

**Circumstances surrounding the death of  
A man at HMP & YOI Hull  
in July 2008**

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

**January 2009**

This is a report of an investigation into the death of a man at HMP Hull on 11 July 2008. The man was 76 years old and had been terminally ill for some time.

The man was diagnosed with lung cancer in August 2007 and had been receiving palliative care within the healthcare wing at Hull. His condition slowly deteriorated and, in July 2008, the healthcare team initiated end of life care. The man had also confirmed that he did not wish to be resuscitated in the event of becoming unconscious. On the evening of 11 July, it was discovered that the man had died.

I would like to offer my condolences to the man's family and to the nursing staff at Hull who had cared for him in his final days and who I know were saddened by his death.

My colleague conducted the investigation on behalf of the Ombudsman. I also asked Hull Teaching Primary Care Trust to conduct a clinical review into the standard of healthcare the man received. The Clinical Governance Manager carried this out and her report is attached as an annex.

I would like to thank the Governor of Hull and his staff for their co-operation and assistance with the investigation. I would particularly like to thank the Head of Safer Custody at Hull for making all the practical arrangements for my investigator.

I make two recommendations relating to access to dying prisoners and improvements to accommodation. However, I also comment on the constructive steps that have been taken at Hull following the recommendations in previous reports and the positive effect that these had on the man's care.

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**January 2009**

## **CONTENTS**

Summary	4
The investigation process	5
HMP & YOI Hull	6
Key findings	7
Issues	16
Recommendations	20

## SUMMARY

The man was sentenced to 12 years imprisonment in 2003. He was 71 years old on his reception into custody and medical staff did not consider him to be in the best of health. He had a number of ongoing chronic illnesses that were managed with medication and had suffered a heart attack in 1997. The man was also reportedly a smoker and told medical staff that he smoked around 40 cigarettes a day. Despite his chronic illnesses and continued smoking, the man had little contact with healthcare during the early part of his sentence.

Following an unsuccessful appeal against his sentence, the man transferred to HMP Hull in December 2005. At Hull, the man initially had limited contact with healthcare. In December 2006, he attended the healthcare centre for a routine pneumonia vaccination. At that clinic, he told the nurse that his ankles were swollen and, following an examination, she referred him to the doctor and chiropodist.

When a doctor assessed the man on 25 January, he recorded that his legs remained swollen and he was also "wheezy". He therefore prescribed medication to be taken via a nebuliser (a machine that creates a mist of medicine to be breathed in by the patient through a mask or mouthpiece). Following this, both the doctor and nursing staff reviewed the man regularly. However, his symptoms persisted and he began to lose weight. The man was referred to the local hospital for tests to ascertain the reason for his continued poor health. Over the next three months, these tests continued in order to rule out stomach or bowel cancer.

The man found it increasingly difficult to cope with life on the residential unit and this led to him being admitted as an inpatient in the healthcare wing in June 2007. The investigations into his health problems continued and in July, a computed tomography (CT) scan (a cross-sectional x-ray of internal organs), which followed an earlier chest x-ray, confirmed he had a lung tumour.

Over the following months, the healthcare team put in place care plans setting out how the man's care would be managed and he attended outside hospital for palliative radiotherapy. As a terminally ill prisoner, the man was eligible to apply for compassionate release and, in February 2008, he expressed his wish for the necessary application to be submitted. However, given the level of risk of him re-offending the application was not supported. A governor explained the reasons to the man, and although disappointed, he accepted the decision. The man told nursing staff that if he was unable to leave prison he wished to die within the healthcare centre with people he knew and these wishes were respected.

As his condition deteriorated, the man was moved to the palliative care suite within the healthcare centre as it provided a quieter atmosphere. Macmillan nurses and prison nursing staff continued to care for him and manage his pain relief to ensure that he was comfortable. On the evening of 11 July 2008 the man died.

It is clear that Hull has made significant progress in its healthcare provision since my previous report. However, I make two recommendations relating to access to patients at night and the standard of accommodation provided in the care suite.

