Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jordan Hullock a prisoner at HMP Doncaster on 30 June 2015

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.

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 Jordan Hullock died in hospital on 30 June 2015 of meningitis, while a prisoner at HMP Doncaster. He was 19 years old. We offer our condolences to his family and friends.

This is a sad and disturbing case in which no one took responsibility for ensuring that Mr Hullock received urgent medical attention as he became seriously unwell. It is unacceptable that any prisoner, and particularly a vulnerable young man, should have been treated in such an uncaring manner, allowed to deteriorate in full view of staff and to spend his final days in appalling conditions before he was finally, belatedly, sent to hospital. We are very troubled that when concerns were raised about Mr Hullock's treatment, including by the chair of the Independent Monitoring Board, no action appears to have been taken.

We are also concerned that Mr Hullock was unnecessarily restrained when he was taken to hospital and that his mother was not informed promptly of his critical condition.

Given the very serious concerns raised by this investigation, we draw this report to the attention of the Head of Contract Management in Her Majesty's Prison and Probation Service who should satisfy himself that effective action is taken to address its recommendations.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **April 2018**

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Summary

Events

1. On 1 June 2015, Mr Jordan Hullock was remanded to HMP Doncaster. Mr Hullock arrived with a police risk assessment warning that he had a heart condition and was undergoing treatment. No one noted this at reception.

2. From 3 June, Mr Hullock complained that he was not feeling well. Healthcare staff referred Mr Hullock to the mental health team but did not consider his physical health.

3. Mr Hullock stopped eating, drinking and communicating. Staff failed to refer him to a prison GP. His condition deteriorated severely to the extent that he repeatedly soiled himself and ate his own faeces. Staff and the Chair of the Independent Monitoring Board raised their concerns about his welfare with wing staff and managers but no action was taken.

4. On 23 June, Mr Hullock collapsed in the shower. When he finally saw a prison GP in the afternoon of 24 June, he was sent urgently to hospital.

5. In hospital, Mr Hullock was placed in an induced coma but did not respond to treatment. At 3.50pm on 30 June, a doctor confirmed Mr Hullock's death at hospital. His family were with him when he died.

Findings

Clinical care

6. We agree with the clinical reviewer that the care Mr Hullock received was not equivalent to that which he could have expected to receive in the community. No one recognised that Mr Hullock's erratic actions and changes in mood were potential signs of being seriously unwell. Mr Hullock's care was neglectful and inadequate.

7. We are not satisfied that prison staff took appropriate action to support Mr Hullock. Record keeping was poor and, when Mr Hullock's health declined, there was no evidence that senior wing managers took action to care appropriately for Mr Hullock. Instead, they relied on officers to try to get help from the healthcare team.

Staff behaviour

8. An officer and the Chair of the Independent Monitoring Board raised serious concerns to senior managers about staff not addressing Mr Hullock's declining health, but there is no evidence that their concerns were taken seriously, still less investigated or addressed.

Family liaison

9. There was a delay in telling Mr Hullock's family that he was seriously ill and had been taken to hospital and in appointing a family liaison officer.

Restraints

10. We are concerned that Mr Hullock was unnecessarily restrained with an escort chain when he was taken to hospital and that he remained restrained until he was placed in a medically induced coma.

Recommendations

- The Director and Head of Healthcare should ensure that in line with PSO 3050:
    - prisoners are offered a secondary health screening; and
    - community GP records and other relevant records are passed to prison GPs for a clinical assessment to ensure continuity of healthcare.
- The Head of Healthcare should ensure that nurses attend quickly to assess prisoners when wing staff have serious concerns about their wellbeing and that prisoners with symptoms of serious conditions are taken to hospital immediately.
- The Director, working with NHS Nottinghamshire Trust, should:
    - review the adequacy of current healthcare processes at HMP Doncaster to ensure that the shortcomings identified by this investigation have been addressed; and
    - consider whether the actions of all healthcare staff were appropriate in relation to Mr Hullock's care.
- The Director should:
    - commission a review of the way in which concerns raised about Mr Hullock's welfare and reports of inappropriate comments on social media were managed, addressing the adequacy of systems and the actions of staff; and
    - consider whether disciplinary action should be initiated as a result.
- The Director should ensure that:
    - a prisoner's next of kin is informed at the earliest opportunity after admission to hospital with a serious illness; and
    - an appropriate member of staff is appointed to engage with families when a prisoner is diagnosed with a serious illness and that after their death, a family liaison officer is appointed without delay and carries out the role in line with Prison Service guidance.
- The Director and Head of Healthcare should ensure that staff who undertake 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.
- The Deputy Director for Operational Contracts should satisfy himself that effective action is taken to address the findings of this investigation.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Doncaster informing them of the investigation and asking anyone with relevant information to contact her. Two prisoners responded. In addition, several months into the investigation, a former prisoner of HMP Doncaster contacted the investigator with information about what he witnessed.

