Circumstances surrounding the death of a man at HMP Holme House in June 2004

Report by the Prisons and Probation Ombudsman for England and Wales

December 2006

This report considers the sad death of a man at HMP Holme House on 6 June 2004. The man was aged 34.

I would like to express here my condolences to the man's family and all those touched by his passing.

The circumstances of the man's death are very unusual in that two experienced pathologists have been unable to find a definite cause. The Home Office pathologist has recorded formally that the cause of the man's death is unascertained. A second pathologist, instructed by the family, has said that the sudden unexpected death of a young man is a well recognised, but relatively rare, phenomenon. He writes that such cases have been termed the "sudden adult death syndrome".

In line with transitional arrangements agreed between my office and the Prison Service and in operation during 2004, the primary investigation into the man's death was conducted by a senior investigating officer appointed by the Prison Service. He interviewed staff at HMP Holme House, where he also examined records. I am grateful to him for his detailed and comprehensive work. This report is substantially as he drafted it, but I have made some amendments and additions, and the sections on post mortem reports and a review of the man's GP records in November 2006 have been added by one of my assistant ombudsmen. The senior investigator and my assistant ombudsman also visited the man's relatives.

A further part of the investigation was the commissioning of a clinical review, which was written by a doctor working for North Tees Primary Care Trust (PCT). Further clinical information has been supplied by a Principal Officer in the Healthcare Centre at HMP Durham, by my deputy ombudsman and by a second doctor commissioned by North Tees PCT.

I wish to thank the Governor at Holme House at the time of the man's death and his staff for the help and cooperation received by the investigators in the course of their work. Facilities were made available and all staff participated fully and readily with the inquiry.

I am very sorry indeed that the investigation has been such a protracted affair. My investigators have done their best to answer questions posed at a number of different stages by the man's family and their solicitor. They have also obtained detailed information about the man's medical history in the community as well as at Holme House. I have been mindful of the need to establish as much reliable information as possible about the circumstances of a death, the cause of which remains a mystery. I trust that endeavour will be of some small comfort to the man's family.

This report makes a number of recommendations, some related to the availability of detoxification and other medication and to other healthcare matters. However, judged overall, I believe the man had good access to healthcare and was looked after well.

STEPHEN SHAW CBE
PRISONS AND PROBATION OMBUDSMAN **December 2006**

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SUMMARY

1. At the time of his death, the man was 34 years of age. He had been received at HMP Holme House on 11 May 2004, having been sentenced to four months imprisonment at Teesside Magistrates' Court the same day for an offence of driving whilst disqualified.

2. At the man's reception screening on 11 May he was described as looking 'fit and well'. He spent the night of 11 May as an inpatient in the Healthcare Centre due to information supplied by him in relation to his alcohol consumption.

3. Subsequently, the man was held on House Block 4 DDU (Drug Detox Unit). He shared Cell A3-6 with a cellmate.

4. Between his arrival at Holme House on 11 May and his death on 6 June, the man had regular contact with the establishment's medical services in relation to a variety of ailments - mainly consisting of generalised aches and pains, including a sore throat. Records show that blood tests and a previous x-ray were requested on two separate occasions. The results eventually arrived at Holme House on 26 May, some ten days before the man's death, and highlighted abnormally raised liver functions on two of the five screenings.

5. On the morning of 6 June, the man's cell mate awoke about 5.15 am to use the in cell toilet. He observed that the man had not stirred despite his flushing the toilet, and checked to see if he was all right. Finding that the man was not moving and icy cold, the cellmate raised the alarm by pressing his cell bell to attract the night officer.

6. Contingency plans were activated resulting in CPR being administered by a nurse and a night patrol officer. This was continued until the ambulance crew arrived at 5.50 am with the man being pronounced dead at 6.43 am by the duty doctor.

7. A clinical review of the man's medical treatment was requested from North Tees Primary Care Trust. A further in-depth assessment from a prison perspective is contained within this report. It was prepared by a Healthcare Principal Officer (PO) from HMP Durham. The same PO assisted in the investigation.

8. I received a copy of the Toxicology Report from Cleveland Police on 20 August 2004. A scientist from the Forensic Science Service stated that the man had ingested Diazepam and Paracetamol at some time prior to his death. The scientist commented as follows:

> "Diazepam (Valium) is a prescription only drug often used in the treatment of anxiety related conditions but is also widely abused. The concentration of Diazepam and its metabolite were 'very low' and would not be expected to have any significant effect on the man at the time of his death. As Diazepam and Desmethyldiazepam are eliminated from the body very slowly, it is possible that these findings could relate to the use of Diazepam some days earlier.
>
> "Paracetamol is a widely used painkiller. The trace amount present in the blood would not be expected to produce any adverse effects on the man."

The conclusion to the scientist's report reads as follows:

> "From the tests carried out there were no indications that alcohol or drugs were a factor in the death of the man.
>
> "The concentrations of diazepam and paracetamol present in his blood would not be expected to produce any significant adverse effects."

9. The report from the Home Office pathologist states that no definite explanation for the man's death has been found. The pathologist adds:

> "In a very small proportion of sudden deaths in young, otherwise healthy people no cause is ever found. These deaths are sometimes labelled sudden adult death syndrome and are probably mostly a result of abnormalities of the electrical rhythm which causes the heart to beat which is undetectable at post-mortem examination. The cause has to remain as unascertained."

10. A post-mortem report was commissioned from a second pathologist by the man's family. The second pathologist carried out his examination on 11 June 2004 and submitted his final report on 29 October 2004. He reported that the man had apparently been a healthy young man with no anatomical evidence of any natural disease to cause or accelerate his death or to cause his collapse. The second pathologist added that the sudden unexpected death of an apparently healthy young individual is a well recognised although relatively rare phenomenon. He added, "such cases have been termed the "sudden adult death syndrome" and they are generally considered to be due to a sudden failure of the heart's pumping action brought about by disorder or normal orderly electrical activity within the heart."

