

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr William Allen a prisoner at HMP Hull on 26 August 2018

A report by the Prisons and Probation Ombudsman

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.

Mr William Allen died on 26 August 2018 of a blood clot in the heart while a prisoner at HMP Hull. He was 84 years old. I offer my condolences to Mr Allen's family and friends.

I am satisfied that the care Mr Allen received at Hull was equivalent to that which he could have expected to receive in the community. Healthcare staff monitored his condition and reviewed him frequently. Staff treated Mr Allen with respect and provided appropriate palliative care, which allowed him to die with dignity and in line with his wishes.

I am concerned that when Mr Allen was taken to hospital in April, he was restrained with an escort chain. I consider the use of restraints was not justified given Mr Allen's advanced age, poor health and limited mobility. We have raised the unjustified use of restraints with Hull before, as recently as October. The prison has committed to improving its risk assessment process to ensure that the level of restraint used is proportionate to the risk posed by the prisoner.

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

Sue McAllister CB
Prisons and Probation Ombudsman

February 2019

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Summary

Events

1. In August 2017, Mr William Allen was remanded in custody for sexual offences and sent to HMP Hull. He was an elderly man and had several long-term health conditions, including aortic stenosis (narrowing of the aortic valve which obstructs the blood flow out of the heart).
2. On 4 March 2018, Mr Allen was taken to hospital by emergency ambulance for a suspected stroke. Hospital staff diagnosed a vasovagal episode (a sudden drop in blood pressure) and severe aortic stenosis. Staff suggested outpatient tests and Mr Allen was returned to prison the next day. He had a heart monitor fitted at hospital on 4 April. He was accompanied by two officers and restrained using an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer).
3. On 24 May, Mr Allen was taken to hospital by emergency ambulance after being found unresponsive. After initially suspecting a heart attack, hospital staff diagnosed severe aortic stenosis, heart failure and fluid in the lungs. Mr Allen declined surgery. On 11 June, Mr Allen was returned to the prison's wellbeing unit for palliative care.
4. On 26 August, at around 11.55am, an officer noticed that Mr Allen appeared to have stopped breathing and called a medical emergency code. A nurse attended and noted that Mr Allen had stopped breathing, did not have a pulse and was cold to touch. She did not attempt cardiopulmonary resuscitation (CPR) as Mr Allen had a Do Not Attempt CPR (DNACPR) order in place. At 12.50pm, paramedics arrived and pronounced that Mr Allen had died.
5. The coroner gave Mr Allen's cause of death as coronary artery thrombosis (a blood clot in the heart) caused by stenosing coronary artery atheroma (a build-up of fatty deposits on the walls of arteries causing them to narrow).

Findings

6. The clinical reviewer found that Mr Allen received a good standard of clinical care at Hull. Healthcare staff reviewed him frequently, followed specialist advice and treated his conditions appropriately. Palliative care was good. We are satisfied that the care Mr Allen received at Hull was equivalent to that which he could have expected to receive in the community.
7. We consider the use of restraints on Mr Allen when he was taken to hospital on 4 April 2018 was unjustified given his advanced age, poor health and limited mobility. We have raised concerns with Hull before about the unjustified use of restraints, most recently in October. The prison has committed to improving its escort risk assessment process to ensure that the use of restraints is proportionate to the risk posed by the prisoner.
8. We make no recommendations.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Hull informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
10. The investigator obtained copies of relevant extracts from Mr Allen's prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr Allen's clinical care at the prison.
12. We informed HM Coroner for East Riding and Kingston-Upon-Hull of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
13. There was no family involvement in the investigation. Mr Allen did not have a nominated next of kin.
14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Hull

15. HMP Hull is a local prison which holds up to 1056 men in ten wings. City Healthcare Partnership provides health services at the prison. The prison has a wellbeing unit to support and progress prisoners with complex needs, which are difficult to meet in the normal prison environment. The unit includes a specialist palliative care cell. GP surgeries are held four days a week, with an out of hour's service at other times.
16. In August 2018, Hull was selected to be part of the "10 Prisons Project", which seeks to improve safety, security and decency in the prisons involved. The project is focusing on improving living conditions, preventing drugs from entering the establishment and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Hull was in April 2018. Inspectors found that health provision was reasonable and governance was mostly effective, but some health services had deteriorated since the last inspection. Staff in the wellbeing unit provided compassionate support to prisoners and, although joint working with health services was good, the diverse mix of prisoners meant it was not sufficiently therapeutic. Care for patients with palliative or end of life needs was excellent.

