Investigation into the death of a man at HMP & YOI Hull in March 2011

Report by the Prisons and Probation Ombudsman for England and Wales

November 2011

This is the report of an investigation into the death of the man, a prisoner at HMP Hull. The man was serving a sentence of 11 years and had been in custody at Hull since June 2010.

I offer my sincere condolences to the man's family and everyone touched by his death.

One of my investigators conducted the investigation. A review of the man's medical care was commissioned by Hull Primary Care Trust (PCT) and undertaken by the clinical reviewer. I am grateful to the clinical reviewer for his report and contribution to this investigation. I would also like to thank the Governor of Hull, and his staff for their cooperation. I am particularly grateful to the two members of staff, who provided a high level of prison liaison and ensured that documentation was in good order.

Shortly before entering custody, the man had undergone open heart surgery at Papworth Hospital. For many years he had suffered from heart conditions and also had difficulty with his mobility caused by a road traffic accident earlier in his life. Staff recorded all his ailments on his reception at Hull, and during his time there he was receiving regular medication. However, his cell mate indicated that he did not always take the medication supplied.

In the early hours of the day he died, the man's cell mate noticed that the man was having difficulty breathing and saw what appeared to be blood around his mouth. The cell mate alerted staff who attempted to gain a response from the man and called for an emergency ambulance. The paramedics took him to Hull Royal Infirmary, where he was pronounced dead at 7.30am.

My investigation has found that the medical care provided to the man at Hull was to a standard that he could have expected in the wider community. No concerns came to light regarding procedures or policies in place at Hull that adversely affected the man and I am satisfied that staff cared for him well during his time at the prison and when he fell ill on the day of his death. The clinical reviewer has made two recommendations about improving the monitoring of prisoners with long term conditions, which I endorse.

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

Nigel Newcomen OBE
Prison and Probation Ombudsman **November 2011**

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SUMMARY

1. The man died at Hull Royal Infirmary. He had been a prisoner at Hull since June 2010, when he was sentenced to 11 years imprisonment.

2. In April 2010, two months before he went into custody, the man had open heart surgery. He had suffered for some years with heart problems and his recent surgery and current medications were recorded by nursing staff on his reception at Hull. Due to his age and some issues that he mentioned during the reception process he was initially accommodated in the healthcare unit, so that a review of his medical and mobility needs could be properly assessed. Once this review had been completed the man was given a cell in one of the residential units, where he remained for the remainder of his time at the prison.

3. As the man was past retirement age he was not required to work. Also as he had decided to appeal against his conviction he was unable to take part in offending behaviour work as participants are required to accept their offence as part of the process. However, the man kept himself busy and would associate with other prisoners on the unit and enjoyed playing pool and board games. He also received regular visits from his partner.

4. Due to the major surgery that the man had shortly before entering custody, staff escorted him to attend external appointments with the consultant at Papworth Hospital. The consultant considered him to have made a good recovery from the surgery and he was discharged from hospital care. In the prison he collected the medication that he had been prescribed daily, although his cell mate said that he did not always take all the tablets he was given. While at Hull he did not complain about his medical care and raised no issues.

5. On 15 March 2011, the man had spent the evening playing pool and after returning to his cell at around 7.00pm he played scrabble with his cell mate. They both had a hot drink and he went to bed at 11.00pm, while the man was still watching the television. The man's cell mate woke at around 12.15am, as the television was still on, and he heard the man making a strange noise. When he looked down at the man from the top bunk he noticed a small amount of blood on his lip and he assumed that he had bitten it in his sleep. However, when he got down from his bed he realised that the man was in some distress but appeared unconscious.

6. The man's cell mate immediately alerted the night staff and both discipline and nursing staff, went into the cell. They assessed the man and called an emergency ambulance who took him to Hull Royal Infirmary (HRI). The man remained unconscious throughout this time.

7. On arrival at HRI, the man underwent further tests and the escorting officers were told that he had suffered a major bleed on his brain and was unlikely to live very long. This information was relayed to the prison and his next of kin details were provided to the hospital who arranged to notify his family.

