Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Fifield a prisoner at HMP Hull on 24 April 2016

A report by the Prisons and Probation Ombudsman
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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 Stephen Fifield died on 24 April 2016 of heart disease and diabetes while a prisoner at HMP Hull. He was 64 years old. I offer my condolences to Mr Fifield's family and friends.

The clinical care Mr Fifield received at Hull was equivalent to that he could have expected to receive in the community. Healthcare staff monitored and treated his health conditions in line with national guidance. While in prison, Mr Fifield had a leg amputated and, from February 2016, was almost entirely reliant on a wheelchair. I am concerned that when he attended hospital after this date, managers approved the use of restraints without appropriately considering whether his health and mobility affected his ability to escape. This is not the first time I have raised this issue and I am disappointed by the prison's continuing failure to address it.

I am also concerned that Mr Fifield was seriously ill in hospital for nearly a week before he died, yet no one from the prison contacted his family until after his death, which meant they did not have the opportunity to see him before he died. This is unacceptable.

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 **November 2016**

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Summary

Events

1. Mr Stephen Fifield was sentenced to eight years in prison on 22 November 2013 and was sent to HMP Hull. He had a number of chronic health conditions, including angina, depression, arthritis, and unstable type one diabetes. Mr Fifield had had a heart bypass in 2003, and three of the toes on his left foot had been amputated before he entered prison. Mr Fifield used a wheelchair and walking aids.
2. Healthcare staff saw Mr Fifield regularly to monitor and treat his conditions.
3. In March 2015, Mr Fifield's left leg was amputated to above the knee, and he had a prosthetic limb. However, his right leg developed an ulcer and by February 2016, he was reliant on a wheelchair for most of the time. When Mr Fifield went to hospital, officers restrained him with an escort chain.
4. In April, the ulcer on Mr Fifield's right foot became infected, and on 18 April a consultant admitted him to hospital for intravenous antibiotics. He declined to have a blood transfusion on 21 April for religious reasons, although doctors told him he may die without one. The same day, officers removed Mr Fifield's escort chain.
5. Mr Fifield's condition deteriorated and he died on 24 April. A family liaison officer contacted his family to inform them of his death that day.

Findings

6. The clinical reviewer found that the care that Mr Fifield received in prison was good. Doctors appropriately monitored all his conditions, including heart disease and diabetes, and prescribed appropriate medication. Healthcare staff also regularly dressed his amputation wounds.
7. We are concerned that the risk assessments when Mr Fifield went to hospital did not reflect how his health and mobility at the time impacted on his risk of escape and to the public. We are also concerned that Mr Fifield's next of kin, his sister, was not informed that he was in hospital with a serious condition and therefore did not have the opportunity to visit him before he died.

Recommendations

- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.
- The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners in hospital are informed as soon as possible so that they have the opportunity to visit them if they wish to.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Hull informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

9. The investigator obtained copies of relevant extracts from Mr Fifield's prison and medical records.

10. NHS England commissioned a clinical reviewer to review Mr Fifield's clinical care at the prison.

11. We informed HM Coroner for East Riding and Kingston upon Hull of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted Mr Fifield's sister to explain the investigation and to ask if she had any matters they wanted the investigation to consider. She raised no specific concerns for the investigation.

13. Mr Fifield's family received a copy of the initial report. They made a number of comments that do not impact on the factual accuracy of this report.

14. 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 Hull

15. HMP Hull is a local prison, which holds up to 1056 men in ten wings. City Healthcare Partnership (CHCP) provides health services at the prison. 24 hour nursing cover is provided within the prison. The Wellbeing Unit was introduced in October 2014 following the closure of the in-patient facility in HMP Hull. The Wellbeing Unit provides an environment to support and progress individuals who are presenting with complex needs which are difficult to meet in the normal prison environment.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Hull was in October 2014. Inspectors reported health services were good. There was a good range of clinics and prisoners were positive about the care they received.

Independent Monitoring Board

17. 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. There are no recent reports from the IMB at Hull.

Previous deaths at HMP Hull

18. Mr Fifield was the sixth prisoner to die of natural causes, since April 2014. We have raised the issue of the unjustified use of restraints before.

