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A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man at HMP Hull in  
July 2014**

## ***Our Vision***

*'To be a leading, independent investigatory body,  
a model to others, that makes a significant contribution  
to safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man, who died of cancer in July 2014, at HMP Hull. He was 51 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received in custody was undertaken. HMP Hull cooperated fully with the investigation.

The man was convicted on 22 October 2009 and subsequently received an indeterminate sentence for public protection. In March 2011 at HMP Durham, he began to complain of hip pain. This persisted and, in August, after he had moved to Hull, he was diagnosed with terminal bone marrow cancer. He had chemotherapy treatment and healthcare staff at the prison managed his pain, with help from a specialist palliative care team in the last few months of his life. In February 2014, he moved to the prison's dedicated palliative care suite and remained there until his death.

The clinical reviewer identified some minor areas for improvement which the Head of Healthcare will need to address but, overall, I am satisfied that the man received good care and support from staff at Hull, who took into account his preferences about his end of life care.

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 CBE**  
**Prisons and Probation Ombudsman**

**February 2015**

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## SUMMARY

1. The man was convicted of sexual offences on 22 October 2009 and sent to HMP Durham. He received an indeterminate sentence for public protection on 29 March 2010. He had a history of epilepsy, asthma, and chronic back pain from an injury in a road traffic accident several years before. He used a wheelchair. In March 2011, he reported hip pain but an X-ray showed no abnormalities.
2. On 25 May 2011, the man transferred to HMP Hull and lived in a specially adapted cell for wheelchair users. In June and July, he continued to complain of hip pain as well as abdominal tenderness, so healthcare staff arranged blood tests. On 27 July, the prison GP urgently referred him to the haematology services at hospital, as the blood tests showed abnormally raised protein levels, indicating a possibility of myeloma (bone marrow cancer).
3. The man had a bone scan on 4 August. On 24 August, a hospital consultant confirmed a diagnosis of myeloma, which was incurable but could be controlled. On 9 September, he began a course of chemotherapy. In December, he decided to stop the chemotherapy and stem cell treatment.
4. Between 2012 and 2013, hospital and prison healthcare staff managed the man's illness with medication and treatments, including a limited, weekly, chemotherapy drug. He spent time in the inpatient unit at Hull and, on several occasions, the hospital admitted him as an inpatient, for observation and treatment. In November 2013, an application for early release on compassionate grounds was refused. He subsequently decided that he wanted to stay in prison until he died.
5. On 18 February 2014, the man fell in his bathroom. He was in severe pain and unable to move. The same day, he moved to the palliative care suite in the healthcare unit, where healthcare staff began end of life care. There were no active treatment options and he received appropriate pain relief medication.
6. The man remained in the palliative care suite. He had appropriate care plans and community palliative care specialists gave advice and support. He died several days later.
7. We agree with the clinical reviewer that the man received comparable care to that he could have expected as a patient in the community. The clinical reviewer has made some recommendations, aimed at improving some healthcare procedures, which the Head of Healthcare will need to address. However, overall we consider that he received a good standard of care at the prison. We make no recommendations in this report.

## THE INVESTIGATION PROCESS

8. On 22 July 2014, the investigator issued notices to staff and prisoners at HMP Hull, informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.
9. NHS England commissioned a clinical reviewer to review the man's clinical care in prison.
10. The investigator went to Hull on 29 July. She visited the palliative care suite where the man lived and spoke to senior managers. She obtained copies of his prison medical records and relevant extracts from his prison record. She gave the Governor initial feedback about the preliminary findings of the investigation.
11. We informed HM Coroner for Humberside of the investigation, who provided the cause of death. We have sent the Coroner a copy of this investigation report.
12. One of the Ombudsman's family liaison officers contacted the man's mother to explain the investigation process. She did not have any specific issues for the investigation to consider.
13. The investigation has assessed the main issues involved in the man's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.
14. The man's family and the prison received a copy of the draft report. Neither raised any issues that changed the factual accuracy.

## **HMP HULL**

15. HMP Hull is a local prison, which holds up to 762 unconvicted and sentenced men in ten wings. NHS Hull provides health services at the prison. There is an inpatient unit with 24-hour nursing cover, which holds a mixture of prisoners with mental health conditions and physical health problems. GP surgeries are provided four days per week, with an out of hours service at other times. The inpatient unit includes a specialist palliative care suite.

