

**Investigation into the death of a man, who was a
prisoner at HMP Altcourse, on 8 July 2005**

**Report by the Prisons and Probation ombudsman for
England and Wales**

December 2005

This is the report of an investigation into the death of a man who died from apparent natural causes on 8 July 2005 at HMP Altcourse. He was 28 years old.

The man had been convicted on 24 May 2005 and sentenced to four months imprisonment. It was his first conviction and his first experience of prison life.

This investigation has been undertaken by one of my investigators. I would like to thank the Director of HMP Altcourse and his staff for their participation in the investigation. The North Liverpool Primary Care Trust commissioned two doctors to undertake a review of the man's clinical care, and I appreciate their assistance.

The loss of a loved one is always distressing and especially so in this case as the man was due to be released the day that he died, and his girlfriend was expecting their first child. I would like to add my personal condolences to those already expressed by my Family Liaison Officer on behalf of this office.

Whilst I do not feel anything could have been done to prevent the man's death, there are lessons to be learnt in the clinical management of patients in prison. I endorse the four recommendations made in the clinical review.

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

December 2005

CONTENTS

Summary	3
The investigation process	4
Background	5
HMP Altcourse	6
Key findings	7
Issues raised by the family	9
Clinical review	11
Recommendations	12

ANNEXES

Summary

1. The man was born in 1976 and was 28 years old when he died on 8 July 2005.
2. The man arrived at HMP Altcourse on 24 May 2005. He was received into custody after being sentenced to four months imprisonment. At his first reception health screen, it was noted that the man had taken a drug overdose the previous year at a difficult time in his life, and that he had previously used heroin. The man was due to be released on 8 July. He was going to return to his mother's house on Home Detention Curfew.
3. At 7:15am on 8 July, the man's cell mate returned from breakfast. He was unable to wake the man and informed staff. A Prisoner Custody Officer entered the man's cell and, as he also could not get a response from the man, immediately summoned medical assistance.
4. Healthcare staff arrived at the man's cell at 7:20am. They first moved the man off his bed to the cell floor, before moving him on to the landing in order to make a full assessment of his needs. As they were moving the man out on to the landing, the prison doctor arrived. After a further assessment, at 7:36am he declared that the man had died.
5. The clinical review noted that, although the man's care was appropriate, there appeared to be information which was not recorded in the man's medical records. The reviewers also concluded that the man's care whilst in prison could have been managed more efficiently.
6. On 15 August, one of my Family Liaison Officers contacted The man's family. Their concerns centred on the cause of the man's death and the possible implications for his children if it was a hereditary condition.

The investigation process

7. My investigator studied all relevant prison records relating to the man. These included his main prison record, his medical record and statements from prison staff.
8. A clinical review was commissioned from North Liverpool Primary Care Trust. I am grateful to the clinical reviewers for undertaking this review in a most timely manner.
9. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist him in his enquiries into the man's death.
10. One of my Family Liaison Officers contacted the man's family who told her of their concerns. These centred on the origins of the condition which resulted in the man's death. They enquired whether:
 - i the condition could have been identified beforehand;
 - ii it was a hereditary condition, and if his children were at risk;
 - iii it was caused by manipulation of The man's neck after a recent sports injury;
 - iv it was caused by a surgical procedure when he was a baby;
 - v The man was in the top bunk and if he had fallen out of the bunk.I hope the report provides the family with answers to their questions.
11. My investigator discussed aspects of the man's treatment and the issues raised by his family with both staff at Altcourse and Ms Whitby. The clinical review found that, although the man's clinical care was appropriate, there were issues with the recording of information about medical interventions in this case. I make a recommendation concerning this.

Background

12. The man was born in the north of England in 1976. He was one of three children. He had a brother and a sister.
13. The man had been married and was the father to three children, two boys and a girl. His girlfriend was pregnant and was going for a pre-natal scan of their baby on the day that he died.
14. The man had several jobs but found it difficult to settle in employment as he got bored very easily. He had wanted to join the army but failed the medical due to raised blood pressure and an enlarged kidney. He was, however, allowed to join the Territorial Army. The man was a big football fan and loved Liverpool Football Club.
15. The man had a history of minor offences and it was a culmination of these that led to him being given a short custodial sentence. The man was due to be released on 8 July on Home Detention Curfew to his mother's address.

