Investigation into the circumstances surrounding the death of a man at Castle Hill Hospital in February 2008 whilst in the custody of HMP Hull

Report by the Prisons and Probation Ombudsman for England and Wales

October 2008

This is the report of an investigation into the death of a man in February 2008 at Castle Hill Hospital, Hull. He suffered from several chronic conditions, and was treated as a hospital in patient on more than one occasion. He was in the custody of HMP Hull when he passed away. 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.

The investigation was conducted by two of my investigating officers. In addition I commissioned a clinical review into the man's healthcare. My thanks to the Clinical Governance Manager of Provider Services at Hull Teaching Primary Care Trust, who undertook this review.

I would like to thank the Governor of Hull and our liaison officer for their assistance during the course of this investigation.

The clinical review includes a recommendation concerning the importance of follow up treatment for the man's pressure sore, which I endorse. I also note the man's cell allocation and his access to a wheelchair as examples of good practice. Finally I commend the prison for removing the restraints from the man during his final hospital stay, and for allowing him and his family privacy during their final moments together.

I am pleased to see that the Prison Service have accepted the recommendation.

Jane Webb
Deputy Prisons and Probation Ombudsman **October 2008**

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SUMMARY

The man died whilst in Castle Hill Hospital, Hull in February 2008. He had been admitted to hospital on 19 February following a long period of ill health whilst he was in HMP Hull. He was struggling to breathe and the prison's healthcare centre requested an ambulance for emergency transfer to hospital.

The man had been in custody since April 2003. He had a long-term chronic chest condition and persistent obstruction of the airways. He regularly attended prison healthcare (HCC), as well as the Royal Hull Infirmary (RHI) and Castle Hill Hospital (CHH) for appointments. He also attended as an in-patient on several occasions.

In view of his health and subsequent mobility problems, the man was allocated a cell near to both the food servery and the treatment hatch which was also close to the showers and association area. He also had access to a wheelchair to help his mobility. Furthermore, the healthcare centre has a lift, so the man did not have to use the stairs.

My investigators confirmed that the man was not handcuffed when he died and that authority had been given by a senior manager on 19 February to remove the restraints. I am pleased that this occurred. At the time that the man died, both bedwatch officers had withdrawn from the room and remained outside the door, allowing the man and his family some privacy during his final moments.

The clinical review contains a number of advisory points for the prison and does not raise any concerns about the care and treatment the man received whilst he was in custody.

THE INVESTIGATION PROCESS

1. My investigators requested all the relevant prison records relating to the man, including:

    - patient record
    - history sheets
    - personal records
    - wing sick applications
    - bedwatch log
    - cell clearance sheets.

2. Notices announcing the investigation were supplied by my investigators and displayed by the prison to staff and prisoners, who were invited to contribute any relevant information. No prisoners or staff made contact.

3. One of my Family Liaison Officers contacted the man's daughter to ask if there were any issues she specifically wanted the investigation to take into account. She had several concerns which she asked us to consider:

    - the man may not have received his medication on several occasions
    - he had undressed bedsores on his body when moved to hospital
    - he may have sat in his own faeces for some days before he was bathed
    - the family were not informed on each occasion he was taken to hospital
    - he had bruises on his body
    - he was very underweight.

    I hope these, and any other questions she may have, have been answered in this report.

4. A clinical review of the man's healthcare was undertaken by the Clinical Governance Manager of the Hull Teaching Primary Care Trust (PCT) and I am grateful to her for the report. She also made herself readily available to answer any queries during the investigation and her assistance was much appreciated. The review provides explanations and insight to ensure that, as far as possible, the full facts are brought to light and any relevant failing is exposed. In addition, it should help ensure that any commendable action or practice is identified, and any lessons from the man's death are learned. It specifically considers the following questions:

    - Was the care the man received whilst in custody at HMP Hull appropriate and comparable to the services the man could expect to receive from a Primary Care Provider in the Community?
    - Would different care have resulted in a different outcome?
    - Are there any learning opportunities following identification of any root causes and examination of policy and practice?

