

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Harry Hillhouse a prisoner at HMP Norwich on 2 September 2015

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

**We are:**

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Harry Hillhouse died of heart failure due to heart disease and diabetes induced kidney disease at HMP Norwich on 2 September 2015. He was 52 years old. I offer my condolences to Mr Hillhouse's family and friends.

The investigation found that Mr Hillhouse received generally good care at both HMP Bure and HMP Norwich, with appropriate and timely referrals to secondary care, and close liaison with palliative specialists.

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

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**April 2016**

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# Summary

## Events

1. Mr Harry Hillhouse was remanded to HMP Brixton on 13 January 2011 and was moved to Norwich in November that year. On 9 January 2012, he was sentenced to 11 years in prison.
2. When he first arrived in prison, healthcare staff noted that he had long-standing diagnoses of coronary heart disease, hypertension and type 2 diabetes, which were advanced. He also had diabetic neuropathy (damage to the nerves) in both legs, which caused mobility difficulties. He had cataracts that led to some loss of vision. In addition, Mr Hillhouse was receiving treatment for historic tuberculosis (TB). After an initial health screen, healthcare staff started a treatment plan to help manage his diabetes and heart disease, and to prevent the return of his TB.
3. In April 2011, a prison GP noted Mr Hillhouse had postural hypotension (a lowering of blood pressure that occurs when a patient stands up) because of damage to the heart and blood vessels as a result of diabetes. Over the next three years, healthcare staff saw Mr Hillhouse frequently to monitor and treat his conditions.
4. In August 2014, Mr Hillhouse was moved to HMP Bure. In September, blood tests showed he had had a deterioration in kidney function and, in December, a renal consultant diagnosed him with Stage 4 chronic kidney disease. The consultant said that Mr Hillhouse should consider dialysis or palliative treatment, but without dialysis his life expectancy was less than six months. Mr Hillhouse indicated that he preferred palliative care because he was afraid of needles. However, in January 2015, a renal education nurse saw Mr Hillhouse and explained the procedure. After this, Mr Hillhouse agreed to dialysis.
5. Unfortunately, there was a delay in starting dialysis because Mr Hillhouse suffered a stroke and the appointment to fit the fistula (through which dialysis is administered) was cancelled. Mr Hillhouse transferred back to Norwich in March 2015 to a specialised unit for elderly prisoners.
6. On 18 June, Mr Hillhouse was treated in hospital for fluid overload. His dialysis started on 22 June 2015. On 25 June, while still in hospital, Mr Hillhouse suffered a heart attack and he told hospital staff he did not want anyone to resuscitate him if his heart or breathing stopped.
7. On 20 July, Mr Hillhouse was discharged from hospital and returned to Norwich. He had 24-hour access to healthcare and a manager agreed that his cell door could remain open so healthcare staff had easy access.
8. After a dialysis appointment in July, Mr Hillhouse decided he did not wish to continue dialysis or to attend any more hospital appointments. He gradually deteriorated, and, on 2 September, staff found him unresponsive. A doctor pronounced him dead at 7.40pm.

## Findings

9. We are satisfied that Mr Hillhouse received a generally good standard of care at both prisons and staff made efforts to appropriately meet his health needs. Both healthcare and prison staff treated him with compassion, dignity and respect. At Norwich, there was particular close liaison with the Priscilla Bacon Centre to ensure there was mostly good palliative care. There were appropriate care plans in place. The clinical reviewer concluded that Mr Hillhouse's care in prison was equivalent to that he could have expected to receive in the community. However, we share the clinical reviewers concern that prescribed medication to treat anxiety was not available over the weekend 22 and 23 August, which potentially led to unnecessary anxiety for Mr Hillhouse.
10. We are satisfied that prison managers at Norwich appropriately considered Mr Hillhouse's declining condition and agreed not to restrain him for any hospital appointments from April 2015. Mr Hillhouse said he did not wish to be considered for compassionate release and so the prison did not progress an application in line with his wishes.

## Recommendation

- The Head of Healthcare at Norwich should ensure that there is an effective process in place to obtain essential palliative care medications without delay when required.

## The Investigation Process

11. The investigator issued notices to staff and prisoners at Norwich informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
12. The investigator obtained copies of relevant extracts from Norwich prison and medical records.
13. NHS England commissioned a clinical reviewer to review Mr Hillhouse's clinical care at the prison.
14. We informed HM Coroner for Norfolk of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
15. One of the Ombudsman's family liaison officers contacted Mr Hillhouse's sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She had no specific issues for the investigation to consider.
16. Mr Hillhouse's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.
17. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly.

