Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Terrence Lyne a prisoner at HMP Hull on 29 February 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*

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 Terrence Lyne died on 29 February 2016 of chronic lung disease at HMP Hull. He was 76 years old. I offer my condolences to Mr Lyne's family and friends.

The investigation found that Mr Lyne received very good care at Hull, with appropriate and timely referrals to hospital services when necessary. He had lived with chronic conditions for many years and was nearing the end of his life. I am satisfied that staff at the prison could not have done anything to prevent his death. However, there was some confusion about relative roles and responsibilities for checking prisoners in the prison's Wellbeing Unit, where Mr Lyne lived, which the prison needs to clarify.

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 **October 2016**

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Summary

Events

1. In December 2014, Mr Terrence Lyne was sentenced to five years in prison for sexual offences and sent to HMP Hull.

2. Mr Lyne suffered from a number of chronic health problems, including heart disease, high blood pressure and chronic obstructive pulmonary disease (COPD - the name for a collection of long-term progressive lung diseases, including chronic bronchitis and emphysema). Healthcare staff monitored Mr Lyne, prescribed relevant medication and implemented a COPD care plan.

3. On 4 September 2015, Mr Lyne was admitted to hospital after suffering constipation and difficulties urinating. He stayed in hospital for four days, had a catheter fitted and was treated for a chest infection with oral antibiotics. The hospital recommended palliative care to treat his symptoms.

4. On 9 September, when Mr Lyne was discharged from hospital, his health was deteriorating and he was moved to the palliative care suite in the prison's Wellbeing Unit (the former healthcare inpatient unit now used for prisoners with a range of complex needs). He decided he did not want to be resuscitated if his heart or breathing stopped. His condition stabilised and on 5 December, he moved to the next cell to make room for another prisoner. Mr Lyne was mostly able to care for himself but a prisoner carer helped him with daily living tasks.

5. Just after 8.00am on 29 February 2016, Mr Lyne's prisoner carer found him unresponsive in bed and alerted staff. Nurses and a prison GP examined him and it was evident that he had died in the night.

Findings

6. We are satisfied that Mr Lyne received very good care at Hull, equivalent to that he might have expected to receive in the community. There was nothing staff at the prison could have done to prevent his death.

7. Although it would not have altered the outcome for Mr Lyne, who appears to have died peacefully in his sleep, we were surprised that no one checked him during the night he died, as a prison manager had decided some days earlier that his cell door should be left unlocked so nurses could have easy access. This decision had not been communicated to healthcare staff, who did not consider he had reached the end of life stage. There was confusion between prison and healthcare staff about responsibilities for some prisoners in the Wellbeing Unit, which the prison will need to address.

Recommendation

- The Governor and Head of Healthcare should clarify the role of the Wellbeing Unit so that all staff working there understand their relative responsibilities. There should be a clear protocol for the palliative care suite and other cells used for seriously ill or terminally ill prisoners, who should have appropriate care plans outlining when night time checks are needed.

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

10. The investigator obtained copies of relevant extracts from Mr Lyne's prison and medical records. She interviewed five members of staff and one prisoner at Hull in April. The clinical reviewer joined her for some interviews.

11. We informed HM Coroner for Hull of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted Mr Lyne's ex-wife, who he had named as his next of kin, to explain the investigation. She did not have any specific matters for the investigation to consider. She received a copy of the initial report and had no comments to make.

13. The prison considered our initial report and recommendation, which they have accepted. The prison has also submitted an action plan detailing what they have done to address the issues we raised.

Background Information

HMP Hull

14. HMP Hull is a local prison, which holds up to 762 men in ten wings. City Healthcare Partnership provides health services at the prison. The prison closed its healthcare inpatient unit in October 2014, which became a Wellbeing Unit to support and progress prisoners with complex needs, which are difficult to meet in the normal prison environment. The unit includes a specialist palliative care cell. GP surgeries are held four days a week, with an out of hours service at other times.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Hull was in October 2014. Inspectors reported that health services were good, and most prisoners were reasonably satisfied with the quality of and access to healthcare. They found that the prison offered a wide range of primary care clinics and healthcare screening programmes, and prisoners could usually see a GP within three days.

16. The upper floor of the healthcare centre had been converted from an inpatient unit to a 'wellbeing unit' two weeks before the inspection. Inspectors noted that the unit provided prisoners with mental health needs with a good environment and included a well equipped palliative care suite. It was also used as a progression opportunity for prisoners from the segregation unit with complex behavioural needs. Inspectors were concerned that the unit lacked direction, its role had not been clearly defined and a distinct strategy that set out the expected working practices and aims of the unit had not been published. Many managers and staff inspectors spoke to, were not clear about what the unit offered or its admission criteria.