5. The investigation team visited the prison. They considered the extent to which the prison complied with local and national procedures for looking after prisoners with health problems and for dealing with deaths in custody. They were given access to the man's records, including his medical records, and spoke to staff at the prison.
6. My investigator contacted HM Coroner for East Riding and Kingston-upon-Hull to inform him of our investigation and report. He kindly provided my office with the post mortem report. The Coroner will receive a copy of this report when it is completed to assist with his enquiries into the man's death.

HMP & YOI HULL

7. 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 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 prisons. In February 1986, Hull assumed its current role as a male local prison and remand centre.
8. In 2002 the prison was expanded and increased in size. Its expansion included four new wings, a new healthcare centre, a new sports hall, a new multi-faith centre and refurbishment to other parts of the prison including the kitchen, education and workshops. Since 1 April 2005, the local Primary Care Trust has assumed commissioning responsibility for the provision of healthcare. It has an operational capacity (maximum crowded capacity) just in excess of 1,000.

Healthcare

9. Nursing staff and professions allied to health at HMP Hull Healthcare have regular performance reviews and supervision to ensure that best practice is identified and embedded within the organisation. Mandatory and statutory training is undertaken by healthcare staff, which includes Basic Life Support, Manual Handling, Risk Assessment, Health and Safety and Managing Diversity. Staff also have access to learning events hosted by Hull Teaching Primary Care Trust.

Do Not Resuscitate Notices (DNRs)

10. A Do Not Resuscitate order (DNR) on a patient's file means that a doctor is not required to resuscitate a patient and is designed to prevent unnecessary suffering. The United Kingdom medical profession has guidelines for circumstances in which a DNR may be issued:
    - if a patient's condition is such that resuscitation is unlikely to succeed
    - if a mentally competent patient has consistently stated or recorded the fact that he or she does not want to be resuscitated
    - if there is advanced notice or a living will which says the patient does not want to be resuscitated
    - if successful resuscitation would not be in the patient's best interest because it would lead to a poor quality of life.

Previous deaths at Hull

11. There have been 15 deaths at Hull since April 2004. Nine of these have been from natural causes. None of the previous investigations are comparable to this one, although in one of my reports I recommended that the Governor should review the policy of using restraints on every prisoner in hospital. I am pleased to find that the recommendation has been achieved and that arrangements for the man allowed the restraints to be removed.

Her Majesty's Inspectorate of Prisons

12. The latest report, following an unannounced inspection of HMP Hull by HM Chief Inspector of Prisons dated February 2006, states "Healthcare had improved and made good use of prisoner forums … The monthly healthcare prisoner forums actively involved prisoners in healthcare issues."

Independent Monitoring Board (IMB)

13. In its latest annual report, covering December 2006 to December 2007, Hull's IMB does not show any issues which are particularly relevant to this investigation. On healthcare the report states "Any client with immediate healthcare needs of an acute nature will be referred to an outside hospital if required or monitored within the healthcare in-patients unit."

KEY FINDINGS

14. The man was remanded to HMP Hull in March 2003, and subsequently sentenced to seven years and six months' imprisonment in April. He was located on the vulnerable prisoner wing. It was his first time in prison.

15. According to staff he appeared to be a quiet, polite and approachable individual. He had health problems prior to his imprisonment and in January 2003, had been diagnosed with mycobacterium kansasii infection, which is a lung disease similar to tuberculosis. The symptoms include a chronic cough, weight loss and discomfort in the lungs. He was still suffering from this disease during the following year.

16. The man went through a medical screening on reception into prison. Because of the state of his health and breathing difficulties his record was marked to indicate that he should only be located on the ground floor**.** He was put onto I wing so that he had easier access to the food servery, medication hatch, showers and association.

17. In April 2003, when discharged from the healthcare centre, the man was recorded as having various physical problems and being on long-term prescribed medication. Four days later on 15 April, the man went to healthcare to speak to a doctor about concerns over his medication. He stated that on several occasions he believed that insufficient medications had been supplied to him. During this investigation no evidence of deliberate withholding of medications was found. The following month, on 2 May, the man was issued with a nebuliser (a device that administers liquid medication to the airways), for a serious chest complaint. Due to his condition the nurse advised the wing that he should not have to attend work whilst in prison.