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

13. The investigator interviewed 15 members of staff and three prisoners at Doncaster in July and August 2015. She also spoke to the Chair of the Independent Monitoring Board on 28 July and interviewed an ex-member of staff on 3 September. She gave feedback to the Director on 18 September. She also spoke to the Ministry of Justice controller on 24 August, 22 September and 15 October.

14. NHS England commissioned a clinical reviewer to review Mr Hullock's clinical care at the prison. He conducted joint interviews of healthcare staff with the investigator.

15. We informed HM Coroner for Doncaster of the investigation and have given the Coroner a copy of this report.

16. We suspended this investigation from 21 August 2015 until 12 October 2017 while the police investigated the circumstances of Mr Hullock's death. We began our investigation again when we were informed that the Crown Prosecution Service (CPS) had decided not to pursue charges.

17. One of the Ombudsman's family liaison officers contacted Mr Hullock's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not have any specific questions or concerns for us to address.

18. Mr Hullock's family received a copy of the initial report. They pointed out some factual inaccuracies and/or omissions. This report has been amended accordingly. Mr Hullock's family also raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Doncaster

20. HMP & YOI Doncaster is a medium category local prison, which can hold up to 1,145 male prisoners and young offenders. SERCO Home Affairs are contracted to manage the prison and at the time of Mr Hullock's death, NHS Nottinghamshire Trust provided healthcare. The healthcare team has mental health and substance misuse teams. Since Mr Hullock's death, Doncaster employs qualified paramedics who respond to emergency calls. Care UK currently provides healthcare.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Doncaster was in July 2017. Inspectors found that health services had improved considerably since the previous inspection in October 2015 and were reasonably good overall. They noted that a wide range of primary care services was available and waiting lists were generally short, although too many patients failed to attend appointments. The management of prisoners with long-term conditions had improved, with several specially trained staff available to patients. The 24-hour in-house paramedic service was an example of good practice.

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 annual report, for the year to September 2016 the Board noted that they had received a high number of applications about healthcare, and that the majority of complaints were about the difficulty in accessing healthcare for routine appointments. The IMB noted good engagement between nurses and prisoners and praised the new initiative of having paramedics on site to deal with serious emergency issues. However, the Board was concerned about the overall standard of healthcare at Doncaster, which it regarded as below that offered in the local community.

Previous deaths at HMP Doncaster

23. Mr Hullock was the third prisoner to die of natural causes at Doncaster since January 2014. There have been eight subsequent deaths and one is still under investigation. In previous investigation reports, we made recommendations to address the delay by nurses in responding when wing staff have raised concerns with them about a prisoner's health, and to address the inappropriate use of restraints.

Key Events

Background

24. On 31 May 2015, Mr Jordan Hullock was arrested for assault and police completed a risk assessment report, which warned that Mr Hullock had had a heart condition (aortic stenosis) since November 2010, had had a mild heart attack two weeks earlier and was waiting for a cardiology appointment. In police custody, he said he felt unwell and a nurse checked on him every thirty minutes.

HMP Doncaster

25. On 1 June, Mr Hullock was remanded to HMP Doncaster. He arrived with a police warning. A substance misuse nurse, carried out a health screen and noted no concerns about Mr Hullock's physical health. She could not recall if she saw the police assessment, which was filed in his medical record. She said Mr Hullock did not mention his heart condition or that he had any outstanding hospital appointments. He declined help to stop smoking and refused a meningitis C vaccination. Prison staff allocated Mr Hullock a standard double cell on a residential unit at Doncaster.

26. On 2 June, a healthcare administration officer asked Mr Hullock's community GP for a summary of his medical history and needs. Later that night, wing staff called a nurse to Mr Hullock's cell. Mr Hullock and his cellmate said they had been assaulted. Mr Hullock said that he had been punched in the chest. No injuries were found and police later confirmed that the alleged assault was not connected to Mr Hullock's death. Mr Hullock said that before his arrest, he had injured his left wrist and had not been able to attend the fracture clinic. The nurse noted that he had a swollen wrist and she referred him to the GP to arrange an x-ray.

