

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Ms Carolee Hickman a prisoner at HMP Eastwood Park on 1 October 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.

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.

Mrs Carolee Hickman died on 1 October 2016 of pneumonia in hospital while a prisoner at HMP Eastwood Park. She was 66 years old. I offer my condolences to Mrs Hickman's family and friends.

Mrs Hickman suffered from a number of serious conditions. The investigation found that the clinical care Mrs Hickman received at HMP Eastwood Park was largely equivalent to that she could have expected to receive in the community, with some examples of good care. I am concerned, however, that healthcare staff did not create an advanced care plan, which would have included an early discussion about Mrs Hickman's resuscitation wishes, and did not accurately use early warning scores to check on her condition.

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

May 2017

Contents

Summary 1
The Investigation Process 2
Background Information 3
Key Events 4
Findings..... 8

Summary

Events

1. On 22 December 2014, Mrs Carolee Hickman was convicted of sexual offences and subsequently sentenced to 17 years in prison. She was sent to HMP Eastwood Park.
2. Mrs Hickman had several long term illnesses, which included diabetes, thyroid disease and rheumatoid arthritis. She had limited mobility and used a wheelchair. Doctors prescribed various medications for pain relief, to prevent infections and to control her illnesses. Healthcare staff monitored Mrs Hickman, and they completed frequent checks on her glucose level.
3. From 23 September 2016, Mrs Hickman's health quickly deteriorated. Healthcare staff regularly reviewed Mrs Hickman and took her clinical observations.
4. On 29 September, a prison GP sent Mrs Hickman to hospital, as she was concerned with the significant decline in her condition. While in hospital, doctors diagnosed her with pneumonia. Mrs Hickman's condition continued to deteriorate and, after suffering a cardiac arrest, she died on 1 October.

Findings

5. The investigation found that the clinical care Mrs Hickman received was largely equivalent to that she could have expected to receive in the community and there were examples of good care. However, we agree with the clinical reviewer's concerns that the observations and scoring, taken as part of an early warning system to check Mrs Hickman for sepsis, were not always accurate and that healthcare staff should have created an advanced care plan, which would have included her resuscitation wishes, before her health deteriorated in September 2016.
6. Mrs Hickman had several falls and we consider that healthcare staff should have assessed her risk of falls earlier to help prevent them.

Recommendations

- The Head of Healthcare should ensure that healthcare staff discuss and record advance care planning with seriously ill prisoners, including their views about resuscitation.
- The Head of Healthcare should ensure that Early Warning Scores are fully embedded into practice and used consistently.
- The Head of Healthcare should ensure that prisoners at risk of falls have an appropriate risk assessment in line with NICE guidelines and the assessment is recorded and acted on.

The Investigation Process

7. 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.
8. The investigator obtained copies of relevant extracts from Mrs Hickman's prison and medical records.
9. NHS England commissioned a clinical reviewer to review Mrs Hickman's clinical care at the prison.
10. The investigator and clinical reviewer interviewed one member of staff at Eastwood Park on 23 November 2016.
11. 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.
12. One of the Ombudsman's family liaison officers contacted Mrs Hickman's sister, 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 Hickman had had, and information on her treatment and medications.
13. Mrs Hickman's family received a copy of the initial report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.
14. The initial report was shared with the Prison Service. The Prison Service pointed out a factual inaccuracy and this report has been amended accordingly.

Background Information

HMP Eastwood Park

15. HMP Eastwood Park in South Gloucestershire is a female prison. It holds over 440 women. Bristol Community Health and Avon and Wiltshire Partnership Trust provide primary care, mental health care and substance misuse services. Hanham Health provides GP cover. Nurses provide 24 hour healthcare.