8. At 7.20am on the day the man died, an escorting officer noticed that the man's breathing had become very shallow and notified a nurse who attended along with a doctor. The man was pronounced dead at 7.26am.

9. My investigation has found that the prison had in place all the relevant policies and that these were adhered to. In addition, a clinical review by the clinical reviewer concluded that the medical care given to the man was appropriate and consistent with Department of Health and prison standards. I endorse two recommendations in relation to the prison developing a more pro-active approach to the monitoring of prisoners with a history of chronic illness. Following sight of the draft report the Prison Service accepted one recommendation and the other relating to the role of the pharmacy was not accepted. Full feedback can be found on page 16.

THE INVESTIGATION PROCESS

10. The investigation was opened by one of my investigator at HMP Hull on 21 March, where he was provided with all documentation relating to the man. Notices were issued informing both staff and prisoners of my investigation. They asked anyone who had information pertinent to my investigation to contact the investigator, but no responses were received.

11. Hull Teaching Primary Care Trust (PCT) was asked to conduct a review of the medical care provided to he man while in custody. The clinical reviewer completed the review and subsequent report, which is attached in full at annex 1. I would like to thank him for his assistance.

12. My investigator wrote to the Coroner to inform him of the investigation and requested a copy of the post mortem report.

13. One of my family liaison officers (FLO) sent an introductory letter to the man's daughter who was his nominated next of kin, on 13 April. She explained the role of my office and the purpose of our investigation. She also spoke to the man's partner on 21 April, who indicated that she would like to receive a copy of the draft report when available. A copy of the draft was sent to the man's daughter and partner. The family made no comments on the draft report.

14. My investigator visited Hull on 15 April to conduct interviews with staff. After he completed the interviews, he wrote to the Governor to confirm his emerging findings.

HMP HULL

15. 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.

16. Hull Teaching Primary Care Trust is responsible 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. It also has the facility to care for those prisoners with palliative care needs.

17. HM Chief Inspector of Prisons carried out an inspection of Hull in November 2008. The inspectorate concluded:

> "…Overall, Hull was achieving some good outcomes for a local prison, particularly in activities and resettlement. There was evidence of commitment and innovation and, with only a few improvements, the prison could be performing well in these areas. The physical environment in the older part of the prison will remain a challenge, but the good relationships between staff and prisoners provide a sound basis for proactive work. The area of most concern was safety, where attention was needed to the basics of safer custody, as well as the development of innovative approaches. With that proviso, it was easy to see Hull becoming a high-performing local prison …"

18. The Prisons Act 1952 and the Immigration and Asylum Act 1999 requires every prison and Immigration Reception Centre (IRC) to be monitored by an independent board appointed by the Ministry of Justice from members of the community in which the prison or centre is situated. The Independent Monitoring Board (IMB) at Hull also published their most recent annual report in 2008. The Board raised no serious concerns with the way Hull was being operated and highlighted positive relationships between staff and prisoners.

19. The Ombudsman's office took over responsibility for investigating all prison deaths in England and Wales in 2004. Since then there have been 13 deaths through natural causes at HMP Hull prior to the man's. Recommendations made following earlier investigations are not repeated in this report.

KEY EVENTS

20. The man was originally remanded into custody at HMP Hull on 27 October 2009. However he was released on conditional bail the following day.

21. The man appeared at Grimsby Crown Court where he was found guilty of the offences with which he had been charged and sentenced to 11 years imprisonment. Following his court appearance he was again taken to HMP Hull.

22. As part of the reception process on his original remand to Hull in October 2009, the man was assessed by Staff Nurse A, who recorded his medical history. She recorded that the man had the following medical conditions:

    - Angina, for which he was awaiting a bypass operation.
    - A lung problem and partial paralysis in his left arm.
    - A history of hypertension (high blood pressure). The man had been taking Atenolol for this. (Atenolol is used to reduce workload on the heart and to make the heart beat regularly as well as to treat people with high blood pressure and to ease their chest pain. Atenolol also protects a patient from heart attacks.)
    - High cholesterol, for which he had been prescribed Simvastatin. (Simvastatin is used to lower cholesterol and other lipids (fats) in the blood and may help prevent medical problems caused by cholesterol such as heart disease.)