Key Events

19. Mr Stephen Fifield was sentenced to eight years in prison for sexual offences on 22 November 2013, and was sent to HMP Hull. At his initial health screening, a nurse noted that he had a number of chronic health conditions. These included angina, depression, arthritis, Raynaud's disease (when the blood flow to fingers and toes is restricted) and unstable type one diabetes. He had monthly eye injections in hospital for swollen retinas (related to his diabetes). In 2003, before he came to prison, he had had a heart bypass operation and a pacemaker inserted. Not long before entering prison three of the toes on his left foot were amputated. Healthcare staff in prison changed the dressings of his amputation wounds twice a week. Clinicians prescribed appropriate medication for his conditions, and regularly monitored his blood sugar levels, blood pressure and kidney function.

20. Mr Fifield's mobility was assessed on 21 February 2014. The assessor noted that his condition was slowly deteriorating; he could only move a short distance using a walking stick and needed a wheelchair for further distances.

21. Healthcare staff continued to dress Mr Fifield's wounds. On 12 May, a nurse sent Mr Fifield to hospital because another toe on his left foot had become gangrenous. While in hospital, he had the final two toes on his left foot amputated. He returned to the prison's healthcare department on 27 June, where staff monitored him.

22. Mr Fifield continued to attend hospital for routine appointments to monitor his chronic conditions. In February 2015, records show specialists diagnosed Mr Fifield with an enlarged heart and prescribed appropriate medication.

23. Despite continued care and dressing changes, the wounds on Mr Fifield's left foot deteriorated and on 19 March, surgeons amputated his left leg to above the knee. Mr Fifield returned to the prison's healthcare centre on 25 March. The same day the Humber Independent Living Service assessed Mr Fifield and provided him with a prosthetic leg, new wheelchair, walking frame, tray, pressure relieving cushion and raised toilet seat. He attended regular physiotherapy sessions at hospital.

24. From 1 July, a social care plan was implemented which included care workers visiting Mr Fifield daily to help him with daily activities, including showering.

25. From August, Mr Fifield reported that his right leg was painful and swollen. A doctor prescribed diuretics (to treat water retention). He also reported that pains in his shoulders made it difficult to move around. On 17 November, Mr Fifield moved to a cell adapted for prisoners with disabilities.

26. When he went to hospital on 19 November for his monthly eye appointment, officers restrained him with an escort chain. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.) Escort officers noted that his behaviour was not a problem.

27. Mr Fifield's health continued to deteriorate and he suffered from several chest infections. Mr Fifield went to hospital as an inpatient from 15 February 2016 to

19 February, for an operation to treat an abdominal hernia (when internal organs come through a weakness in a muscle wall). During his stay in hospital, officers restrained him with an escort chain, which they removed during the surgery.

28. From 29 February, records show that Mr Fifield began developing an ulcer on his right foot. Healthcare staff monitored and dressed this ulcer and Mr Fifield began using a wheelchair for most of the time.

29. On 1 April, a nurse saw Mr Fifield in his cell because he was unwell and had vomited three times. He had a high temperature (39.1 degrees), high pulse (114 beats per minute), and slightly high blood pressure (124/90). His blood sugar levels were within normal range (5.9mmols). Healthcare staff gave him paracetamol and monitored him. On 16 April, a doctor prescribed antibiotics for a suspected infected ulcer on his foot.

30. On 18 April, Mr Fifield had a diabetic podiatry appointment at the hospital. A consultant admitted him because of his foot ulcer and treated him with intravenous antibiotics. Officers restrained him with an escort chain and they noted that Mr Fifield could be rude and difficult towards staff.

31. Mr Fifield remained in hospital. On 21 April, hospital doctors advised him to have a blood transfusion, and told him that without one he may die. Mr Fifield declined to have a blood transfusion, because he said he was a Jehovah's Witness. He understood this might cause his death. Later that day, officers removed the escort chain but remained at his bedside. Mr Fifield's health continued to deteriorate and a hospital doctor pronounced him dead at 3.31am, on 24 April 2016.

