INVESTIGATION INTO THE CIRCUMSTANCES

SURROUNDING THE DEATH OF A MAN AT

HMYOI NORTHALLERTON ON 31 MAY 2007

Report by the Prisons and Probation Ombudsman for England and Wales

February 2008

This is the report of an investigation into the circumstances of the death of a man on 31 May 2007. The man had collapsed in his cell at HMYOI Northallerton. He was just 20 years old. The provisional post mortem report found that the man died of natural causes, although the cause has yet to be determined.

The death of a loved one is always difficult to bear, particularly of someone so young and when the reason is far from clear. I offer my sincere condolences to this young man's family and those touched by his death.

One of my investigators conducted the investigation on my behalf. Both she and I would like to thank the Governor of Northallerton and the prison's Liaison Officer for their cooperation during the course of our inquiries. I would also like to thank the Detective Superintendent for sharing information from his comprehensive investigation. His help was greatly appreciated.

A clinical review was conducted by the North Yorkshire and York Primary Care Trust (PCT). The Primary Care Clinical Director at the PCT, answered further questions from my investigator. I also thank them for their efforts.

The man had only been in Northallerton for two months prior to his death. From the outset, it was apparent that he was unwell. He certainly felt depressed at times, and was frequently sick after meals although he did not always report the extent of this. He may have been withdrawing from heavy alcohol use. In those two months in prison, the man lost a considerable amount of weight. The day before his death, he saw the doctor as he was concerned about blood in his vomit and dizziness on standing. The doctor ordered a blood test and warned that, if blood was again present in his vomit, he should be transferred to hospital. The following day, the man collapsed in his cell. His cellmate reported that in falling, he had hit his head hard and had a seizure. Staff attempts to save him were unsuccessful.

Questions remain as to how someone so young died so suddenly. This certainly compounds the sense of anguish for his family. The shock and dismay has also been felt by staff and prisoners at Northallerton.

My investigator found that the man had received a good level of clinical care whilst at Northallerton. However, there is a need for improvement in some record keeping, as well as in the monitoring and follow up of patients. I make five recommendations.

Stephen Shaw CBE
Prisons and Probation Ombudsman **February 2008**

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SUMMARY

The man appeared in court in mid March 2007 and arrived at Northallerton YOI on 27 March to serve a sentence of 14 months. He told staff he had been a heavy drinker outside prison. He felt particularly unhappy and was referred to the mental health in-reach team (MHIT).

The following day the man told a nurse he had been vomiting after meals and blood had been present. He was monitored and referred to see the doctor. The prison doctor ordered blood tests which later proved to be normal. The doctor did not think that the man was experiencing withdrawal from alcohol at that time.

Due to his low mood, staff opened an Assessment, Care in Custody and Teamwork (ACCT) plan - a document used to monitor those thought to be at risk of suicide or self harm. A thorough assessment was completed and efforts were made to encourage him to contact his family and to occupy his time. He himself had asked for sharp items to be removed from his cell. He had also lost his appetite, and was encouraged to eat small amounts. The ACCT was closed on 17 April 2007 as the man said he was feeling brighter, he was attending education and had a cellmate with whom he got on well.

In addition to education, he attended the short duration programme for alcohol awareness. He contributed fully and was said to be committed and making good progress.

Intermittently, the man complained of feeling unwell. He said he felt dizzy, and at times complained of headaches. In a review by the MHIT on 27 April, he was low in mood, and lacked appetite and sleep. He was tearful during the interview, and again mentioned the fact he had been abusing alcohol before coming into prison. The MHIT agreed to start seeing him on a one to one basis, starting a few days later.

The clinical record shows that on the same day he had seen a second prison doctor. The doctor noted that the man was suffering from anxiety/depression, low mood and that he sometimes felt dizzy when standing up. The man had stopped taking his vitamin B tablets and was advised to start taking them again. He had also been prescribed anti-depressants and was taking them regularly. There is no record of when they were prescribed or how they were monitored.