11. I commissioned a further review from North Tees PCT to establish whether there was any information of significance in the medical records held by the man's GP. In his summary of the man's medical history, the reviewing doctor recorded an influenza infection and pneumonia in July 1986 which was treated with antibiotics. In July 1986, the man was found to have tachycardia (an abnormally rapid heart rate) but no treatment was given and

it was not clear from his medical records whether an echocardiogram requested by the consultant cardiologist had actually been arranged.

12. The man attended his GP's surgery in April and May 2003. On 15 April 2003, an x-ray of his chest showed atelectasis (partial collapse of the lung) but a later x-ray of his chest on 28 May 2003 showed that his lungs were clear.

13. Shortly before his death, the man wrote from prison to his GP to tell him that a recent blood test showed that his liver was badly damaged. He thought it best to tell the doctor about his symptoms "just in case my condition gets worse." The undated letter was not received at the GP's surgery until 9 June 2004, three days after the man's death.

DESCRIPTION OF HMP HOLME HOUSE

14. HMP Holme House is a purpose built local Category B prison which opened in May 1992. It expanded in the late 1990s with the building of two further house blocks providing 235 additional places. The prison serves the communities of Tees Valley, South West Durham, East Durham and North Yorkshire. It has a certified normal accommodation (CAN) of 854, and an operational capacity (maximum crowded capacity) of 994. On the morning of the man's death, the unlock figure was 964. The accommodation consists of six self contained living units with integral sanitation, with a mixture of single and double cells.

15. A snapshot of the convicted population on 22 July 2004 shows the following:

Less than 6 months	=	78
6 months - less than 12 months	=	67
12 months - less than 2 years	=	104
2 years - less than 3 years	=	122
3 years - less than 4 years	=	164
4 years - less than 10 years	=	217
10 years less than life	=	11
Life Sentence	=	7
Total	=	770

16. The remainder of the population was made up of unconvicted or unsentenced prisoners.

17. The regime offers prisoners a variety of employment opportunities within its modern workshop complex. These are complemented and supported by a purpose built education department, offering both part time and full time classes.

18. The prison has a first night centre that provides support to prisoners when they are first received into the establishment.

19. A Listener scheme operates on a 24 hour basis and is fully integrated into prison arrangements for those in need of support. (Listeners are prisoners who provide support for their peers, each Listener having received training from the Samaritans.)

20. My investigator had sight of a very comprehensive policy document on 'Safer Custody', which included everything from suicide prevention to anti-bullying, with many references on referrals or access to help.

21. He examined a report entitled 'An Unannounced Follow Up Inspection of HM Prison Holme House 31 March – 3 April 2003' by HM Chief Inspector of Prisons, and reviewed compliance with recommendations during the course of the investigation.

INVESTIGATION PROCESS

22 The senior investigator visited Holme House on 25 June 2004 when he met the nominated Liaison Officer and set out the parameters of the investigation. The senior investigator and my assistant ombudsman visited the man's relatives at their request.

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23. On 12 and 19 July 2004, the senior investigator returned to Holme House with the Healthcare PO and examined all available documentation in relation to the man's treatment in prison and some core documents. He also interviewed a number of members of staff.

24. As Ombudsman, I issued my draft report in January 2005. In September 2005, the man's sister wrote to me, indicating that the family wished to raise some further concerns after considering the draft report. In response to these concerns my deputy ombudsman produced a short supplementary report in February 2006. My deputy is a trained nurse.

25. In May 2006, the solicitor acting for the family wrote to my assistant ombudsman expressing the hope that a number of issues might be resolved from the man's GP medical records, "including what, if any, treatment the doctor was giving or enquiries being pursued with regards to any problems with the man's liver and secondly did the doctor [the man's GP] receive a letter directly from the man seeking help with regards to the medical problems that the man was experiencing."

26. On receipt of the solicitor's letter, my assistant ombudsman wrote to the Head of Risk Management at North Tees PCT, asking for a report on the clinical care the man received in the community prior to his reception at Holme House. The Head of Risk Management commissioned a review from the Clinical Governance Clinician at the neighbouring Middlesbrough PCT. Once written consent had been obtained from the family, the second reviewer accessed the medical records held by the man's GP and submitted his report to the Head of Risk Management on 6 November 2006.

27. At the time that the senior investigator wrote his draft report, he did not have access to the post-mortem reports written by the Home Office pathologist and the second pathologist. An early version of the second pathologist's report was kindly made available to me by the man's family on 30 June 2004. The second pathologist's final report, dated October 2004, was disclosed to my office by the family's solicitor in May 2006. The Home Office pathologist's report was disclosed to me by the coroner in late 2005.

EVENTS LEADING UP TO THE DEATH OF THE MAN

28. In interview, the man's cell mate outlined the evening of Saturday 5 June 2004. He said, 'The man and myself had been watching the football highlights. I can recall it because it was the night President Reagan died. We both commented on what a good innings he had.' The man then went to sleep whilst his cellmate stayed up and watched a film about a dingo stealing a baby. He said that the film finished at approximately 2.00 am and the man appeared to wake up. The cellmate said that the man sat up in his bed and was 'fighting for breath'. The cellmate offered him his inhaler but got no response or acknowledgement. The man lay back down on the bed and then appeared to be breathing normally.

29. The cellmate then went to sleep and woke up at approximately 5.00 am to go to the toilet. He observed that the man appeared to be in exactly the same body position as when the cellmate had last seen him prior to going to sleep. The man was on his front, with the blanket only partially covering him. The cellmate said during interview that, after using the toilet, he closed the cell window as it was cold. He thought that the man might be cold as his blanket was not covering him. He also thought it strange that the man had not stirred after he flushed the toilet. When the cellmate checked on him 'he felt icy cold', so he put the cell buzzer on to summon assistance and kicked the door a few times to attract the night patrol officer.