## Background Information

### HMP Norwich

18. HMP Norwich is a multi-function prison, which predominantly serves the courts of Norfolk and Suffolk. The prison holds up to 769 men. Virgin Care provides healthcare services. There is a healthcare centre, which provides 24-hour nursing cover and a dedicated unit for older prisoners

### HM Inspectorate of Prisons

19. The most recent inspection of Norwich was in August 2013. Inspectors reported that the prison had progressed since the last inspection. Relations between staff and prisoners were mostly positive and the inpatient and older prisoner units provided good care. However, although the nurse practitioner service was very good there was a concern about the high level use of locum GP's which could lead to inconsistencies in treatment, care and prescribing.

### Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to February 2015, the IMB reported that Norwich continued to improve. Although they considered that the healthcare centre was out dated and lacked the facilities of a good community medical centre, they did note that the older prisoner unit continued to improve. The level of care from staff was commendable but the use of agency staff compromised continuity.

### Previous deaths at HMP [Prison]

21. As Norwich has a special unit for elderly prisoners, there have been a relatively high number of deaths. Mr Hillhouse was the seventh prisoner to die from natural causes at the prison since September 2014. There were no significant similarities between Mr Hillhouse's death and the circumstances of the other deaths.

### HMP Bure

22. HMP Bure is a medium security prison near Norwich, which holds approximately 520 men, convicted of sexual offences.
23. Virgin Care provides healthcare services, commissioned by NHS England. Healthcare staff are on duty between 8.00am and 6.30pm, Monday to Friday and between 8.00am and 5.30pm at weekends. NHS 111 and Medicom provide out of hours services. There are five GP clinics each week

### HM Inspectorate of Prisons

24. The most recent inspection of HMP Bure was in May 2013. Inspectors reported that prisoners were positive about the healthcare they received, and there was a good range of nurse-led clinics. Provision for older prisoners was well developed and there were cells, adapted for better mobility and wheelchair access.

## Independent Monitoring Board

25. In its latest annual report, for the year to July 2014, the IMB reported that since the new healthcare provider took over in April 2014, there had been problems caused by GP and nursing staff shortages, as well as pharmacy supply and a change in the mental health services provider. Existing staff were working above and beyond to limit the effect of these problems, however the IMB reported that Virgin Care lacked ability to provide adequate healthcare for the needs of the prison population.

## Key Events

26. Mr Harry Hillhouse was remanded to HMP Brixton on 13 January 2011. He arrived in prison with long-standing diagnoses of type 2 diabetes, hypertension and coronary heart disease, which were already advanced. He also had diabetic nephropathy (damage to the nerves) in both legs, which caused mobility difficulties. He had cataracts that led to some loss of vision. Mr Hillhouse was also receiving treatment for historic tuberculosis (TB). After an initial health screening, healthcare staff started a treatment plan to help manage his diabetes, heart disease and to prevent the return of his TB.
27. In April, a prison GP noted Mr Hillhouse had postural hypotension (a lowering of blood pressure that occurs when a patient stands up) which he considered was because of damage to the heart and blood vessels as a result of diabetes.
28. Mr Hillhouse was moved to HMP Norwich on 21 November. Records show that healthcare staff created care plans for his blood pressure, diabetes, heart condition and general welfare. Records show he often refused to attend hospital, but did attend several times for a range of health issues, including dental, respiratory and gastroenteritis, that were unrelated to the cause of death. On 9 January 2012, Mr Hillhouse was sentenced to 11 years in prison for sexual offences. Over the next eighteen months, healthcare staff saw Mr Hillhouse frequently to monitor and treat his conditions.

### HMP Bure

29. On 7 August 2014, Mr Hillhouse was transferred to HMP Bure. On 19 September, he had a glomerular filtration rate test (GFR test – which establishes the rate of filtration of the blood by the kidneys) as part of his regular diabetes monitoring. On 9 October 2014, a prison GP reviewed the results. The test showed deterioration in the rate of filtration indicating stage 4 chronic kidney disease. The doctor considered this was the result of diabetic neuropathy (where diabetes damages kidney function) and referred Mr Hillhouse to a renal specialist at hospital.
30. Mr Hillhouse refused to attend a renal outpatient appointment on 10 October. He later stated that he had thought it was for a dental examination. Staff rearranged the appointment for the 21 November, but Mr Hillhouse did not attend, it is not clear why not, but records show that Mr Hillhouse often refused to attend appointments. Mr Hillhouse attended hospital for a renal scan on 4 December.
31. On 16 December, a renal consultant saw Mr Hillhouse at the hospital. He told Mr Hillhouse that he was rapidly approaching end-stage renal failure. A biopsy confirmed this was a result of diabetic nephropathy. The consultant said there were two approaches, either dialysis or palliative management. Mr Hillhouse was worried about dialysis as he had a fear of needles and injections and indicated he would prefer palliative care. The consultant told him that his life expectancy would be less than six months if he did not have dialysis.

