

**Investigation into the circumstances surrounding the
death of a man at HMP Hull in September 2007**

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

April 2008

This is the report of an investigation into the circumstances surrounding the death of a man. He died from natural causes in the healthcare centre at HMP Hull in September 2007. He was 82 years old.

The man had lived a long life, but the loss of a loved one is always distressing. I would like to add my condolences to the man's family, to those already expressed by my investigator and by one of my Family Liaison Officers.

The man was serving a sentence of seven years imprisonment and had been in custody for two and a half years at the time of his death. Shortly after admission into prison custody he was diagnosed with caecal cancer (cancer in the colon) and his physical health gradually deteriorated. The man spent periods in hospital before returning to Hull on 11 September.

This investigation has been undertaken by my colleague. I would like to thank the Governor of Hull and his staff for their participation. Particular thanks go to the Principal Officer for making all the practical arrangements.

The Assistant Director of Risk and Integrated Governance at Hull Teaching Primary Care Trust, was commissioned to undertake a review of the man's clinical care, and I much appreciate his assistance. I have been pleased to learn of his conclusion that the man's terminal care was managed appropriately. The side room where he died, though not ideal, supported his wish to die in the prison's healthcare centre.

Following the issue of my draft report the family expressed concern that handcuffs had been applied to the man during some of his visits to outside hospital prior to his death. I do not make a formal recommendation on this matter but the Governor should be aware that this caused the family some distress. I refer him to the letter to Governors from the Head of Security Group dated 14 April 2008. The letter relates to a review on the use of restraints.

I make five recommendations for the Governor and seven recommendations for the healthcare centre.

Stephen Shaw CBE
Prisons and Probation Ombudsman

April 2008

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SUMMARY

The man died at HMP Hull in September 2007. He was aged 82.

The man has been convicted and sentenced in March 2005 to a total of seven years imprisonment. After an unsuccessful appeal against his conviction, he declined to participate in offending behaviour work. In all other respects the man cooperated fully with the prison authorities.

In May 2005, the man was referred to Hull Royal Infirmary (HRI) and was subsequently diagnosed with caecal cancer. This was followed by frequent admissions to the prison healthcare centre and local hospitals. In the final stages of his illness a place at a local hospice was considered, as was Early Release on Compassionate Grounds (ERCG) and Release On Temporary Licence (ROTL). However, there is no documentary evidence of the decisions made.

On 11 September 2007, the man returned to Hull after his final period in hospital. He was located in a small four-person ward. The man was isolated in a former association/education area in the healthcare centre in September, four days before he died. This was to avoid cross contamination from Methicillin-resistant *Staphylococcus aureus* (MRSA).

The post mortem report carried out in September concluded that the man died of bronchopneumonia. This was linked to cancer of the colon.

The Clinical Reviewer, was asked to look at two central matters: whether it was appropriate for the man's terminal care to be provided in the healthcare centre, and whether it was reasonable to move him to a side room in the days shortly before he died? The Clinical Reviewer has judged that, under the circumstances, it was indeed appropriate to manage the man's terminal care in the healthcare centre. His removal to a side room, though not ideal, was necessary. It is to be noted that the man's own wish was to be allowed to die in the healthcare centre.

I believe that staff in the healthcare centre managed the man's terminal care effectively and to the best of their ability. However the necessary policies, facilities and equipment to manage prisoners requiring palliative care were not fully in place. I accept that it might have been possible to release the man on ERCG or ROTL. (A move to a hospice was also considered.) However, I am critical of the fact that there is no audit trail to show that these options were properly explored.

The man's children do not seem to have been aware of matters relating to their father's terminal care. They expressed concern about several issues that I have endeavoured to address in this report.

THE INVESTIGATION PROCESS

1. My investigator obtained the man's prison and medical records and, following initial contact with the acting Governor of HMP Hull in September, formally opened the investigation on 8 October 2007. Eight members of staff and two prisoners were interviewed.
2. Prior to the investigator arriving at Hull, notices were issued to staff and prisoners. These announced the investigation and invited anyone who had information about the man's death to make themselves known. In the event, nobody came forward.
3. Interviews with staff and prisoners were either recorded or notes were taken. Copies are attached as an annex to this report.
4. A Clinical Reviewer at Hull Teaching Primary Care Trust carried out an independent clinical review of the healthcare the man received whilst in custody. The Clinical Reviewer was asked to consider all clinical issues. In addition, he was asked to look at two key issues relating to where the man died:
 - Was it appropriate for the man's terminal care to be provided in the prison healthcare centre?
 - Given the man's wish to remain with friends in the centre, was it reasonable to move him to a side room in the days shortly before he died?
5. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and to request a copy of the post mortem report. A copy of this investigation report will be sent to the Coroner to assist in his enquiries.
6. One of my Family Liaison Officers contacted the man's next-of-kin to offer them the opportunity to participate in the investigation. My investigator and FLO visited the family. Several concerns were raised about the care the man received whilst at Hull. Where these were within my terms of reference, I have addressed the concerns within this report. My investigator was able to answer some of the concerns during his visit with the family and in subsequent correspondence. I hope this report helps the family to better understand the events leading up to the man's death.