30. The night patrol officer came to the door and instructed the cellmate to shake the man and check for a pulse. When he got no response, the cellmate was told to sit on his own bed and wait for assistance. The cellmate also confirmed that this was the first time during the week when either he or the man had cause to press the cell buzzer. The night patrol went to the centre office and raised the alarm via the Orderly Officer who alerted the Healthcare Centre.

31. Within five minutes, the Orderly Officer arrived with a male nurse and two assistants. The nurse entered the cell to assess the situation but got no response from the man. There were no signs of life, no spontaneous respiration or pulse. The nurse and the night patrol officer commenced CPR on the man. The nurse attached a defibrillator to assess him further. This indicated 'no need to shock'. The two staff therefore continued administering CPR until the ambulance arrived.

32. The cellmate, who appeared very shocked at this time, was put into the 'crisis suite' cell where he had assistance from the on call Listener.

33. An officer escorted the ambulance into the prison. The prison's medical officer was contacted and asked to attend the prison. He declined, saying that another doctor was on call.

34. The Orderly Officer obtained statements from all members of staff involved. At 6.40 am, the duty doctor arrived to examine the man and at 6.43 am he pronounced life extinct. At 9.25 am, a Senior Officer arrived in company with three detectives and a Police Liaison Officer. The Coroner's Officer arrived at 11.00 am. The undertakers removed the man's body at 11.45 am for post mortem later the same day. A 'hot debrief' for staff was conducted by the duty governor.

35. The prison authorities initially had problems establishing and contacting the man's next of kin. His core record recorded his next of kin as his mother, but with an incomplete address. Police in Wales were asked by Holme House to try and supply details to very little effect. At approximately 10.45 am, the prison was contacted by the man's estranged wife. She had been contacted by another prisoner from Holme House who had told her about the man's death. Back records from a previous sentence the man had served in 2002 show that he had given her name then as his next of kin.

SUMMARY OF MEDICAL INTERVENTIONS

36. This chapter contains a summary of all the man's contact with medical services, from his first reception at Holme House on Tuesday 11 May 2004 until his death on Sunday 6 June 2004.

37. On 11 May 2004, the man was convicted and received at Holme House at approximately 3.00pm. A modified First Reception Healthscreen and secondary health assessment was carried out by nursing staff. During this interview process, the man volunteered information regarding his medical background. The following information was identified as a result of these questions:

- previous prison history.
- recent visit to his GP, complaining of fluid on his lungs. States prescribed Amoxil *tds.*
- prescribed treatment for asthma. States prescribed Becotide Inhaler. Listed as Asthmatic.
- recently stopped smoking.
- heavy drinker. 4 bottles of wine per day.
- drug user, now and again, specifically cocaine.
- weight recorded as 73kg.
- states problems with cholesterol, but not specified or treated.
- blood pressure recorded as 126/80.
- nurse's comment, "Looks fit and well".
- action after interview, refer to nurse-led clinic, "Drug detox unit".

38. The man also had an interview later the same day with the medical officer at Holme House. This consisted of a stamped tick box in the medical notes. The medical officer noted the man's asthma and excessive drinking, and passed him fit labour 1, which means fit for any work or activity within the prison. The man was admitted to the Healthcare Centre later that day, as per the protocol for people with alcohol problems at Holme House. No Chlordiazepoxide detox was started at this stage.

39. On the morning of 12 May, some time before 10.00am, the medical officer saw the man for a more in-depth interview and examination. The following information was identified as a result of this consultation:

- The man suffered from asthma and used inhalers. He was prescribed Becotide Inhaler and this was given to and signed for by the man, in-possession.
- He suffered from fluid on his lungs. Amoxycillin 250mgs *tds* was prescribed not in-possession. Prescription sheet indicates it was not given until teatime that day, 24hrs after first reception.
- The medical officer noted that the man had had an x-ray taken at a local hospital one month previously.
- Physical examination notes good, nothing else noted.

Action points, noted in the Inmate Medical Record (IMR) by the medical officer as a result of above consultation:

1. To ring the hospital to obtain x-ray report.
2. Chlordiazepoxide detox to start. Prescription sheet indicates not given until teatime that day, 24hrs after first reception.
3. Thiamine 100mgs *od* 28days. Prescription sheet indicates not given until teatime that day, 24hrs after first reception.
4. Bloods requested for LFT's [liver function tests].
5. Pharmacy dispensing sheet indicates time of dispensing at 10.57am, 12 May 2004.

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40. The man was discharged from the Healthcare Centre on the morning of 12 May at 10.00am. The next contact with medical staff, according to medical notes/prescription sheet, was at teatime treatments on house block four, when the man received his first dose of Chlordiazepoxide, Thiamine and Amoxycillin. (That is some 24hours after initial reception.) The inmate medical record (IMR) and a healthcare centre discharge sheet accompanied the man.

41. Some time during 13 May, a Healthcare Officer who works on the DDU completed a detoxification unit pathway of care nursing record. A comprehensive general history was taken for this document, spanning several pages of mostly fixed field questions. This document noted that the man informed staff that he drank excessively at weekends and occasionally used cocaine. However, no signs of withdrawal were noted. There was no record in the IMR or DDU diary of the x-ray report or the request to the local hospital for it, or for anyone to action this. Neither was there a record of bloods taken for LFT's on this occasion.

42. The next recorded intervention by medical staff noted in the IMR was on 23 May. The man was seen on a follow up appointment, complaining of stomach pains, sore throat and general malaise. "No signs of withdrawal noted, to have Paracetamol PRN, see again in one week", was recorded. On the following day, the man was triaged by a nurse, having complained of pain all over his body, especially his throat. He also said the glands under his arms were up. Later that day, at a time not stated, he was seen by the medical officer who carried out a physical examination.