A third prison doctor saw him on 8 May. The man said that for several weeks he had an ache in his right side. However, in reporting this he did not relate this to food or mention that he had been vomiting. After examination, the doctor prescribed some pain relief and ordered a urine test for blood, protein and glucose. The man had been asked to return to the doctor the following day, but did not do so. The reason is not known, there is no indication of any follow up action and the result of the urine test was not recorded. For the next few days, he saw the nurse to take his citalopram but refused to take the vitamin B tablet.

On 29 May, his cellmate told a nurse that the man was vomiting after everything he ate and some blood was in the vomit. The nurse referred him to see the doctor. His

cellmates told my investigators that the he was sick most days after food, but they had not seen him make himself sick.

The man was last examined by a doctor on 30 May, the day before he died. He told the third doctor that he had been vomiting, mainly after lunch, for two months. He said that, if he did not eat, he did not vomit. He said there had been a small amount of blood in the vomit, but this had been worse about two months before and had only increased again over the previous two weeks. He also said he felt light-headed when standing. The doctor examined him and noted that he had lost a lot of weight (1.5 stone). The weight loss combined with the presence of blood in his vomit warranted further attention. The doctor saw that previous blood test results had been normal. He then ordered further blood tests and prescribed medication to help alleviate the sickness. He also noted that, if further blood was found, he should be transferred to hospital for investigation.

The man did not attend for his blood test on 31 May. Again, it is not clear why, or if this was followed up. His new cellmate said that after lunch he had been sick for most of the afternoon. That night, after standing to make a cup of tea, he had fainted and hit his head on the floor. It would appear that he had a fit, but afterwards was able to stand. His cellmate helped him to bed. After several minutes, he looked pale and did not appear to be breathing so his cellmate pressed the cell bell to raise the alarm.

A prison officer entered the cell and attempted Cardio Pulmonary Resuscitation until paramedics arrived. The ambulance took the man to hospital where he was pronounced dead.

The provisional post mortem has been unable to ascertain the cause of his death. Clearly, the man's family, and those involved in his care have been very concerned how someone so young died so suddenly.

The man's clinical care has been reviewed by several clinicians from North Yorkshire Primary Care Trust. In general, they found the level of care the man received was as good as, if not better than, what would be expected in the community. Regular consultations with nurses and doctors had taken place.

Although he did not receive a formal detoxification from alcohol, his alcohol problem is well documented and he was receiving support. Some of his symptoms, such as anxiety, sickness and/or loss of appetite, can be related to alcohol withdrawal. Exceptionaqlly, alcohol detoxification can lead to seizures.

His family are particulalry concerned that he lost a dramatic amount of weight (12.2 kgs) in the two months he was at Northallerton. He frequently presented with concerns relating to sickness or abdominal pain. Whilst his blood pressure and pulse were regularly monitored, given his symptoms it might have been sensible to monitor his weight.

Healthcare staff had a great deal of involvement with him. Generally, the entries in the clinical record are thorough and compassionate. However, not all results of tests were clearly documented. There is no note of when he started taking anti-

depressant medication or of subsequent monitoring. There were also times he did not attend for appointments. As in the community, it was his right not to do so but, given the level of concern exhibited by the prison doctor and others, it might have been appropriate to follow up the reasons and I make a recommendation on this issue.

The prison officer acted professionally and compassionately in his efforts to save the deceased. However, no one on duty was trained in the use of defibrillator equipment. Whilst I do not suggest this could have saved this man’s life, in another instance it could prove critical.

I also make recommendations regarding the need to appoint and train staff in the role of family liaison officer.