HM Inspectorate of Prisons

16. There was an inspection of Eastwood Park in November 2016, but the report has yet to be published. The previous inspection 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

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. In its latest annual report, for the year to October 2015, the IMB reported that Pathways, the primary care centre, operated up to eight clinics per day, seeing between 60 and 70 patients a day. The IMB noted that there had been a problem with missed appointments but efforts had been taken to improve attendance. Overall, prisoners reported that healthcare staff showed them a high degree of courtesy, respect and confidentiality.

Previous deaths at HMP Eastwood Park

18. Mrs Hickman was the third prisoner to die of natural causes at HMP Eastwood Park since January 2015. We have made a previous recommendation about the need to use the National Early Warning Scores (NEWS) system when assessing a prisoner's condition.

Key Events

19. On 22 December 2014, Mrs Carolee Hickman was convicted of sexual offences and subsequently sentenced to 17 years in prison. She was sent to HMP Eastwood Park.
20. Mrs Hickman suffered from complex medical conditions. She suffered from type 2 diabetes, thyroid disease, kidney problems, arthritis and spinal osteoporosis. She had restricted mobility, and used walking sticks and a wheelchair. Prison GPs arranged for her to continue to receive her medication.
21. During 2015, Mrs Hickman suffered five falls in her cell. Healthcare staff reviewed her following the falls though there was no evidence that they considered the need for a falls risk assessment.
22. On 20 May at approximately 4.30am, Mrs Hickman woke up with left sided weakness and numbness. A nurse examined her and noted that Mrs Hickman was alert, orientated and able to lift her arms with no facial drooping, pain, headaches or nausea. Her pulse (86bpm) and blood pressure (123/65) were within the normal range. The nurse concluded that there was no evidence that Mrs Hickman had had a stroke. She checked on Mrs Hickman at 30 minute intervals and noted she was sleeping peacefully.
23. Just after 8.00am on the same day, a healthcare assistant checked Mrs Hickman. Mrs Hickman said that she had numbness in her left arm and hand. She told her to contact healthcare immediately if anything changed and made a GP appointment. Prior to the GP appointment, a nurse checked Mrs Hickman's observations. Her blood pressure (127/85) was higher than normal and her pulse (56bpm) was a little slow. The GP saw Mrs Hickman at 5.00pm. She suspected Mrs Hickman had had a stroke so she made arrangements for her to go to hospital. Hospital doctors confirmed that Mrs Hickman had had a mini stroke and appointments were made for her to attend a stroke clinic. Mrs Hickman attended the neurology clinic on 22 May and the consultant neurologist prescribed clopidogrel to lower the risk of heart disease and stroke.
24. On 23 December, Mrs Hickman fell again in her cell and bruised her forehead. A prison GP arranged for Mrs Hickman to go to hospital for a head injury assessment. She was unable to have a CT scan as she said she was claustrophobic. She said that apart from a headache she felt fine. Healthcare staff at the prison told her that if she had worsening headaches (particularly down her neck) and any confusion or memory problems, she should immediately let them know.
25. Between December 2015 and September 2016, Mrs Hickman's condition remained unchanged and healthcare staff saw her frequently to monitor her conditions. Mrs Hickman notified the kitchen staff that she had a carrot allergy, though staff told her that there were plenty of alternatives that she could choose from so no adjustments were made.
26. In February 2016, Mrs Hickman had two falls. A prison GP noted that she thought on one occasion Mrs Hickman had fainted and the other was when Mrs Hickman had fallen out of bed.