HMP HULL

7. HMP Hull opened in 1870 and is now a category B local prison serving the courts in East and North Yorkshire and North Lincolnshire. There are nine residential units. The maximum number of prisoners that can be held is 1,071.
8. In March 2004, Her Majesty's Chief Inspector of Prisons carried out an announced visit. She subsequently reported that the prison was providing a largely safe and decent environment.
9. The healthcare centre is a modern purpose-built building that is six years old. The facility includes out-patients clinics on the ground floor and a residential unit on the first floor that can accommodate up to 18 in-patients. The centre is staffed by a combination of qualified nursing staff and prison officers. Several of the prison officers are former healthcare officers. The regime provided for in-patients is broadly similar to that available in the main prison.
10. Access to prisoners at night is not permitted except in an emergency. In such circumstances, prisoners have their cell doors opened for very brief periods. A minimum of three prison officers would normally need to be present. Some prisoners may be located in a cell with greater visibility. These cells normally have a door that is left open and a gate that is locked. Access would be as for a normal cell. In exceptional circumstances, a cell or room door may be left open. This would follow an in-depth risk assessment of the location and prisoner involved.
11. When the man returned for his last stay in the healthcare centre he was located in a small side ward that held up to four prisoners. He was moved into a former association/education area within the centre four days before his death. This room was not normally used as prisoner accommodation. A risk assessment was carried out and 24 hour access was approved.
12. The man was the first patient for whom HMP Hull provided terminal care for in the healthcare centre. Recommendations for the healthcare centre that I have made in previous death in custody investigations at Hull are not relevant in this case.

KEY FINDINGS

13. The man began his prison sentence at Hull in March 2005. Shortly afterwards he was diagnosed with cancer in the colon. In August of that year a right hemicolectomy was carried out. (This is an operation to remove part of the large intestine.) The operation resulted in the need for a colostomy bag.
14. The man spent time in the prison healthcare centre on several occasions. He moved there on a more permanent basis in early 2007. A locum doctor, noted in the man's patient record that in May 2007 she discussed compassionate release with a governor.
15. The man visited the local acute hospital for chemotherapy sessions and clinical assessments. His final visit was in August 2007. The man was transferred back to the prison on 11 September 2007 following this last period in hospital. He was located in a small four-person ward in the healthcare centre. It is recorded in the medical notes that the man returned to Hull with Methicillin-resistant *Staphylococcus aureus* (MRSA) and had to be barrier nursed to avoid cross contamination.
16. The man was moved from the small ward into a room on his own on 18 September. This room was a former association/education area that required equipping before use.
17. A final entry was made in the notes several days later saying that the man appeared settled and in minimal distress. Family members visited him that afternoon.
18. At about 7.00pm that evening, a Staff Nurse visited the man and noticed his breathing had become shallow. She felt that he was close to death. Another Staff Nurse remained in the room with her, and the man, until he died approximately ten minutes later. They covered the man with a sheet and secured the scene. The time of death recorded by paramedics was 7.58pm.
19. The Governor and one of the prison's Family Liaison Officers (FLOs), visited the man's next of kin at about 9.40pm that evening. They intended to tell the man's daughter, that her father had died. The man's daughter telephoned the healthcare centre to check on her father's condition shortly before they arrived. She was told that he had died by a member of the healthcare team.
20. A 'hot' debrief for staff on duty that evening was carried out by the Duty Governor. (Hot debriefs are primarily carried out to ensure staff have the opportunity to discuss emotive issues relating to incidents. Minutes are not normally taken at these meetings.)

21. A post mortem was carried out at Hull Royal Infirmary the next day by a Consultant Forensic Pathologist. It concluded that the man died from natural causes.
22. The Governor wrote to the man's son offering the condolences of staff at Hull. The letter advised the man's son that his father's property and monies would be forwarded to him. It added that, if financial assistance with funeral expenses was needed, he should contact the Duty Governor. A similar letter was sent to the man's daughter. Notices to staff and prisoners informing them of the man's death were issued by the Governor on the same day.
23. The man's cell was sealed on the evening of his death by a Senior Officer. A third Staff Nurse and an officer cleared the man's belongings from the room during the morning two days later. A cell clearance form lists items of the man's property that were in the room at the time. The man's daughter received her father's property about two weeks after his death. It was delivered to her home by the Deputy Governor.