27. On 3 June, prison staff asked a nurse to see Mr Hullock. She said that prison staff told her that Mr Hullock had been moved to another residential unit (Houseblock 1) after an alleged assault. She said that when she saw Mr Hullock, he was distressed about the assault and in pain. She gave him painkillers and noted that he should be checked during the night and reviewed in the morning.

28. Later that night, Mr Hullock complained of rib pain and a nurse went to his cell. She checked his observations (which were in the normal range) and told him that she would check again in two hours. She checked on him later that night and Mr Hullock told her that he was feeling better. She noted that he had a GP appointment in two days' time but told him to alert staff if he needed.

29. On 4 June, Mr Hullock complained of rib pain and breathing problems. A nurse examined him but she said she found no problems.

30. On 5 June, Mr Hullock's community GP faxed his medical history to Doncaster. It showed that a year earlier, he had been prescribed concerta to treat ADHD and that he was having ongoing treatment for heart disease. (The GP's fax was scanned to Mr Hullock's electronic medical records but there is no evidence that a GP at Doncaster reviewed his medication or medical history.)

31. A nurse said that she had seen the GP note that Mr Hullock had taken concerta but was no longer taking it. She said that she referred to the mental health team for advice.

32. In his police statement, Mr Hullock's cellmate said that a week after he arrived, Mr Hullock started vomiting. He said that Mr Hullock was constantly pressing his cell bell and asking wing staff to call for a nurse as he could not get out of bed. He said that he heard Mr Hullock tell wing staff and nurses that he had a heart condition but no one took any action. He said that approximately one week after his arrival in prison, Mr Hullock started feeling unwell. He said he collected Mr Hullock's meals for him when he was too weak to leave his bed. However, he said that as Mr Hullock became weaker, he would not eat, and he helped him to sip water and to use the toilet. He said that Mr Hullock said he had headaches and felt dizzy. He said that he saw nurses check Mr Hullock's blood pressure and give him paracetamol and ibuprofen tablets. He was released from prison after two and a half weeks. He said that when he left, Mr Hullock never left his bed and wing staff and nurses were aware of this.

33. A prison officer who had worked with Mr Hullock as his outreach worker before he arrived in prison. She had started work at Doncaster and first spoke to Mr Hullock on 3 June as she attended his cell with a nurse. She said he had told her that he had been feeling ill for a number of days. She said that on 11 June, she rang Mr Hullock's wing to tell staff his visitor was waiting for him in the legal visits area. She said she heard him tell wing staff that he could not meet probation staff as he felt ill.

34. The prison officer said that on 12 June, she spoke to Mr Hullock and his mother in the visits hall. He said that he had a headache and his mother asked if he had received his ADHD medication and if an appointment had been made for him to see a heart specialist. She said she passed this information to wing staff.

35. On 14 June, wing staff asked the healthcare team to see Mr Hullock. A nurse saw him in his cell. She noted in his medical record that Mr Hullock told her that he had a headache and had taken two paracetamol tablets. She took his observations (which were within the normal range). She advised him to drink plenty of fluids and told a prison officer to contact the healthcare team if there were any further concerns.

36. Mr Hullock's name appears at the bottom of the healthcare duty manager's report of 16 June, with an entry that reads, "leg". There are no further details.

37. On 17 June, wing staff called a nurse to see Mr Hullock in his cell. He said that he had leg pain, a terrible headache and chest pain. She noted that he was standing up, wrapped in a sheet and there were two plates of food in his cell. She noted that he had not left his cell for four days. She advised him to leave his cell and start eating and drinking.

38. On 18 June, a nurse went to Mr Hullock's cell. Mr Hullock told him that he had not left his cell for two weeks, had painful legs and felt dizzy when he stood up. The nurse noted that Mr Hullock was dishevelled and unshaven, checked his record and noted he had a heart condition. He checked his blood pressure and it was low at 106/50. He referred him to the mental health team.

39. On 19 June, a modern matron considered the mental health referral without examining Mr Hullock. He noted that Mr Hullock's issues appeared related to his physical health and recent alleged assault. He said that he should be referred to a GP. Later that day, a nurse went to Mr Hullock's cell with a wheelchair to help Mr Hullock get to his GP appointment but Mr Hullock refused to attend.

40. A prison officer met Mr Hullock's mother in the visits' hall, where she told his mother that she would ask a nurse to visit him and get him his medication. She submitted a security report about this, and she said that she told healthcare staff who said that they were unaware of Mr Hullock's condition.