23. The man also told Nurse A that he had been involved in a road traffic accident (RTA), 40 years before and since then had a weakness to his left side. He said that he could walk well but only slowly. Nurse A recorded that the man had odeamatus (a collection of fluid under the skin) in his left ankle. When asked about this he said that it was usually more swollen than the right one in the morning and more swollen at night. He confirmed that he had not been in custody before, and consented to his medical information being shared with other agencies responsible for delivering care. At that time, his weight was recorded as 17 stone. He told Nurse A that apart from the information he had disclosed he had no other concerns about his physical health.

24. Nurse A discussed with the man his outstanding appointment with a cardiologist (heart specialist) at the Princess Diana Hospital, Grimsby, on 5 November. The man said that he was awaiting a heart bypass operation and his next appointment was for a check up and to find out about the bypass. A referral was made for him to be seen by the prison doctor. He was assessed the following day by prison doctor, who re-prescribed the same medications that he had been receiving in the community. However, an application for bail, made on the man's behalf, was granted and he was released from custody later that day.

25. When the man returned to Hull on 7 June 2010, following sentencing, he was again seen by a member of the medical team, Nurse B, and a health screen completed. The nurse recorded that he was calm and quiet in his manner and 'chatted' freely. The existing medication that he was taking for his heart condition was recorded and he told the nurse that he had undergone two coronary artery

bypass grafts and a valve replacement at Papworth Hospital on 18 April 2010. The nurse again recorded the man's past medical history, and wrote that he was using a walking stick to move around, as a result of the previous RTA. He told the nurse that he had an outstanding post-operative appointment at Papworth Hospital on 8 July. He raised no other concerns and the nurse put in place a post operative care plan.

26. Due to his medical condition and age, Nurse B recorded that the man should be admitted to the inpatients' unit on the healthcare wing for further assessment of his medical and physical needs, as part of the 'Over 65 Care Pathway'. The Pathway begins with a prisoner being admitted to the healthcare centre in order for nursing staff to assess their individual needs, such as whether they are mobile, can dress themselves and generally care for themselves without assistance, as well as any ongoing medical concerns.

27. The man was admitted to the healthcare centre and remained as an inpatient until 18 June. A blood test confirmed that his liver and kidney function was normal. He also was seen by the prison doctor on 8 June after he complained of intermittent chest pain, and was subsequently prescribed a Glycerol Trinitrate (GTN) spray. (GTN spray is commonly used for the treatment of angina.) Healthcare staff checked his blood pressure and weight frequently as part of his care plan, and gave him advice on diet and exercise. They recorded that he socialised with other prisoners and walked around well with the aid of his walking stick. In addition to his other medications and GTN spray, the man was prescribed pain relief when he complained of chest pain related to his post-operative healing. In addition to routine observations while he resided on the healthcare unit, as part of his ongoing care plan, regular checks of his blood pressure and weight were carried out.

28. When he arrived at Hull, the man had told the nurse that he had an outstanding follow-up appointment at Papworth hospital. For security reasons, prisoners are not supposed to be told when they will be going to outside hospital, until the day of the appointment. Therefore nursing staff contacted Papworth and rearranged the appointment for 16 July.

29. Once he moved to the residential unit, the man was given a shared cell. My investigator interviewed his cell mate who said that he had got to know the man, 'very well.' He described him as a 'very stubborn person' and explained that he was the type of person that would not let people take advantage of him, and that he would get agitated if things did not work out. He said that due to the man's poor mobility, he had the bottom bunk in their cell. He was asked whether the man ever complained about the medical treatment that he was receiving, and he said that he did recall him complaining that the prison were not allowing him to attend a follow- up medical appointment at a local hospital. However, there is no evidence that this was the case, and documentation seen during the investigation indicates that he had attended all his routine hospital appointments.