ISSUES

24. Following the right hemicolectomy in August 2005, the man required a colostomy bag. The family told my investigator that the man's bag often leaked. They added that he arrived at one visit in the prison visits room with a towel round him to prevent leaks. The Staff Nurse said at interview that bags were changed at least daily and were cut to size for the man. She said that the man preferred these bags as they stuck to his stomach better than others, though occasional leaks did occur. Prison healthcare staff sent some bags out with the man when he visited outside hospitals. The clinical reviewer has confirmed that there were some issues with the stoma bags but these appear to have been effectively addressed. The patient record indicates that the bags were changed regularly. I agree with the clinical reviewer that the care relating to the man's colostomy bag was appropriate.
25. Although compassionate release was discussed with a prison governor, I was surprised to discover there is no documented evidence that it was fully considered. The man might have been suitable for ERCG as set out in Prison Service Order (PSO) 6000. (PSOs provide instruction and guidance for the management of prisons.) The Head of Operations, said at interview that she did not consider ERCG. She said she did consider Release on Temporary Licence (ROTL) and felt that it would be inappropriate in this case due to the man's offence. I do not doubt the Head of Operations evidence, but there is no documentation to confirm it either.

The Governor should ensure that all decisions regarding compassionate and temporary release are fully documented in the prisoner's record.

26. The man's family asked my investigator if a hospice had been considered. The Healthcare Principal Officer said during her interview that the man had been asked if he wanted to go to a Hospice. He had replied that he did not wish to do so. When my investigator asked if the family had been involved in these discussions, the Healthcare Principal Officer said that they had not. She added that the man was always advised to discuss issues with his family. The Head of Custodial Healthcare, said the family would always be involved if the patient requested it. The Head of Operations said she believed that the Hospice had refused to take the man because he would have prison staff with him. It is a concern to me that there is no documentary evidence to confirm this information.

The Governor should ensure that all discussions relating to placement in a hospice are fully documented in the prisoner's record.

27. The Head of Operations said that, when she visited the man in Hull Royal Infirmary (HRI), he made several requests to be returned to the prison. He expressed concern about the treatment he was receiving in HRI. The

Head of Operations added she was surprised to discover, on her return from leave, that the man had returned to the prison. The Healthcare Principal Officer and Staff Nurse also said they were not expecting him to return. This goes some way to explain why the prison had to provide the man's palliative care in the healthcare centre. The Clinical Reviewer makes one recommendation for the healthcare centre on this matter relating to record keeping.

The patient's wishes regarding their care, for example where they prefer to be cared for, should be explicitly recorded and reviewed as appropriate.

28. Several entries appear in the medical record confirming contact, advice and visits by the community Macmillan nurse. The man's family said they were unaware that Macmillan was involved. They were concerned more generally about what information had been given to the man about his illness. They were also concerned about the support offered to the man to help him come to terms with it. The man was aware of Macmillan support as he met the community nurse. It is possible that he did not fully communicate this information to his family. The clinical review makes one recommendation for the healthcare centre relating to record keeping in the patient record on this issue.

The family's understanding/opinion regarding care matters should be noted and updated as appropriate.

29. The Clinical Reviewer notes that the Macmillan nurse visited the man but found access to the prison difficult. He makes the following recommendation relating to access by visiting clinicians.

Prison healthcare staff should consider if any actions can be identified to facilitate the speedier access of visiting clinicians to patients in healthcare.

30. The Clinical Reviewer finds that staff had consulted with the man and recorded his wishes and preferences. Care plans appear comprehensive and were regularly updated to address the man's changing needs. Pain management was appropriate, although the healthcare centre did not have access to a syringe pump. The Clinical Reviewer makes one recommendation relating to this matter.

A Graseby syringe driver should be purchased and staff trained in its use.

31. The man returned to Hull from hospital on 11 September to receive his terminal care. The Clinical Reviewer feels it is unlikely that the standard of care received in the healthcare centre would be comparable to that received in a hospice. He believes the care was similar to that the man would have received in a hospital setting. The prison broadly followed the principles of the Liverpool Care Pathway. (This is a care pathway for

people who are terminally ill. The idea behind the pathway is to provide the same care for people who are dying, wherever they are.) Staff at Hull had little or no training in palliative care and no clear palliative care policy was in place. The man's wish to remain in the healthcare centre with friends in a similar environment was in line with supporting patient choice, but the healthcare centre was not an ideal location. However, under the circumstances, I agree with the Clinical Reviewer that it was reasonable to continue to care for the man in the healthcare centre. The clinical review makes the following recommendation for the healthcare centre relating to palliative care.