## **THE INVESTIGATION PROCESS**

1. My investigator opened the investigation on 17 July 2008 on behalf of the Ombudsman. Hull issued notices to staff and prisoners informing them of the investigation process and inviting anyone who had relevant information to come forward. No responses were received.
2. My investigator visited the prison on 3 October. He met the Chaplain and a member of the Independent Monitoring Board (IMB). He also visited the healthcare centre where he spoke with a member of staff who had been instrumental in caring for the man during the last year of his life.
3. One of the Ombudsman's Family Liaison Officers (FLOs), contacted the man's son on 1 August and explained the investigation process. The family did not raise any concerns about the man's care whilst in custody. They were very grateful to the prison for the way that they had been supported since the man's death.
4. HM Coroner was informed of the investigation and a request was made for the investigator to be provided with any post mortem or toxicology reports when available. A copy of this report will be forwarded to the coroner to assist the inquest process.

## HMP & YOI HULL

5. HMP Hull opened in 1870 and has had various roles. It is currently a category B local prison holding both adult males and young offenders. Hull serves the courts in East and North Yorkshire and North Lincolnshire. The prison has eight residential units. There has been extensive work in recent years, which has provided new wings and a new healthcare centre. The certified normal accommodation (CNA) is 723, but the maximum number of prisoners that Hull can hold is 1,044.
6. Hull Teaching Primary Care Trust has responsibility for the provision of healthcare services in the prison. In addition, a General Practitioner (GP) service is provided by a local GP practice. The healthcare centre has 18 beds and provides 24 hour nursing care.
7. HM Chief Inspector of Prisons, Ms Anne Owers, carried out a follow up inspection of Hull in November 2005. At the time, Ms Owers found that in general "the healthcare centre provided a good service". Since the last inspection, there have been considerable changes, including a new Governor in the last 18 months. The positive changes and improvements at the prison culminated in August 2008 with the prison achieving level four status on the Prison Service performance scale. This signifies that the prison is performing to an exceptionally high standard.
8. While visiting the prison the investigator talked to representatives from both the chaplaincy and the local IMB. The investigator was told that neither department had any concerns with the procedures or processes in place at Hull. The chaplain, who has been at Hull for over five years, said that he had seen very positive changes and that these had been beneficial for both staff and prisoners.
9. The Ombudsman's office took over responsibility for investigating all prison deaths in England and Wales in 2004. Since then there have been nine deaths through natural causes at HMP Hull.

## KEY FINDINGS

10. The man was sentenced to 12 years imprisonment in 2003 and taken to HMP Manchester. On reception into prison, he was assessed by a nurse who recorded that he was taking medication for angina and emphysema. The healthcare department assessed him on three occasions over the next seven months, mainly to give advice on using inhalers to aid his breathing. There were no significant health issues during this time.
11. During his time at Manchester, the man tended to mix with a select group of people, but was considered by staff to be polite and respectful. He was encouraged to become involved in offending behaviour groups as part of his sentence plan, but was adamant that he would not. Staff tried on several occasions to persuade him, but he continually refused.
12. On 19 July 2004, the man was transferred to HMP Wakefield. On his arrival, a nurse conducted a health screen. The entry in his medical record reads “does not enjoy good health”. During the screen, the nurse established that he had suffered a myocardial infarction (heart attack) in 1997, after which he had suffered from asthma and emphysema. He also had a history of chronic obstructive pulmonary disease (COPD), ischaemic heart disease (IHD) and congestive cardiac failure (CCF). The man also said that he smoked 40 cigarettes a day and had done so for the past 40 years. Following the screening, he was allocated to a wing.
13. The man decided to appeal against the length of his sentence and, later in July, the Criminal Appeal Office requested a psychiatric report. Although he could not understand why they wanted the report, the man was happy to assist. Over the next 18 months, the man had little contact with healthcare other than for his medication to be reviewed. He continued to receive favourable reports from staff on the wing.
14. On 20 December 2005, the man transferred to HMP Hull. The reason for the transfer was to enable him to access offending behaviour programmes on offer at that prison as he was still being encouraged to undertake relevant courses. On arrival, a member of the health care team assessed the man and recorded his medical problems. The man was located onto a residential unit and settled in well. Staff regularly recorded in his wing history that he was polite and respectful, and gave no cause for concern.
15. As at Wakefield, the man initially had little contact with the healthcare team except to request repeat prescriptions. He did however attend healthcare in November 2006 to be given a flu vaccination, at his own request. He was also offered an injection against pneumonia in December but declined as he had already had one. While in the clinic, the man mentioned that his ankles were swollen. On examination, it was evident that he had not been attending to his hygiene and he explained that he was unable to bend down and had no means to soak his feet. Referrals were made by a nurse for him to be assessed by the GP and chiropodist. Arrangements were also made for a bowl to be provided

