Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Hughes a prisoner at HMP North Sea Camp on 14 November 2016

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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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*

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.

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

Mr Peter Hughes died on 14 November 2016 of a heart failure at hospital. Mr Hughes was 74 years old. I offer my condolences to Mr Hughes' family and friends.

Mr Hughes received a good standard of care at HMP North Sea Camp, equivalent to that he could have expected to receive in the community.

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

Richard Pickering
Deputy Prisons and Probation Ombudsman **April 2017**

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Summary

Events

1. On 30 August 2000, Mr Peter Hughes was sentenced to life imprisonment for kidnapping, robbery and possession of an imitation firearm. He was sent to HMP Leeds. On 17 December 2013, he was transferred to HMP North Sea Camp.

2. Mr Hughes had high blood pressure, high cholesterol, asthma, lung disease and atrial fibrillation (an irregular heartbeat). Healthcare staff prescribed appropriate medication and monitored him regularly throughout his time at North Sea Camp.

3. On 24 December 2013, a prison doctor referred Mr Hughes to a cardiac specialist when he reported swollen legs and shortness of breath. The consultant saw him in June 2014 and diagnosed chronic venous insufficiency (a condition where the veins have problems sending blood from the legs back to the heart). He advised Mr Hughes to continue with his current medication.

4. In January 2014, a routine blood test identified some abnormalities with Mr Hughes' thyroid function. A prison doctor had the tests repeated a month later and again three months after that. Results from the later tests were within the normal range.

5. Healthcare staff saw Mr Hughes, as appropriate, to review his lung disease and asthma. Against their advice, he continued to smoke cigarettes. As Mr Hughes suffered from various chronic diseases, he had regular blood tests to check his haemoglobin and white cell counts, and his liver and renal function.

6. In February 2016, Mr Hughes reported back pain and a nurse gave him painkillers. The pain continued and following further reviews, a doctor arranged for a blood test, an X-ray and a scan to assess bone density. Results of the X-ray and the scan were normal but the blood test identified low immunoglobulin M levels, which can lead to infection. A prison doctor referred Mr Hughes to a haematology specialist, who he saw in May and August but did not need to see again.

7. On 14 November 2016, at about 6.40am, Mr Hughes collapsed when reporting for a morning roll check. Staff put him in the recovery position and called an ambulance. When his condition deteriorated, they began cardiopulmonary resuscitation and applied a defibrillator to his chest.

8. An ambulance crew arrived at 7.10am and Mr Hughes was taken to hospital, where he died later that day of heart failure.

Findings

9. The clinical reviewer considered that the care Mr Hughes received at North Sea Camp was equivalent to that he could have expected to receive in the community. We are satisfied that Mr Hughes received good care at the prison.

10. When Mr Hughes collapsed, the member of staff who responded did not radio a medical emergency code. Instead, he contacted the night manager, who immediately telephoned for an ambulance. There were no healthcare staff on

duty to respond to a medical emergency and, as the night manager called an ambulance immediately, the lack of an emergency code did not result in a significant delay in its arrival.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP North Sea Camp informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

12. The investigator visited the prison on 22 November 2016. He obtained copies of relevant extracts from Mr Hughes' prison and medical records and interviewed a prisoner.

13. NHS England commissioned a clinical reviewer to review Mr Hughes' clinical care at the prison.

14. The investigator and clinical reviewer interviewed three members of staff at North Sea Camp on 12 December 2016.

15. We informed HM Coroner for South Lincolnshire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

16. The investigator wrote to Mr Hughes' brother, his nominated next of kin, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr Hughes' brother did not respond to our letter.

17. We shared the initial report with the Prison Service. They pointed out two factual inaccuracies and this report has been amended accordingly.

Background Information

HMP North Sea Camp

18. North Sea Camp is an open prison near Boston in Lincolnshire. (Open prisons are for the lowest security category of prisoners who can be reasonably trusted not to escape.) The prison holds over 400 sentenced men in six units. Prisoners assessed as suitable are able to work in the community.

19. Nottingham Healthcare NHS Foundation Trust provides primary healthcare services. A senior nurse manager is in charge of primary care and four doctors from a Boston Practice provide three GP sessions a week. Healthcare staff are on duty from 7.30am to 6.30pm during the week and until 12.30pm at the weekend.

HM Inspectorate of Prisons

20. The most recent inspection of North Sea Camp was in July 2014. The inspectorate found that primary care arrangements, including those for prisoners with long-term conditions, were very good, and support and care for the large number of older prisoners were particularly effective. Pharmacy services were good but medicine administration was not sufficiently confidential. There was an excellent range of emotional support and mental health services.

Independent Monitoring Board

21. 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. In its annual report for the year to 29 February 2016, the IMB was generally positive about health services at the prison. The IMB noted that at times during the reporting period there had been a shortage of trained nurses due to resignations and the unreliability of agency staff. However, the prison has since appointed additional permanent staff.