18. On 5 November, the man was diagnosed, by a consultant physician, with moderately severe tobacco-related obstructive airways disease and mycobacterium kansasii infection (treatment for which had started in January 2003). He was due to attend Hull Royal Infirmary for an appointment on 3 December, but informed staff that he did not wish to attend and signed the appointment letter to the effect that he understood this was done at his own risk.

19. At 11.50am on 12 January 2004, staff on the wing contacted healthcare because the man was having breathing difficulties. His records give no further information about the treatment he was given. On 11 March, healthcare staff were called again because he was having difficulty breathing. Oxygen was given and after a while his breathing returned to normal. Healthcare staff later returned to the man's cell to monitor his breathing.

20. The next time that the man is recorded as having breathing difficulties was on 23 June, when he was taken to HRI. He was treated for a productive cough and shortness of breath. On 8 July, he was admitted to the healthcare centre with extreme breathing difficulties. An ambulance had been called to the wing but the man refused to go to hospital and he returned to his cell later the same day.

21. On 2 November, the man was also diagnosed with severe chronic obstructive pulmonary disease (COPD), which is a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease. COPD

occurs as a result of damage to the lungs, usually due to smoking, and the condition is not curable. Treatment mainly relieves the symptoms and the responses vary from person to person. Some people can experience severe weight loss, in part because shortness of breath makes eating difficult. During severe episodes a life-threatening condition called acute respiratory failure may develop. Contracting influenza or developing pneumonia may markedly worsen COPD.

22. The man continued to be treated at both HRI and CHH where he was under the care of a consultant surgeon. There was regular correspondence between the hospitals and the prison healthcare centre outlining the man's health problems. He was regularly reviewed in the chest clinic where his lung function suggested prominent emphysema. It was thought that he was probably using his nebuliser too often and so different medications were given. He was also frequently prescribed antibiotics for reoccurring respiratory tract infections, and had intermittent steroid therapy when the COPD was particularly severe.

23. It was recorded in January 2005 that the man still had severe COPD but that the treatment for the mycobacterium kansasii infection was stopped after two years of combination therapy.

24. Two months later, in March, the man was found to be having trouble overcoming a recent chest infection. Later in the month, on 22 March, it was recorded that he had been losing weight recently and had complained of dysphagia (difficulty swallowing) for about four weeks. He was given regular meals at all times, but often preferred a slice of toast and liquids. He also ordered Fortisips, which are a meal supplement. The man attended hospital about once a month for regular reviews of his condition.

25. On 8 April, the man underwent an endoscopy (a procedure to view inside the body), which reported normal. He gave up smoking and was put on a waiting list for a hernia operation. At his appointment on 25 July, he told his consultant that he had been coughing up blood for a few months. A bronchoscopy (a procedure to examine the lungs and take a sample of cells for tests) took place on 17 August, which proved normal.

26. The man was also diagnosed with Raynaud's disease (a condition that causes some areas of the body – such as fingers, toes, tip of nose and ears – to feel numb and cool in response to cold temperatures or stress) on 24 October. The doctor recorded that "His joints had a good range of movement … There are a few bruises, most likely from steroids." The man's daughter has asked about the bruises on her father's body and the clinical reviewer advises that steroid medication can cause the skin to look as though it is bruised.

27. Early the following year, in February 2006, the man's chest was scanned at CHH and he was diagnosed with a lump (nodule) in the thyroid gland of his neck. Three weeks later, on 21 March, it was recorded that he had quite significant lung disease, a retro-sternal goitre (when the thyroid enlarges downwards into chest) and a year long history of dysphagia.

28. On 15 June, the man was seen by the prison doctor who recorded that he was short of breath, was wheezing and could not finish a sentence. He had also lost weight and the COPD had worsened. Two days afterwards, on 17 June, the man returned to HCC as he had more difficulty breathing. Oxygen was administered

but he was still having difficulties after an hour and a half and was taken to HRI. He was treated for the exacerbation of COPD and remained in hospital for ten days until 27 June.