for the man to remain in his cell or for baths to be taken on the inpatients' unit in healthcare.

16. A week later, the man was reviewed again by the nurse who had arranged for him to have a bath on the inpatients' unit. However, he said that he would prefer for a bowl to be made available so that he could wash his feet in his cell. Following his request, a member of the healthcare team spoke to an officer on the man's wing to arrange for him to be provided with a washbowl.
17. Unfortunately, when the man attended for a review in the clinic on 10 January he said that he had not been provided with the bowl as he had forgotten which officer he had to ask. The nurse again arranged for one to be made available. On examination, it was evident to the nurse that the man's legs were still swollen. She checked his blood pressure and pulse and although she found them to be within a healthy range, due to the continuing problems with his legs the nurse referred the man to the prison doctor.
18. The nurse saw the man again at the clinic two weeks later on 22 January. His blood pressure was slightly raised and he was breathless at times. Although the GP referral had been received, the man had still not been given an appointment. The investigator was told that it was normal for a prisoner to wait a fortnight to see a doctor unless the referral was urgent, in which case they would be seen the next day. A doctor eventually examined him on 25 January and prescribed medication. However, when seen again on 29 January by a doctor, the man had still not been given the medication. On examination, the doctor recorded that there was no sign of chest infection but the man was very "wheezy" and his legs remained swollen. The doctor prescribed medication to be taken via a nebuliser and said that he would be reviewed in five days.
19. On 2 February, it was recorded in the man's medical record that he had still not had his nebulised medications but had received the other medication prescribed. He was also said to be "still wheezy but slightly better". Five days later, the doctor saw him again on the wing and recorded that no nebulisers were available in the prison. The man said that he felt better but the doctor considered that he would still benefit from nebulisation when possible, so arrangements were made for a nebuliser to be obtained from the healthcare unit.
20. The man's shortness of breath continued, along with other symptoms including weight loss. Investigations into the cause were conducted over the next month with a colonoscopy being carried out on 1 March. On his return from having the procedure, the nurse conducted a review in the clinic and advised him to increase his intake of fluids as he appeared dehydrated. The man's blood pressure was raised but he assured the nurse that he felt fine and just wanted to return to his cell and rest. He promised to drink more fluids and the nurse advised that she would check his blood pressure again the following day.
21. When the nurse visited the man on the wing the following day, his blood pressure was again raised but he appeared better in himself. The man said that he had pain in his right hip but was reluctant to take any pain killers without

discussing it with the doctor first. In view of this and the fact that his diuretic medication, which had initially been prescribed as a trial, was about to run out the nurse made an urgent doctor referral.

22. The prison GP visited the man in his cell that afternoon and recorded in his medical record that:

“Looks well, not short of breath sitting down but shortness of breath on slight excursion , COPD (Chronic Obstructive Pulmonary Disorder), both feet are swollen, pitting oedema (swollen ankles), keeps his feet hanging all day. To see him again in one month. Has shown me a cyst on his right deltoid muscle, was given flu jab in 06 on his right. Refer to Dermatologist.”

23. The nurse reviewed the man again in the clinic on 23 March when he was still complaining of pain in his hip. His blood pressure was recorded as 120 over 58 and his pulse 80 bpm (these levels are considered to be within the normal range). The nurse recorded that he would require another blood test the following week in view of the results of his most recent one.