THE INVESTIGATION PROCESS

I appointed one investigator to lead the investigation on my behalf. She visited HMYOI Northallerton where she met the deputy governor. She was given a tour of Northallerton, including the cell in which the man had been found. She spoke with the local committee of the Prison Officers' Association (POA) and the Independent Monitoring Board (IMB). Notices were issued to both prisoners and staff inviting anyone who might have information relating to the deceased to make themselves known to the inquiry.

Along with the investigator, one of my family liaison officers visited the man's family to discuss the investigation and find out whether they had any questions. They were particularly concerned that he had been vomiting and had not been taken to hospital sooner. They asked whether there was evidence that the prison had noticed the man's weight loss. They also questioned whether his previous heavy drinking could have been related to his death. These issues are discussed further in this report.

The police had conducted a thorough examination of events. The Detective Superintendent met the investigators and shared information the police had gathered. This included all witness statements. The investigator spoke with prison staff and prisoners and also examined the man's prison record, medical records and a series of prison documents.

A clinical review of the man's healthcare in custody was undertaken by the North Yorkshire and York Primary Care Trust. On receipt of the clinical review, my investigator asked further clinical questions which were answered by the Primary Care Clinical Director, North Yorkshire and York Primary Care Trust. The investigation was suspended in September 2007 pending the results of the post mortem, and reopened in December 2007.

HMYOI NORTHALLERTON

HMYOI Northallerton was formerly the county gaol for the North Riding of Yorkshire. The establishment dates from 1783. It has had a number of changes of role over the years, including use as a military prison, a training prison for adults and a remand centre. Since the summer of 2002, it has operated as a Young Offender Institution holding young men aged between 18 and 21 serving under two years imprisonment.

Northallerton has a healthcare centre with no in-patient facilities. It is a wholly contracted service from the local NHS trust, with an emphasis on retaining staff with skills in mental health nursing.

There is a daily doctor's surgery, weekly dental facility, and also a consultant psychiatric service. There is a strong ethos of managing patients in the "community" via the full time "outreach" nursing facility. This outreach provides monitoring and support for all, and is supplemented with services such as stress reduction, smoking cessation, health promotion, information and counselling.

HM Chief Inspector of Prisons, Ms Anne Owers, conducted a full inspection of Northallerton in October 2005. She found it to be a generally safe prison, focussed on resettlement. More prisoners than the benchmark for similar jails regarded the healthcare provision as good. Her report commented that healthcare staff provided a generally good service in spite of inadequate working conditions.

The Chief Inspector found that Northallerton required significant investment. Prisoners had insufficient time out of cell, some physical conditions were below par and there were not enough facilities for training. However, other resettlement work was commended.

KEY EVENTS

The man was remanded into HMYOI Lancaster Farms on 19 March 2007. He transferred to Northallerton on 27 March to serve his sentence of 14 months.

On arrival at Northallerton, he underwent a thorough initial health screen in which his weight was recorded as 76.2 kg (11 stone 10lb). He said that prior to coming into prison he had been a heavy drinker, consuming about 15 units per day. He felt low in mood and sometimes dizzy. His blood pressure was recorded as 110/70. He was also referred to the mental health in reach team (MHIT).

The following day he had abdominal pain. He told the nurse that he vomited twice daily after meals, and there was blood in his vomit. The nurse took his blood pressure (140/84) and pulse, and advised him to rest, sip water, and to try to save his vomit for inspection. Later, the nurse saw there was some blood-stained vomit. She repeated the blood pressure test (134/82) and referred him to see the doctor.

An Assessment, Care in Custody and Teamwork (ACCT) plan - a document used to monitor and support those thought to be at risk of suicide or self harm - was opened due to his low mood. (The precise date on which the ACCT form was opened is unclear.) He had himself asked that sharp items be removed from his cell. The following morning, an officer conducted an ACCT assessment. The man did not feel suicidal but felt low due to his alcohol dependence, past bereavement and isolation from his family who lived some distance away. Notes indicate that he was polite, articulate and respectful.