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 annual reports from the IMB at Hull.

Previous deaths at HMP Hull

18. Mr Lyne was the fourth prisoner to die from natural causes at Hull since January 2014. Three more men have died from natural causes since Mr Lyne. There were no significant similarities between the circumstances of Mr Lyne's death and the previous deaths we have investigated.

Key Events

19. On 12 December 2014, Mr Terence Lyne was convicted of sexual offences, sentenced to five years in prison, and sent to HMP Hull. He had suffered poor health for a number of years and had been diagnosed with chronic obstructive pulmonary disease (COPD) in 1983. His condition became severe from 1990. He required medication, monitoring, long-term oxygen therapy, antibiotics for chest infections and had frequent hospital admissions. From 2009, he needed continuous oxygen therapy. He arrived at Hull with oxygen tanks.

20. Mr Lyne had regular COPD reviews with doctors and the respiratory team at hospital. He had a nebuliser (a machine that creates a mist of medicine, breathed in through a mask or mouthpiece) and an oxygenator in his cell. In May 2015, he was given a wheelchair to help him get about.

21. On 4 September 2015, Mr Lyne told a nurse that he had been unable to open his bowels for nine days and had difficulties urinating. He sent Mr Lyne to hospital for assessment. The hospital admitted him, fitted a catheter, and treated a chest infection with oral antibiotics.

22. At the hospital on 5 September, Mr Lyne decided that he did not want anyone to try to resuscitate him if his heart or breathing stopped and the decision was formally recorded. A prison GP and a nurse discussed this with him and Mr Lyne said he only wanted to be kept as comfortable as possible.

23. On 9 September, the hospital discharged Mr Lyne. The hospital discharge summary recommended palliative care and the hospital's palliative care team arranged to support the prison healthcare staff caring for Mr Lyne. When he got back to the prison, staff moved Mr Lyne to a palliative care cell in the prison's Wellbeing Unit.

24. On 10 September, healthcare staff created a COPD care plan, which included a nurse visiting Mr Lyne every day to offer any help he needed with hygiene, dressing, and any other necessary support.

25. On 24 September, a modern matron spoke to Mr Lyne about the possibility of him being released early on compassionate grounds. Mr Lyne told her the only place he wanted to go was his home or, failing that, he would rather stay at the prison. At a multidisciplinary meeting that day, she reported that Mr Lyne had multiple organ failure, was at end stage COPD, had poor mobility, and used a wheelchair. She said his condition was rapidly deteriorating. Three prison managers considered the compassionate release application but it did not proceed, as Mr Lyne did not fully meet the criteria. Further meetings were held each month after that, but the application was not progressed, as his condition had stabilised and he had no clear prognosis.

26. In October, Mr Lyne was given a prisoner carer who helped collect his meals, assisted with daily living tasks and acted as a companion to him.

27. On 2 October, a nurse assessed Mr Lyne and asked a prison GP to review him. Mr Lyne had increased shortness of breath and produced thick yellow and green sputum. The GP sent him to hospital for treatment. Mr Lyne was admitted to

hospital and received intravenous antibiotics. The hospital discharged him on 5 October.

28. A nurse reviewed Mr Lyne's COPD when he got back to the prison. He noted that Mr Lyne had access to oxygen and a nebuliser and that he wanted to be an independent as possible. Mr Lyne said he would ask for help when he needed it.

29. Healthcare staff assessed Mr Lyne's pain every day and prescribed appropriate medication. Mr Lyne took his medication only when he felt he needed it. He kept as independent as he could, but accepted additional support when he needed it. Although he very ill, his condition stabilised over the next two months.

30. On 5 December, Mr Lyne moved to the cell next to the palliative care cell, as it was needed for another terminally ill prisoner, who was at the end of his life. He had a hospital bed in his new cell.

31. On 22 February 2016, a respiratory specialist nurse visited the prison and reviewed Mr Lyne. The nurse recommended continuing oxygen therapy and said she would arrange for further oxygen assessments when necessary.

32. From 26 February, Mr Lyne required more assistance with his hygiene, and he slept for most of the time. That evening, a prison manager decided that Mr Lyne's cell door should be unlocked at all times, including during the night, to allow staff access to his cell at any time, but did not discuss this with healthcare staff. Nurses continued to check Mr Lyne every day but there was no arrangement to check him during the night, as he needed no night time treatment and was not yet identified as needing end of life care. A nurse saw Mr Lyne at 6.32pm on 28 February. He told her his bed mechanism was not working properly and she said she would contact someone about it the next day.