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43. The LFT blood results arrived at the prison on 26 May and showed significantly raised levels of ALT 84 (Range 0-40), Gamma GT 194, (Range 8-61). On 27 May, the medical officer had sight of the LFT results and noted they were abnormal due to alcohol abuse. He asked for them to be repeated in three to four weeks. The following day (28 May), the man was seen by the medical officer and complained of generalised aches and pains. Paracetamol (two tablets, eight-hourly) was prescribed.

44. On 30 May, there was a note in the IMR: "attended gym before coming down to get his treatments." However, according to the gym log, the man had not

attended the gym during this sentence. A similar entry was made the following day, but again it was not confirmed in the gym log.

45. The man was seen in the healthcare centre twice on 4 June. First, he was seen on triage by the nurse as he complained of generalised pain. Later, he was seen by the medical officer when complaining of acid reflux. The man was prescribed Gaviscon 10mls *tds* 14 days. A request for H-Pyloric test was made which had an action noted in the DDU diary for Monday 7 June.

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46. There are no further entries in the man's medical notes with regard to his general health, or any other written interventions, until the morning of 6 June.

47. Healthcare staff were called at approx 5.30am to attend the man's cell. Upon arriving, staff stated he was unresponsive. The male nurse said that the man was lying on his side and was unresponsive, with no detectable breathing or pulse. The nurse immediately commenced CPR, assisted by the night patrol officer. They continued this for approx 15-20 minutes until ambulance paramedics arrived. The paramedics asked the staff to stop CPR whilst an ECG heart trace could be connected through three chest leads. This showed an Asystole reading, which indicates no electrical activity in the heart. They felt further CPR was not indicated. The duty doctor arrived shortly after, about 06.34am. After examination of vital signs, he pronounced life extinct.

48. Two post mortems have been carried out, the second at the request of the man's family. Both were inconclusive, with no cause of death established. The toxicology results have provided no other additional information.

COMMENTS

49. The man had numerous contacts with medical services at Holme House in the short time he was there, showing a good level of access and availability. The medical officer's medical notes were good and show evidence of comprehensive physical examinations on two occasions. The response and care given to the man in his cell on the morning of 6 June 2004 were of a high standard and a credit to the nurse and prison officer involved. .

50. However, I believe that the man had to wait too long after initial reception to receive detox, vitamin and antibiotic medication. A delay of 24 hours is too great, especially in the case of those considered to misuse alcohol. In addition, the x-ray and liver function tests requested in the IMR, in-patient discharge sheet and ward round book, should have been followed up and not left until the man reported ill some 11 days later before being made. There were also some discrepancies between the reception interview and DDU pathway of care interview as to the level of alcohol the man said he drank.

51. Nursing medical notes/comments in the IMR about the man going to the gym before attending for medical treatment may be inappropriate and, in any event, upon investigation were found not to be factual. A referral to the CARATS (drugs) team was recorded in the DDU pathway of care form, but no action was taken and the senior investigator found no evidence of CARAT intervention on this sentence.

CONTACT WITH THE MAN'S FAMILY AND QUESTIONS RAISED BY THEM

52. On 7 June 2004, the family's solicitors requested documents relating to the man and his care within Holme House. These were dispatched on 8 June by the duty governor.

53. The duty governor also arranged for the family to attend Holme House on 8 June. Eight members of the family attended and a meeting was held in the Learning Centre outside the jail. The family was offered the opportunity of visiting the cell where the man had died, and told that a cheque in the sum of £61.50 had been collected by fellow prisoners and would be sent to the man's nephew to be given to his children.

54. At the request of the man's family, my assistant ombudsman made arrangements to visit the family at their home at a convenient time and date. The nephew who was acting as the spokesperson for the family invited my assistant ombudsman and the senior investigator to his aunt's home. The visit took place on the evening of 30 June. The functions of an Ombudsman's investigation were explained, together with its likely scope.

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55. The family asked the investigators to look in some detail at a number of issues. I have outlined below those questions and what my investigation has uncovered.

The family had information that during the night of 5-6 June help was requested for the man from a named night patrol officer but he did not supply it.

The night patrol officer said in interview that his set of nights was generally quiet, with only the odd cell bell requesting toilet rolls or Paracetamol. He said that, prior to answering the cell bell at approximately 5.30am on 6 June, neither the man nor his cell mate had used the cell bell call system during that week for any reason. When alerted by the cellmate that something was wrong with the man, the night patrol officer gave instructions through the door and quickly summoned medical help. When the nurse arrived, both the night patrol officer and the nurse commenced CPR on the man and kept this up continuously until the paramedics arrived. (As a relatively new officer, the night patrol officer was well in date with his first aid qualification and took his lead from the nurse. Both these members of staff are to be commended for their prompt action and skill in trying to save the life of the man.) I have uncovered no other evidence suggesting that help was requested for the man during the night of 5-6 June.

Was the man transferred to an outside hospital prior to his death and if so why?

Between the dates of 11 May 2004 and 6 June 2004, the man did not visit an outside hospital. The night of the man's reception was the only one he spent as an inpatient in the Healthcare Centre.

The family expressed concern about bruises noted on the man's arms during the second post mortem.

I am unable to provide an answer to this question. However, I am aware from many of my investigations that apparent injuries can result from resuscitation efforts.

The family expressed concern about the presence of a few small petechiae around the eyes noted at the second post mortem.

I am unable to provide an answer to this question.

The family supplied a list of prisoners at Holme House who had relevant information and would be willing to assist the Ombudsman's investigation.