24. The man continued to be assessed regularly by healthcare staff. In May, he was referred to outside hospital for investigations to rule out possible stomach cancer. He was due to attend the hospital in June for the investigations to be carried out but was prevented from doing so due to problems with transport. The man had been unable to get into the taxi that had been supplied as he was in a wheelchair. Following this missed appointment, a senior nurse assessed the man at the request of the Modern Matron. The senior nurse made notes in the man’s medical record in which she reflected that this was the first time that she had been made aware of him using a wheelchair. She went on to write that:

“On my arrival (the man) was sat on his bed, I observed him transferring onto his chair which he did with difficulty, using furniture and was unsteady. He was wrapped up in several layers of clothing including a towel around his neck. The man expressed that he was concerned as his right leg is very weak and he said that his muscle has worn out and gone very thin. On examination, this muscle wasting was very evident with marked atrophy (wasting) of his right sided quadriceps. He also expressed that he had tenderness in the base of his spine.”

25. The senior nurse considered that the man required a full assessment, which could not be completed in his cell, so she arranged for him to be admitted to the in-patients department of the healthcare unit. She also recorded that she would discuss the man with the doctor and his appointment the hospital should be re-scheduled. The man moved to the in-patients unit the following day.

26. On 28 June, a prison doctor, saw the man as part of her surgery in healthcare. The prison doctor recorded that the man had pain in his right thigh that was making it difficult to sleep, and pains in his left arm and chest that the man said were different from the pain he normally associated with angina. The prison doctor also recorded that he had previously had an endoscopy and colonoscopy to rule out possible bowel cancer. There was still swelling to the man's legs and he appeared slightly dehydrated. During her examination, the prison doctor noted the muscle wastage previously seen by the senior nurse and a lump on the man's right arm. The prison doctor made a routine referral to a neurologist for further tests.
27. An entry in the man's medical notes on 29 June refers to a telephone call made by the healthcare department to the hospital to arrange a new appointment for the man's computed tomography (CT) scan. (This scan produces cross-sectional x-ray images of internal organs.) However, the prison were informed by the consultant's secretary that the consultant was unhappy that the man had not attended his earlier appointment and therefore refused to make another at this time.
28. Nursing staff reviewed the man daily and conducted blood tests routinely to monitor his condition. On 2 July, a nurse recorded that a second nurse who dealt with patients with long term conditions in the community should see him when she next visited the prison.
29. That afternoon, the first nurse received a call from the detail department (a department within the prison responsible for allocating staff to different tasks and providing staffing for escorts) and was informed that the taxi sent to take the man for his x-ray appointment was unsuitable for wheelchairs. The detail department said that another taxi could not be provided until 4.00pm and asked the first nurse if she could contact them to find out if they could see the man at 4.30pm. The x-ray department confirmed that he would still be seen but should arrive at the department no later than 4.30pm. Unfortunately, the escort arrived at Hull Royal Infirmary (HRI) 15 minutes late and the man was not seen.
30. The prison made a further appointment for 4 July for the x-ray and rescheduled the missed CT scan at Castle Hill Hospital for 11 July. A member from the healthcare admin department emphasised to the detail department the importance of booking the correct transport for both appointments. They were subsequently attended without further problems.
31. The second nurse a Community Matron, Long Term Conditions assessed the man when she visited the prison on 18 July. The man explained that he had pain in his right leg that had started five months before at the same time as his weight loss. The nurse recorded that the man had some pressure sores on his back and that he was having some difficulty with personal hygiene due to his immobility. The nursing staff had regularly assisted him with his hygiene throughout his time in healthcare. The nurse also made a referral for the man to be seen by an occupational therapist to provide a walking aid. When the nurse made a follow up visit on 1 August, she noted that a hospital style bed

had been provided for the man to alleviate the pressure sores that he was experiencing.