29. When next seen at the chest clinic at CHH on 29 August, although the diagnosis of severe COPD remained, there was very substantial improvement to the man's condition. However, two months afterwards on 26 October, he was admitted to CHH suffering from pneumonia and kept in hospital until 31 October.

30. The man continued to visit the hospital as an out patient. On 6 January 2007, he complained of breathing difficulties and was given emergency oxygen in the healthcare centre. He was told on 25 June that he had been removed from the hospital waiting list for a hernia operation because his thyroid gland was abnormal. A chest infection developed on 14 July and at the HRI four days later on 18 July, he was found to be suffering from haemoptysis (coughing up of blood or bloody sputum). It was also recorded that the man was allergic to morphine.

31. The man was admitted to CHH again on 28 September and was diagnosed with acute exacerbation of COPD, asthma and angina. On 5 October, he had another bronchoscopy which showed as normal, but he was now having to use a wheelchair on long distances. He was given his annual flu vaccination on 7 November.

32. On 21 November, the man again complained of difficulty breathing and he was seen by a doctor on the wing. He was given oxygen which eased his breathing, but continued to have difficulty and so the paramedics were called. Excess medication was found in the man's cell the following day, which was removed until his return from hospital. He was taken to the Accident and Emergency Department at the HRI by ambulance at midnight.on 23 November. Following further investigation and treatment, the man was diagnosed with infective exacerbation of COPD and he remained in hospital until 30 November.

33. The consultant surgeon again diagnosed severe COPD on 13 December, together with the previous mycobacterium kansasii infection. The man's breathing remained poor and it was suggested that he should have a chest x-ray in about six to eight weeks time. He was admitted to CHH again from 19 December until 24 December, due to the exacerbation of the COPD.

34. The man was given a formal warning on 4 January 2008, because he had been found again with excess medication, had requested medication which he was not entitled to and misused his cell bell. His punishment was subsequently set at loss of half his earnings, loss of association, and loss of canteen facilities for 28 days. He was admitted to healthcare the same day for medical assessment and review.

35. On 10 January, the man was admitted again to CHH with infective exacerbation of COPD. He stayed in hospital for a week until 17 January, and then returned to the prison. His wing history sheet has an entry for 19 January, which states "Not a good week as he was quite poorly". At the end of the month, on 28 January, he had to be reminded to take all his medication when it was given to him. The man's wing history sheet also indicates that he felt that staff were incorrectly refusing to let him out for association, despite the earlier punishment.

36. At the beginning of February, the man was noted to have a pressure sore on his sacral area (an area of localised damage to the skin and underlying tissue

caused by pressure, shear, friction and or a combination). On 19 February, the man collapsed and was found to have low blood pressure and low levels of oxygen saturation. A nebuliser was administered and an urgent doctor's review was requested. The man's condition continued to deteriorate and an ambulance was called. He had suffered from incontinence and the staff cleaned him before the ambulance arrived.

37. The man was admitted to HRI at 11.40 am on 19 February under bedwatch arrangements, which means that two officers remained with him throughout the day and night time. Normally a prisoner would be handcuffed to one of the officers but this did not apply to the man as at 1.30pm a governor authorised the removal of the restraints at the request of a hospital doctor. On 22 February, the man was transferred to CHH where his treatment continued. With the man's consent, a Do Not Resuscitate notice was made.

38. The following week, on 25 February, medical staff made it clear that the man's condition was deteriorating. At 10.30am the bedwatch officers withdrew from his bedside, with the permission of a governor. This allowed the man and his family privacy during his final moments. A doctor certified his death at 6.10pm.

39. The prison's contingency plans were activated after the man's death. The Governor, the Coroner and the Independent Monitoring Board were informed. A family liaison officer was appointed. The bedwatch officers returned to Hull, where they were spoken to by a member of the care team, and a governor conducted a hot debrief. A book of condolence was placed in the healthcare centre.

40. A governor and a family liaison officer visited the man's daughter on 26 February, and handed all his remaining property to her. She also visited the prison wing and the cell that her father had occupied. The prison offered to meet the funeral costs.