41. On the same day, the prison officer saw Mr Hullock in his cell. She said that there were plates of untouched food and Mr Hullock told her that he felt ill. She said she told both custodial managers, that she was concerned about his care. She also said that she told one of the custodial managers, that Mr Hullock had a heart condition, for which he was not receiving medication. She said she reported her concerns about the lack of medical care to the Chair of the Independent Monitoring Board. The prison officer said that later that night, she sent a private message on social media to another officer who she knew worked on Mr Hullock's wing. She said that she asked how Mr Hullock was. She said the officer made inappropriate and offensive remarks on social media that Mr Hullock had taken drugs. The prison officer reported this to the security department at the prison.

42. From 20 to 22 June, three nurses separately visited Mr Hullock in his cell at the request of wing staff. Each were told of his poor appetite, noted that he looked unwell and told him to see the prison GP at his rescheduled appointment. A nurse gave him water and paracetamol and took his observations. His blood pressure was 140/60, which was pre-high, his pulse was regular, his oxygen saturation was normal but his temperature was elevated at 37.9 degrees. Another nurse noted that Mr Hullock was motionless in bed and gave incoherent responses. She said that he had blood and food stuck to his teeth. She diagnosed mental health issues and referred him to the mental health team. A mental health nurse, saw Mr Hullock, he was on the bed, under his mattress. She said that he did not respond to her and his cell was in a poor state, with dried food left around it. She noted that officers had started a food diary for Mr Hullock and the mental health nurse, said there should be a mental health review. No record has been found of a food diary.

43. Officers noted concerns about Mr Hullock's deteriorating health in the wing observation book. A prisoner on his wing at the time said that he saw a rapid change in Mr Hullock's appearance in seven days. He said that prison staff only glanced at him through the cell observation panel and he said that visits from healthcare staff "may have well have been non-existent".

44. In his police statement, a prisoner said that he would deliver meals to prisoners who were unable to leave their cell. He said that he saw Mr Hullock in his cell, huddled under blankets and uncommunicative, for at least one week. He said that he had told prison staff that Mr Hullock should be in hospital.

Events from 23 June 2015

45. On 23 June, a prison officer went to Mr Hullock's cell. She said that she saw Mr Hullock through the door observation panel, lying on his bed, with excrement and urine on the floor. She said that she asked two officers why his cell was in such a mess and was told that staff were waiting for biohazard equipment to be brought to the wing for officers to clean his cell. She said that shortly afterwards, when she returned to his cell door, she saw through the observation panel that he was eating his faeces.

46. The IMB Chair, told senior mental health nurse that officers had complained that nurses had neglected Mr Hullock. He told her that healthcare staff had tried to interact with Mr Hullock and refer him to a doctor. He also said that officers had been asked to start a food log but this did not happen.

47. Later that day, wing staff asked a nurse to check on Mr Hullock in his cell. He was on the bed, and his body and cell were covered in faeces and urine. Mr Hullock told her that he felt sick. She told him that he should have a shower so that he could be helped. She said that she would return after she had finished her clinic but never did. (At the request of the police, we did not interview the nurse.)

48. A prisoner, said that he was the cell cleaner (his job was to clean cells.) He said that on 23 June, prison staff asked him to clean Mr Hullock's cell in the late afternoon. He went to the cell and saw Mr Hullock lying on the lower bunk bed, facing away from the door. He said that there were piles of faeces on the floor. He said that Mr Hullock did not respond when he tried speaking to him. He said that a member of staff - he could not recall who - asked him to clean the cell but he refused. He said that he needed specialist biohazard equipment. At approximately 6.30pm, prison staff asked him to return to clean Mr Hullock's cell. He said that they told him that Mr Hullock had been moved from his cell and staff were trying to find the biohazard equipment.

49. Two officers moved Mr Hullock from his cell to the shower area. The prisoner who was the cell cleaner, said that he saw the two officers trying to wash Mr Hullock. He went into the shower area to help. He said that they washed faeces from Mr Hullock's hair, mouth and body. As they tried to wash him, he collapsed. An officer radioed for healthcare assistance. Two nurses went to the shower area. CCTV footage showed that they went into the shower unit for approximately nine minutes and then left.