27. From 20 September, healthcare staff began measuring Mrs Hickman's National Early Warning Score (NEWS) to detect and act on signs of septicaemia. Healthcare assistants scored her level of alertness and her first NEWS score was one (a low score is one to four, a medium five or six and a high score above seven). On 22 September, Mrs Hickman's NEWS score had increased to three though she was noted as being alert.
28. From 23 September, Mrs Hickman's health quickly deteriorated. She was becoming too weak to feed herself or move around. Prison officers told healthcare staff that Mrs Hickman looked unwell. A prison GP examined Mrs Hickman and noted that she looked pale. Her pulse (74bpm) and blood pressure (115/65) were within normal range. He said healthcare staff should check her observations later that day. Her observations were regularly taken over the next three days, including her NEWS score which varied between one and three.
29. A prison GP examined Mrs Hickman on 24 September. She noted Mrs Hickman had fluctuating blood sugar levels and was taking antibiotics for a urine infection. She said Mrs Hickman's observations were within normal range and she issued a repeat prescription of antibiotics for the urine infection. Healthcare staff visited Mrs Hickman several times a day to check on her. Mrs Hickman said she felt weak but was improving.
30. On 27 September, Mrs Hickman told a prison GP that she was feeling weaker and had dizzy spells when standing. She also said that she felt breathless, had a swollen ankle and a burning sensation in her mouth. Her blood pressure (118/67) and pulse (98bpm) were within normal range. He noted that nurses were unable to check her blood sugar levels, as they could not locate her arm veins for the blood collection. She said the blood tests should be completed the next day. Healthcare staff should continue to monitor Mrs Hickman and, if there were any concerns, they should contact a doctor. Later that evening, a nurse was able to test Mrs Hickman's blood glucose level (8.4mmol/L), which was normal for someone with type 2 diabetes.
31. Healthcare staff visited Mrs Hickman in her cell several times a day and helped her take her medication. They recorded that she was weak and frail with poor motor skills and coordination. On 28 September, a nurse noted that Mrs Hickman was struggling to eat and swallow. She scored her NEWS score as three, though she booked a GP appointment for the next day. Later that day, she scored Mrs Hickman's NEWS score as two and noted that she had difficulty swallowing and had delayed responses to questions.
32. The following day, a nurse scored Mrs Hickman's NEWS score as one but noted that Mrs Hickman was weak. She requested an urgent GP appointment. At 11.54am, a GP examined Mrs Hickman and noted that she was drowsy, had very poor mobility, was struggling to eat and she said it was a dramatic decline from when she had last seen her (on 26 and 28 September). Mrs Hickman told her she felt she was dying, wanted her sister to know and did not wish to be resuscitated. The GP completed the resuscitation form to record her wishes. Due to her level of drowsiness and acute deterioration, the GP told nurses to arrange for an ambulance to take Mrs Hickman to hospital within two hours, although nurses did not request the ambulance until 1.41pm.

33. At 2.00pm, a senior nurse went to see Mrs Hickman. She decided that she should go to hospital sooner and she escalated the ambulance request to one hour. Records show that the ambulance arrived at 3.36pm and took Mrs Hickman to hospital. Two officers escorted Mrs Hickman, but did not restrain her.
34. Hospital doctors treated Mrs Hickman with a broad spectrum of antibiotics for suspected sepsis but she suffered a cardiac arrest. Hospital staff attempted resuscitation, as they were unable to use the form that the prison GP had completed, as it was incomplete, and the hospital doctor had not signed the latest form. Despite the resuscitation attempt, Mrs Hickman died on 1 October.

Contact with Mrs Hickman's family

35. When Mrs Hickman went to hospital on 29 September, one of the escorting staff noted that the duty manager had told him to contact Mrs Hickman's sister. He rang Mrs Hickman's sister to tell her that Mrs Hickman was in hospital. Mrs Hickman said she did not want her husband to know.
36. When Mrs Hickman died, hospital staff rang her sister and left a message breaking the news. The prison duty manager also rang and left a message asking Mrs Hickman's sister to ring the prison. When Mrs Hickman's sister rang, prison staff offered her condolences and support.
37. Mrs Hickman's husband was in prison so staff at Eastwood Park contacted staff at HMP Isle of Wight and asked them to break the news of her death. A member of the chaplaincy team broke the news to Mrs Hickman's husband.
38. Eastwood Park appointed a Senior Officer (SO) as a family liaison officer on 1 October. At the request of Mrs Hickman's sister, the SO and an officer visited her on 4 October and offered ongoing support.
39. Mrs Hickman's funeral was held on 26 October, and Eastwood Park contributed towards the costs, in line with national instructions.