The senior investigator interviewed several prisoners named by the family. The main gist of their interviews is contained in this report. However, all talked of being aware that the man had problems with fluid on the lungs and some chest pain. All confirm the man had been seeing the doctor and nursing staff, although some believe the care could have been better. (I have uncovered nothing more to substantiate that view.) One of the interviewees made reference to the man staying in his cell during association periods, but suggested that had been some two weeks prior to his death. All said they saw the man earlier on the Friday/Saturday prior to his death and commented 'he seemed fine,' and 'looked okay'.

The family expressed surprise that PE staff at the prison were not aware of the man's death soon after the event.

Having checked through the attendance records for the gymnasium, it appears that the man did not in fact attend the gym. This is corroborated by his cell mate and the other four prisoners interviewed at the family's request. (The man did attend the gym on previous sentences at Holme House.) As to PE staff not being aware of the man's death, notices to staff and prisoners were properly displayed around the establishment.

The family complained that the duty governor at the prison had lied about the identity of the man's cell mate at the meeting on 8 June 2004.

During interview with the duty governor, the senior investigator asked about the meeting she had with the man's family on 8 June. He judged that the notes she made at the time were very helpful. At the time, the family had understood that the man's cell mate was called Mr X. However, the duty governor was correct when she said that the man's cell mate was not Mr X. As noted in this report, the man's cell mate at the time of his death was Mr Y. The duty governor's decision not to divulge the cellmate's name at the time was not unreasonable as the Prison Service also had a duty of care to him. During interview, it became apparent that the cellmate had been good friends with the man and was very shocked by the tragic events.

The family observed that the man's weight at the time of his death was much lower than they would have expected

The man's weight is recorded on his medical records during screening on his reception in Holme House as 73kg. In the second post mortem requested by the family, the man's weight at death is recorded as 67kg. The difference between his reception weight and his weight at death is thus some 6kg. I have found no evidence to show whether this loss in weight was caused by a change in eating habits or lifestyle, or for other reasons.

56. A number of other issues raised by the family in relation to the timing of the second post mortem, alleged delay on the part of the Home Office pathologist, and the way in which the man was presented at the mortuary, are outside my remit.

57. In addition, I made contact with the man's mother in Wales. She was his nominated next of kin. She was obviously very sad about the loss of her son as, according to a letter found in his cell, he had been planning to relocate to Wales. I have, as agreed, passed on to her copies of her son's last known letters.

58. In September 2005, the man's sister wrote to my office and set out a list of further questions that the family wished to raise. These further questions were:

    1. Why did medical staff state in the records that the man had frequently attended the gym when this clearly was not the case?

    2. Why did the man weigh 6 kilograms less at the time of his death than when he began his prison sentence only 4/5 weeks previously?

    3. Why did the doctor not arrive until 6.36am when the alarm had been raised at 5.30am on the morning of the man's death?

    4. The man was seen by a doctor on a number of occasions and the family believe that his visits were not taken seriously enough. He was only prescribed Gaviscon and Paracetamol, which are both medications that can be bought over a shop counter, despite the fact that blood tests had returned showing abnormalities.

    5. Did chest x-ray results ever arrive at the prison?

    6. Was there any indication that the man was taking Methadone?

59. In response to these further issues raised by the family, I commissioned a report from my deputy ombudsman, who is a trained nurse. Her responses to the family questions are as follows:

    1. *Frequent attendance at the gym?* – My deputy reports that the healthcare staff would have based their entry regarding the man's

attendance at the gym on the information he gave them. Unless there was a clinical reason for him not to attend the gym, they would have no reason to check what the man told them.

2. *The man's significant weight loss* – My deputy cannot explain the differences in the man's weight, although she points out that the scales used in the prison and the mortuary were not the same. She notes that, in the first post-mortem conducted by the Home Office pathologist, the man does not appear to have been weighed although the pathologist indicated in the External Examination section of his report that the man "was of average build."

3. *The doctor did not arrive until 6.36am* – My deputy comments that she would not have expected the doctor to be called initially as a 999 ambulance call had been made. She adds that this is entirely consistent with community based primary care. I have, however, made a recommendation about the need for an effective system to ensure that all managers are aware which doctor is on call.

4. *The man's visits to Healthcare were not taken seriously enough* – My deputy observes that the man presented at Healthcare on a number of occasions. She considers that the care he was afforded was entirely appropriate to his presenting symptoms. Full examinations were undertaken and tests were ordered accordingly. The majority of his blood results were within normal limits. The Liver Function tests were slightly raised and the man was scheduled to have them re-screened.

5. *Chest x-ray results* – there is no evidence that these x-ray results ever arrived at the prison.

6. *Was the man prescribed Methadone*? – My deputy comments that the man was never prescribed Methadone and that the Methadone chart belonged to another prisoner.

My deputy ends her report by stating her belief that an improved system needs to be put in place for following-up tests and examination requests.

60. The man's sister expressed disappointment that his family in the north east learned of his death as a result of telephone calls made by other prisoners to their families. She was aware that the man had nominated his mother as his next of kin, but the family suggested that prisoners should be asked to put two or three people as next of kin. Clearly, prisoners should not be pressurised into naming more contacts than they would choose to do. However, I think there is some merit in the proposal and draw it to the attention of Holme House and to the Prison Service generally.

POST MORTEMS AFTER THE MAN'S DEATH

61. The first post-mortem after the man's death was conducted on 6 June 2004 (the day of the man's death) by the experienced and highly qualified pathologist who is a Senior Lecturer in Forensic Pathology at the University of Newcastle and Home Office Pathologist for the North-East of England. In his report to the Coroner of 9 November 2004, the Home Office pathologist wrote that the cause of death was in his opinion unascertained. In the History section of his report, he noted that the man had a past medical history of asthma, reflux and abnormal liver function tests thought to be due to alcohol excess.

62. In the initial Toxicology section of his report, the Home Office pathologist said that samples of blood, urine and stomach contents were sent to the Forensic Science Laboratory at Chorley. The Home Office pathologist noted the comment of a scientist at that laboratory that the results provided no indication that alcohol or drugs were a factor in the man's death.