Contact with Mr Fifield's family

32. Mr Fifield had nominated one of his sisters as his next of kin. The prison appointed an officer as the family liaison officer on 24 April. She and a prison manager visited Mr Fifield's sister to inform her of his death and offer their support and condolences. They telephoned another sister, who was out of the country, to inform her and offer condolences. The officer offered ongoing support to both sisters.

33. Mr Fifield's funeral was on 10 May 2016. The prison contributed to the costs in line with national policy.

Support for prisoners and staff

34. After Mr Fifield's death, a prison manager debriefed the escort staff to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

35. The prison posted notices informing staff and prisoners of Mr Fifield's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Fifield's death.

Post-mortem

36. A post-mortem revealed that Mr Fifield died of myocardial ischaemia (reduced blood flow to the heart) thrombosis of coronary artery bypass graft (a blood clot within a previous bypass) and graft atheroma (a build-up of materials within the graft). Diabetes also contributed to his death.

Findings

Clinical care

37. The clinical reviewer concluded that the care Mr Fifield received in prison was equivalent to that he could have expected in the community. Healthcare staff cared for his diabetes in line with national protocols, and appropriately monitored and dressed his amputation wounds. He was given appropriate social care and equipment to help him mobilise independently. Communication between the prison and hospital was good, and Mr Fifield's care was well co-ordinated.

38. The clinical reviewer said that Mr Fifield had symptoms of severe cardiovascular disease with a narrowing of the arteries to his heart. He suffered with angina (a chest pain relating to a lack of oxygen reaching the heart muscle due to partial blockages of the blood vessels. The clinical reviewer noted that, in 2003, before he entered prison, Mr Fifield had had a coronary artery bypass graft to increase the blood supply to his heart and had a pacemaker to regulate his heartbeat. Both hospital and prison clinicians monitored Mr Fifield's heart condition and prescribed appropriate medication.

39. The clinical reviewer makes a number of recommendations not directly relevant to this investigation, which we do not repeat but which the Head of Healthcare will need to address.

Restraints, security and escorts

40. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

41. Whenever Mr Fifield went to hospital, managers authorised officers to restrain him with an escort chain. This was despite Mr Fifield's left leg amputation in March 2015 and him being almost fully reliant on wheelchair from February 2016.

42. In November 2015, a prison manager authorised officers to restrain Mr Fifield with an escort chain for a routine eye appointment. In February 2016, the manager again authorised the use of an escort chain while Mr Fifield was in hospital for an operation (although officers removed the restraints during surgery). On each occasion, there was minimal healthcare input into the risk assessment about his current health condition or how it impacted on his risk of escape.

43. On 18 April, Mr Fifield went to hospital for the last time, initially for a podiatry appointment with an infected leg. At this time he was not mobile. There was input from a nurse into the risk assessment, noting that Mr Fifield used a

wheelchair. However, the nurse did not state that he was completely reliant on a wheelchair or that he had previously had an amputation. Security staff had assessed Mr Fifield as a medium risk to the public and hospital staff, but a low risk of escape and the manager approved the use of an escort chain, which remained in place once he was admitted to hospital. He told us that he based the decision to restrain Mr Fifield on information that he could be rude and difficult and there were no healthcare objections. However, it was evident from the records that prison staff did not have difficulty in controlling him.

44. We are pleased to note that officers removed the restraints a few days before Mr Fifield died. However, we are not satisfied that restraining him on all previous occasions, certainly after February 2016, was fully justified. There was insufficient medical information on the risk assessments about Mr Fifield's condition at the time or how it impacted on his risk of escape for a manager to have made an informed decision. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Contact with Mr Fifield's family

45. Prison Rule 22(1) requires that when a prisoner is seriously ill "the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed". Prison Service Instruction (PSI) 64/2011, Safer Custody, says, "Where prisoners have a terminal illness or suffer an unpredicted and/or rapid deterioration in their physical health, prisons must have in place procedures for supporting the prisoner [and] engaging with their next of kin".

46. We consider that someone from the prison should have informed Mr Fifield's next of kin that he was in hospital on 18 April but certainly once he had deteriorated (to an extent where the restraints were removed) on 21 April. This would have given his family the opportunity to see him before he died. We make the following recommendation:

The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners in hospital are informed as soon as possible so that they have the opportunity to visit them if they wish to.

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