30. In relation to his medication, the man's cell mate said that the man took this daily. He added that he was required to collect one particular tablet daily and, unlike other medications, was not allowed this in possession. This frustrated the man

as he could not understand the reason for this. (Prisoners are sometimes given medications to hold in their possession and take as required or directed. However, there are certain medications that due to the risks to other prisoners or the opportunity for these to be abused, have to be collected daily and taken in sight of a nurse.) The man's cell mate also told my investigator that the man would often flush some of his medication down the toilet rather than taking them, and this sometimes led to them having a disagreement, as they used to float in the toilet. The man's cell mate was unable to confirm which tablets they were, but described them as the 'yellow and white' ones and also said that he knew the man did not take many of his aspirin. (Aspirin is regularly prescribed in low doses to people with heart problems to thin the blood and reduce the risk of heart attack.)

31. There is little recorded information about the man on the residential unit. Due to his age he was not required to work, and he did not participate in any offending behaviour group work. He was appealing against his conviction, this meant that he was unable to start offending behaviour work, as this requires participants admitting to the offence. His partner visited him regularly, and the man's cell mate said that the man looked forward to the visits.

32. It is noticeable that once discharged form the healthcare unit, the man's contact with nursing staff reduced and there is no evidence that regular checks on his weight and blood pressure continued. The clinical reviewer has commented in his report that National Institute for Clinical Excellence (NICE) guidelines suggest that annual checks on blood pressure are appropriate. However, the man had a history of heart problems and some doctors would have completed more frequent checks on both his blood pressure and weight.

33. Prison doctor A assessed the man on 8 July 2010. The doctor recorded that he had swelling in both legs, and prescribed him medication to treat this. His pulse rate was also recorded during the assessment as 80 beats per minute (bpm), which is within the normal range. On 16 July, the man was taken by prison staff to the rearranged outpatients appointment at Papworth hospital, to see the cardiothoracic surgeon (a surgeon who specialises in heart surgery). Following the appointment, the surgeon sent a letter to the healthcare department at Hull that indicated the man had made a good recovery from the operation and in light of his progress had been discharged from his care.

34. At the start of January 2011, the man submitted an application asking to be assessed for a wheelchair due to his limited mobility. He was assessed by Staff Nurse C, on 10 January. She completed a form on which she recorded his height and weight, and then passed it to the doctor. There is no evidence that a full assessment was conducted before the man's death.

35. When a prisoner wishes to see a doctor they are required to make an application, and will often be triaged by a nurse. This means that the nurse will decide on the urgency and priority of the case, before placing them on a waiting list. In most prisons, a GP's surgery is operated along the same lines as it would be in the community, with a prisoner being allocated an appointment. It can take up to a week for a prisoner to be seen for a routine appointment. The man submitted a

medical application on 11 January, indicating that he had ‘growths’ appearing on his arms and legs. In response to this application he was seen and assessed by the Modern Matron on 21 January. The Modern Matron recorded that the man said that his partner had noticed small patches on his skin during a recent visit and urged him to have them checked. On examination, they were less than 5mm in diameter, flat, white and scaly. The man said that been there for around 5-6 months, mostly on his arms, legs and chest. No other symptoms were recorded, and he said that there was no family history of serious skin problems. The Modern Matron prescribed anti-fungal cream and arranged for the man to be reviewed by the doctor in two weeks. However, no other issues or reviews relating to the man’s skin complaint are recorded.

Events in March

36. The man’s cell mate told my investigator that the man had not complained of feeling unwell during the day on 14 March. He said that during the evening they had been on association. The man had been playing pool and had even won a game against one of the better players on the wing, which had cheered him up. Association is the term used for the time that prisoners are given out of their cells to socialise and use the telephones or take showers etc. He said that evening they were locked in their cells at the end of the association period at around 7.00pm. Once back in their cell, they played a couple of games of scrabble, and had a hot drink, before he went to bed at around 11.00pm. He said that when he went to sleep, the man was still sitting in the chair watching television, which was not unusual. At around midnight he woke up and noticed that the television was still turned on, but tried to get back to sleep. He could hear the man snoring. The man’s cell mate said that he woke again at around 12.15am, due to the television being on and also he felt that the man did not sound right, he described him as ‘gurgling.’