22. The IMB also noted that NHS changes have often resulted in prisoners with complex conditions no longer receiving treatment in local hospitals. This has put a strain on the provision of hospital escorts and some planned appointments at local hospitals have been missed or rearranged. However, no urgent appointments have been missed.

Previous deaths at HMP North Sea Camp

23. Mr Hughes was the second prisoner to die from natural causes at North Sea Camp since January 2015. There were no similarities between the circumstances of Mr Hughes' death and the previous death at the prison.

Key Events

24. On 30 August 2000, at Crown Court, Mr Peter Hughes was sentenced to life imprisonment for kidnapping, robbery and possession of an imitation firearm. He was sent to HMP Leeds. On 17 December 2013, Mr Hughes was transferred to HMP North Sea Camp.

25. Mr Hughes had high blood pressure, high cholesterol, asthma, chronic obstructive pulmonary disease (COPD, a type of obstructive lung disease) and atrial fibrillation (an irregular heartbeat). He smoked up to 15 cigarettes a day and had been a recovering alcoholic since 2000. Healthcare staff prescribed Mr Hughes appropriate medication for these conditions, which he continued to take at North Sea Camp. Healthcare staff also reviewed his asthma and COPD, and prescribed alternative medications. They offered him help to stop smoking but he declined.

26. A locum GP reviewed Mr Hughes on 24 December 2013. He had swollen legs and told the doctor he was short of breath. The GP referred him to the cardiac department at hospital.

27. On 6 January 2014, a locum GP reviewed Mr Hughes and arranged blood tests to check his liver function, urea and electrolytes, fasting glucose and thyroid function. The thyroid function test showed an abnormality and the GP had the tests repeated a month later. The results of the repeat tests were recorded as 'borderline' and the GP arranged for further tests three months later. The results of these further tests are not in the medical record. However, the results from routine blood tests taken in September were within the normal range.

28. On 2 June, Mr Hughes had a consultation with the cardiologist at the hospital, who arranged an echocardiogram (a record of the electrical activity of the heart). On 7 July, the consultant wrote to the prison having diagnosed chronic venous insufficiency (CVI – a condition where the veins have problems sending blood from the legs back to the heart) as the cause of the swelling in his legs and feet. He advised Mr Hughes to continue with his current medication but also arranged for him to have medical support stockings to help the symptoms of his CVI.

29. Healthcare staff reviewed Mr Hughes annually for COPD and asthma. Despite their advice, other than for a short period in January 2015, he continued to smoke. On 30 January 2015, a prison GP prescribed clenil modulite inhalers to treat his symptoms.

30. On 7 September, a prison GP reviewed Mr Hughes and arranged routine blood tests. The results were all within the normal range.

31. On 21 February 2016, a nurse gave Mr Hughes painkillers after he reported back pain. A prison GP reviewed him three days later and again on 23 March. Mr Hughes said he could manage the pain using paracetamol. The GP arranged for a scan to measure Mr Hughes' bone density, blood tests and a chest X-ray. The X-ray and the scan results were normal; however, the blood test later identified low immunoglobulin M levels (this has the potential to lead to severe infection).

32. A prison GP examined Mr Hughes on 8 April, who continued to report back pain. The GP reviewed the blood test results and referred him to the hospital's haematology department. An appointment was made for 16 May.

33. On 19 April, a specialist palliative care nurse spoke to Mr Hughes after he referred himself to the Advanced Care Planning Clinic. Mr Hughes said he needed support to plan his future care, particularly after his possible release on parole. Mr Hughes told her that he was currently under investigation for bone density and COPD. They discussed his care needs and preferences, and agreed to keep this under review.

34. On 26 April, a nurse reviewed Mr Hughes' COPD, which had worsened. He said clenil modulite no longer worked. She referred him to the GP and the GP prescribed fostair (an inhalation solution with anti-inflammatory properties to reduce swelling and irritation in the lungs).

35. Mr Hughes attended hospital on 16 May for his haematology consultation. The consultant arranged blood tests and agreed to see him again in six weeks. The consultant saw Mr Hughes on 30 August, after which he decided that he did not need to see him again.

36. On 14 June, Mr Hughes told a nurse he felt better using fostair but, on 4 August, he went to the healthcare unit with chest pain after severe coughing. There was no sign of a chest infection and she advised him to take painkillers and come back if things did not improve. On 16 August, Mr Hughes reported feeling better. She reviewed him again on 27 September, and discussed deep breathing exercises and giving up smoking.

37. On 18 October, a nurse examined Mr Hughes at the request of prison staff after he returned breathless from a home visit. Mr Hughes told the nurse that the cold, windy weather had taken his breath away. His condition improved after using his inhaler and his blood pressure, pulse and respiration rate were within the normal range. She accompanied Mr Hughes back to his room and told him to alert staff if he felt unwell again.

Events of 14 November 2016

38. On 14 November, at approximately 6.40am, Mr Hughes approached the staff office on Llewellyn unit, for the morning roll check. As he walked towards the office, an Operational Support Grade (OSG) saw Mr Hughes stumble. He left the office and went to check that Mr Hughes was all right. He sat him on a chair and gave him a cup of water. Mr Hughes told him that he just needed some air. He was not overly concerned as Mr Hughes regularly went outside to get some air first thing in the morning.