The Liverpool Care Pathway should be used for all terminally ill prisoners until palliative care policies, sufficient equipment and appropriate staff training are in place.

32. Although the Clinical Reviewer feels it was reasonable to care for the man at HMP Hull he makes one recommendation for the healthcare centre relating to the recording of assessments.

Any future requests by patients to remain at Hull should be carefully assessed, on a case-by-case basis, and the outcome of the assessment recorded and retained as part of the patient record.

33. The man's son and daughter asked whether their father's treatment was appropriate following his return from hospital. They wondered if the prison knew he was suffering from pneumonia. They also asked why he was not on a ventilator, whether he was receiving morphine, and whether this could have adversely impacted on his cancer. The Clinical Reviewer has confirmed that healthcare staff were aware that the man was suffering with pneumonia and he had been prescribed Amoxicillin 500mg TDS (three times daily) to address this. The last prescription was for two weeks and dated 17 September 2007. The Clinical Reviewer adds that, although the man had some difficulty swallowing, he was taking his medication up to the day before his death. The man was on morphine for pain relief, which is standard good practice. Dosage was monitored by the medical practitioner in conjunction with the specialist Macmillan nurse. Morphine would not have had an impact on the cancer. The Clinical Reviewer confirms it would not be standard practice to place an individual on a ventilator in the final stages of palliative care. Ventilation is an active treatment and would normally be used only where the patient had a good chance of recovery. He adds this was not the case with the man who was at the end stage of his life.
34. On 18 September, the man was moved into a side room on his own. The Healthcare Principal Officer said that the man was moved to avoid cross-contamination from MRSA. She added that it also gave the man privacy and allowed him to see whom he wished. On a few occasions he had stopped people visiting him as sometimes he wanted to be alone. Following a risk assessment, essential 24 hour access to the man was

approved. The clinical review considers the decision to move the man into a side room was appropriate. I agree.

35. The side room itself is a large room that was once used for association or education. Although locating the man there provided the necessary isolation and access, it was by no means ideal. At the time, the room was in need of decoration and had not been fully equipped. The family felt that little was done to make the room more comfortable and welcoming, as promised by the prison. They also commented that the privacy screens were rarely pulled across and anyone passing was able to see in.

The Governor should ensure that an appropriate room, with the necessary equipment, is available for the palliative care of prisoners.

36. The man's family expressed concern at the time it took from arriving at the prison to being escorted to the healthcare centre when visiting their father. I have not been able to confirm this information. Delays experienced may have been due to routine procedures. The family do not appear to have been made aware that delays were likely. I make no formal recommendation but invite the Governor to consider ways that the speed of visitors' access to prisoners in the healthcare centre could be improved.
37. The man died at around 7.10pm. Entries were made in the patient record indicating that the man had requested not to be resuscitated on at least three occasions. To comply with the man's wish, staff at the scene did not attempt resuscitation. Death was confirmed by paramedics at 7.58pm. The staff who nursed the man during his final hours appear to have been caring and fully aware of his needs and his wishes. The Clinical Reviewer notes that an entry was not made in the patient record relating to the man's death. He makes one recommendation for the healthcare centre.

Prison healthcare staff should ensure that circumstances at the time of death are recorded in the patient record.

38. The man's son told my investigator that he had asked staff in the healthcare centre to be notified of his father's death. He would then inform other family members. The Duty Governor on the day confirmed in interview that he was aware of this request. The Duty Governor has responsibility for informing next of kin when a death in custody occurs. The Duty Governor said that he could only act on the information noted on page one of a prisoner's record. This information is provided by a prisoner when received into custody. The man's daughter was the person nominated by the man to be his next of kin when he first arrived at Hull. The healthcare Principal Officer said she believed that nursing staff should inform the next of kin as they know the patient and the family. There is no evidence that the man had been consulted about who he wished to be informed first when he died. I believe the procedures laid down may be too inflexible.

The Governor should ensure that, in cases where palliative care is necessary, the patient's wishes relating to who should be informed of their death and by whom, should be taken into consideration.

39. The debrief process carried out with staff on duty on the evening of the man's death and a later full debrief, were appropriate and in line with policy. Post incident actions were on the whole managed effectively. However, the man's personal officer, said he was not offered support. He had known the man for some time. He felt that support should be given to all staff who work with terminally ill patients. He added that they were not used to working with prisoners in the late stages of a terminal illness. I agree that support should be provided.