The man then had a consultation with the first prison doctor. The focus was mainly on his mental state. He told the doctor he had drunk six litres of cider daily for over a year. The doctor noted that the man had suffered some mild withdrawal symptoms on arrival at his previous prison, but was not thought to be in withdrawal at that stage. He also wrote that he should "monitor blood in his vomit". He prescribed vitamin B tablets and ordered a full blood count and liver function tests. These particular investigations later proved to be within normal limits.

A sentence planning board was held with the man to discuss how best to spend his time in Northallerton. He was keen to engage with the Counselling Advice Resettlement and Throughcare Service (CARATs) to address his alcohol issues. He also said he wanted to take part in education. Throughout his time in Northallerton, he attended education classes and was said to work hard.

On 3 April, a nurse who saw him to conduct a blood test noticed he had made three long superficial cuts to his right forearm. The nurse wrote in the clinical record that the man had been very embarrassed about it. He said he had made the cuts two nights previously when he was feeling particularly down, but that he was feeling a bit better. However, the nurse thought that he appeared quite low, with poor eye contact, and was reluctant to speak. The nurse noted in the clinical record that he spent some time in the healthcare centre rather than going to education classes as he felt light headed and had a headache. The nurse further noted, "still appears to be struggling with alcohol withdrawal, review pm."

The man also attended an ACCT review with a senior officer, a nurse and a member of the education department. They had a long discussion about his mood as he had said he felt “three out of 10”. The man said he was not sleeping well and felt tired all the time. He reported that he had not collected his meals since Sunday (three days earlier) as he did not feel hungry. He said that outside of prison, as he drank so much, it was usual for him to only eat in the evenings. Staff encouraged him to try and eat small quantities. He said he was in touch with the mother of his child, and liked talking about his son. He said he would not contemplate suicide as he could not upset his own mother. Staff noted that he did not appear comfortable talking about himself, and made poor eye contact. They also felt he had a tendency to say what he felt people wanted to hear. He admitted he was struggling on the wing and would like to share a cell. This was arranged, and the level of risk was raised from low to medium. The SO set up a phone call to a friend of the man’s mother to try and arrange a visit.

The same day, he was also visited by an officer from the CARATs team. They discussed a plan to address his alcohol problems. He agreed to have one to one sessions with a CARATs worker and to attend the short duration programme (SDP).

The third prison doctor provided a written statement regarding his involvement with the man. He said that his first contact was on 4 April 2007 when he conducted a general mental health review. The doctor found him to be slightly depressed. There was no evidence that he was experiencing hallucinations, delusions or suicidal thought. He also showed no signs of alcohol withdrawal. The doctor felt that the man did not have a major depressive illness but warranted help with his alcohol consumption. The man continued to be monitored over the coming days as part of the ACCT process, and engaged well with staff.

On 7 April, the nurse visited him in his cell as he had been complaining of a headache, abdominal pain and constipation. The nurse gave him some paracetamol and advised him to drink plenty of fluids.

The following week, the laboratory dealing with his blood test provided some results. They also notified the prison that they had not conducted all the necessary tests. They required a further blood test which was arranged.

On 17 April, another ACCT review took place. The man had been feeling much brighter in the preceding days. He was settled into a routine, busy during the day attending education and sharing a cell with someone he liked. All agreed to close the ACCT.

The MHIT conducted a review on 27 April. They noted that he was low in mood and was experiencing a lack of appetite and sleep. He was tearful during the interview, and again mentioned that he had been abusing alcohol before coming into prison. The MHIT agreed to start seeing him on a one to one basis, starting several days later.

The clinical record shows that the man visited the second prison doctor the same day. The doctor noted that the man was suffering anxiety/depression, and low

mood, and that he sometimes felt dizzy when standing up. He had not been taking his vitamin B tablets, and was advised to start taking them again.

