Mr Green's cell so that Mr Green could collect his medication. He told us that he unlocked Mr Green's door and went into his cell. He said that he could see he had been given his breakfast, but he did not get a verbal response from Mr Green. He said that he shook him but there was still no response, so he called out to his colleagues, Officer C and Officer E.

48. Officer C told the investigator that he went into Mr Green's cell, pushed Mr Green and shook him in an attempt to rouse him but he did not respond. Officer E also came into the cell, concluded that Mr Green had died, and, at 8.09am, radioed a code blue medical emergency.

49. At 8.09am, the prison's control room requested an ambulance.

50. Officer E said that he had considered starting cardiopulmonary resuscitation (CPR) but did not proceed as there was evidence that rigor mortis (a sign of death) had already set in.

51. Officer E told the investigator that officers were meant to conduct a roll check at 5.00am to check that the prisoner was there, and nothing had happened to them. He said that when breakfast was handed out, a further welfare check should be conducted and that officers were expected to get a response from the prisoner.

52. At 8.11am, a nurse went into Mr Green's cell. CCTV footage shows that she was not carrying any medical equipment. One minute later, further healthcare staff arrived with medical treatment bags.

53. The nurse told the investigator that Mr Green was lying on his side, in bed, with his arm hanging over the side of the bed. She said that she tried to move him to feel a pulse but there was none, and his lips were blue. She said she told the officers that she wanted Mr Green to be moved out of the cell so they could assess him properly. Officers carried Mr Green from the cell and placed him on the floor in the communal area. The nurse said that the defibrillation pads were placed on Mr Green and another nurse listened for chest sounds.

54. At 8.26am, the ambulance crew arrived, and they agreed that resuscitation attempts would be futile. They confirmed that Mr Green had died.

Contact with Mr Green's Family

55. On 6 May, a prison family liaison officer (FLO)was appointed. He checked Mr Green's prison records for his next of kin contact details and found contact numbers for different family members.

56. At 10.15am, the FLO and the Director called Mr Green's sister but were unable to reach her. They subsequently called Mr Green's daughter. She was very shocked

by the news and advised that she believed Mr Green's sister would represent the family as the next of kin.

57. At 11.30am, Mr Green's sister called the prison and spoke to the Director. He told her as much information as possible about the circumstances of Mr Green's death. He gave her with the family liaison officer's name and agreed that the family liaison officer would call her again on 9 May to discuss matters.

58. Mr Green's funeral took place on 6 July. The prison contributed to its cost in line with national instructions.

Support for prisoners and staff

59. After Mr Green's death, a prison manager debriefed the prison 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.

60. A senior nurse spoke to all the healthcare staff involved in the emergency response and offered them the opportunity to access the prison care team.

61. The prison posted notices informing other prisoners of Mr Green's death and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Green's death.

Post-mortem report

62. A post-mortem examination established that Mr Green died of acute myocardial insufficiency (a reduction in blood flow to the heart) and hypertensive heart disease, with moderate calcific coronary artery disease (heart disease caused by narrowed heart arteries and high blood pressure) and obesity. He also had cirrhosis (scarring of the liver) which contributed to but did not cause his death.

Inquest into Mr Green's death

63. The inquest into Mr Green's death was held on 19 December 2022 and a verdict of natural causes was recorded.

64. The coroner concluded that Mr Green's death was due to acute myocardial insufficiency and hypertensive heart disease, with moderate calcific coronary artery disease and obesity. Cirrhosis would have been a contributory factor but did not cause his death.

Clinical Findings

65. The clinical reviewer concluded that the physical healthcare that Mr Green received was not of the required standard and was not equivalent to that which he could have expected to receive in the community.

66. The clinical reviewer made five recommendations to Altcourse, which the Head of Healthcare will need to address.

Non-Clinical Findings

Welfare and Roll Checks

67. Prison Service instruction 75/2011 on residential services states that four formal roll checks should be carried out each day. HMP Altcourse provided us with a document that detailed that their roll checks should take place at 6.00am, 12.30pm, 5.30pm and 7.30pm.

68. The prison did not provide us with a copy of their local policy on welfare checks. They told us that at the time of Mr Green's death, they had been operating in line with G4S policies which they had not retained following the change of management (which took place on 1 June 2023). The prison also told us that Sodexo's welfare policy was in the process of being written so there was no policy currently in place.

69. The Safer Custody Manager told us that officers learnt how to conduct roll checks and welfare checks during their initial training. He said that before prisoners were unlocked, staff should physically check the presence of the occupants in every cell and get a positive response from them, failing which it may be necessary to open the cell.

70. The prison told us that their morning welfare check takes place when breakfast is delivered at around 7.30am and that officers were expected to get a verbal response from prisoners.

71. Officer C arrived at Mr Green's at 7.58am. He opened the door and placed his breakfast in the sink. He told us and the police that he said *"good morning"* to Mr Green. However, he gave contradictory statements about his perception of whether Mr Green was awake or asleep at the time.

72. At interview, Officer C told us that he was aware that a verbal response should be sought but he also told us that officers do not always get a response.

73. While it is evident that Mr Green had been dead from sometime before the welfare check was carried out, it is clear that the welfare check had not been undertaken correctly.

74. It was also clear from the interviews that officers were unclear about when roll and welfare checks were meant to be carried out and what they were expected to do. We therefore make the following recommendation:

    The Director should update and train against a clear welfare check policy so that staff fully understand their responsibilities.

Director to Note

Emergency response

75. Prison Service Instruction (PSI) 03/2013 and Altcourse's local protocol instruct staff to call a code blue promptly if a prisoner is found unconscious. It also directs that the duty nurse should attend with the necessary equipment.

76. There was a delay of three minutes in calling a code blue. Officer D was concerned that Mr Green might have died at 8:06am. He requested assistance from colleagues. It was not until the third officer went into the cell that a medical emergency code blue was called at 8.09am.

77. CCTV footage showed that the first healthcare professional on the scene, a nurse, arrived without any medical equipment. The Director and Head of Healthcare will want to reflect on the learning.

Body-worn video cameras

78. Officers C and D were both wearing body-worn video cameras at the time yet neither turned them on. Officer E told us that he was aware that he should wear a camera but did not always do this. While in this case, the lack of body-worn camera footage was not significantly detrimental to our investigation, officers should wear and use body-worn video cameras consistently to allow for a more detailed examination of how incidents are managed.

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