32. The chest x-ray conducted in early July revealed a possible lung tumour and a following CT scan confirmed the diagnoses. The man was informed of the findings and fentanyl (opiate-based pain relief) was prescribed in the form of patches. When he was first prescribed with fentanyl, the man appeared confused due to the strength of the medication but he was closely monitored so that changes could be made as required. He also needed to use a nebuliser (this creates a mist of medicine, which is then breathed in through a mask or mouthpiece to aid breathing) on a number of occasions.
33. Nursing staff continued to assess the man daily and he also attended outside hospital for treatment and assessments without further problems. Despite his poor prognosis, the man remained positive. He attended the "Over 60's" club in the healthcare unit on a regular basis and seldom complained about his situation. Nursing staff told the investigator that he never seemed to let his condition get him down and, although some days were better than others, he was always polite and never demanding. Staff provided board games in his ward to encourage him to interact with other prisoners but at times he was too tired because of his treatment. On 24 August, he said to a nurse "I feel settled in my head now because the consultant has told me what will happen to me, I know I am dying, we all have to. I know my time is soon" the nurse recorded that despite this he was still very cheerful and was aware that staff were available to talk to and assist him as much as possible.
34. The man had been experiencing more pain during late August, which caused problems with his sleep. In view of this, the doctor increased his fentanyl. The man thanked staff and said that he was looking forward to a nights sleep. It was noted in his medical record that the man appeared much brighter following the increase in his pain relief. Care plans were in place that allowed the nursing staff to ensure that the man's changing needs could be met and, as part of this, nursing staff continued to assist him with his personal hygiene.

35. On 3 September, a Macmillan nurse (Macmillan nurses provide expert information, advice and support to improve the lives of people with cancer) and the doctor again reviewed the man's medication and decided that he should start taking oramorph (morphine) for two days and then be reviewed. The Macmillan nurse also recorded that the man should be advised to be a little more active each day but that he appeared pleasant in his mood. The man continued to go to appointments at **Castle Hill Hospital** and was comfortable on the ward in the healthcare unit. The Macmillan nurses were in regular contact with the prisons nursing staff and advised on equipment that they felt would make the man more comfortable.
36. The man's condition continued to be closely monitored and, in January 2008, a governor spoke to him about possible early release on compassionate grounds. He confirmed that he would like to be considered for release and the process was started. (The criteria for a prisoner to be released early on compassionate grounds are standard across the prison estate and focus not only on their health and life expectancy but also on the risk that they might pose to the public.) In The man's case, the decision was taken not to support his application.
37. On 6 February, a second governor visited the man in the healthcare unit to explain the reasons for the decision. Both the prison and outside services considered that the man continued to pose a risk to the public and also thought that there was a potential risk to him from victims of his offences. Following his meeting with the second governor, nursing staff spoke to the man and recorded that he appeared to have taken the news "philosophically", although it was felt that he was probably upset so support would be offered as required.
38. The second nurse also spoke with the man on 6 February and recorded on his care plan that:

"would prefer to die a 'free man' but does not wish to return to Manchester he would like to be released and go to a nursing home locally. If this is not possible he wants to die in prison and be cared for by the staff he knows."
39. The man's palliative care continued to be delivered effectively within healthcare and he did not appear to have been affected by the decision not to release him from prison on compassionate grounds. The second nurse, who saw the man regularly, recorded in his medical notes that staff had raised concerns about his pain relief. He did not request additional pain relief during the day but waited for routine medication to be issued. Another member of the healthcare team spoke to the man following the nurse's assessment and discussed with him the pain relief available.
40. Over the next few weeks, nursing staff and doctor's reviewed the man's pain relief more frequently as his pain increased. In addition, the man was asked whether he wished to move from the ward into the care suite. (The care suite is a room on the healthcare landing that had previously been used by patients for

association, watching TV and playing board games.) The man initially declined the move saying that he preferred to stay on the ward. However, on 7 March, he decided that he would like to move to the care suite as the noise levels had increased and he needed more nursing intervention at night. The nurse explained to the man that other patients could visit him at any time and recorded in his medical notes that he was happy with his move.