63. The Home Office pathologist's report recorded that he attended the mortuary for a second time on 11 June 2004. He was met there by the pathologist instructed by the man's family. The two pathologists discussed the circumstances of the man's death and the second pathologist then examined the man's body. The Home Office pathologist observed that a number of bruises had become visible since his previous examination. Two bruises were noted on the upper part of the man's right arm. A bruise was also seen on the man's right elbow and on the upper part of his left arm. Two further bruises were observed on his right forearm.

64. In the summary and conclusions part of his report, the Home Office pathologist notes that the man was found dead in his cell on the morning of 6 June, after he had been heard wheezing some hours previously. He had a past history of asthma, alcohol and cocaine abuse and had recently complained of abdominal and other pains. The principal findings at post-mortem were:

    1. Occasional small recent bruises

    2. No natural disease

    3. No significant toxicological findings.

65. The concluding paragraph of the Home Office pathologist's report is significant and I reproduce it in full.

> "Thus, despite a full and detailed post-mortem examination including microscopy and toxicology, no definite explanation for the man's death has been found. There was, however, no evidence whatsoever that he died as a result of either injury or poisoning and by exclusion at least it appears likely that his death was from natural disease. It is well recognised that in a very small proportion of sudden deaths in young,

otherwise healthy people no cause is ever found. These deaths are sometimes labelled Sudden Adult Death Syndrome and are probably mostly a result of abnormalities of the electrical rhythm which causes the heart to beat which is undetectable at post-mortem examination. The cause, at least in terms of certification, however, has to remain as unascertained. The occasional small bruises present on the arms in no way provide a cause of death and do not indicate an assault."

66. The man's family kindly made available to my investigators an early version of the report written by the pathologist they had instructed. The second pathologist's early conclusions were that post-mortem examination had shown no obvious anatomical evidence of any lesion to account for the man's death. It appeared to the second pathologist that a death from violence could be excluded, "although the presence of a few small petechiae [minute discoloured spots on the surface of the skin caused by an underlying ruptured blood vessel] around the eyes has to be noted."

67. In May 2006, my colleague wrote to the solicitor acting for the man's family. He enquired whether a copy of the second pathologist's final report might be made available to my office and this was duly supplied. The second pathologist's report, dated 29 October 2004, explains that he conducted a second examination of the man's body on 11 June 2004 after a post mortem had been carried out on 6 June 2004 by the Home Office pathologist on behalf of the Coroner. The second pathologist's report begins by saying that the Home Office pathologist provided him with a draft version of his report. The Home Office pathologist also attended the second pathologist's examination and they re-examined the body jointly. The two pathologists discussed the findings in the case together "in some detail." Further technical assistance was provided to the second pathologist in the form of microscope slides, sight of the report on the toxicological examination, and photographs taken in the prison and at the mortuary during the first post-mortem examination.

68. The second pathologist's detailed commentary at the end of his report begins thus:

> "The post-mortem examination in this case has shown that this has apparently been a healthy young man, with no anatomical evidence of any natural disease to cause or accelerate his death or to cause his collapse. Specifically, despite the history of mild asthma, and indeed of some form of breathing abnormality prior to his demise, there was no evidence that the deceased died during the cause of an asthma attack, and a death from asthma can effectively be ruled out."

69. In the second paragraph of his commentary, the second pathologist observes that "only very occasional trivial nondescript external marks of injury were present about the body" and there were no internal indications of injury at all. The second pathologist concludes that "a death from violent injury can therefore be ruled out, insofar as it is ever possible to do this."

70. In the third paragraph, the second pathologist writes that, despite the history of alleged drug abuse, there were no signs of intravenous drugs abuse about the body. He therefore concludes that a toxicological cause of death can be excluded.

71. In the fourth paragraph, the second pathologist writes that the man's death has no anatomical cause and in the next paragraph he writes about "sudden adult death syndrome" as follows:

> "The sudden unexpected death of apparently healthy young individuals is, however, a well recognised although relatively rare phenomenon. Such cases have been termed the 'sudden adult death syndrome' and they are generally considered to be due to a sudden failure of the heart's pumping action brought about by disorder of the normal orderly electrical activity within the heart, and occurring in the absence of any structural abnormality of the heart."

72. At the end of his commentary, the second pathologist writes that, in some cases of sudden adult death syndrome, clues to the tendency to sudden cardiac death can be found in the clinical history. His final paragraph notes that, "there was certainly no evidence of any overt disease, treatment of which could have effected a happier outcome."

73. A letter of 31 May 2006 from the family solicitor to my colleague said that at that stage he did not have any copies of the man's GP medical records. The solicitor speculated that a number of issues might be resolved from the medical records including what, if any, treatment the doctor (the man's GP) was giving, or what enquiries were being pursued with regard to any problems with the man's liver. The GP records might also show whether the doctor received a letter directly from the man seeking help for the medical problems he was experiencing.

74. On receipt of the solicitor's letter, my assistant ombudsman wrote to the Head of Risk Management at North Tees Primary Care Trust. He said that he would be grateful for any information and analysis that the PCT was able to submit in connection with the clinical care the man received in the community prior to his reception at Holme House on 11 May 2004. The Head of Risk Management made a request to the Clinical Governance Clinician at Middlesbrough PCT for a clinical review into the GP notes to be undertaken. After written consent for access to the man's GP record had been supplied by his sister, a second clinical review was duly undertaken. The second clinical reviewer submitted his report to the Head of Risk Management on 6 November 2006.

THE SECOND CLINICAL REVIEWER'S REVIEW

75. The second clinical reviewer's review says that he received photocopies of the man's GP medical record from North Tees PCT in October 2006. He also obtained copies of x-ray results and blood tests carried out in 2002/03 from the Medical Centre which the man had attended. The GP medical records contained manual and computer medical records along with the copies of blood results, x-ray reports and hospital correspondence.