The Governor should ensure that appropriate support is provided for staff working with terminally ill prisoners.

40. The post mortem report indicated that the man's death was due to bronchopneumonia that had arisen as a result of septicaemia. This developed from a right abdominal abscess that formed in association with recurrence of the man's colonic carcinoma within the right iliac fossa. The Pathologist concluded that death came from natural causes.
41. The family accepted the Governor's offer of financial assistance with funeral costs. Issues arose concerning the sum that was to be paid. Eventually the establishment complied with the guidelines outlined in Prison Service Order 2710, Follow up to Deaths in Custody. My investigator has not made a recommendation on this matter but I draw to the Governor's attention that it caused distress to the man's family.
42. Following her father's death, the man's daughter asked that his suit be cleaned and returned before the funeral. The Governor has confirmed this did not happen as requested. Following a telephone conversation with the man's daughter, the Deputy Governor took the man's property to her home in a prison property bag. He has apologised for this error and has said that property is normally returned in an appropriate holdall. He told my investigator the oversight was due to a communication breakdown with the prison FLO. The Deputy Governor added that the man's daughter accepted his apology for this oversight.
43. A signet ring, listed as in possession on the man's property card, was not returned to the family. The ring was not recorded as an item removed when the man's cell was cleared. The Pathologist makes no reference to the ring in his post mortem report. My investigator could not discover the whereabouts of the ring and I therefore invite the Governor to look into this matter.

RECOMMENDATIONS

I make five recommendations for the Governor of Hull:

The Governor should ensure that all decisions regarding compassionate and temporary release are fully documented in the prisoner's record.

Prison Service response: Recommendation accepted. *"All decisions regarding compassionate and temporary release will be recorded appropriately".*

The Governor should ensure that all discussions relating to placement in a hospice are fully documented in the prisoner's record.

Prison Service response: Recommendation accepted. *"All requests/discussions relating to a placement in a hospice are documented and logged within the core record and within the inmate medical record".*

The Governor should ensure that an appropriate room, with the necessary equipment, is available for the palliative care of prisoners.

Prison Service response: Recommendation accepted. *"A room is now available to provide palliative care, additional work has been identified and is in progress".*

The Governor should ensure that, in cases where palliative care is necessary, the patient's wishes relating to who should be informed of their death and by whom, should be taken into consideration.

Prison Service response: Recommendation partially accepted. *"PSO 2710 states family should be informed of the death by a family liaison officer working alongside a Chaplain or Governor. However if the patient wishes for a particular member of staff to be also present when the news is passed the prison would endeavour to meet the patient's wishes".*

The Governor should ensure appropriate support is provided for staff working with terminally ill prisoners.

Prison Service response: Recommendation accepted. *"Staff working with terminally ill prisoners are afforded the facility of the staff welfare team. They have also been issued with information notices to ensure a better understanding of the needs of patients in need of palliative care".*

I make seven recommendations for the healthcare centre;

The patient's wishes regarding their care, for example where they prefer to be cared for, should be explicitly recorded and reviewed as appropriate.

Primary Care Trust response: Recommendation accepted. *"PCT Preferred Place of Care (PPC) Nursing team aware of document and will implement where appropriate".*

The family's understanding/opinion regarding care matters should be noted and updated as appropriate.

Primary Care Trust response: Recommendation accepted. *"Nursing team to document dialogue undertaken with relatives regarding palliative patient".*

Prison healthcare staff should consider if any actions can be identified to facilitate the speedier access of visiting clinicians to patients in the healthcare centre

Primary Care Trust response: Recommendation accepted. *"All clinicians visiting the establishment are escorted by Health Care staff as soon as they are made aware of their arrival".*

A Graseby syringe driver should be purchased and staff trained in its use.

Primary Care Trust response: Recommendation accepted. *"Purchased and PCT Syringe Driver Policy document has been implemented".*

The Liverpool Care Pathway should be used for all terminally ill prisoners until palliative care policies, sufficient equipment and appropriate staff training are in place.

Primary Care Trust response: Recommendation accepted. *"Liverpool care Pathway will be used at the appropriate time with the intervention of the Macmillan nursing team".*

Any future requests by patients to remain at Hull should be carefully assessed, on a case-by-case basis, and the outcome of the assessment recorded and retained as part of the patient record.

Primary Care Trust response: Recommendation accepted. *"Preferred Place of Care facilitates this".*

Prison healthcare staff should ensure that circumstances at the time of death are recorded in the patient record.

Primary Care Trust response: Recommendation accepted. *"Nursing team aware that documentation must be recorded accurately in accordance with NMC Guidelines".*