50. A nursing assistant, also went to the shower area. She noted that Mr Hullock was lying motionless on the floor, his eyes fixed open and he said that he felt sick. She said that she was unable to take his blood pressure. She said that a senior nurse said his observations were fine. She left the unit but returned thirty minutes later. Mr Hullock was still in the shower. She said that he was dressed and appeared to have dried blood or food around his mouth. In her statement, she said that she helped him on to a chair and gave him a breakfast bar to eat before leaving the wing. CCTV footage showed that an officer helped him on to a chair and she gave him water to drink.

51. A prisoner said in his police statement that while Mr Hullock was in the shower area, a unit manager asked him to help the cell cleaner, clean Mr Hullock's cell using biohazard equipment. They started cleaning the cell at around 8.00pm.

The bed and the cell floor were covered in faeces. All of Mr Hullock's property was contaminated and was thrown away.

52. An administrator, noted in Mr Hullock's medical record that the National Probation Service's divisional hub in Dewsbury rang at approximately 10.45am on 24 June and told her that Mr Hullock might not have disclosed that he had a diastolic heart murmur. There is no record that any action was taken about this.

53. On 24 June, the cell cleaner returned to Mr. Hullock's cell. He said that Mr Hullock was lying in his bunk bed and the cell smelled of urine. At 10.58am, wing staff called a nurse to the wing as Mr Hullock had collapsed on the cell floor. Officers helped him on to a chair. They told the nurse that they were unsure whether Mr Hullock had been eating or drinking. Mr Hullock was wearing wet jogging bottoms and he was unable to have a conversation with her. She took his observations. His temperature was raised at 37.6 degrees. His blood pressure was low at 133/49. She said that she saw from the notes that he was scheduled to have a mental health assessment but she was not sure what had been arranged as she saw that a mental health nurse had already seen him. The nurse took no action to ensure that a GP assessed him. The healthcare duty manager's daily report and handover log noted that Mr Hullock was "very anxious and was showing "bizarre behaviour".

54. Later that day, a nurse visited Mr Hullock in his cell to complete a mental health assessment. She was concerned that he was unresponsive and looked unwell. She asked another nurse to make an urgent appointment for Mr Hullock to see a GP and for officers to bring him to the healthcare unit. Officers put Mr Hullock in a wheelchair and took him to the healthcare unit for a GP review.

55. Just after 3pm, a locum GP reviewed Mr Hullock. He noted that Mr Hullock had a cardiac history, abnormal vital signs and looked very dehydrated and malnourished. He noted that Mr Hullock had become socially withdrawn, staying in his cell in the dark and had become increasingly drowsy. He referred him urgently to hospital. Control room staff called an ambulance at 3.25pm and paramedics arrived at the prison at 3.29pm. The ambulance left the prison at 4pm.

56. Two officers escorted Mr Hullock to the hospital and they restrained him using an escort chain (a long chain with a handcuff at each end one of which is attached to a prisoner and another to an officer).

57. A nurse had seen Mr Hullock on 24 June on the cell floor, uncommunicative and unable to move unaided. She completed the medical section of the escort risk assessment and did not provide any information about his current condition. She said that she was unsure how long the hospital treatment would take and the appointment was unlikely to turn into a bed watch. She also said that his medical condition did not restrict his ability to escape, he would not need an anaesthetic and that restraints would not need to be removed for treatment or examination.

58. The prison's security department assessed that Mr Hullock had medium potential to escape and was medium risk to the public. The risk assessment was authorised by a prison manager. He assessed that Mr Hullock should be restrained using an escort chain and two officers should escort him.

59. Hospital doctors diagnosed suspected encephalitis (brain inflammation from a viral infection) and arranged for Mr Hullock to be transferred to another hospital.

60. On 27 June, Nurse B and Nurse C entered retrospective entries on Mr Hullock's medical record. Nurse B said that she responded with Nurse C to a call to attend the shower area as Mr Hullock had collapsed. She said she saw Mr Hullock on the floor on his back, staring at the ceiling. He was conscious but unresponsive. She said a healthcare assistant, was talking to Mr Hullock and was able to get a response but was unable to get a blood pressure reading, as Mr Hullock would not allow her to put the arm cuff on him. When they managed to do so, it failed to inflate. Nurse B said that he was helped to sit and was fully orientated. His blood sugar level, saturations and pulse were checked. (She did not note the results.) She said that Mr Hullock was not short of breath and said that he felt nauseous. She said when she left the wing, officers were going to take him back to the cell after it had been cleaned. She said she told officers to get him dry clothes. She heard the healthcare assistant say that she would return to check on him.