41. Over the next two months, the man continued to deteriorate and his increasing pain was managed accordingly. He was also becoming weaker and frailer but refused to stay in bed saying that the pain was worse when he did. This resulted in the man having some minor falls when trying to move around in his room, which often happened at night. The investigator was told that on a number of occasions nursing staff and prison managers discussed the possibility of leaving the door to the man's room open during the night to aid quicker access in an emergency. However, it was felt that while he remained mobile and given the reduced staffing levels in healthcare at night, this would not be possible.
42. On 30 April, the second nurse, who had not seen him for two weeks, assessed the man. She recorded in his medical notes:

“Condition seems to have deteriorated in two weeks since previous visit. Mood appeared down this morning. On questioning, stated that the falls he has had in the past two weeks have taken it out of him and the pain in his right arm is worse since then. Also stated that his confidence has reduced and he does not want to walk around anymore, even with the staff for assistance. Stated that his pain had increased over the last two weeks and that his falls were due to feeling dizzy. I advised him to call staff if he wished to mobilise.”
43. A doctor assessed the man on 13 May and recorded in his medical notes that he was clearly going downhill and appeared more confused. The second nurse followed this up the next day. When she assessed the man, she recorded that he appeared brighter than her last visit and was verbalising well in full sentences.
44. As part of the man's care plan, the first nurse spoke with him on 15 May and discussed his wishes regarding resuscitation. The first nurse recorded that the man made it clear to her that at the end he did not want this to happen and said to her “I want to die with dignity and do not want jumping on”. The nurse said that she would get the doctor to talk to the man about this issue and she would attend if he wished. The man completed a living will on 29 May in which he stated that he did not wish to be resuscitated. The doctor and Healthcare Officer (HCO) witnessed it. The man also expressed a wish for his son to be contacted after his death but he had always been adamant that he did not wish his family to be told of his condition any sooner.
45. Reviews of the man's pain relief and monitoring of his condition continued. He remained polite, cheerful and spent time watching television and having an occasional cigarette. The man continued to move around well with the aid of a

Zimmer frame. On 27 May, the first nurse discussed with the man his pain relief and the man made it clear that he did not want to be “doped up”. The nurse reassured him that this would not be that case and said that nursing staff would monitor all his medication. The nurse also recorded on the man’s notes that a Water Low Assessment needed to be carried out the following day (this is an assessment used to predict a patients risk of pressure sores.)

46. The man’s condition continued to deteriorate but he remained mobile. However, despite being advised to request staff assistance, he tried to move around by himself, which led to further falls. On 19 June, the nurse wrote in his medical notes:

“All staff are aware that at the point he becomes immobile and an increase in the level of hands on care required, security with nursing multi disciplinary team will review the decision made regarding his door being open. At the moment, he is so ambulant and able to walk around his room and the landing the security process still applies, as it does with every other prisoner. He is still fully aware of all that he does, understands why he is in prison and acknowledges that he can be cantankerous when he wants his own way. Still direct with his wishes of ‘do not resuscitate’.”

47. At 1.15am on 22 June, the man had another fall and on this occasion needed to be sent to the Accident and Emergency department at Hull Royal Infirmary. The man was x-rayed and it was found that he had a slight injury to his hip but the hospital were unwilling to admit him as there was little treatment that they could offer. Also, they did not want to interfere with the palliative care the man was receiving at the prison. On his return to the healthcare wing from hospital, healthcare staff advised the man that all night time wanderings were to cease. The man agreed that it would be in his best interests.
48. On 8 July, nursing staff decided that the man would benefit from using a syringe driver (a small, portable battery-driver infusion pump, used to give medication under the skin via a syringe, usually over 24 hours) as his condition had significantly deteriorated. In addition, the Liverpool Care Pathway (LCP) was initiated. (The LCP was developed to transfer the hospice model of care for dying patients into other care settings.)
49. Over the next couple of days, nursing staff continued to provide assistance to the man in tending to his personal hygiene. They checked on him regularly ensuring that he remained comfortable and that his dignity was maintained.
50. On the evening of 11 July, a staff nurse was making a routine check on the man at around 10.00pm and noted that he did not appear to be breathing. She observed him through the observation panel on the cell door which was locked and she had no keys to enter the room. The staff nurse contacted the night orderly officer and requested access to the man’s room so that nursing staff could check him. The night orderly officer went to healthcare, along with a prison officer. Together with two nurses, they entered the man’s room. The

nurses checked the man and no vital signs (pulse, breathing) could be found and so paramedics and the duty governor were called.

