

**The investigation into the circumstances surrounding
the death of a man in custody
at Hull Royal Infirmary
on 9 September 2004**

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

December 2004

This is the report of my investigation into the circumstances surrounding the death of a man on 9 September 2004 at Hull Royal Infirmary. The investigation was conducted by one of my senior investigating officers. In addition I commissioned a Clinical Review into the care and treatment received by the man at both HMP Hull Healthcare Department and in the Hull Royal Infirmary. This was undertaken by the East Hull Primary Care Trust.

The loss of any family member is upsetting, but especially so whilst they are in custody. I offer my sincere condolences to the man's family and friends.

I would like to thank the then Governor of Hull and the Liaison Officer for their assistance to my investigator.

The report includes three advisory points for Prison Health and three recommendations for the prison.

STEPHEN SHAW CBE
Prisons and Probation Ombudsman

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SUMMARY

1. The man died whilst in Hull Royal Infirmary (HRI) on 9 September 2004. He had been admitted to the hospital on 13 August where he underwent an oesophagectomy following a short illness whilst at Hull Prison. Prison officers had noticed that he was having difficulty eating and had raised concerns with the prison's Healthcare Department, who in turn referred him to the HRI.
2. During this investigation, the man's sister raised a concern about the diet he had received from the prison once it had become known that he was experiencing difficulty in swallowing. He had complained to his sister that the food was lumpy and that the prison was unable to provide an adequate meal for him. The Governor was asked to comment on the meal arrangements and identify if the man had ever raised a formal or informal complaint regarding the food. The Governor's reply confirms that the man did not raise a formal complaint and that liquid food supplements were given. Additionally, the man's sister believed that a "germ" had been found at the prison which might have contributed to his death. My investigator made enquires of HMP Hull and there was no record of any outbreak of disease/infection. There were, however, cases of the "Norwalk Virus" at the HRI, which resulted in the closure of 22 wards at the peak of the infection in September.
3. The Clinical Review commissioned from the East Hull Primary Care Trust includes a number of advisory points for the establishment and the Prison Service nationally. It does not raise any concerns about the care and treatment the man received whilst in custody.
4. A post mortem was carried out on 11 September. This concluded that the cause of death was "Carcinoma of Oesophagus (operated)". It is not clear why the man deteriorated so rapidly but he developed a post-operative leak from the oesophageal anastomosis. There was no evidence of any avoidable surgical complication.

THE MAN

5. He was born on 4 May 1926 and was aged 78 when he died at HRI on 9 September, following a short illness. His condition had been diagnosed as carcinoma of the oesophagus.
6. Prior to his retirement in 1983, the man and his sister had run a school in a small village near Hereford, where he was the Principal and his sister the Matron. He had continued to offer home tuition following his retirement.
7. On 25 November 1999, he was sentenced at Worcester Crown Court to 12 years imprisonment. Following his conviction and sentence, he was transferred from HMP Blakenhurst to HMP Birmingham and finally to HMP Hull.
8. During the final weeks of his life, prison officers at Hull had become concerned that he was not eating correctly and raised the matter with Healthcare staff. The Clinical Review details the care and treatment he received whilst in Hull. He was admitted to the HRI on 13 August and accompanied at all times by two prison officers under "Bedwatch" arrangements. This means that under normal circumstances, throughout his stay in hospital, two officers would have remained with him 24 hours a day and that he would have been handcuffed to one of the officers. It is the policy of Hull to facilitate all external escorts to Category B standards. My investigator confirmed that the man was not handcuffed when he died and that authority had been given by a senior manager in the prison on 28 August to remove the restraints. I am pleased this occurred. At the time he died, there was just one prison officer with him. Indeed, once it became clear from the medical staff that death was imminent, that officer had withdrawn from the room and remained outside.