32. On 6 January 2015, a patient education renal nurse saw Mr Hillhouse to reassure him about the treatment and what to expect at each stage, and Mr Hillhouse agreed to start dialysis. Mr Hillhouse required a fistula implant (a procedure to connect a vein and artery to allow access to the vascular system) in order to start dialysis and an appointment was made for 3 February.
33. However, on 3 February, the hospital admitted Mr Hillhouse with right sided weakness and expressive dysphasia (problem with word finding). After investigation, hospital doctors diagnosed a cerebral infarct (stroke) and cancelled his appointment for the fistula implant for that day. Mr Hillhouse returned to prison on 6 February.
34. The hospital rearranged the appointment for the fistula implant for 10 February, but also cancelled this appointment, as Mr Hillhouse had not had a recent renal scan.
35. On 3 March, the renal consultant saw Mr Hillhouse and informed him that he was now at stage 5 (end stage) chronic kidney disease. The consultant referred him to the Intravenous Iron Clinic (as he was not absorbing sufficient levels of iron)

#### **HMP Norwich**

36. On 13 March 2015, Mr Hillhouse was transferred back to Norwich and went to the Older Prisoner's Wing where he could receive additional care.
37. On 17 April, the Head of Healthcare and senior prison managers met to discuss Mr Hillhouse's condition and hospital appointments. They agreed that he would not be restrained for any future appointments.
38. Mr Hillhouse attended hospital on 22 April, for scans in preparation for the fistula implant. He attended hospital again on 5 May, for injections to treat low levels of red blood cells. On 20 May, the fistula was implanted.
39. On 18 June, the hospital admitted Mr Hillhouse with difficulty breathing and an overload of fluid in his body. Mr Hillhouse began dialysis on 22 June (the fistula needed to be in place for six weeks before it could be used), with a plan for it to take place every Monday, Wednesday and Friday.
40. On 25 June, hospital staff informed the prison that Mr Hillhouse had suffered a heart attack. The following day Mr Hillhouse informed hospital staff that he did not wish to be resuscitated if his heart or breathing stopped and signed an order to that effect.
41. On 20 July, Mr Hillhouse returned to prison with a discharge plan that included details of his new medication regime, dietary requirements and advice on how to manage his dialysis programme. Healthcare staff amended Mr Hillhouse's care plan to reflect this and moved him to a cell close to the office in the Older Prisoner's Unit. A manager agreed for his cell door to be left open to allow healthcare staff easy access.

42. Mr Hillhouse continued to attend his dialysis appointments as planned. However, after his appointment on 22 July, Mr Hillhouse said he did not wish to continue with the treatment. A prison GP saw him the next day to discuss his decision about stopping treatment and resuscitation. Mr Hillhouse was clear about both decisions, but said he wanted to avoid being in any pain.
43. On 24 July, a nurse assessed Mr Hillhouse and concluded he had full capacity to make decisions about his care. Mr Hillhouse said he wished to remain and die at Norwich where he had a good relationship with staff. Although Mr Hillhouse did attend for dialysis on 25 July, he said he would not go again.
44. On 28 July, healthcare staff put in place an Advanced Care Plan (a plan agreed in advance for the end of life) and discussed with the local community palliative centre (Priscilla Bacon Lodge) how best to provide pain relief and care. A prison GP contacted the renal consultant on 30 July, for advice on the palliative care of an end-stage renal patient.
45. A nurse from the prison mental health team assessed Mr Hillhouse again on 30 July and considered he was not depressed and had the capacity to make decisions about this care. The same day Mr Hillhouse signed a disclaimer refusing any further dialysis treatment or appointments.
46. During the first three weeks of August, healthcare staff recorded that Mr Hillhouse was tolerating his palliative medication and was often in good spirits. The prison started an application for compassionate release, but Mr Hillhouse told a governor (who was his family liaison officer) that he did not want this to go ahead as he was happy at Norwich. He said he had a good relationship with staff and good friends.
47. From 21 August, records show that Mr Hillhouse became more agitated, anxious and restless. Healthcare staff discussed this with palliative care specialists who reviewed and increased his medication, including Levomepromazine (to treat anxiety). Nurses set up a syringe driver to deliver Mr Hillhouse's medication.
48. Over the weekend of 22 and 23 August, records show that there was no Levomepromazine in the prison pharmacy. Nurses gave Mr Hillhouse short-term oxygen therapy to assist with anxiety.
49. On 1 and 2 September, healthcare staff reported that Mr Hillhouse remained settled and comfortable, though often unresponsive.
50. On 2 September, at 7.20pm, an officer asked nurses to attend as he believed that Mr Hillhouse had died. Two nurses assessed Mr Hillhouse and although there was a faint pulse, this stopped within minutes. The nurses did not attempt resuscitation in line with Mr Hillhouse's wishes. A prison GP pronounced Mr Hillhouse dead at 7.40pm.