33. On the night of 28/29 February, an operational support grade was the night patrol officer on the Wellbeing Unit. At around 3.00am, she looked through the observation panel of Mr Lyne's cell door and saw him apparently sleeping on his back. She heard his oxygen machine working and the television was on. She checked all prisoners were present in their cells at 5.00am, as a routine security count, but was only able to say that Mr Lyne was in his cell at the time.

34. A nurse was on night duty that night. He visited the Wellbeing Unit during the night to check and give medication to the prisoner in the palliative care suite, but did not check Mr Lyne.

35. At 6.15am on 29 February, an officer came on duty. After a handover from the night patrol officer, he checked prisoners in the unit who had been assessed as at risk of suicide and self-harm. He then did a further count to check prisoners were present in their cells, but this was just a visual check. He did not note anything amiss with Mr Lyne. The official start time for the morning shift was 7.45am, by which time other staff had arrived. At about 8.00am, they unlocked the orderlies, including Mr Lyne's carer. Other prisoners would not usually be unlocked until after 8.15am.

36. At 8.10am, Mr Lyne's prisoner carer went to his cell and found him unresponsive. He went to the office and told staff that he thought Mr Lyne had died. A

Supervising Officer (SO) and two officers went to the cell. The SO assessed Mr Lyne and they called healthcare staff.

37. Two nurses examined Mr Lyne and could not find any signs of life. They considered he had been dead for some time and did not attempt resuscitation, in line with Mr Lyne's decision. A prison GP attended and recorded that Mr Lyne had died.

Contact with Mr Lyne's family

38. On 14 September, the prison appointed a SO as Mr Lyne's family liaison officer. From that date, the SO visited Mr Lyne several times to offer support. Mr Lyne had named his ex-wife as his next of kin, but he did not want anyone to contact her until after his death.

39. Mr Lyne's ex-wife lived some distance from Hull. On the morning of 29 February, the SO contacted a prison near her home and arranged for a member of staff to visit her and inform her that Mr Lyne had died. The SO rang her afterwards to offer condolences and support.

40. Mr Lyne's funeral was held on 24 March. The prison contributed to the funeral expenses in line with national instructions.

Support for prisoners and staff

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

42. The prison posted notices informing staff and prisoners of Mr Lyne's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Lyne's death. Mr Lyne's carer said that a SO and a nurse offered him individual support but he had not wanted to speak about it at the time. He had been shocked as he had got on well with Mr Lyne and had not seen a dead body before. He suggested that it would be useful for carers to meet together regularly as a group to exchange experiences and support each other. We have passed this sensible suggestion on to the Governor.

Cause of death

43. The coroner confirmed that Mr Lyne died of bronchopneumonia and severe pulmonary emphysema due to ischaemic heart disease.

Findings

Clinical care

44. We agree with the clinical reviewer that the care Mr Lyne received at Hull was very good and equivalent to that he could have expected to receive in the community. Healthcare staff provided effective personalised care and his prisoner carer provided social care and companionship.

45. However, we had some concerns about the operation of the Wellbeing Unit. On 26 February, a prison manager had agreed that Mr Lyne's cell should be left open at all times to allow appropriate care, but had not discussed this with healthcare staff. There were no arrangements to check him at night at the time, as he needed no treatment and had not reached the point of end of life care.

46. There was some confusion between prison staff and healthcare staff about the functions and responsibilities of the unit, particularly in relation to the prisoners, such as Mr Lyne, who were in the unit because of his physical health. We note that HM Inspectorate of Prisons found similar uncertainties at the time of the last inspection, shortly after the unit was opened in the former inpatient unit. The Head of Healthcare told us that it was now a residential unit but it had a palliative care cell and another healthcare cell. We found that the lines of responsibility were not clear.

47. Mr Lyne appears to have died peacefully in his sleep. He had said he did not want anyone to attempt resuscitation, so it is unlikely that checks during the night would have changed the outcome. However, it is good practice to check seriously or terminally ill prisoners during the night, to ensure they are not in distress or discomfort. A palliative or end of life plan should reflect when checks are needed. We consider that more clarity about the purpose of the unit is needed so that there is better coordination of care and responsibilities between healthcare staff and prison operational staff responsible for the unit. We make the following recommendation:

The Governor and Head of Healthcare should clarify the role of the Wellbeing Unit so that all staff working there understand their relative responsibilities. There should be a clear protocol for the palliative care suite and other cells used for seriously ill or terminally ill prisoners, who should have appropriate care plans outlining when night time checks are needed.

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