HMP Altcourse

16. Altcourse opened in 1997 and is a privately managed prison run by Global Solutions Ltd (GSL). It has an operational capacity (maximum crowded capacity) of 1,010. The prison has six main houseblocks, each divided into two units. Approximately a third of the prisoners are on remand and the remainder convicted and sentenced or awaiting sentence. The full facilities and regime of the prison are available to all prisoners.
17. After the evening roll call which is held at 9:00pm to confirm all prisoners are accounted for, the prison enters what is called patrol state. This is defined as 'Prisoners are locked up and staff numbers are reduced to the minimum needed to patrol. The main role of staff at this time is to maintain the security of the prison.'
18. When the Night patrol arrives on the wing a hand-over is given by the officer on evening duty and a sealed packet containing keys is given to the Night patrol officer. The keys in the sealed packet are only to be opened in an emergency. When the Officer who is on duty during the next day arrives, they are given a hand-over from the Night patrol officer and a roll check is carried out before the Night patrol officer is relieved and leaves the wing.
19. From when Altcourse opened until 31 January 2005, Primecare Forensic Medical provided the healthcare service. On 1 February, the contract for healthcare services was transferred to a new provider, Veritas Limited. The healthcare unit can accommodate 32 prisoners and offers a range of primary care services.
20. Her Majesty's Chief Inspector of Prisons (HMCIP) carried out an announced inspection of Altcourse in February 2005. Her report described Altcourse as a safe prison with good interaction between staff and prisoners.
21. There have been five deaths at Altcourse since the beginning of this year – two from natural causes and four apparently self-inflicted deaths.

Key Findings

22. The man arrived at Altcourse on 24 May 2005 and was allocated a cell on the Furlong residential unit, which is the induction and detoxification unit. During his initial health screen interview, it was noted that the man had recently seen a doctor concerning addiction to heroin. The man requested detoxification (reduction or removal of the toxic properties of a drug) as he had previously been receiving prescribed medication (Subutex) to help him with his withdrawal from heroin. The man also told staff that he had previously taken an overdose and, as he later threatened to harm himself, he was placed on an open Suicide and Self Harm (SASH) observation regime.
23. On 26 May, the man was admitted to healthcare for observation because of chest pain, shortness of breath and high blood pressure. He also told staff that he had a pre-existing heart condition, a hole in the heart. The man's blood pressure subsequently settled and he was discharged from the health care centre the following day. On 1 June, The man's blood pressure was checked and it was noted that it was no longer high.
24. The SASH observation regime was closed on 2 June after a multi-disciplinary case review decided that The man was no longer at risk of self-harm.
25. On 22 June, the man reported to healthcare due to a football injury. On examination, there was found to be limited movement in his neck. The man's blood pressure was checked again and the reading was high. The man was admitted to healthcare the following day for bed rest and observation. The man then requested to return to the Furlong unit. There was no plan for further monitoring of his condition, and there was no further review of his blood pressure.
26. On 25 June, the man told staff that he had a headache and was given paracetamol.
27. On 28 June, a prison doctor saw the man as his neck was still painful. He advised the man to keep it mobilised.
28. On 8 July at 7:15am, the man's cellmate returned from breakfast to their cell in the Furlong unit. The cellmate found the man still in bed and, as he could not rouse him, he informed prison staff. A Prisoner Custody Officer entered the man's cell. He also failed to get a response from the man and immediately summoned urgent assistance via his radio.

29. Prison medical staff responded to the request for medical assistance and arrived at the man's cell within five minutes. They initially moved the man off his bed to the cell floor. As the man had no pulse and was not breathing, they decided to move him to the landing, which had been cleared of prisoners, so that a full assessment of his needs could be carried out. It was at this point that the prison doctor arrived at the cell. At 7:36am, the prison doctor certified that the man had died. The man was then returned to his cell which was secured.
30. The Duty Director and a representative from the prison's Chaplaincy contacted the man's family to inform them of his death and to offer their condolences and support.
31. The Chaplaincy maintained contact with the family and offered to assist with arranging the funeral and providing financial help. The family were invited to visit the prison to see the man's cell. While they were in the prison, the family also met the man's cellmate. The man's family told my Family Liaison Officer that they felt that the prison had handled these matters sensitively. I am pleased to share that commendation more widely through the medium of this report.
32. From comments made by staff at Altcourse, it seems that the man was a respected and well liked prisoner. This was demonstrated by the fact that £400 was collected by the prisoners on his wing after his death, and also from the letters of support received by the man's family.
33. The post mortem states that the cause of death was due to natural causes as a consequence of a subarachnoid haemorrhage and a ruptured intracranial aneurysm (a ruptured artery in the brain).