The third prison doctor assessed the man on 8 May. He told him that for several weeks he had mild aches in his right side and this had increased to a stabbing pain. He did not relate this to food, but said it increased with movement and coughing. He did not mention that he had been vomiting. His blood pressure and pulse were normal. The doctor felt his abdomen and it was slightly tender on the right side. The doctor prescribed pain relief, ordered a urine test for blood, protein and glucose and asked to see him the following morning for a review. He declined the offer to see the doctor the following day, but there is no record of the reason, any follow up action, nor the results of the urine test.

On 25 May, the first prison doctor carried out a mental health review. He found him to be slightly low and recommended exercise. He had also been prescribed citalopram, an anti-depressant, but my investigator could not ascertain when this was prescribed or what monitoring or review took place regarding it. For the next few days, the man saw the nurse to take his citalopram but refused to take the vitamin B tablet.

On 29 May, his cellmate at the time, told the nurse that the man was vomiting everything he ate, and that blood was in the vomit. The nurse referred him to see the doctor. The third prison doctor saw him the following day and the man told him that he had suffered from vomiting, mainly after lunch for two months. He said that if he did not eat, he did not vomit. There had been a small amount of blood in the vomit, but this had been worse about two months before. He denied any melaena (this refers to the black, "tarry" faeces that are associated with gastrointestinal haemorrhage). The man said that, since coming to Northallerton, his vomiting symptoms had first improved but had deteriorated over the previous two weeks. He also said that he sometimes felt light headed when standing. Again, his blood pressure and pulse were normal. The third prison doctor examined his abdomen which he felt was 'soft with no masses'. He noted that the man weighed 61 kgs (the following day, a nurse recorded his weight as 69kg).

In the doctor's statement, he said that his major concern about the man was that his weight loss combined with blood in his vomit warranted further investigation. The doctor found that the full blood count from the end of March had been filed in his medical record and the results were normal. The liver function tests that had been taken on 12 April had not been filed, so he phoned the laboratory at Friage Hospital in the town and they were able to tell him that they too were normal. The doctor prescribed Lansoprazole 30mg, once daily (a drug which helps prevent the stomach producing acid). The first dose was given immediately after the consultation. The doctor also requested a full blood count. An appointment was made to review him the following week and to discuss a possible referral for an endoscopy examination. The doctor wrote in the medical record that, if any further blood was seen in the vomit, the man should be admitted to hospital. The request for the blood tests was listed in the nurse's job book. The man did not attend for his blood test on 31 May. Again, no reason or follow up was recorded.

The man's key worker on the short duration programme (SDP – a programme to help those addicted to drugs or alcohol). The man was two weeks into the four week programme which requires attendance every day. (There is an additional weekly meeting with the key worker.) His key worker described him as quiet, but he interacted well with his peers. He seemed happy to watch others playing pool and cards and would chat with them. He was very well liked, placid, and never confrontational with others.

The man did not always speak openly in the group, but when asked questions, he contributed well. The key worker said that he seemed unhappy about his situation. He recognised the harm he had caused others by drinking and was desperate to make amends. On a one to one basis, he had told his key worker he had reached a point where he was ready to change. He had hope for the future and wanted to be a better person and a better father.

The man never directly told his key worker that he had been sick, but she said the man was always hungry. She described him as skinny. She said there had been a couple of days in the previous two weeks, although she could not remember exactly when, that he had looked very unwell. He said he had a migraine and she could see he was squinting at the light. She said that some of the prisoners needed little excuse to miss a session, but he never did and did not complain even when it was clear he was unwell. In fact, he even apologised for being a bit quiet.

A prisoner had shared a cell with him from around 1 May until 31 May. He said that he liked him but knew something was wrong. The man was always sick after food, and he wondered whether the man had an eating disorder. He also said that the man had "head rushes" which would last for several minutes. These meant that he would either sit down quickly or hold onto something so he did not collapse. The man had described it to his cellmate as a black out.