76. The man was born in 1969 and the second clinical reviewer's review refers to one entry in the GP records in 1970, a gap between 1970 and 1979 and then complete records from 1979 until 2003.

77. In the Summary section of his report, the second clinical reviewer writes that the man made multiple attendances at Accident and Emergency for multiple musculo – skeletal injuries, including stab wounds with a machete on 29 May 1995. In addition to the machete attack in 1995, the man had been admitted to Accident and Emergency in August 1986 after being hit on the left side of his chest. He was discharged five days later. In March 1990, he sustained a road traffic accident when he fell off a motorbike. He was discharged from hospital four days after his arrival with a diagnosis of head injury, facial injuries and fracture of left zygoma (the bony arch of the cheek.) The third paragraph of the second clinical reviewer's summary observes that the man had haemophilus influenza infection and pneumonia in July 1986 and was treated with antibiotics. He was seen by a chest physician in August 1986 and no treatment was given. In an earlier section of his review, the second clinical reviewer reveals that the man was referred to the chest physician because of haemoptysis (the coughing up of blood).

78. The fourth paragraph of the second clinical reviewer's summary indicates that, in July 1986, the man was found by his GP and a chest physician to have tachycardia (an abnormally rapid heart rate). A 24 hour ECG showed supraventricular tachycardia. No treatment was given and the second clinical reviewer says it is not clear from the medical records whether an echocardiogram was arranged. An earlier section of the review notes that a consultant cardiologist agreed to arrange an echocardiogram after a few months. The second clinical reviewer's note of this 1986 agreement by the consultant records that there is no further correspondence in the medical records to confirm whether this was actually arranged. Nor are there any results from an echocardiogram.

79. In terms of more recent general practitioner consultations, the second clinical reviewer's review shows that the man attended the GP surgery on 24 June 2002 when he felt depressed and tired. Blood and urine tests showed no abnormality and liver function tests showed a slight increase in gamma-gt at 85 (normal being up to 65).

80. On 10 April 2003, the man attended the surgery with shortness of breath, which was worse on exertion, during the previous three weeks. On examination, his chest was clear but he was prescribed a Salbutamol inhaler

and a chest x-ray was arranged. On 15 April 2003, the chest x-ray showed atelectasis (partial collapse or incomplete inflation of the lung) in the right lower zone.

81. On 21 May, the man was seen in the surgery and prescribed antibiotics and a Salbutamol inhaler. On 28 May, an x-ray showed that his chest and lungs were clear. A note on 20 June states that the patient was reviewed and his x-ray was explained. The man appears to have been seen for the last time at the surgery on 28 October when he had a sore throat. He was prescribed Co-codamol, Salbutamol and Erythromycin.

82. The last piece of information to which reference is made in the second clinical reviewer's review is very poignant. It is an undated letter sent by the man from Holme House and addressed to Dear Doctor. The second clinical reviewer reports that the letter was received at the surgery of the man's GP on 9 June 2004, three days after the man's death. It was scanned into his medical records. In the letter, the man says:

> "I am a patient of yours and I am not feeling too good. I have been feeling bad for a long time as you can see from my files, inhalers, x-rays, blood test. I had a blood test last week and the results show my liver is badly damaged. Does this explain why my eyesight is bad and I feel irritable and have pins and needles on the top of my crown ... I just thought doctor it's best to tell you just in case my condition gets worse. Yours sincerely, ……………."

83. It has already been noted (at paragraph 45) that the man's liver function tests arrived at the prison on 26 May and showed significantly raised levels of ALT and gamma-gt. On 27 May, the medical officer had sight of these results and wrote in the clinical record that they were "abnormal due to alcohol problems." He requested that the tests be repeated in three to four weeks time.

FINDINGS

84. The man arrived at Holme House on 11 May 2004 after receiving a sentence of 4 months from Teesside Magistrates' Court for an offence of driving whilst disqualified. Due to information supplied by the man in relation to his alcohol intake, he was admitted overnight into the prison's Healthcare Centre. He was initially medically assessed using the 'Grubin Tool' (an assessment procedure named after Donald Grubin, Professor of Forensic Psychiatry at Newcastle University). During that assessment, he said that he had recently seen his doctor in relation to 'fluid on his lungs'. His weight was then recorded as 73kg. The man said that he was prescribed a 'Brown Inhaler' and Amoxil from his GP. The following day he was prescribed Chlordiazepoxide (Detox), Thiamine and Amoxycillin.

85. The medical officer's notes show the man advised him that he had had a chest x-ray about a month prior to coming to prison. The doctor requested a chest x-ray be obtained from a local hospital, and asked for blood samples to be taken for 'liver function tests'. The medical notes were good and showed evidence of comprehensive physical examinations on two occasions.

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86. Waiting for 24 hours after initial reception to receive detox, vitamin and antibiotic medication is too long, especially in the case of suspected alcoholics.

87. The x-ray and liver function tests requested in the IMR and inpatient discharge sheet and ward round book should have been followed up and should not have been left until the man reported ill some 11 days later, when they were requested again. There were some discrepancies between reception interview and DDU Pathway of Care interview as to the level of alcohol the man stated that he drank.

88. Although a referral to the CARATS Team was mentioned in DDU Pathway of Care form, no action was taken and there was no evidence of CARAT intervention during this sentence.

89. On 12 May, after one night in Healthcare, the man was allocated to House Block 4, Drug Detox Unit. He shared his cell there with an unconvicted prisoner (his cellmate).

90. Some nursing medical notes/comments in the IMR may be inappropriate and upon investigation were found not to be factual.

