

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Ms Joanna Hackney a prisoner at HMP Eastwood Park on 8 September 2016

**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.

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

Ms Joanna Hackney died on 9 September 2016, of an inflamed abdomen caused by a perforated bowel at HMP Eastwood Park. Ms Hackney was 34 years old. I offer my condolences to Ms Hackney's family and friends.

Ms Hackney suffered from a number of serious conditions. The investigation found that the care Ms Hackney received was largely equivalent to that she could have expected to receive in the community, with some examples of outstanding care. There were, though, some concerns that dressings were not always changed promptly and that observations were not always consistent or in line with NHS guidelines.

When Ms Hackney had her right leg amputated, for most of her stay in hospital officers restrained her. We do not feel that the use of restraints was justified.

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. Ms Joanna Hackney was sent to HMP Foston Hall on remand for violent offences, on 28 March 2014. She was convicted on 2 September, and sentenced to four years and ten months imprisonment. She was transferred to HMP Drake Hall on 2 October 2014.
2. Ms Hackney had a history of substance misuse and suffered from depression. She had an ulcerated right leg and needed crutches to walk. Doctors prescribed medications for depression, pain relief, to prevent infections, and opiate replacement therapy. She took illicit substances while in prison including other prisoners' medication.
3. Healthcare staff monitored Ms Hackney, and changed the dressing on her abscess. Ms Hackney's mobility deteriorated so that she needed a wheelchair to get around, and hospital doctors explored the possibility of amputating Ms Hackney's leg.
4. In March 2016, following several episodes of rectal bleeding and 2 blood transfusions to top up her anaemia, Ms Hackney underwent an exploratory abdominal operation. She also had a skin graft onto the leg ulcer, which went well. By May the condition of the ulcer had deteriorated. In July, she developed a sore on her abdomen which was dressed for the first time when she went to hospital. She went in to hospital on 26 July, when doctors amputated her right leg below the knee. She remained in hospital until 17 August, and was restrained throughout most of her time there.
5. It became apparent that Drake Hall would not be able to manage Ms Hackney's healthcare needs effectively. She was transferred to HMP Eastwood Park, where there is 24 hour healthcare provision.
6. Ms Hackney became unwell shortly after her transfer with diarrhoea and vomiting. Healthcare staff monitored her and a nurse noted that the amputation wound looked infected on 26 August, but Ms Hackney declined to go to hospital. Her health continued to deteriorate and on 30 August a prison nurse sent her to hospital, concerned that she might have sepsis. While in hospital, doctors unexpectedly diagnosed a perforated bowel. Ms Hackney underwent surgery and was placed in a coma. She never regained consciousness and died on 8 September.

Findings

7. The investigation found that the clinical care Ms Hackney received was largely equivalent to that she could have expected to receive in the community and there were examples of outstanding care. However, there were occasions when the dressing of wounds was not changed and blood test results were not reviewed promptly.

8. While in Eastwood Park, healthcare staff monitored Ms Hackney for potential sepsis. The observations taken as part of an early warning system for this were not consistent between nurses.
9. Drake Hall's reasons for using restraints for Ms Hackney's time in hospital did not take fully into account the actual risk that she posed at that time.
10. When Ms Hackney went to hospital for the final time, healthcare staff did not suspect that she had a perforated bowel. She did not show any specific symptoms, and we do not think the prison could have predicted it.

Recommendations

- The Head of Healthcare at HMP Drake Hall and HMP Eastwood Park should ensure that prisoners with wounds that need dressing have these reviewed frequently and that wounds are dressed as necessary.
- The Head of Healthcare at HMP Eastwood Park should ensure that Early Warning Scores are fully embedded into practice and used consistently.
- The Governor at HMP Drake Hall should ensure that all staff authorising 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 Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Eastwood Park informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
12. The investigator obtained copies of relevant extracts from Ms Hackney's prison and medical records. She interviewed one member of staff at HMP Drake Hall over the telephone, on 3 November 2016.
13. NHS England commissioned a clinical reviewer to review Ms Hackney's clinical care at the prison.
14. We informed HM Coroner for Avon 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 Ms Hackney's mother, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She wanted to know about any falls that Ms Hackney had had, and information on her treatment and medications before she went to hospital. Ms Hackney's mother also had other concerns, which we have addressed in separate correspondence.
16. Ms Hackney'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. We are disappointed they have not responded in time. They have not submitted an action plan addressing our recommendations or detailed any factual inaccuracies.