31 May

Another prisoner was moved to share a cell with the young man. They knew each other from the SDP rehabilitation programme, and both attended the course in the morning and then went for their lunch around midday. After collecting their meals they returned to their cell. The cellmate told police that on 31 May they both had cheeseburger and chips with coleslaw. The man ate all his lunch and even finished his cellmate's coleslaw. This surprised him as he had heard that the man did not eat much. About 15 minutes after they had finished their food, the man started to vomit. His cellmate said this lasted on and off for around two to three hours. In between the episodes of vomiting, they played poker together. He told police that he offered to press the buzzer to get help from staff, but the man said he would be okay. During their conversations that afternoon, the man told his new cellmate that he sometimes suffered from fits. They joked about this, and the cellmate said that if the man ever fitted in front of him he would call staff straightaway. He said that, overall, he had not been too concerned about the man's health. He knew that the man had been an alcoholic and thought he was on a "bit of a downer".

The key worker had a one to one session with the man. She remembered that another young offender walked past and said, "are you the lad that makes himself

sick?" When she asked him about this, he said he was sick but was taking medication from the doctor and was happy with the treatment he was receiving. In this session, the man was feeling positive about the future and wanted to make amends for his actions.

At around 4.00pm, the man and his cellmate and went to collect their tea packs. The man said he was not hungry and gave his tea pack to his cellmate, saying that if he ate it he would probably be sick all night. They then watched television together in their cell until about 6.20pm when they went out onto the landing to socialise with other prisoners. His cellmate said there was a good atmosphere on the wing. The man played pool, and went back to his cell around 7.30pm. The cellmate returned to the cell soon after and the man was lying on the bottom bunk of the bed watching television. They continued to watch television and the cellmate began to write a letter. Soon after 9.00pm, the man got up and asked his cellmate if he wanted a cup of tea and was looking around for the cups. The man's cellmate was still writing his letter, and heard the man swear and start to fall backwards towards the floor. The cellmate said he reached out to try and stop the man falling, but just caught his arms and was unable to stop his head from hitting the floor. He pointed out that the man's head had hit the concrete floor with force.

While the man was on the floor his body began to shake, but after a minute or so he was able to stand. The cellmate remembered that the man said something like "my head feels like it is going to explode". He told him that he had hit his head, and advised him to lie down. He helped him to his bed and then continued to write his letter. After a couple of minutes, the man flung his leg and arm off the side of the bed and was breathing in a noisy and peculiar way. After a while, the noises stopped. The cellmate could hear him breathing normally and assumed he was alright. After a few minutes, he looked at him and realised he had turned quite pale. The cellmate told police he began to feel worried as he could not see the man's chest go up and down much. He placed his hand on his chest and could not feel much movement, then checked for a pulse in his wrist and "could not really feel this". He shook him and again got no response so he pressed his cell bell.

The Operational Support Grade (OSG) answered the cell bell within a couple of minutes. The cellmate told him what had happened. The night orderly officer was in the office on A wing completing paperwork. At approximately 9.20pm, the OSG went to the office and told him what the man's cellmate had said. The orderly officer went to the man's cell and spoke to his cellmate through the door. He explained that the man had passed out, had a fit and had been helped onto his bed. The officer said that his cellmate had found a pulse but could not wake him out. The orderly officer could see that the man was on the bottom bunk and was pale. The orderly officer then asked the OSG to fetch the wing officer.

On entering the cell, the orderly officer checked but could find no pulse. He sent the wing officer to call an ambulance. In the meantime, the orderly officer and the cellmate moved the man onto the floor, and the orderly officer told the cellmate to ask the wing officer for the first aid box. The orderly officer commenced cardio pulmonary resuscitation (CPR). The orderly officer was not trained in the use of defibrillators and was not entirely clear where they were kept.