HMP HULL

9. The prison is located two miles east of Hull city centre and first opened in 1870, holding male and female prisoners. In 1939 it was used as a military prison and later a civil prison defence depot. In 1950 it re-opened as a closed male borstal. In 1969, after extensive security work, Hull became one of the first maximum security dispersal prisons. In February 1986, Hull assumed its current role as a male prison and remand centre.
10. The population of Hull prison is made up of category B, C, D adults, young offenders and remand/unsentenced prisoners. The Certified Normal Accommodation (CNA) is 812 and the operational capacity is 1,071.
11. The prison offers a variety of regime activities including education classes, workshops, training courses, physical education and also accredited courses designed to address offending behaviour.
12. In March, HM Chief Inspector of Prisons carried out an announced visit and reported that the prison was providing a largely safe and decent environment. Additionally, the prison has undergone a full Standards and Security Audit this year and has been rated as good in both areas. Since 2000, there have been 13 deaths at the establishment, of which five were due to natural causes.

FINDINGS

13. I am satisfied that the level of care offered to the man during his time in custody was appropriate. However, the learning points raised from the Clinical Review need to be considered by both the prison and Prison Service Headquarters.
14. The officers on the wing where the man lived are to be commended for identifying and alerting medical staff to the fact that he was experiencing difficulty in eating and swallowing. They ensured that he was seen as soon as possible by the Healthcare Department and his condition cared for.
15. He had been restrained by the use of handcuffs or escort chain up until 28 August, after which a risk assessment was conducted and they were removed. Given the fact that he was aged 78, connected to a variety of medical equipment and two or three floors above ground level, it does appear disproportionate to have kept him in restraints. My investigator discussed this with the Acting Governor and it appears to be Hull's normal practice to treat all escorts to category B standards. In the man's case it is clear that the decision was based on his offence rather than on an individual risk assessment.
16. I understand that consideration was being given to the possibility of release on temporary licence (ROTL), but found no evidence to suggest that the documentation process had begun. Consideration of ROTL was not actively pursued until the day of his death, which is unfortunate given that restraints had been removed for some days and that the escort staffing level had been reduced to one officer.
17. In relation to the points raised by his sister, I have been unable to find any evidence that food supplied to him was in any way inappropriate, and he was given food supplements as part of his ongoing treatment from the Healthcare Department. The managers of the Clinical Team and Kitchen have subsequently arranged for kitchen staff to receive specialist training from the Eastern Hull Primary Care Trust Dietician. This is good practice which I commend.
18. I was unable to find any evidence of a "germ" outbreak at the prison. However, I am aware that HRI had an outbreak of the "Norwalk Virus" during the summer, which resulted in the closure of 22 wards at its peak in September. HRI was asked to comment on this and to assess whether the virus had any bearing on the care and treatment of the man. The response from the Clinical Director of Medicine at HRI was that he found no evidence that the course of the man's illness was influenced in any way by the infection. He added, "The two infections which affected HRI are (Norwalk Virus) Norovirus and (MRSA) Multi Resistant Staphylococcus Aureus: the patient in question did not have evidence of either, and there is no indication that his treatment was affected by the outbreak at the hospital. He was found to have a number of bacteria and fungi in his sputum while on Intensive Care

(which may be the origin of the concern about infection); however these organisms are commonly found in ventilated patients and are not clinically significant.”

19. The points raised in the Clinical Review were fully acknowledged and accepted by the Clinical Team Manager and Acting Governor. At the time of the investigation, work had commenced in ensuring that the learning points were being actioned. However, it was also accepted (concerning the entries in the Inmate Medical Record) that learning points had been raised in previous reports and, despite issuing written instructions to prison nursing staff, a minority were not complying. Additionally, the Clinical Team Manager has identified a number of other issues and concerns that she is addressing regarding the care and treatment of inpatients.
20. My investigator established that the officers who were with the man at the time of his death had been offered support from the establishment. However, it was apparent that the senior manager dealing with the death was not offered the same level of support.

RECOMMENDATIONS

Prison Health advisory points

All prison establishments should be operating within the following guidelines:

- Guidelines for records and record keeping (Nursing and Midwifery Council)
- Management of dyspepsia in adults in primary care (Clinical Guideline 17 issued August 2004)
- Code of professional conduct (Nursing and Midwifery Council).

Recommendations for Hull Prison

In addition to the recommendations of the Clinical Review, I recommend:

1. The Governor should review the policy of using restraints on every prisoner in hospital.
2. Consideration should be given to starting the ROTL process at an early stage when a prisoner is in hospital and reviewing/amending the decisions on a regular basis.
3. The Governor should review support mechanisms to ensure they are in place for all staff who are involved with an incident.