51. The paramedics arrived at 10.30pm and, in view of the man's wishes not to be resuscitated, no treatment was administered. Paramedics confirmed the man's death at 10.40pm.
52. Following the man's death, a member of the Care Team (staff volunteers who provide emotional support to staff), came into the prison and spoke with all the staff members involved. The duty governor wished to notify the man's son in Manchester he was unable to confirm that he still lived at the address listed at the prison, as the man had not received any visits. In the light of this, the duty governor asked Humberside Police to liaise with their colleagues in Greater Manchester with a view to visiting the address and breaking the news to his son. The duty governor was subsequently informed that the man's son had been located and told of his father's death at 10.15am on 12 July. At 10.30am, the duty governor spoke with the man's son who confirmed that he had no immediate concerns.
53. The duty governor and the prison Family Liaison Officer (FLO), visited the man's son after the news had been broken. This gave the family the chance to ask further questions and be informed about the investigation and inquest process. The prison stayed in contact with the man's son and, at his request, the Prison Chaplain led the man's funeral.

## **ISSUES**

54. Following an investigation into a previous death from natural causes at HMP Hull, the Ombudsman made a number of recommendations about the care of terminally ill patients. During this investigation, it was evident that the majority of these had been implemented to the benefit of the man. I reflect on these in the following paragraphs.

### **Consideration for compassionate release**

55. The Ombudsman recommended previously that all decisions regarding compassionate and temporary release should be fully documented had evidently been implemented in the man's case. Although it had not been supported, the application was filed within the medical record and a clear report on the reasons for the prison's decision was produced. Most importantly for the man, the Governor making the decision spoke at length to him personally and ensured that he understood the process and that the decision would not affect the quality of palliative care that he would receive.

### **The man's wishes regarding his care and where he was located**

56. The care plans and medical notes clearly show that the man's wishes were respected and documented at each stage of his illness. This included the place he wanted to die and who he wished to be contacted and when. This again demonstrates the positive steps made by the prison to act upon recommendations made from my earlier report, in which the Clinical Reviewer had recommended that patient's wishes regarding their care should be explicitly recorded and reviewed as appropriate.

### **Delivery and access to care from outside agencies**

57. The man was visited and assessed regularly by the nurse, Community Matron, Long Term Conditions. Macmillan Nurses, who had access to the prison healthcare as required, also assessed him regularly. Additionally, all outside agencies were in regular telephone contact with nursing staff at the prison to get updates on the man's condition. My earlier case endorsed a recommendation from the Clinical Reviewer that healthcare staff should consider what actions could be identified to facilitate the speedier access of visiting clinicians to healthcare. This appears to have been addressed and the man benefited from the regular care and input provided by the nurse and the Macmillan team.

### **Access to medication and pain relief**

58. The medical documentation and the care plans show that the man's changing needs regarding pain relief and medication were regularly monitored and updated. The man was reluctant to request additional pain relief, preferring to wait for his routine prescription. However, the nursing staff quickly identified this and advised the man of the additional pain relief that was available. In my previous investigation, the Clinical Reviewer recommended that the healthcare

department purchase a Graseby syringe driver and that staff were trained in its use. This recommendation had been accepted and the syringe driver was in place and benefited the man in the later stages of his illness.

### **Accommodation/care suite**

59. In the previous case at Hull in which I made recommendations, I raised concerns about the former association room that had been converted for use as a care suite, most notably for those patients with terminal illnesses. During this investigation, my investigator viewed the room and found that efforts had indeed been made by healthcare staff to make it more comfortable for the man. A locker had been obtained as well as a table and soft chair and it was clean. However, the room remained partitioned by a curtain and, due to its size, felt cold and the decoration very austere. Nursing staff told my investigator that most of the fittings in the room had been obtained by borrowing from other areas. Along with the medical equipment and the additional furniture, it is clear that the healthcare staff have attempted to make the room more suitable for the palliative care of prisoners. However, in my view, more could be done but I am conscious of budgetary constraints. I therefore make the following recommendation:

**The Governor of Hull should liaise with Head of Healthcare and the Primary Care Trust to consider how the care suite can be further improved and the options for funding such improvements.**

### **The man's end of life care**

60. Since the last death of a terminally ill prisoner at Hull, action has also been taken to ensure that staff are trained in palliative care and a policy has been produced. The Liverpool Care Pathway was used very effectively to ensure that the man's end of life care was delivered to an equal standard to that which could be expected in the community.