39. The OSG radioed the night manager, a Senior Officer (SO), and asked him to telephone him in the office. The SO was in the gate lodge, at the entrance to the prison, a short distance from Llewellin unit. The OSG told him that Mr Hughes had stumbled and the SO said to monitor him, until a nurse arrived at the prison shortly after 7.00am. The SO said he would leave directions at the gate lodge for the first nurse to arrive to come and see Mr Hughes straight away.

40. The OSG then returned to Mr Hughes, but as he did so Mr Hughes dropped the cup of water, slumped over in his chair and lost colour from his face. The OSG initially supported him and then, with the help of a prisoner, put him on the floor in the recovery position. The OSG confirmed that Mr Hughes was conscious and breathing, with a weak pulse. He put a blanket over him and a pillow under his head. He radioed the SO, who called him back immediately on the telephone. He told him that Mr Hughes had deteriorated and they needed an ambulance. The SO called the ambulance straight away at 6.50am. He left the gate lodge shortly after and went to Llewellin unit.

41. Mr Hughes' condition continued to deteriorate and he started to froth at the mouth. The OSG, the prisoner and a second prisoner began cardiopulmonary resuscitation (CPR) while the SO got the defibrillator from the office. The officers attached the defibrillator to Mr Hughes' chest and followed the machine's instructions. The ambulance control room telephoned the prison and the SO was able to update them and take instructions. The OSG and the two prisoners continued CPR and the SO later assisted them. The defibrillator did not 'shock' Mr Hughes at any point.

42. A nurse arrived at about 7.05am. She repositioned the pillow under Mr Hughes' neck to open his airway further. The first ambulance crew arrived at 7.10am and a second three minutes later. The ambulance crew treated and monitored Mr Hughes while the officers and two prisoners continued CPR.

43. Mr Hughes was transferred to the ambulance at 7.42am and it left the prison seven minutes later. A prison officer accompanied Mr Hughes in the ambulance to the hospital. No restraints were used. Mr Hughes' condition continued to deteriorate and he died in hospital, shortly after 1.00pm.

Contact with Mr Hughes' family

44. On 14 November, the prison appointed an Instructional Officer as the family liaison officer. At 9.10am, the officer telephoned Mr Hughes' brother and told him that Mr Hughes was in hospital.

45. Mr Hughes' brother and niece travelled to the hospital, though Mr Hughes died before they arrived. Hospital staff informed them of his death and took them to see the body.

46. The officer and the Prison Governor met Mr Hughes' brother and niece at the hospital and offered their condolences and support.

47. The officer kept in contact with the family. Mr Hughes' funeral was held on 13 December, and the prison contributed towards the cost, in line with national guidelines.

Support for prisoners and staff

48. After Mr Hughes' death, a senior manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support. Prison staff also offered support to the two prisoners involved in the emergency response.

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

Post-mortem report

50. A post-mortem examination indicated that the immediate cause of Mr Hughes' death was acute left ventricular failure (heart failure) caused by cardiac arrhythmia (abnormal heart rhythm) and atrial fibrillation (irregular heart rate).

Findings

Clinical care

51. The clinical reviewer was satisfied that the care Mr Hughes received at North Sea Camp was equivalent to that he could have expected to receive in the community.

52. Mr Hughes had taken medication for high blood pressure and high cholesterol for many years. He had annual blood reviews and blood pressure monitoring in line with NICE guidelines. Mr Hughes also attended specialist cardiologist appointments for the management of his atrial fibrillation. He was referred appropriately when he reported back pain and his blood test results were abnormal.

53. Mr Hughes lived in a standard prison unit and for the majority of the time was able to maintain his independence and engage in the prison regime, as appropriate for a man of his age with a chronic respiratory illness.

54. There was no indication that Mr Hughes' health deteriorated significantly in the weeks before his death and we agree with the clinical reviewer that his death was neither preventable nor predictable.

Emergency response

55. Prison Service Instruction 03/2013 'Medical Emergency Response Codes' requires governors to have a two code medical emergency response system based on the instruction. As is usual, North Sea Camp uses code blue to indicate an emergency when a prisoner is unconscious or having breathing difficulties, and code red when a prisoner is bleeding. Calling an emergency code should automatically trigger the control room to call an ambulance.

56. The OSG did not use a medical emergency code but instead telephoned the SO in the gate lodge. There were no healthcare staff in the prison to respond to an emergency call and the SO was the closest officer able to respond. The OSG was also aware that the gate lodge had the only telephone in the establishment that could be used to telephone for an ambulance.

57. The OSG explained that he did not consider calling an emergency code immediately and once he had spoken to the SO, who called an ambulance straight away, it became unnecessary. He accepts that under the circumstances he should have used an emergency code. We are satisfied that he understood how and when to use an emergency code and that although he failed to do so on this occasion it did not cause significant delay or change the final outcome for Mr Hughes. As a result, we do not make a recommendation.

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