41. A post mortem was carried out at HRI on 27 February. It concluded that the cause of death was due to natural causes. Lung disease was the immediate cause of death, with ischaemic heart disease as a contributing factor.

ISSUES

The man's location at HMP Hull

42. The prison ensured that the man's social and mobility requirements were met. He was allocated a cell close to the food servery and medical treatment hatch, which meant that he did not have to use the stairs. He had the use of a wheelchair when he needed to get from one part of the prison to another. This is good practice.

Clinical care

43. The clinical reviewer considered whether the care the man received whilst in custody at HMP Hull was appropriate and comparable to the services he could expect in the community. She concluded that it was. Referrals were made to appropriate health care professionals, and the man had access to advice on request regarding various healthcare issues. He received care and assistance by nursing and medical staff, including the long-term conditions team, which the reviewer judges was comparable to care within the wider community.

44. The reviewer also assessed whether different care might have resulted in a different outcome. She notes that the treatment for the man's chronic obstructive pulmonary disease was managed within recommended guidelines for long-term conditions. Changes to his care were made with reference to appropriate specialists. It is the clinical reviewer's view that different care would not have resulted in a different outcome.

45. The man's family asked that this investigation consider whether he had received the correct medication. The man was concerned about his medications and on several occasions said that he thought he was not receiving the correct prescriptions. Explanations for his care and treatment were regularly given to him. On one occasion he was moved to the healthcare centre for observation and for his medication to be administered after a cell search identified that he had been stockpiling his medication. At other times he requested medication which he did not need. The clinical reviewer found no evidence of withholding or mismanagement of medication.

46. The man was aware of the system for requesting review by staff at Hull, and on occasion requested that specific staff attend. He was also aware of the system for summoning emergency attention when he felt he needed it.

47. The man's care plans and records appear to be comprehensive and were regularly updated to address his needs. Communication between health professional staff was documented and actions and plans were identified and followed up. Communications between the prison's healthcare and outside hospitals were also documented.

48. The exception was that on 23 February 2008 the man was noted to have a bed sore (also known as a pressure sore or pressure ulcer). His medical record does not show how bad the sore was or whether an action plan was put in place to prevent further deterioration. The man did not request further attention for the sore or complain of any pain and he was not referred to a tissue viability nurse. Referrals are often not made unless an ulcer is of a high grade or does not

respond to treatment. Although there was no follow up, the clinical reviewer judges that it did not contribute to his collapse and respiratory distress and different treatment would not have resulted in a different outcome.

The healthcare manager should be reminded of Hull Teaching Primary Care Trust's Protocol for the Prevention and Management of Pressure Ulcers, utilisation of wound management charts, and referral processes for specialist aids to prevent further pressure area damage.

Information for the family

49. The man's daughter was concerned that she was not informed each time her father was taken to hospital. It is prison policy to inform the family when a medical condition is thought to be life-threatening. I judge that, in the light of the prison's responsibility for the security of prisoners and the community, the policy is reasonable.

Bedwatch arrangements

50. The man was an ill man when he was taken to hospital for the last time. He was subject to bedwatch arrangements, escorted by two members of staff, and handcuffed to one of them. However, soon after his arrival, permission was given for the removal of the restraints. This was a humane act in the circumstances and the prison should be commended. Whilst security implications are of prime importance, removing restraints gave dignity and privacy to the man and his family. The bedwatch officers left the bedside at an early stage which again, is good practice and the prison should be commended for doing so.

I commend the prison for their decision to remove restraints and bedwatch officers when it was deemed safe, thus allowing the man and his family some privacy during his final moments.

RECOMMENDATION

1. The healthcare manager should be reminded of Hull Teaching Primary Care Trust's Protocol for the Prevention and Management of Pressure Ulcers, utilisation of wound management charts, and referral processes for specialist aids to prevent further pressure area damage.

   The Prison Service have accepted this recommendation. They said that the protocol for the management of pressure ulceration will be redistributed in October 2008.

2. I commend the prison for their decision to remove restraints and bedwatch officers when it was deemed safe, thus allowing the man and his family some privacy during his final moments.