The wing officer instructed the gatekeeper to call an ambulance, and took the keys from the orderly officer so he could facilitate the ambulance entry when it arrived. The ambulance arrived at 9.29pm. The paramedics took over CPR from the orderly officer and rushed the man to hospital with the wing officer. The paramedics continued CPR all the way to the hospital. Soon after arrival at hospital, the doctors pronounced the man dead.

Following his death, contingency plans were followed. A family liaison officer was appointed. Northallerton staff contacted a prison in closer proximity to his family home and asked them to visit the man's family to break the news in person. A plan was put in place to break the news and offer support to staff and prisoners. I understand that both staff and prisoners felt a sense of disbelief and shock.

ISSUES

The man had been progressing well in his sentence, having made a determined effort to change. He attended education classes, and the short duration programme. He wrote and phoned his family, spent time drawing, and associated with others. On the whole, his time was occupied and constructive. He was well liked by his peers.

Staff acted appropriately in opening an ACCT to support and monitor him when he was feeling down and self harmed. The reviews and support were of a good standard.

His clinical care has been reviewed by several clinicans from North Yorkshire Primary Care Trust. In general, they found the level of care he received was as good as, if not better than, that which could be expected in the community. It was clear that the man had regular consultations with nurses and doctors.

The provisonal post mortem was unable to ascertain a conclusive cause of death despite thorough examination.

Alcohol withdrawal

It was recorded at Lancaster Farms that the man had been a heavy drinker. When he arrived at Northallerton on 27 March, he told staff he drank approximately 15 units of alcohol per day. The clinical review concluded that no detoxification programme was deemed necessary. The man was offered one to one counselling regarding his alcohol issues. He also was prescribed vitamin B supplements (a vitamin which is depleted by excessive use of alcohol and poor diet). It is noted in the clinical record that the man appeared to be struggling with alcohol withdrawal on 3 April. When he saw a doctor the following day, he noted no major signs of withdrawal such as sweats or tremors.

The man's family are concerned about the effect his alcohol consumption may have had on his health and eventual death. However, it appears that he did receive support while in custody for his alcohol problems. Some of his symptoms, such as anxiety, sickness and/or loss of appetite, can be related to alcohol withdrawal. In exceptional circumstances, alcohol detoxification can also lead to seizures. However, the man presented with a variety of symptoms which could equally have been attributable to another cause.

Weight loss

On arrival at Northallerton, the man's weight was recorded as 76.2kg. The post mortem records his weight as 64kg at the time of death. This is a loss of 12.2kg (just under two stone).

After his death, his family were able to view his body. They were particularly distressed to see how much weight he had lost, given he had been a healthy size when he was imprisoned only two months previously.

One of the family's key questions was whether anyone had noticed the weight loss. Some staff described him as "skinny". The prison officer said he had not realised how much weight the man had lost until he saw a picture of him when he had first come into prison.

Healthcare staff had a great deal of interaction with the man at Northallerton. His blood pressure and pulse were regularly taken. However, he does not appear to have been weighed between 27 March and 29 May. There are several entries in the clinical record during this time indicating he had mentioned a lack of appetite, sickness or abdominal pain.

The head of healthcare should remind staff to weigh prisoners who report appetite or stomach ailments.

Other health considerations

The possibility that the man may have been suffering from bulimia was raised by other prisoners after his death. My investigator and police spoke with both his last and previous cellmate. Both said that he was often sick after food, but they had not actually seen him make himself sick. This is something that had previously been of concern to his family members.

As concluded above, the healthcare provided was of a good standard with appropriate investigation into the man's complaints of ill health. He was regularly monitored, and received prompt referral and assessment from the mental health team.

The man was prescribed citalopram for anxiety/depression. However, it is not clear from the records when this was prescribed or what subsequent monitoring took place.

The head of healthcare should remind staff of the importance of clear, comprehensive and accurate record keeping in accordance with guidelines from their professional bodies.

