Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alex John, a prisoner at HMP Pentonville, on 13 January 2020

A report by the Prisons and Probation Ombudsman

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OUR VISION

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

WHAT WE DO

WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Alex John died of heart failure in hospital on 13 January 2020 while a prisoner at HMP Pentonville. This was caused by uremic cardiomyopathy (heart disease that accompanies chronic kidney disease) which in turn was caused by end-stage diabetic glomerulopathy (diabetic kidney disease). He also had ischaemic coronary heart disease, systemic hypertension (high blood pressure) and Type 1 diabetes which did not cause but contributed to his death. He was 57 years old. I offer my condolences to Mr John's family and friends.

The clinical reviewer found that the clinical care that Mr John received at Pentonville was good and equivalent to that which he could have expected to receive in the community. However, I am concerned that specialist advice was not sought for his diabetes.

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

Adrian Usher
Prisons and Probation Ombudsman **April 2024**

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Summary

Events

1. On 2 November 2009, Mr Alex John received an indeterminate sentence for public protection for aggravated burglary, with a minimum term to serve of three years.

2. Mr John had a significant number of chronic health conditions, including hypertension, chronic kidney disease, cardio-renal failure, chronic anaemia, Type 1 diabetes, high cholesterol, ischaemic heart disease, personality disorder and a history of substance misuse. Mr John had a history of refusing heart and diabetic medication and dialysis treatment.

3. In 2017, Mr John was transferred to HMP Pentonville, where he lived in the healthcare wing and received dialysis as a hospital outpatient.

4. In 2019, Mr John frequently refused to attend the hospital for dialysis and to take his medication. His diabetes was poorly controlled, and he was unwilling to engage with treatment or adhere to dietary guidelines. Although his mental health influenced his decision-making, clinicians deemed that he had capacity to accept or refuse treatment for his physical health problems. Specialist advice was sought for his heart and kidney problems but not for his diabetes.

5. On 10 January, Mr John was taken to hospital for a scheduled dialysis appointment and returned to the prison that afternoon.

6. Later that day, Mr John told healthcare staff that he felt weak and unwell and that he had vomited. A nurse examined him and informed a prison GP that his pulse and oxygen saturation levels were low. The GP called a medical emergency code blue and Mr John was taken to hospital straightaway, where he remained until 13 January.

7. At 7.45am on 13 January, Mr John was transferred by ambulance to another hospital for dialysis. He started treatment at 8.00am. At 9.45am, during dialysis, Mr John had breathing difficulties and became unconscious. Officers immediately alerted hospital staff, who started cardiopulmonary resuscitation (CPR). They continued until approximately 10.00am when paramedics arrived, and officers removed Mr John's restraints. Paramedics continued CPR until 11.26am, when they pronounced him dead.

Findings

8. The clinical reviewer found that the clinical care that Mr John received at Pentonville was good and equivalent to that which he could have expected to receive in the community.

9. However, she concluded that healthcare staff should have sought specialist advice about Mr John's diabetes. She made two recommendations about data entry which were not related to Mr John's death but which the Head of Healthcare will need to address.

10. Although we recognise that Mr John remained restrained for 15 minutes after he developed breathing difficulties during his dialysis and then became unconscious, we are satisfied that the supervising officer who was with him took reasonable steps to ensure that the restraints were removed, particularly as Mr John's behaviour was challenging and he had an escort protocol in place. We therefore found it reasonable that the supervising officer promptly sought permission to remove the restraints and when the prison did not respond, she acted appropriately in using her discretion to remove the restraints.

Recommendations

- The Head of Healthcare should ensure that specialist advice is sought to manage long-term conditions such as diabetes.

The Investigation Process

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

12. The investigator did not visit HMP Pentonville due to the COVID-19 pandemic. She obtained copies of relevant extracts from Mr John's prison and medical records.