91. Blood samples were again requested to be taken from the man for liver function tests to be done on 24 May. On 27 May 2004, the results from LFT's were received and showed abnormalities in two of the five results. Subsequently, on 4 June the man was triaged for generalised stomach ache and was prescribed Gaviscon for abdominal pan and acid reflux, also H Pyloric test required. Paracetamol was also prescribed.

92. The prisoners interviewed spoke of the man telling them he had a variety of ailments. Several of the man's friends within Holme House, some of whom were also interviewed, commented that on the Friday/Saturday prior to his death he seemed okay.

93. The man had numerous contacts with medical services at Holme House in the short time he was there, showing a good level of access and availability.

94. The cellmate raised the alarm shortly after 5.00am on 6 June. The night patrol officer answered the cell buzzer and gave advice to the cellmate, prior to raising the alarm. The Night Orderly Officer arrived at the cell with a male nurse. The nurse and a night patrol officer commenced CPR on the man. The man's cellmate was comforted by a Listener.

95. The medical officer did not attend, as he said that another doctor was on call. The duty doctor pronounced death at 6.43am. An ambulance arrived, escorted by a prison officer. The police arrived at 9.25am and the Coroner's Officer at 11.00am, followed by the undertaker at 11.45am. Later a hot debrief for staff was conducted by the duty governor.

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96. Establishing contact with the man's nominated next of kin proved extremely difficult. At 10.45am, Holme House was contacted by the man's estranged wife who had been informed of his death by another prisoner.

97. The response and care given to the man in his cell on the morning of 6 June 2004 was of a high standard and a credit to the nurse and officer involved.

98. Two post-mortem examinations have failed to establish clearly the cause of death. The Home Office pathologist's report of 9 November 2004 observed that, despite a full and detailed post-mortem examination including microscopy and toxicology, no definite explanation for the man's death has been found. The Home Office pathologist wrote that there was no evidence whatsoever that he died as a result of either injury or poisoning and, by exclusion at least, it appeared likely to the Home Office pathologist that his death was from natural disease. The pathologist explained that it is well recognised "that in a very small portion of sudden deaths in young, otherwise healthy people no cause [of death] is ever found. These deaths are sometimes labelled sudden adult death syndrome and are probably mostly a result of abnormalities of the electrical rhythm which causes the heart to beat which is undetectable at post-mortem examination. The occasional small bruises present on the arms in no way provide a cause of death and do not indicate an assault."

99. The second post-mortem report was conducted by another pathologist at the request of the man's family. The second pathologist's commentary effectively ruled out a death from asthma. He also ruled out a death from violent injury. Despite a history of alleged drug abuse, there was no sign of intravenous drug abuse about the man's body and the second pathologist deduced that a toxicological cause of death could be excluded.

100 The second pathologist added that the “sudden unexpected death of apparently young individuals is, however, a well recognised although relatively rare phenomenon. Such cases have been termed the ‘sudden adult death syndrome’ and they are generally recognised to be due to a sudden failure of the heart’s pumping action brought about by disorder of the normal orderly electrical activity within the heart, and occurring in absence of any structural abnormalities of the heart.”

101. In response to questions in May 2006 from the solicitor acting for the family, I commissioned a further review from North Tees PTC. This review examined the records held by the man’s GP and reported in November 2006.

102. The second clinical reviewer’s summary of the man’s medical history refers to multiple attendances at Accident and Emergency for multiple musculo-skeletal injuries, including stab wounds with a machete on 29 May 1995. The man had influenza and pneumonia in July 1986 and was treated with antibiotics. He was seen by a chest physician in August 1986 and no treatment was given.

103. In July 1986, the man was found to have tachycardia. No treatment was given and the second clinical reviewer reports it is not clear from the medical records whether an echocardiogram was arranged.

104 The second clinical reviewer writes that the man last attended his GP’s surgery in April 2003 with a chest infection which was treated with antibiotics. X-rays showed some changes in the right lower zone but a repeat x-ray in May 2003 showed that the lungs were clear. A later section in the second clinical reviewer’s summary says that the man’s last attendance at the surgery was on 20 October 2003 when he was seen with a sore throat.

105. The man’s cellmate was interviewed at Holme House on 22 July 2004. In interview, the cellmate said that, on the Thursday before he died, the man posted out a letter to his “outside doctor”. The cellmate’s evidence suggests that the letter was posted on Thursday 3 June 2004. A letter was indeed received by the surgery and was scanned into the man’s medical records. The letter is undated but was apparently received at the surgery on 9 June, three days after the man’s death. The man told the GP that he had been feeling bad for a long time and that the results of a blood test “last week” showed that his liver was badly damaged. He asked his GP if that explained why his eyesight was bad and he felt irritable and had pins and needles on the top of his crown.

RECOMMENDATIONS

Local

In respect of prisoners received at reception whose alcohol consumption is high, consideration should be given to the immediate availability of an appropriate detoxification regime, to prevent possible seizures and the risk of fatalities in chronic cases.

Procedures should be in place to ensure prescribed treatment is collected from the pharmacy and administered promptly, and within a morning or afternoon period.

An auditable system should be put in place for administration staff at Holme House to action instructions from doctors and nurses. This might be achieved by attaching a request check list to the front of the clinical records.

A system should be considered to ensure referrals to CARATS are made appropriately and promptly.

An effective system should be put in place to ensure all managers are aware which doctor is on call, especially during out of hours periods.

All staff involved should be thanked for their professional conduct and prompt actions during this incident. In particular, the nurse and night patrol officer should be commended for their attempts to save the life of the man by administering CPR.

As proposed in HM Chief Inspector of Prisons' unannounced inspection report, a system should be set up to ensure that convicted and unconvicted prisoners who share cells sign a document to that effect.

All recommendations in the unannounced inspection which have not been addressed in relation to the Healthcare Department should be re-visited and implemented to ensure compliance.

National

The Prison Service should consider asking prisoners to give more than one contact name and address when recording next of kin details.