Background Information

HMP Drake Hall

18. Drake Hall is a closed prison which holds just over 300 sentenced women. Accommodation consists of 15 residential units with mainly single rooms. Each house unit has a small kitchen, a laundry room and a television lounge. Care UK has provided healthcare at the prison since April 2016. Healthcare services are provided between 7.15am and 6.30pm daily.

HMP Eastwood Park

19. HMP Eastwood Park in South Gloucestershire opened as a female prison in March 1996, taking in prisoners from HMP Pucklechurch. It holds over 440 women. Inspire Better Health provides healthcare services, 24 hours a day. There is a Detoxification Unit and a Drug Recovery Community.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Drake Hall was in July 2016. Inspectors found that a higher number of women than at comparator prisons were unhappy with the healthcare they received. Entries on the medical notes were generally good and information shared between departments. Appropriate clinics were available and there was good access to external hospital appointments.
21. The most recent inspection of HMP Eastwood Park was in November 2013. Inspectors reported that more women than at comparator prisons were positive about the healthcare available. Women also frequently refused to go to hospital, because they were given little notice and therefore had not prepared to go.

Independent Monitoring Board

22. 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 October 2015, the IMB of HMP Drake Hall reported that healthcare services were generally to a high standard.
23. In its latest annual report, for the year to October 2015, the IMB of HMP Eastwood Park reported that there was some under reporting of disabilities. They also noted patient care was tailored to clinical need.

Previous deaths

24. There have been no natural cause deaths at HMP Drake Hall within the past two years.
25. Ms Hackney was the second prisoner to die of natural causes at HMP Eastwood Park since January 2015, and there has been one death since. There are no similarities between the circumstances of these deaths.

Key Events

26. Ms Joanna Hackney was admitted into HMP Foston Hall on remand for violent offences, on 28 March 2014. She was convicted on 2 September, and sentenced to four years and ten months imprisonment. She was admitted into HMP Drake Hall on 2 October 2014.
27. At her initial health screen in Drake Hall, a nurse noted that Ms Hackney had a history of substance misuse and suffered from depression. Ms Hackney had an abscess on her right leg and she needed crutches to walk. She was prescribed venlafaxine and amitriptyline (to treat depression), nefopam (for pain relief), methadone (as opiate replacement therapy) and metronidazole (to treat infections).
28. On 14 October, a disability care plan was completed. Healthcare staff re-dressed the ulcer on Ms Hackney's leg two to three times a week. She was also found to have taken heroin while in prison, and smoked buscopan (usually taken in tablet form to treat irritable bowel symptoms, but when smoked imitates an illicit substance). Ms Hackney also used other prisoner's prescription medicine. The prison's drug reduction services tried to support her but she did not fully engage with them.
29. Ms Hackney was under the care of a consultant at the hospital to monitor her leg ulcer and provide care. From February 2015 Ms Hackney was advised by the hospital that the ulcer needed extensive surgery with skin grafting. There was a possibility that the lower leg might have to be amputated. Over time, Ms Hackney's mobility decreased and she began to use a wheelchair in August 2015.
30. In November and December Ms Hackney had episodes of rectal bleeding. She declined further investigation. On 27 January 2016, she reported blood in her stools and a doctor made a fast track referral for suspected cancer. Investigations showed no cancer.
31. Ms Hackney had low iron levels. She had a blood transfusion in hospital on 26 February. She became more unwell and on 2 March, went to hospital. While there, doctors treated her for opioid toxicity and kidney failure, as well as giving her more blood transfusions. She also had an abdominal exploration operation, which showed no concerns. Doctors in hospital investigated operating on her right leg. She received a skin graft which went well. She returned to prison on 25 March.
32. Paramedics attended to Ms Hackney on 30 March, because she had taken NPS (New Psychoactive Substances which imitate the effects of other illicit drugs), and was behaving strangely. On 9 April, Ms Hackney was punished under the prison's internal discipline process for illicit drug use. Staff noted in her prison records more instances where it appeared she was under the influence of illicit substances. She was not always given her full range of medications to avoid the risk of interaction between substances. Staff reported Ms Hackney's drug misuse as a security concern and monitored her. The last recording that Ms Hackney was under the influence of a substance was on 24 June.