Support for prisoners and staff

40. After Mrs Hickman's death, the prison duty manager debriefed the escort staff at the hospital to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
41. The prison posted notices informing other prisoners of Mrs Hickman's 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 Mrs Hickman's death.

Post-mortem report

42. A post-mortem examination concluded that Mrs Hickman died of lower respiratory tract infection (pneumonia) due to heart disease, chronic renal failure, hypothyroidism (thyroid disease), diabetes mellitus, hypertension (high blood pressure), chronic pancreatitis (inflammation of the pancreas) and cirrhosis of the liver (liver disease).

43. The pathologist said that overall Mrs Hickman had multiple pre existing medical conditions and suffered a general deterioration with the final event being the development of lower tract infection (pneumonia).

Findings

Clinical care

44. The clinical reviewer found that Mrs Hickman was physically frail when she arrived at prison. He said her long term illnesses were complicated and healthcare staff monitored and managed them appropriately, including referrals to specialists. We agree with the clinical reviewer that the clinical care that Mrs Hickman received was largely equivalent to that she could have expected to receive in the community. However, we agree with the clinical reviewer that there were some failings.
45. The clinical reviewer considered that Mrs Hickman's frailty, diabetes and TIA in May 2015 should have caused healthcare staff to consider an advanced care plan. The combination of diabetes, frailty and TIA in May 2015 should have been a trigger to consider an advanced care plan. Mrs Hickman's sudden deterioration at the end of September 2016 should also have triggered a discussion about care plans.
46. The clinical reviewer said that on 28 September when Mrs Hickman was struggling to eat and respond to questions, she should have seen a doctor the same day rather than the next day. The clinical reviewer considered that this decision, coupled with the lack of an advanced care plan, meant that Mrs Hickman's care at this stage was unlikely to have reached a standard equivalent to community care.
47. The clinical reviewer also considered that an advanced care plan would also have allowed healthcare staff to have discussed resuscitation with Mrs Hickman when she had capacity to make a decision rather than leaving it until 29 September when she was too drowsy to make the decision. We agree and make the following recommendation:

The Head of Healthcare should ensure that healthcare staff discuss and record advance care planning with seriously ill prisoners, including their views about resuscitation.

48. The clinical reviewer also said that healthcare staff started using the National Early Warning Score (NEWS) scores in September 2016 to detect and act on signs of septicaemia. He said that although healthcare staff took measurements, they did not consistently record the observations as suggested by National Institute for Health and Care Excellence (NICE) guidance. The clinical reviewer said that healthcare staff had underestimated the scoring, due to the inaccurate assessment of Mrs Hickman's conscious level on 28 and 29 September, and that her NEWS score was more likely four. We have raised this issue with the prison in a previous investigation and the prison said they had implemented changes. However, Mrs Hickman's circumstances show that there were still shortcomings in the practice and we agree with the clinical reviewer that healthcare staff require additional training in this area. We therefore repeat the recommendation:

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

Falls risk assessment

49. Mrs Hickman was known to have low glucose levels and one of the symptoms is unsteadiness. This could account for the number of falls that she had. After her first fall, healthcare staff should have assessed Mrs Hickman with an emphasis of keeping her safe in the environment in which she lived. In line with the NICE guidelines for dealing with the assessment and prevention of falls in older people, an assessment after her second fall should have highlighted the hazards, interventions needed and the need for a medication review to determine what effect her medication might have had on her stability. She should have been referred for a falls risk assessment, but there is nothing in her medical record to show an assessment was ever carried out. No adjustments were made and there was nothing to alert staff to her very high risk of falls. As a result, Mrs Hickman suffered from at least seven falls during her time at Eastwood Park. We make the following recommendation:

The Head of Healthcare should ensure that prisoners at risk of falls have an appropriate risk assessment in line with NICE guidelines and the assessment is recorded and acted on.

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