The man's family are keen to know whether he should have been transferred to a hospital when he told the doctor about blood in his vomit. He had reported this soon after first coming into Northallerton. When he saw the third doctor on 30 May, he said this had first subsided but had worsened in the previous two weeks. The doctor examined him and noted his weight loss. He checked previous blood test results, and ordered another blood test. He prescribed medication to reduce the acid in his stomach, and left instructions that if blood was present in his vomit again he should be taken to hospital for further examination.

All three clinicians involved in reviewing the man's care said that the actions of the third doctor were reasonable, and there were no other indicators to merit sending him for investigations at hospital sooner.

On 31 May, the man did not attend for the blood test the doctor had requested. There had been several occasions on which he had not attended appointments or collected medication.

Of course, it would have been for him to decide whether he wished to attend, as it would be had he been in the community. However, where there are clear concerns about a non-compliant patient, as there were from the third doctor, it is good practice to follow up non-attendance.

The healthcare manager told my investigator that healthcare staff tend to follow up if there are concerns about a patient. This has yet to be formalised in policy.

The head of healthcare should consider implementing a local policy to ensure non-compliant patients are followed up where healthcare staff have concerns.

Crisis Management

When the man's cellmate raised the alarm, staff responded quickly and appropriately. Particularly noteworthy were the efforts of the night orderly officer. He took charge of the situation, instructed staff to activate contingency plans and commenced CPR. (the officer had recently completed CPR training.)

The defibrillator machine has been described as the single most important development in the treatment of cardiac arrest. Defibrillators are used in a variety of public settings, including railway stations, airports and prisons. Whilst there are defibrillators in the prison, no one on duty at the time of the man's collapse had been trained in their use.

The governor should ensure that all staff are made aware of the location of defibrillator machines and provide suitable training in their use.

Following the man's death, contingency plans were followed. Staff from a prison closer to the man's family visited to break the news in person. An SO was appointed the prison family liaison officer but had not been trained for this role.

The governor should appoint and train an appropriate number of staff to perform the role of family liaison officer.

Conclusion

Given the uncertainty as to cause of death following the post mortem examination, questions remain as to how someone so young as this young man could die so suddenly. These questions can only add to the anguish of his family, and the shock that was felt by staff and fellow prisoners at Northallerton.

I regret that this investigation cannot answer all the remaining questions. What I may reasonably conclude, however, is that the man received a good level of clinical care whilst at Northallerton and was properly supported by staff.

RECOMMENDATIONS

The head of healthcare should remind staff to weigh prisoners who report appetite or stomach ailments.

The Prison Service accepted this recommendation:

"Written guidance will be issued in order to remind healthcare staff to weigh prisoners who report appetite or stomach ailments and record it accordingly. This will be documented in line with the PCT appraisal system."

The head of healthcare should remind staff of the importance of clear, comprehensive and accurate record keeping in accordance with guidelines from their professional bodies.

The Prison Service accepted this recommendation:

"Written guidance will be issued in order to remind healthcare staff of the importance of clear, comprehensive and accurate record keeping. This will be documented in line with the PCT appraisal system."

The head of healthcare should consider implementing a local policy to ensure non-compliant patients are followed up where healthcare staff have concerns.

The Prison Service accepted this recommendation:

"A local policy will be developed and implemented to ensure non-compliance by patients is followed up where healthcare staff have concerns".

The governor should ensure that all staff are made aware of the location of defibrillator machines and provide suitable training in their use.

The Prison Service accepted this recommendation:

"Five non PCT staff were trained in the use of defibrillator machines in June 2007. A new PCT trainer has now been appointed and so training of the PCT staff in the use of defibrillator machines will take place. This will be included in the annual training plan.

A staff information notice will be published to make all staff aware of the location of defibrillator machines."

The governor should appoint and train an appropriate number of staff to perform the role of family liaison officer.

The Prison Service accepted this recommendation:

"Two members of staff have been identified to perform the role of family liaison officer. They are awaiting a course date so training in this role can be carried out."