33. Prison records indicate that substance misuse services engaged with Ms Hackney, although she did not always attend appointments. When she chose not to attend appointments, she received warnings for non-attendance. On other occasions, Ms Hackney was attending hospital appointments instead. They discussed with her the risks of using illicit substances and stated she could access the services when needed.
34. On 4 May, the hospital reviewed Ms Hackney's skin graft. She had been scratching it and some of the graft was damaged. Ms Hackney was prescribed antibiotics but the wound deteriorated. Healthcare staff changed the dressing every other day.
35. A nurse contacted the hospital on 17 June to discuss concerns about Ms Hackney's health. The next day she went to hospital for antibiotics and for her wound to be assessed, but returned to prison before this happened. It is unclear whether the hospital discharged Ms Hackney, or whether she discharged herself. It is clear that the hospital did not assess Ms Hackney as the nurse had arranged over the phone.
36. Ms Hackney went to hospital again on 21 June, and returned to prison on 23 June. Her wound was still deteriorating and healthcare staff monitored her and re-dressed the wound. She developed ulcers on her abdomen, possibly linked to the scar from the abdominal operation performed in March, on 1 July, which the GP noted needed dressing. There is no record that this happened until she went to hospital three weeks later. On 21 July, the nurse noted Ms Hackney had a temperature. She sent her to hospital because she was concerned of the risk of sepsis. Hospital staff discharged Ms Hackney that evening.
37. Ms Hackney went to hospital on 24 July. She had a sore on her abdomen which was painful and possibly infected. On 26 July Ms Hackney had her right leg amputated below her knee, and further operations to monitor the resulting wound. During this time, 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) was applied before and after the operation. Officers removed the restraint at times for Ms Hackney's comfort, for example to make it easier for her to change her clothes. The nurse recorded that hospital doctors had said restraints were hindering Ms Hackney's rehabilitation on 11 August, but there is no record of any subsequent discussion.
38. After an occupational therapist assessed Ms Hackney, she was discharged back to Drake Hall on 17 August. However, nurses at Drake Hall were concerned that Ms Hackney would need 24 hour care because she could not get to the toilet or shower without help. Drake Hall transferred Ms Hackney to HMP Eastwood Park, which provides 24 hour care.
39. The next day, 18 August, Ms Hackney had a social care assessment which planned to change her dressings and monitor her. Her dressing was first changed on 21 August. She began to suffer from vomiting and diarrhoea, which healthcare staff monitored.

40. Ms Hackney was given a personal alarm to alert staff if she needed help. Meals were delivered to her cell and a care worker attended to her three times a day. The sickness and diarrhoea continued.
41. A nurse reviewed Ms Hackney on 26 August. She noted that her amputation wound was infected and bleeding following an undocumented fall. She offered the opportunity to go to hospital but Ms Hackney declined and signed an agreement stating that she understood the consequences. On 28 August, the wound was noted to be mildly inflamed.
42. On 30 August, Ms Hackney was unable to hold objects, and was making jerky movements. A nurse called an ambulance, suspecting sepsis. The prison applied no restraints. Hospital doctors diagnosed Ms Hackney with a perforated bowel and she had an operation that day.
43. Doctors placed Ms Hackney on a ventilator, and into a coma. Doctors operated on her bowel again, however it was not successful. Ms Hackney never regained consciousness and died on 8 September.

Contact with Ms Hackney's family

44. Ms Hackney's family visited her in hospital when she had had her leg amputated. When Ms Hackney went to hospital the final time, the hospital asked for them to be informed and they visited on 31 August.
45. The prison appointed a Family Liaison Officer (FLO) from HMP Drake Hall on 9 August. He made contact with Ms Hackney's mother that day and visited her and other family members on 10 August. They offered ongoing support, and he remained the FLO for the family after Ms Hackney transferred to Eastwood Park.
46. A memorial was held at Drake Hall on 13 September, which Ms Hackney's family attended. The funeral was held on 5 October, and the prison paid towards the costs, in line with national protocol.

Support for prisoners and staff

47. There is no evidence that the staff involved in escorting Ms Hackney to hospital, or any staff that knew her were offered a debrief after her death to ensure they had the opportunity to discuss any issues arising, and to offer support. No staff came forward to say they felt unsupported.
48. Both Drake Hall and Eastwood Park posted notices informing other prisoners of Ms Hackney's death, and offering support.