## **HM Inspectorate of Prisons**

16. The most recent published inspection report of Hull is of an inspection in February 2012. The report of a more recent inspection in October 2014 has yet to be published. In 2012, the Inspectorate found that healthcare had improved since their previous inspection in 2008 and included a specific member of staff to lead on the care of older prisoners and those with disabilities. Inspectors were concerned that some prisoners had been admitted to healthcare inpatient beds on 'Governor's orders', without a diagnosed physical or mental health need.

## **Independent Monitoring Board**

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. There are no recent annual reports from the IMB at Hull.

## **Previous deaths at HMP Hull**

18. Four prisoners have died at Hull since 2013, one on the same day as the man and one subsequently. There were no significant similarities between the circumstances of the deaths we have investigated.

## ISSUES

### The diagnosis of the man's terminal illness

19. The man was convicted of sexual offences on 22 October 2009 and taken to HMP Durham. Reception staff noted that he was in poor health. He had injured his spine in a road traffic accident several years before, which caused chronic back pain and he used a wheelchair. He also had asthma and epilepsy. On 29 March 2010, he received an indeterminate prison sentence for public protection, with a minimum period to serve of one year and 299 days.
20. On 30 March 2011, a doctor examined the man after he had reported pain in his left hip and pins and needles in his left thigh and both legs. The doctor suspected a possible disease of the bone joint and referred him for an X-ray of his pelvis, hips and lower spine. The doctor reviewed the X-rays on 16 May, which showed no abnormality. He wanted to refer him to an orthopaedic consultant but, as he was due to transfer to HMP Hull the next day, he noted that the healthcare staff at Hull should complete the referral. The medical record shows that, on the same day, Hull contacted his neurologist, who advised that he did not need to see an orthopaedic specialist.
21. The man transferred to Hull on 25 May 2011. At an appointment with a doctor on 28 June, he again reported hip pain. The doctor noted that his X-rays had shown no abnormalities and did not prescribe any additional medication.
22. On 13 July, the doctor examined the man after he complained of abdominal tenderness and pain around his lower back. The doctor ordered a full blood test. On 21 July, another doctor reviewed the test results, which indicated a rise in his protein levels. The doctor requested further blood tests and a urine protein test to screen for myeloma (bone marrow cancer), which were completed on the same day.
23. A doctor reviewed the results on 27 July and noted they were abnormal. The next day, he explained the test results to the man and told him that he suspected cancer. On 29 July, an urgent referral was made to the haematology services at hospital under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.
24. A consultant haematologist at hospital examined the man on 3 August. He told him that he suspected cancer and that he would arrange for a bone marrow test and a skeletal survey. A prison doctor spoke to him the next day to discuss the news. The doctor also reviewed and increased his morphine pain relief medication, originally prescribed to help him manage the pain from his spinal injury. On 11 August, he had bone marrow and skeletal tests.
25. The consultant wrote to Hull on 24 August, to confirm the diagnosis of multiple myelomas at stage two. (An intermediate prognosis on a scale of one to three.) The condition was incurable, but could be controlled with treatment

(chemotherapy and a bone marrow transplant) and a remission of two to three years was possible.

26. We are satisfied that, after the man transferred from Durham, doctors at Hull continued to investigate his symptoms and quickly referred him to a specialist when they first suspected cancer. He received prompt information about his condition and appropriate support.