Issues raised by the family

34. The man's family asked whether the cause of his death was a condition that could have been identified beforehand. The Clinical Reviewer stated that the man received appropriate care following his presentation to healthcare staff. In retrospect, the reviewer stated that it would have been difficult for the healthcare team to link the symptoms and signs with which the man presented, namely headache and raised blood pressure, to what turned out to be the actual cause of death.
35. The family stated that the man suffered from migraine and wondered if this was connected to his cause of death. The Clinical Reviewer stated that the man did not tell healthcare staff that he suffered from migraines, and that he was treated appropriately when he said that he had a headache. The reviewer added that headaches may or may not have been relevant to the cause of death but this would be impossible to determine.
36. The family pointed out that the man's aunt died of the same condition and asked whether it is hereditary as his children may be at risk. The reviewer stated that this condition can be hereditary and recommended that the family seek guidance from their family doctor on this matter.
37. The man had told his mother in a telephone call that he had hurt his neck playing football a couple of weeks prior to his death, and had reported it to medical staff who said they would manipulate his neck. The family wanted to know if the manipulation could be linked to his death. The reviewer stated that the man's football injury was treated and monitored appropriately. The reviewer added that there was nothing in the clinical records to suggest that the man's neck had been manipulated, although he was advised to keep his neck mobilised.
38. When the family visited the prison, the man's cellmate had asked the family if the man's death could have been caused by a knock to his head during the football game when he injured his neck. The clinical records confirm that the man did sustain an injury following a football game. However, it is impossible to determine whether this is directly linked to his cause of death.
39. The family also asked whether it was possible that having a drip put into his head when he was a baby could have had any impact on his death. The reviewer stated that there was no evidence that this had any bearing at all.

40. The family also asked whether the man had fallen out of his bed. My investigator noted that, although the man did occupy the upper bunk in his cell, there was no evidence that he fell out of his bed. I do not think his death was attributable to falling from height.
41. My investigator also noted that Altcourse were in the process of fitting all upper bunks with top railings to prevent accidental falls before the man's death.

Clinical Review

42. The clinical review concluded that, although the man's care was appropriate, there appeared to be information that had not been properly recorded in the man's medical records.
43. During the First Reception Health Screen, the man reported no significant concerns in relation to his physical health. On 26 May 2005, the man was admitted to the healthcare centre because of chest pain, shortness of breath and high blood pressure. The plan was to monitor the cause and effect of the chest pain and to relieve the pain with effective interventions. Observations were to be carried out half hourly. On the same day, he received a once only prescription for Atenolol. The man's blood pressure subsequently settled and he was discharged from the healthcare centre the day after.
44. The man's blood pressure was checked again on two further occasions on 1 June and 22 June; the latter reading was elevated. No plan for further monitoring was apparent. The man then sought medical assistance on 25 June with a headache and was given paracetamol. His blood pressure was not reviewed at this time. Differential diagnosis does not appear to have been illustrated in relation to the man's chest pain.
45. No entries in the clinical notes were signed and some entries were difficult to read.
46. The reviewer also drew attention to issues concerning the management of The man's care. These included:
 - i. the absence of a differential diagnosis, which is a list of the possible diagnoses for symptoms and signs, from which the correct diagnosis can be extracted after further investigation;
 - ii. recording blood pressure monitoring in cases where it is indicated;
 - iii. better maintenance of medical records.

Recommendations

Healthcare

I accept the recommendations of the clinical review, which are summarised as:

- 1 The standards in relation to clinical records should be reviewed, particularly the legibility and signing of some individual entries.
- 2 The RMN progress notes should be amended to include space to record the date.
- 3 Care should be taken to record all blood pressure monitoring.
- 4 A differential diagnosis should be carried out and recorded in the clinical notes.