Post-mortem report

49. The post-mortem report concluded that Ms Hackney died of peritonitis that complicated a perforated ischaemic bowel.
50. Peritonitis is an inflammation of the lining of the abdomen, caused by an infection. An ischaemic bowel is an inflammation of the bowel. A hole then formed in the bowel (perforated), and the bowel contents can leak into the abdomen.

Findings

Clinical care

51. The clinical care Ms Hackney received was largely equivalent to that she could have expected to receive in the community and there were examples of outstanding care. However, the clinical reviewer noted occasions at both Drake Hall and Eastwood Park when the dressing of her leg, was not changed as frequently as it should have been. For Ms Hackney's first four days at Eastwood Park, healthcare staff did not change her dressing. There was also a three week delay in responding to the ulcer that had developed on her abdomen on 1 July. The Heads of Healthcare at both establishments will need to address the delay in changing dressings, as it is not equivalent to the care Ms Hackney could have expected in the community.

The Head of Healthcare at HMP Drake Hall and HMP Eastwood Park should ensure that prisoners with wounds that need dressing have these reviewed frequently and that wounds are dressed as necessary.

52. The clinical reviewer also makes a recommendation about reviewing blood test results. There were two occasions when GPs in Drake Hall did not review results in a timely manner. The Head of Healthcare at Drake Hall will need to address this.
53. Before Ms Hackney was admitted to hospital for the final time, she had not reported any abdominal concerns that indicated perforation of her bowel. Eastwood Park could not have foreseen from the vomiting and diarrhoea that she had a perforated bowel, and therefore taken any different action. However, they were not consistently using Early Warning Scores (EWS) as an indicator of the development of sepsis. Although healthcare staff at Eastwood Park took measurements, they did not consistently record the observations as suggested by NICE guidance. The prison told the clinical reviewer that they had implemented this since Ms Hackney's death.

The Head of Healthcare at HMP Eastwood Park should ensure that Early Warning Scores are fully embedded into practice and used consistently.

Illicit substances

54. There were several occasions when Ms Hackney appeared to be under the influence of an illicit substance while in Drake Hall, although the substance she took was often not confirmed. Ms Hackney had stopped taking methadone replacement therapy in December 2015.
55. Prison staff submitted intelligence reports to the security department appropriately and the prison held at least one adjudication with Ms Hackney. Substance misuse workers at Drake Hall also visited Ms Hackney, and tried to engage her in the services. She was not always responsive, despite efforts to encourage her to interact.

Restraints

56. 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.
57. The Head of Security Intelligence and Operations at Drake Hall carried out the risk assessment for Ms Hackney's 24 July hospital visit. The risk assessment document contained intelligence about Ms Hackney's involvement with drugs and stated that she knew people working in the hospital, and in the local community. He considered that Ms Hackney may have been an escape risk. Overall Ms Hackney was recorded as a medium risk to the public and of outside assistance, low risk to staff and escape. He decided the use of restraints for the escort was appropriate and did not specify circumstances in which restraints could be removed.
58. Healthcare staff at Drake Hall input into the initial risk assessment on 26 July, stating that Ms Hackney had poor mobility and a disability. It appears healthcare staff did not physically update the risk assessment after this, but officers spoke to hospital staff about Ms Hackney's condition.
59. The hospital raised concerns on 11 August that the use of restraints was hindering Ms Hackney's recovery. A nurse raised this with security staff. Although there is no record of what happened after 11 August, the Head of Security Intelligence and Operations told the investigator that he remembered discussing the issue with hospital nurses, and did not agree to the removal of restraints. He said that the nurses could request restraints be removed for specific activities and that nurses should discuss this with escort officers, who would then ask the duty governor for permission. There is no record that hospital staff did ask for further restraint removal, and it is apparent that restraints mostly remained in place.
60. When Ms Hackney went to hospital on 30 August from Eastwood Park, the prison did not apply any restraints.
61. We do not regard the initial decision to use restraints as proportionate or appropriate as it does not address or meet the considerations and criteria set out in the High Court judgement. It is not apparent that Ms Hackney did represent a risk of escape; either alone or with outside help. Certainly Ms Hackney was unable to mobilise easily, and needed a lot of support to perform daily activities. We make the following recommendation:

The Governor at HMP Drake Hall should ensure that all staff authorising 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.

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