61. Nurse C's retrospective entry said that he attended the medical response and Mr Hullock was on the floor. He said his observations were fine – there was nothing recorded- and that Mr Hullock said he felt sick. He said Mr Hullock was alert, communicating and with no physical sign of being unwell. He advised officers to help Mr Hullock back to the cell. He later said that the healthcare assistant told him that she had returned to give Mr Hullock some food.

62. CCTV footage showed that Nurse's B and C and the healthcare assistant went into the shower area at 7.13pm. The two nurses left the shower area nine minutes later and did not return.

63. In hospital, Mr Hullock was in an induced coma but did not respond to treatment.

64. At 3.50pm on 30 June, a doctor confirmed Mr Hullock's death at hospital. His family were with him when he died.

Contact with Mr Hullock's family

65. Mr Hullock's family said that his mother telephoned the prison several times on 20 and 22 June asking if he was okay because he had not contacted his family. They said staff said, "he was getting on with what he should be doing".

66. On 24 June, Mr Hullock's mother rang the prison again. She said she was told that wing staff had been told to tell Mr Hullock to ring her. She said there was no mention that he was in hospital.

67. On 25 June, the day after Mr Hullock was admitted to hospital, staff in the prison control room contacted the prison chaplain, to ask him to check if Mr Hullock's family had been notified of his hospital admission. He telephoned the hospital chaplain who told him that hospital staff had contacted his family.

68. Mr Hullock's mother, father and other family members went to the hospital. A prison officer also attended and spent several hours at the hospital with the family.

69. On 26 June, Doncaster appointed a family liaison officer. She did not visit Mr Hullock's family when he was in hospital or on the day he died. She visited Mr Hullock's mother with the prison chaplain on 1 July to explain the procedures for families dealing with a death in custody.

70. In line with Prison Service guidance, the prison contributed to the cost of Mr Hullock's funeral, which was held on 14 August 2015.

Support for prisoners and staff

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

72. The prison posted notices informing other prisoners of Mr Hullock's death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Hullock's death.

Post-mortem report

73. The post-mortem examination established that Mr Hullock died of bacterial meningitis, bacterial endocarditis (an infection in the heart) and pneumonia. The report noted that congenital bicuspid aortic valve (an inherited form of heart disease) and mitral valve stenosis (narrowing of the heart valve) were significant contributing factors.

Findings

Clinical care

Continuity of care

74. The clinical reviewer said that if Mr Hullock had been in the community and had complained of headaches, nausea and dizziness, it was likely that he would have consulted his GP, who was aware of his significant heart disease. His GP would have checked his temperature, noted that he was clinically dehydrated and arranged an urgent referral to hospital. As this did not happen at Doncaster, he concluded – and we agree - that Mr Hullock's care was not equivalent to the care that he could have expected to receive in the community.

75. Prison Service Order (PSO) 3050, *Continuity of Healthcare for Prisoners,* provides guidance on healthcare. It says that within a week of the first reception assessment, staff should offer all prisoners a general health assessment. It also says that if immediate health needs are detected at the reception assessment, staff should refer a prisoner to an appropriate healthcare worker. There is no record that Mr Hullock had a second physical assessment with a prison GP, as we would have expected, and no plans were put in place to help him if his health deteriorated.

76. At his reception screen, a nurse said that she was unaware of Mr Hullock's heart condition. There was information about his heart problems but the reception staff failed to refer to it when completing their assessments.

77. Two days after Mr Hullock arrived at Doncaster, the healthcare team received details of his health history and medication from his community GP. It indicated that his concerta medication was last prescribed the previous year and that he had an ongoing heart condition at 19 years old. We are concerned that this very clear evidence of concern did not trigger staff activity, specifically that no one took action to review Mr Hullock's medication or escalate the need for him to see a GP. We make the following recommendation:

The Director and Head of Healthcare should ensure that in line with PSO 3050:

- **prisoners are offered a secondary health screening; and**
- **community GP records and other relevant records are passed to prison GPs for a clinical assessment to ensure continuity of healthcare.**

Delay in assessing concerns about wellbeing

78. When a nurse received the summary of Mr Hullock's medical history and needs from his community GP, she noted his history of ADHD and booked a mental health assessment. The clinical reviewer said that this referral to the mental health team caused confusion when Mr Hullock became unwell as nurses who saw him had concerns that he had mental health issues that had not been fully explored. In contrast, the mental health team felt that his health needs were likely to be in relation to his physical rather than mental health.