### **Staff access to the care suite**

61. Nursing staff told my investigator that they were upset that the man died alone in his locked room and that they had been unable to gain access to him. The medical notes and care plans show that this was indeed a concern and had been remarked upon by nursing staff. A meeting between the security department and healthcare clearly documented the reasons for the door remaining locked during the night. The reasons given at the time were based on the man's continued mobility and as such, the consequent security risks he posed, which all parties seemed to accept. However, once the man deteriorated to the stage where he was confined to bed and the Liverpool Care Pathway was implemented, there does not seem to have been any further reviews of the closed-door policy. I feel it would have been a comfort to the man to know that someone was with him in his final hours. It was known that his death was imminent, so it was unnecessary for him to die alone and happened due to a lack of communication. I make the following recommendation:

**When the Liverpool Care Pathway is initiated for a terminally ill prisoner who has been refused compassionate release or chosen to die within the prison, the Governor and Head of Healthcare should ensure that daily meetings are held to assess the prisoner's condition. These meetings should be documented and take into account the need for medical staff to access the prisoner outside of normal operating hours.**

## **Clinical Review**

62. The Clinical Governance Manager, Hull Teaching PCT, who carried out the clinical review into the man's care, makes no recommendations in her report but does reflect on the good progress made by Hull in respect of the recommendations made in the earlier report. In the conclusion to her report, the clinical reviewer answers the following two questions:

*Was the care the man received whilst in custody at HMP Hull appropriate and comparable to the services he could expect to receive from a Primary Care Provider in the community?*

"The care the man received at HMP Hull Healthcare was broadly similar to that he would have received in a community setting. The man had referrals made to appropriate health care professionals, and had access to advice regarding healthcare issues on request. The man received care and assistance by nursing and medical staff that was comparable to care within the wider community and received care from the long-term conditions team, Macmillan team and occupational health. He was referred appropriately to the acute hospital trust and appointments were followed up in a timely manner. The man had a planned programme of care in which he was able to participate and received some outstanding care from the inpatients team."

*Would different care have resulted in a different outcome?*

"The man's treatment for his terminal disease was managed within recommended guidelines. Changes to his care were complete in collaboration with specialists in the acute hospital setting and within the scope of this clinical review, it is the author's belief that different care for the man would not have resulted in a different outcome, due to the terminal nature of his disease. The care the man received seems to have ensured that the man did not suffer and received adequate psychological support, interventions to maintain his dignity and privacy."

## **CONCLUSION**

63. The man was an elderly man with a terminal illness. It is evident that he received a high standard of care throughout and I concur with the view of the Clinical Reviewer that his care was at least equitable to that which he would have received in the community. I am particularly pleased to note that throughout my investigation the implementation of recommendations from one of my earlier reports was of direct benefit to the man and, no doubt, will continue to be so for other prisoners.
64. The inquest into the man's death was held on 10 December 2008. After hearing the evidence provided the jury concluded that the man died as a result of natural causes brought on by a terminal illness.

## RECOMMENDATIONS

1. The Governor of Hull should liaise with Head of Healthcare and the Primary Care Trust to consider how the care suite can be further improved and the options for funding such improvements.

*Following the publication of the draft report the prison accepted this recommendation and are to discuss between both agencies and put in place costing plans for how to improve the care suite by May 31 2009.*

2. When the Liverpool Care Pathway is initiated for a terminally ill prisoner who has been refused compassionate release or chosen to die within the prison, the Governor and Head of Healthcare should ensure that daily meetings are held to assess the prisoner's condition. These meetings should be documented and take into account the need for medical staff to access the prisoner outside of normal operating hours.

*Following the publication of the draft report the prison accepted the recommendation. Once a patient has been admitted to the Palliative Care suite regular meetings are to be held to discuss individual cases, as the prognosis becomes critical these meetings are to be held daily between the Duty Healthcare Manager and Security Manager with regard to access to the suite. All meetings are to be documented. The prison has set an implementation date of 31 December 2008 for this to be in place.*