13. NHS England commissioned a clinical reviewer to review Mr John's clinical care at the prison.

14. We informed HM Coroner for London Inner North of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

15. Our family liaison officer contacted Mr John's sister to explain the investigation and to ask if she had any matters she wanted us to consider. Mr John's family wrote to the Coroner and gave us a copy of the letter. They asked about the healthcare that Mr John received. They also asked a number of issues which fall outside the remit of our investigation such as about Mr John's prison sentence, the complaints he made and his autopsy. We have addressed their concerns in the clinical review, this report and by way of separate correspondence.

16. Mr John's family received a copy of the initial report. They did not identify any factual inaccuracies.

17. The prison also received a copy of the report. They did not identify any factual inaccuracies.

Background Information

HMP Pentonville

18. HMP Pentonville is a local prison in London that holds around 1,300 prisoners. The prison primarily serves the courts of north and east London. Practice Plus Group, in partnership with Enfield and Haringey Mental Health Trust, provides healthcare services.

HM Inspectorate of Prisons

19. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Pentonville in April 2019. Inspectors reported that there was sound governance of healthcare, staffing levels were sufficient, there had been demonstrable learning from deaths in custody and regular sharing of health information between specialist teams at health and wellbeing referral meetings.

20. Reporting on previous deaths at the prison, inspectors raised concerns that while PPO recommendations about healthcare had been actioned, most of the other PPO recommendations had not been achieved.

21. HMIP reviewed progress at Pentonville in January 2020. Inspectors reported that progress had been disappointingly slow and found that little had been done to respond to a very poor inspection report in 2019 until a few days before their visit.

22. Inspectors completed a scrutiny visit of Pentonville in October and November 2020. They reported that healthcare was reasonable, and the administration of medication was safe. They found that waiting times for most health services were reasonable.

Independent Monitoring Board

23. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to 31 March 2020, the IMB reported that healthcare waiting times were equivalent to the community. They noted that the wellbeing centre had received a national award for the best team in clinical services.

Previous deaths at HMP Pentonville

24. Mr John was the eighth prisoner to die at Pentonville since February 2018. One of the previous deaths was from natural causes, five were self-inflicted and one was drug-related. There have been eight further deaths: four self-inflicted, three from natural causes and one unascertained. There were no similarities between our findings in this investigation and those of the previous deaths.

Key Events

25. On 2 November 2009, Mr Alex John was sentenced to an indeterminate sentence for public protection, with a minimum term to serve of three years for aggravated burglary. He was sent to HMP Belmarsh.

26. Mr John had a number of chronic health conditions, including hypertension, chronic kidney disease (CKD), cardio-renal failure, chronic anaemia, Type 1 diabetes, high cholesterol, ischaemic heart disease, personality disorder and a history of substance misuse. Mr John had a history of not taking his prescribed heart and diabetes medication and refusing dialysis treatment. His behaviour was sometimes inappropriate and challenging to manage. This resulted in him having an escort protocol in place which stated that he needed three experienced staff to escort him, he had to be restrained with double handcuffs for his regular hospital appointments, and his restraints could only to be removed in a medical emergency. Mr John had several hospital admissions and appointments during his time in prison.

27. In 2017, Mr John was transferred to HMP Pentonville, where he lived in the healthcare wing and received dialysis as a hospital outpatient.

28. In July 2019, Mr John twice refused to attend dialysis and another session was cut short due to his inappropriate behaviour towards hospital staff. Pentonville's ward manager contacted the hospital for advice, and they discussed transferring Mr John to HMP Full Sutton (because it has a unit for managing prisoners with challenging behaviour and a dialysis unit).

29. On 19 July, a prison GP saw Mr John to discuss his dialysis refusal. Mr John said that he disliked being restrained with double handcuffs while attending dialysis and he felt uncomfortable going to his regular hospital, St Pancras, because of the number of incidents that had happened there and the number of times that hospital staff had telephoned the police.

30. On 22 July, Mr John was discussed at Pentonville's healthcare wing ward round and a plan was made to encourage him to attend dialysis.