### **The man's medical treatment**

27. A doctor had discussed treatment options with the man. He advised that if he did not have treatment, he might die from renal failure or infection within one to two years.
28. On 25 August, a doctor received a letter from the hospital outlining the man's chemotherapy plan and suggesting a possible bone marrow transplant. He explained that the treatment would require long admissions to hospital as an inpatient and that without treatment, there was an increased risk of death.
29. The same day, a nurse fully assessed the man and developed a care plan to manage his pain and monitor any nausea and vomiting arising from his chemotherapy treatment. She referred him to a Macmillan nurse for support and advice. The clinical reviewer indicated that pain control was a significant challenge as he had chronic pain from his back injury, as well as that from his cancer and also neurological pain as a side effect of his treatment. (Over the next two years, healthcare staff reviewed and revised his pain relief medication as necessary. They also gave him oxygen therapy and a spray, to ease breathlessness and chest pain.)
30. The man began his first course of chemotherapy at hospital on 9 September. Another five courses of chemotherapy took place between September and December. On 14 December, he told a nurse that he wanted to stop his chemotherapy and stem cell treatment but did not give a reason. The nurse advised him to discuss it with a Macmillan nurse. He said he had discussed it at a recent hospital appointment and the hospital had agreed that they would treat his symptoms as they arose.
31. On several occasions, healthcare staff at Hull noted that the man had refused treatment or to attend outpatient appointments, although they did not always record the reasons. The clinical reviewer notes that the haematology specialist at the hospital had explained to him that the proposed high dose therapy and transplant was to control his disease for as long as possible. The specialist was satisfied that he was aware of the benefits and risks and had made an informed decision in deciding against the treatment.
32. The man asked to speak to a Macmillan nurse in March 2012, to discuss his blood test results since his treatment had stopped. There is no evidence in his medical record that staff followed up this request, but he received ongoing support from Hull's healthcare team. A modern matron at Hull told the clinical reviewer that he had been under the care of a specialist nurse at a specialist

unit for patients with cancer and blood disorders). She believed that, as the centre liaises directly with community-based nursing teams, this would account for the absence of some medical notes. We accept that it appears that he received support from specialist nurses, even though this was not always reflected in his prison medical record.

33. On 10 January 2013, a doctor discussed the man's treatment with a haematology specialist at hospital. The doctor noted a plan to start him on a limited course of cyclophosphamide (a chemotherapy drug, to be taken weekly. Prison healthcare staff would manage and monitor this. The specialist told the doctor that his life expectancy was one to three years.
34. Healthcare staff continued to manage the man's condition, under direction from the hospital's haematology department. He attended outpatient appointments to manage his pain and ongoing symptoms associated with his cancer.
35. In May 2013, a doctor discussed with the man his end of life arrangements. He decided that he did not want staff to attempt to resuscitate him if he had a cardiac or respiratory arrest. He signed an order to that effect on 4 June and the doctor noted that he had the capacity to do so.
36. On 23 May, the man refused to attend a palliative care appointment, as he wanted to go in a wheelchair-adapted taxi rather than a prison vehicle. The appointment was re-arranged for 19 June. At the appointment, doctors referred him for physiotherapy and acupuncture to help alleviate his pain.
37. On 10 October, the hospital wrote to the prison, instructing them to stop the cyclophosphamide treatment and give palliative care only. On 29 October, the man refused to attend a pain management appointment at hospital, as he did not want to travel in mini-bus, although it had been adapted for wheelchair users. The appointment was to be re-arranged, but healthcare staff did not record the new date in his medical record.
38. The man continued to attend outpatient appointments at hospital during the early months of 2014. The hospital liaised with prison healthcare staff and palliative care specialists to adjust his pain relief to meet his increasing discomfort. He received radiotherapy treatment to limit the spread of cancer and reduce associated pain.
39. On 18 February, the man's pain worsened. He fell in the bathroom of his cell and was unable to move. Healthcare staff noted that he now required end of life care and the community palliative care team become actively involved in his care. They reassessed him, changed his medication from morphine to transtec, another morphine-related painkiller, and moved him to the palliative care suite.
40. On 3 March 2014, staff noted that the man now wanted to be resuscitated and go to hospital if his condition deteriorated. They amended the order the next

day. On 28 April, while an inpatient at hospital, his medical record notes that the order had been reinstated.