79. On 17 June, a senior nurse visited Mr Hullock in his cell. She did not check his observations or make any enquiries about why he had not left his cell for four days. She did not check his medical record, which noted that three days earlier, nurses had already examined Mr Hullock.

80. The next evening, a nurse found that Mr Hullock's blood pressure was low. She did not make comparisons to recognise or consider possible reasons for the low blood pressure. The clinical reviewer said that low blood pressure can be a symptom of aortic regurgitation (heart blood flow problems). He said that other causes might be dehydration or developing severe infection.

81. The clinical reviewer said that from 22 June, nurses should have arranged for a prison GP to examine Mr Hullock due to his declining physical state. The clinical reviewer said that it was very concerning that the two nurses who went to the shower area when Mr Hullock collapsed on 23 June did not make an entry in his healthcare record at the time. Even after Mr Hullock collapsed in the shower area, he did not see a GP.

82. The medical record shows that the two nurses made entries four days later on 27 June – that is, after Mr Hullock had been admitted to hospital on 24 June and diagnosed with suspected encephalitis. This was at odds with the Nursing and Midwifery Council's guidance for record keeping which says that entries in medical records should be made as close to the actual time as possible. The late entries were also at variance with the notes of the healthcare assistant, who had made her entries at the time that she went to help Mr Hullock.

83. The clinical reviewer also considered that other healthcare staff did not complete Mr Hullock's medical record fully enough or in line with national standards.

84. On 24 June, a nurse was the first nurse to see Mr Hullock on his cell floor. She made the entry in his medical record at 10.58am. Another nurse updated the record after seeing Mr Hullock at 2.47pm. It is clear that it took approximately four hours for Mr Hullock to be seen by a doctor as the prison GP, saw Mr Hullock as an emergency at 3.09pm. The GP suspected Mr Hullock was seriously ill and referred him urgently to hospital. The clinical reviewer said that on the morning of 24 June when Mr Hullock was uncommunicative in his cell, from his presentation at that time staff should have arranged for him to be urgently transferred to hospital.

85. NHS guidelines on meningitis say that cases have been rising since 2009. They identify that older teenagers are at higher risk of infection because many of them mix closely with lots of new people, some of whom may unknowingly carry the meningococcal bacteria at the back of their noses and throats. With his symptoms, Mr Hullock should have been taken to hospital far more promptly.

86. The clinical reviewer noted that the prison GP did not see Mr Hullock until ten days after he first complained about headaches at Doncaster, despite nurses seeing him on nine occasions during this period. Mr Hullock's erratic actions and changes in mood and were not recognised as potential signs of being unwell, but instead were treated as poor behaviour. Staff should have sent him to hospital far sooner. While we cannot say whether this would have made a difference to the outcome for Mr Hullock, he would have received earlier treatment. Mr

Hullock's care was neglectful and inadequate. We make the following recommendation:

The Head of Healthcare should ensure that nurses attend quickly to assess prisoners when wing staff have serious concerns about their wellbeing and that prisoners with symptoms of serious conditions are taken to hospital immediately.

87. The actions of healthcare staff raise very serious concerns and have been the subject of a police investigation. Four nurses were facing criminal charges but the CPS decided not to pursue charges. We did not interview Nurse B, Nurse C or the healthcare assistant at the request of the police as they were subject to a police investigation. We understand that Nurse C left HMP Doncaster shortly after Mr Hullock's death and that Nurse B was dismissed. As the CPS decided not to pursue charges against the nurses and there were no charges pending for healthcare assistant, she continued working. The Nursing and Midwifery Council are currently investigating the actions of four nurses in relation to Mr Hullock's care. We are concerned to ensure that, given the range of investigations and their outcomes, opportunities for learning are not missed. We make the following recommendation:

The Director, working with NHS Nottinghamshire Trust, should:

- **review the adequacy of current healthcare processes at HMP Doncaster to ensure that the shortcomings identified in this investigation have been addressed; and**
- **consider whether the actions of all healthcare staff were appropriate in relation to Mr Hullock's care.**

Staff behaviour

88. We are concerned about the custodial management of Mr Hullock's care. Shortly after his arrival at Doncaster, he was the victim of violence. Although this was not a factor that contributed to his death, it was very serious and we found shortcomings in how staff handled the situation. We did not find any evidence that staff supported him. While this did not affect the outcome for him, in other circumstances, it might make a difference.