31. Between 1 and 12 August, Mr John refused to attend five dialysis sessions. On 9 August, it was noted that Mr John had asked to be transferred to another hospital for dialysis.

32. On 12 August, a multidisciplinary team (MDT) meeting at Pentonville noted that a transfer to Full Sutton was being considered, with a view to Mr John receiving dialysis three times a week at the prison, with support from the hospital.

33. By 19 August, Mr John had missed another three dialysis sessions. Records show that St Pancras gave Pentonville a set of red flag indicators to show when Mr John's health was deteriorating, and he needed to transfer to hospital. An MDT review was planned to consider Mr John's capacity and to discuss with him the consequences of his actions. The next day and for the remainder of sessions that month, he attended dialysis.

34. In September, Mr John missed several dialysis sessions. On 16 September, an MDT meeting noted that Mr John did not have an order in place not to be resuscitated and asked the ward manager to discuss this with him.

35. On 25 September, Mr John said that he would not attend any more appointments. Two days later, he attended dialysis.

36. Throughout October, Mr John refused to attend dialysis once a week on average. On 31 October, he said that he could not attend dialysis because he was being persecuted by the governors. (There is no evidence to conclude what he meant by this.) After a discussion with a prison GP, he agreed to attend dialysis the next day.

37. On 1 November, Mr John refused to attend dialysis and was sent to the emergency department instead.

38. On 2 November, Mr John refused to take his medication and a revised care plan was written to include red flags.

39. On 5 November, Mr John was unwell and so a prison GP reviewed him in his cell. The GP recorded that he had the mental capacity to make decisions and discussed with him what might happen if he were to temporarily lose capacity, for example, if he was unconscious. A plan was made to put an order in place not to resuscitate Mr John and to discuss his care with a renal consultant. Mr John was also referred to a forensic psychiatrist for assessment.

40. On 20 November, a forensic psychiatrist saw Mr John and assessed that his mental state was stable and that he had the mental capacity to accept or refuse treatment for his physical health problems.

41. On 7 December, attendees at an MDT meeting considered whether to relax Mr John's restraints requirements. Mr John attended the meeting, apologised for his behaviour and said that he felt better. He said that he would take his medication and attend dialysis.

January 2020

42. On 9 January 2020, Mr John refused to attend his hospital cardiology appointment.

43. On the morning on 10 January, Mr John was taken to hospital for a scheduled hospital appointment for dialysis.

44. At around 4.30pm, Mr John told healthcare staff that he felt weak and unwell and that he had vomited. A nurse took his observations and noted that his pulse and oxygen saturation levels were low. The nurse in charge was informed, who in turn told a prison GP who, at 4.58pm, called a medical emergency code blue. An ambulance was called, and Mr John was taken to hospital by ambulance and admitted to a cardiology ward.

45. Mr John remained in hospital until 13 January. At 7.45am that morning, he was discharged from hospital and transferred to St Pancras Hospital for his regular dialysis treatment, escorted by three officers. During dialysis, at approximately 9.45am, Mr John had breathing difficulties and became unconscious. Prison escort

officers alerted hospital staff, who started CPR. As soon as she alerted hospital staff, a Supervising Officer (SO) contacted the prison seeking permission to remove Mr John's handcuffs immediately but received no reply. She telephoned the prison again and as no one answered for a second time, she used her discretion to remove Mr John's handcuffs. Hospital staff performed CPR until approximately 10.00am, when paramedics arrived. At approximately 10.25am, the duty governor authorised the escort officers to remove Mr John's handcuffs but the SO had already removed them. Paramedics continued CPR until 11.26am, when they pronounced that Mr John had died.

Contact with Mr John's family

46. On 13 January, a Custodial Manager (CM) was appointed as the prison's family liaison officer, and she visited Mr John's sister at 3.30pm that day, accompanied by a prison manager. They broke the news of Mr John's death and offered their condolences and support. The CM remained in contact with Mr John's sister and arranged for his family to visit his cell. Pentonville contributed to the cost of the funeral in line with national instructions.