41. On 3 July, a nurse noted an end of life discussion with the man about the deterioration of his health. They discussed his preferred place of care and he told the nurse he wanted to stay in the prison's healthcare unit. He was aware of the existing order that he should not be resuscitated. He told the nurse that his mother was his next of kin. He was now bed-bound and cared for on a 24-hour nursing plan. On 10 July, staff inserted a syringe driver, to give diamorphine medication continuously.
42. Several days later a nurse checked the man and saw he was not breathing. She called for assistance and healthcare officers requested an ambulance. Paramedics arrived at 6.40pm and, at 6.45pm, pronounced him dead.
43. The clinical reviewer noted that it was evident from the man's record that he had been a challenging patient. He had sometimes hidden and traded his medication with other prisoners, but staff dealt with this appropriately by supervising him taking his medication. He had also missed appointments and refused to attend hospital in prison transport.
44. There were difficulties controlling the man's pain as the development of his cancer and the nerve pain linked to his historical spinal injuries led to chronic pain. Throughout his care, the hospital and the palliative care team assessed and considered alternative courses of pain control. Towards the end of his life, a syringe driver successfully controlled his pain and he died peacefully.
45. The clinical reviewer noted that there was good cooperation between prison healthcare staff and the hospital to support and manage the man's needs. He also noted the positive input of the palliative care team in the last few months of his life, although this input could possibly have been earlier. Medical records were not always fully comprehensive.
46. The clinical reviewer has made recommendations about some procedural aspects of the man's care, which the Head of Healthcare will need to address. However, the clinical reviewer was satisfied that healthcare staff at the prison made every effort to work with and care for him. We agree that, overall, he was well care for and the treatment for his terminal illness and his end of life care at the prison was equivalent to that he could have expected in the community.

### **The man's location**

47. When the man arrived at Hull, staff allocated him a cell on A wing, adapted for disabled prisoners, with extra room for a wheelchair.
48. On 11 September 2011, after his first cycle of chemotherapy, healthcare staff admitted the man to the healthcare unit as an inpatient. However, the next day he discharged himself and went back to his cell on A wing. He told a nurse that he felt he would cope better on a wing. He understood that due to

the type of medication he was taking and his previous management of it, he could not keep his medication in his cell. He agreed that he would go back to the inpatient unit if he became too ill to cope on the wing.

49. On 2 February 2012, a doctor offered to admit the man to the inpatient unit. He asked to use the palliative care suite to give him more room and healthcare staff agreed to a temporary move, subject to him moving out if someone else needed it. In October, he went back to his wing.
50. Over the next two years, the man also spent some periods in the inpatient unit and in hospital. At all times, healthcare staff tried to accommodate his preferred location of his cell on A wing.
51. On 22 September 2013, staff admitted the man to the palliative care suite in the inpatient unit as the hospital had written to say that he might only have a few months to live. Healthcare staff planned to assess him and review his nursing care to meet his needs. He appeared to settle in the suite, although he found it difficult to sleep. On 1 October, he decided to return to his cell on A wing as healthcare staff considered that he did not yet need end of life care.
52. On 18 February 2014, after a significant increase in pain and a fall in his cell bathroom, the man moved to the palliative care suite. The palliative care suite is directly opposite the nurses' station and prison managers agreed that his door should be kept open at all times from 12 July. This allowed nurses to observe him frequently and ensured they had full access to him throughout the night, to manage his pain. With the exception of periods as a hospital inpatient, he remained in the suite, until he died.
53. The clinical reviewer noted that the prison supported the man's wish to remain on his wing for as long as possible and handled his transfer to the palliative care suite sensitively. We are satisfied that he was appropriately located in the prison throughout his illness.

#### **Liaison with the man's family**

54. The man had limited contact with his mother while in prison but, during their occasional phone conversations, he had told her about his illness.
55. At 8.00am on 4 July 2014, a prison manager told the prison's family liaison officer (FLO) that the man's medical condition had deteriorated. He asked him to inform the man's next of kin and offer a visit. Later that day, the FLO spoke to the man's mother and arranged for her to visit her son the next day.
56. When the man's mother arrived at the prison, the FLO met her and took her to the healthcare unit. She spent two hours with her son and healthcare staff, who told her that his condition was terminal. Prison staff continued to support her and gave her their contact details. She asked them to telephone her when he died.

57. After the man died, the FLO attempted to telephone the man's mother several times. He broke the news to her at 8.40pm. The prison chaplain officiated at the funeral on 7 August. In line with national policy, the prison contributed to the funeral expenses. We are satisfied that the prison appropriately supported family contact.

### **Compassionate release**

58. Prisoners can be released from custody on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.
59. On 28 November 2013, prison managers completed an application for compassionate release. Although they were aware of the man's terminal diagnosis, the Parole Board refused to approve his release. The prison reviewed the position at a meeting on 17 December, and agreed to re-submit the application if there was significant change in his condition.
60. On 3 July 2014, senior managers and healthcare staff attended an end of life review meeting. They noted that the man had deteriorated, but no longer wanted to be released and preferred to remain in the palliative care suite at Hull until his death. We are satisfied that the prison appropriately considered compassionate release.