37. On looking down from his bed at the man, the man’s cell mate said that he could see a small amount of blood in the right hand corner of his mouth, and thought maybe he had bitten his lip. When he got down from his bed, he could tell something was wrong and, although apparently unconscious, the man was patting his chest. He then immediately pressed the cell call bell and banged on the door to attract the attention of the night staff. (All cells are fitted with a cell call bell that can be pressed to alert staff in the event of an emergency.)

38. Officer A and the Operational Support Grade (OSG) were the two members of staff working on the wing that evening and heard the man’s request for assistance. The OSG said that when both she and Officer A arrived at the cell, Officer A looked in via the observation panel, and the man’s cell mate told him that the man was coughing up blood and needed to be seen by a nurse. The OSG said that, understandably, the man’s cell mate was quite distressed and she attempted to calm him down while Officer A requested assistance form the orderly officer (the person in charge of the prison at night) and healthcare staff via his radio. Most prisons have a coding system for use in medical emergencies. This usually consists of code blue, which indicates a prisoner is having breathing difficulties or is unconscious, and code red which would indicate bleeding. Use of the codes enables medical staff to attend the emergency with the correct

equipment. When interviewed, staff said that Hull has such a coding system in place, but on the morning of the man's death, it was not used as it was considered to be unnecessary.

39. Staff Nurse D was on duty in the healthcare unit and received a call requesting him to attend J wing immediately. The Senior Officer (SO), was the orderly officer, in charge of the prison, and he too was asked via the radio to attend the wing immediately. The SO said that on receiving the call he immediately made his way to J wing and also contacted the healthcare department to ensure that Nurse D was on his way. When he arrived at the wing, Nurse D was already there, and he used his cell key to enter the cell. (During the night state cell keys are carried in sealed pouches by patrol staff. These are able to be opened in an emergency, however, the orderly officer does carry a cell key on their key chain, and in this situation was used rather than opening a sealed pouch.)

40. Nurse D entered the cell and began to check the man. He recorded that initially the man was laying on his bed and there was a large amount of 'coffee ground' vomit on the bed and floor. He was unresponsive to verbal commands and appeared to be having some pain in his right side as his arm was "thrashing" around. Nurse D checked the man's observations and recorded that his pulse was 68 bpm and his blood pressure was 140/62, which is considered 'high.' Due to the man's previous medical history, Nurse D contacted the control room and asked for an ambulance to be called.

41. While Nurse D was carrying out his assessment of the man, the man's cell mate stood outside the cell with staff. Officer A said that after the ambulance had been called, the ambulance service called the prison back to clarify the situation and Nurse D spoke to them, to provide an update of the man's condition. Nurse D remained with him and continued to record his pulse and blood pressure, until the arrival of paramedics at around 12.50am. The paramedics carried out further checks on the man who remained unconscious and unresponsive. He was carried to the ambulance and taken to Hull Royal Infirmary (HRI.)

42. Officer A was one of two officers who escorted the man to HRI. He said that before leaving the prison, the paramedics gave further treatment to the man in the ambulance and stabilised him before leaving. On arrival at HRI, the man was taken straight to the resuscitation room, where he was further assessed by the duty doctor, who told the officer that a computerised tomography (CT) scan would be carried out to determine what treatment was required. (A CT scan is used to provide a better picture than a standard x-ray and is particularly useful in identifying bleeding on the brain.) Officer D said that nursing staff at the hospital asked him to contact the prison and obtain the man's next of kin details. He did so and passed them onto the nursing staff. Officer D confirmed that no restraints were used on the man.