Support for prisoners and staff

47. After Mr John's death, a chaplain went to the hospital to support the bedwatch staff and escort them back to the prison for a debrief. She debriefed the officers who wanted to attend the debrief, to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

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

Post-mortem report

49. The post-mortem report concluded that Mr John died of cardiac failure, caused by uremic cardiomyopathy which in turn was caused by end-stage diabetic glomerulopathy. He also had ischaemic coronary heart disease, systemic hypertension and Type I diabetes which did not cause but contributed to his death.

50. The inquest concluded on 8 September 2023 with a verdict of natural causes.

Findings

Clinical care

51. The clinical reviewer considered that the care that Mr John received at Pentonville was of a good standard and was equivalent to that which he could have expected to receive in the community. The clinical reviewer made recommendations about data entry in medical records which did not relate to Mr John's death but which the Head of Healthcare will need to address.

52. Mr John's health was poor, and he frequently refused to take his hypertension and diabetes medication and to attend dialysis. She found that healthcare staff managed his challenging behaviour appropriately and reviewed his mental capacity when needed.

53. She concluded that Mr John's behaviour in NHS healthcare settings while he was a prisoner was unacceptable and that had he been in the community, he would not have been able to register with a GP and would have been managed under the special allocation scheme (where a GP practice removes violent or aggressive patients from its practice list and instead treats them in a secure environment). She concluded that it would have been unclear that appropriate care would have been possible if he was in the community.

Management of Mr John's diabetes

54. Mr John's diabetes was poorly controlled, which affected his other health conditions and accelerated the decline in his kidney function. Specialist advice was sought for his heart and kidney problems but not for his diabetes. This should have been considered, and we recommend that:

    The Head of Healthcare should ensure that long-term conditions, such as diabetes, are managed in line with national guidance.

Restraints, security and escorts

55. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and considers a prisoner's health and mobility.

56. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when they have a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and reviewed as circumstances change. The judgement found that using handcuffs or other restraints on terminally or seriously ill prisoners was inhumane, unless justified by security considerations.

57. On 13 January, Mr John was handcuffed during dialysis treatment. As soon as he became unwell with breathing difficulties at 9.45am, a SO alerted hospital staff and then contacted the prison for permission to remove his handcuffs. Mr John lost consciousness and hospital staff started CPR. The SO received no reply from the prison and tried again very shortly afterwards. Receiving no reply for the second time, she used her discretion and removed Mr John's handcuffs. At 10.00am, paramedics arrived and took over CPR. At 10.25am, a duty governor authorised removing Mr John's handcuffs, but the SO had already removed them.

58. The clinical reviewer concluded that Mr John's behaviour in NHS healthcare settings was unacceptable. His challenging behaviour in both prison and hospital settings resulted in him having an escort protocol in place which meant that he needed three experienced staff to escort him and that he had to be restrained with double handcuffs for his regular hospital appointments, and for his restraints only to be removed in a medical emergency.

59. Although we recognise that there was a delay of 15 minutes from the time that Mr John became unwell with breathing difficulties and then lost consciousness to when his handcuffs were removed. we also recognise that there was a protocol in place to deal with his extremely challenging behaviour. While the protocol stated that restraints could be removed in a medical emergency, we consider that it was reasonable that the SO first and promptly sought permission to remove them, and that there was a fine balance between ensuring security and public protection on the one hand and effectively managing the unfolding medical emergency for Mr John.

60. We also recognise that the SO appropriately removed Mr John's handcuffs at her discretion and without waiting for a response from the prison after she twice tried to seek permission. In different circumstances (without such a stringent escort protocol in place), we would find it inappropriate for a prisoner to be handcuffed while unconscious, even for a few minutes. However, in this case, we accept that there was a difficult judgement to be made and that the supervising officer took reasonable and appropriate steps in the circumstances to balance Mr John's escort risk with his dignity and health needs.

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