### **Contact with Mr Hillhouse's family**

51. On 18 June 2015, the prison appointed a governor as the prison's family liaison officer. Mr Hillhouse had nominated his sister, who lived in Scotland, as his next of kin, but was adamant that he did not want anyone to contact his family until after he had died.
52. In preparation for Mr Hillhouse's death, the prison contacted a prison close to his sister's home to arrange for a member of their staff to inform her. However, the prison said they would normally rely on the police to inform the next of kin when someone died. A governor and another senior prison manager discussed this and agreed that it would be better for someone from Norwich to telephone Mr Hillhouse's sister with the news.
53. After Mr Hillhouse died, the governor telephoned his sister to inform her of his death. An officer remained in regular contact with Mr Hillhouse's family and liaised with the funeral director on their behalf.
54. Mr Hillhouse's funeral was on 28 September, and the prison contributed to the costs in line with national policy.

### **Support for prisoners and staff**

55. A prison manager debriefed staff involved in the care of Mr Hillhouse and the care team offered support. A notice informed staff and prisoners of Mr Hillhouse's death and offered support to anyone affected. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by the news of Mr Hillhouse's death.

### **Post-mortem report**

56. A post-mortem examination revealed Mr Hillhouse had died of acute left ventricular failure (heart failure) due to coronary artery disease (blocked arteries to the heart) and hypertensive cardiomyopathy (heart failure due to high blood pressure); arising against a background of diabetes mellitus induced renal disease.

# Findings

## Clinical Care

57. Mr Hillhouse arrived in prison with numerous advanced and complex pre-existing conditions. The clinical reviewer noted that he was often not compliant with healthcare, often refusing to go to hospital appointments. The care he received at both Bure and Norwich was delivered professionally and was generally of a good standard.
58. However, the clinical reviewer said that despite care plans and Mr Hillhouse being treated with appropriate medications for his diabetes and hypertension, it was not always clear that optimum control was always achieved for these conditions at either Bure or Norwich. Records show his blood sugar readings and blood pressure readings were sometimes outside of the normal range and there was no obvious plan to deal with this. The clinical reviewer also makes a number of recommendations that we do not repeat in this report but the Head of Healthcare at both HMP Bure and HMP Norwich will need to address.
59. There was a good working relationship between Norwich and the palliative care specialists at the Priscilla Bacon Centre, ensuring Mr Hillhouse received generally good end of life care. However, we share the clinical reviewer's concern that prescribed medication to treat anxiety (Levomepromazine) was not available from the prison pharmacy over the weekend 22 and 23 August, and that this potentially led to unnecessary anxiety for Mr Hillhouse. End of life medication often includes drugs to reduce the patient's anxiety and it is important that this is available when required. Although we accept this may not be a stock item in the prison pharmacy, we would expect there to be a process in place to ensure such medication can be quickly and easily obtained when required. We make the following recommendations:

**The Head of Healthcare at Norwich should ensure that there is an effective process in place to obtain essential palliative care medications without delay when required.**

## Restraints, security and escorts

60. When prisoners have to travel outside of the prison to a hospital or hospice, a risk assessment is conducted to determine the nature and level of any security arrangements, including any restraints
61. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity and maintain their dignity. The level of restraints used should be necessary in the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes account of factors such as the prisoner's health and mobility.
62. We are pleased to note that prison managers at Norwich considered Mr Hillhouse's declining condition and agreed not to restrain him when attending hospital appointments for the last four months of his life.

## Compassionate release

63. Prisoners can be released from custody before their sentence has expired 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.
64. In August 2015, the prison started an application for early release on compassionate grounds. However, Mr Hillhouse said he did not want the application to go ahead as he preferred to remain at Norwich where he had a supportive network of friends and officers, so the application was not progressed. We are satisfied that the prison acted appropriately, and in line with Mr Hillhouse's wishes.

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