43. The officers remained with the man and went with him for the CT scan. Following this they were told that he had a "massive" bleed on his brain and was likely to die within the next few hours. Officer D said that he believed that nursing staff had relayed this information to his next of kin. The man was taken to the acute assessment unit (AAU) where he continued to be monitored by nursing staff.

Officers D and B remained with him until 6.50am, when they were relieved by Officers C and D. At around 7.20am, Officer D noticed that the man's breathing had become very shallow. He told the nursing staff who examined him, and a doctor was also asked to attend. At 7.26am, the man was pronounced dead.

44. Following the man's death the prison management team met his daughter, who had been notified of her father's condition by the hospital. A debrief and support was offered to the staff that had given first aid to the man and to any other staff and prisoners affected by his death.

45. The prison remained in contact with the man's next of kin and assisted the family with funeral arrangements as well as providing advice on the role of my office and the investigation procedures.

ISSUES

Clinical care

46. The clinical reviewer conducted a review of the medical care provided to the man while he was in custody, and his report is attached as an annex. The man died of a brain haemorrhage.

47. The clinical reviewer outlined the man's history of high blood pressure, ischaemic heart disease and heart valve disease. He considers that record keeping and reception health screening at the prison were appropriate and the correct diagnoses and conclusions were made in respect of his medical conditions. He concluded that the healthcare team at Hull adhered to all national guidelines and policies. However, while he found that the healthcare teams approach to monitoring a patient's blood pressure, weight and other vital signs are conducted in line with NICE guidelines, he considers that more frequent checks might have been desirable, given the man's previous history of major heart surgery. It is also felt that pharmacy staff could help in this process by ensuring that patients who have long-term conditions have been seen and assessed prior to repeat prescriptions being re-authorised. The clinical reviewer makes the following recommendations, which I have slightly reworded and endorse:

    The Head of Healthcare should consider adopting a more pro-active approach to monitoring patients with long-term conditions such as heart disease.

    The Head of Healthcare should consider reviewing of the role of the pharmacy staff to enable them to monitor that such patients have had regular checks when repeat prescriptions are re-authorised.

48. With regard to the prison's overall management of the man, my investigation has found that all the relevant Prison Service policies and procedures were in place and adhered to and that he was managed well. As a result I make no recommendations on the non-clinical aspects of his care. I was particularly pleased to note that at an early stage, the man was placed on the Over 65 Care Pathway.

CONCLUSION

49. The man had undergone major heart surgery and had been diagnosed with several medical conditions prior to being sentenced and going into prison. While in custody he was provided with all the necessary medications that he required and attended appointments with his consultant.

50. Although the investigator was told that the man did not always take all the medication that he was prescribed, this is unsubstantiated. During his time at Hull he raised no concerns about his medical care. In the days before his death he had not reported feeling unwell to staff and his cellmate told the investigation that on 14 March, the man seemed to be fine during the day.

51. Despite his poor health, the man’s death was sudden and unforeseen, and staff acted quickly and correctly when alerted to his condition. I am satisfied that he received a level of care equitable to that he would have expected had he been resident in the community. However, there is scope for the prisons healthcare team to develop a more pro-active approach to monitoring patients with long term conditions.

RECOMMENDATIONS

1. The Head of Healthcare should consider adopting a more pro-active approach to monitoring patients with long-term conditions such as heart disease.

   This recommendation was accepted by the Prison Service who said:

   "… *Long term conditions clinics are in the process of being reviewed to bring them in line with community services. We have a meeting in August to follow community specific guidelines and policies. Monitoring clinics for long term conditions will be set up from September 2011 …"*

2. The Head of Healthcare should consider reviewing of the role of the pharmacy staff to enable them to monitor that such patients have had regular checks when repeat prescriptions are re-authorised.

   This recommendation was not accepted by the Prison Service who said:

   "… *All repeat prescriptions are written up with specific review dates. These dates are checked by Pharmacy each time the repeat is renewed. No repeats are given after a twelve month period unless the prisoner is seen by a Doctor. This is in line with community services …"*