89. Prison Service Instruction (PSI) 21/2013 on reporting wrongdoing says that staff should be encouraged to raise concerns about possible wrongdoing or malpractice at work in an appropriate way. The prison officer (who did not work on Mr Hullock's wing) raised concerns to senior prison managers about staff not responding to Mr Hullock's declining condition. The Chair of the IMB, also raised concerns. It is extremely troubling that there is no evidence that senior managers addressed these concerns in any meaningful way and that no action was taken.

90. The prison officer raised serious concerns about the prison's ability to keep Mr Hullock safe and about his deteriorating health in a number of security reports. One security report noted that she had briefed at least 10 members of prison and

healthcare staff, yet no one recognised the seriousness of his condition. None of the prison staff made any entries about their observations of Mr Hullock in his prison record. The prison officer also made serious allegations about inappropriate staff comments on social media, which indicated that Mr Hullock was being neglected. There is evidence that senior managers were aware but there is no record that the allegations were investigated, as they should have been. The prison officer was a lone voice among prison staff, trying to get help for Mr Hullock. She has since resigned and she made it clear that she did not feel properly supported by the prison. There is no record of any investigation into these allegations. We therefore recommend that:

The Director should:

- **commission a review of the way in which concerns raised about Mr Hullock's welfare and reports of inappropriate comments on social media were managed, addressing the adequacy of systems and the actions of staff; and**

- **consider whether disciplinary action should be initiated as a result.**

Liaison with Mr Hullock's family

91. Prison Rule 22 about the notification of illness or death says that, "If a prisoner …becomes 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." PSI 64/2011 also says that when prisoners have a terminal illness or their health deteriorates unpredictably or rapidly, the prison must have procedures in place for supporting the prisoner and engaging with their next of kin or nominated person.

92. No one at the prison contacted Mr Hullock's family when he was sent to hospital on 24 June. Hospital staff contacted Mr Hullock's family the next day to inform them of his condition. It is clear from the records that Mr Hullock was seriously ill when he was admitted to hospital, and prison staff should have informed his family and appointed a member of staff to engage with them.

93. The prison officer took on the role of engaging with the family. However, managers at the prison took issue with her remaining with the family at the hospital as Mr Hullock deteriorated. She said that she had the Director's permission. There is a record of the former Director, telling her that she could attend the hospital when off duty but that she should not compromise her professional position. On 26 June, the prison appointed a family liaison officer who told her that she should not have any contact with the family in an official capacity. As prison staff did not immediately visit Mr Hullock's family, we make the following recommendation:

The Director should ensure that:

- **a prisoner's next of kin is informed at the earliest opportunity after admission to hospital with a serious illness; and**

- **an appropriate member of staff is appointed to engage with families when a prisoner is diagnosed with a serious illness and that after their death, a family liaison officer is appointed without delay and carries out the role in line with Prison Service guidance.**

Restraints

94. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital, and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. 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 which also takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when he presents with a serious medical condition. The judgement required medical opinion about the prisoner's ability to escape to be considered as part of the assessment process. It also concluded that restraining a prisoner receiving chemotherapy (and by implication, other life-saving treatment) by handcuffs was degrading and would likely be regarded as inhumane, unless justified by other relevant considerations.

95. Prison Service guidance says that restraints are not normally necessary to escort a prisoner when his mobility is severely limited. At the time of his emergency hospital admission, Mr Hullock had been lying in his cell, unable to move for several days. There is no evidence that Mr Hullock presented a risk of escape or to the public that two escorting officers could not have managed and yet he was restrained with an escort chain. It was only when he was placed in a medically induced coma and a hospital doctor asked for the restraints to be removed, that the escorting staff obtained permission from the duty governor to remove and not reapply them.

96. We are not satisfied that a nurse (who completed the medical section of the risk assessment) or the prison manager (who authorised the use of restraints) properly understood the legal position on restraints.

97. We have raised the issue of the use of restraints following previous deaths at Doncaster and despite prison assurances that this has been addressed, we repeat the following recommendation:

The Director and Head of Healthcare should ensure that staff who undertake 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.

Service delivery

98. From his arrival at Doncaster, Mr Hullock was the victim of unacceptable standards of care. This includes the poor handling of the alleged assault, the reasons for Mr Hullock's transfer to a new wing, the lack of support given to him as a new prisoner, his poor clinical care and the neglect of his welfare on the

wing. Given the very serious concerns raised as a result of this investigation, we make the following recommendation:

The Deputy Director for Operational Contracts should satisfy himself that effective action is taken to address the findings of this investigation.

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