Independent Monitoring Board

18. 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 2015, the IMB noted that the prison was effectively run, provided a safe environment for all and had benefited from the strong leadership of the Governor and Management Team.
19. The IMB noted that there was a full health screen at reception, which identified immediate risks, and outpatient clinics to manage long-term medical conditions. However, the Board had received many complaints, mostly about medication and prescribing issues. The Board reported that inpatient care was provided in the wellbeing unit and that a terminal care suite had been adapted to manage the rising population of older prisoners.

Previous deaths at HMP Hull

20. Mr Allen's death was the 16th at Hull since August 2015, 11 of which have been from natural causes. There has been one death since, which was self-inflicted. We have made recommendations about ensuring staff properly justify the use of restraints on prisoners taken to hospital in several previous investigations, most recently in October 2018 when we made a recommendation to the Prison Group Director for Yorkshire. We raise the inappropriate use of restraints yet again in this case.

Key Events

21. On 14 August 2017, Mr William Allen was remanded in custody for sexual offences and sent to HMP Hull. He was aged 84 and suffered from several long-term conditions including aortic stenosis (a narrowing of the aortic valve which obstructs the blood flow out of the heart), dry macular degeneration (a condition that results in blurred or no vision in the centre of the visual field) and hearing and memory loss. Mr Allen smoked cigarettes and received support to stop.
22. On 20 September, a nurse saw Mr Allen for a risk of falls assessment as he had fallen over on three occasions since arriving at prison. She recorded that there was no obvious reason for his falls and requested a GP appointment as Mr Allen had a chesty cough and a high blood pressure reading of 168/92 mmHg (normal being below 140/90mmHg).
23. On 28 September, a prison GP saw Mr Allen for a review and noted that he had crackly chest sounds and a heart murmur. Suspecting heart failure, he prescribed furosemide (a medication that helps to reduce the build-up of fluid in the body) and requested a series of blood tests and a cardiology referral. On 10 October, he reviewed Mr Allen's blood test results which showed that he had heart failure and a vitamin D deficiency.
24. On 25 October, a nurse recorded that an occupational therapist and a social worker had seen Mr Allen for a review and had reported concerns about his impaired memory. She referred Mr Allen to the prison's mental health team for a memory assessment and noted that arrangements would be made for him to have access to a wheelchair to assist with mobility.
25. On 20 November, Mr Allen attended a cardiology appointment at hospital. Two officers escorted him without using restraints. When Mr Allen returned to prison, a nurse recorded that he had an electrocardiogram (ECG – to monitor the electrical rhythms of the heart) and that hospital staff had requested an echocardiogram (a type of ultrasound scan used to look at the heart). Healthcare staff monitored Mr Allen frequently over the next three months and made several attempts to conduct a memory assessment, but despite new hearing aids, his poor hearing meant staff could not assess him.
26. On 4 March 2018, a nurse saw Mr Allen for an emergency examination after an officer reported that he had left sided drooping and weakness. She recorded that Mr Allen had laboured breathing and was talking incoherently. He had high blood pressure (144/100mmHg) and a low oxygen saturation level of 89% (normal being 95-100%). He gave him oxygen and suspecting a stroke, sent Mr Allen by ambulance to hospital. Two officers escorted him without using restraints.
27. Hospital staff admitted Mr Allen and diagnosed a vasovagal episode (a sudden drop in blood pressure) and severe aortic stenosis. A computerised tomography (CT) scan of Mr Allen's brain revealed age-related deterioration, but no acute injury. Hospital staff suggested several outpatient tests, including a 24-hour tracing of the heart, and Mr Allen was returned to prison the next day. On 30 March, a nurse completed a dementia care plan.

28. On 4 April, Mr Allen attended hospital to have a 24-hour heart monitor fitted and was returned to prison. Two officers escorted him and restrained him using an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). The monitoring equipment was collected the following day and sent for analysis.
29. On 24 May, an officer told a healthcare assistant that Mr Allen looked unwell and asked if she could see him. The healthcare assistant entered his cell, noticed Mr Allen lying unresponsive on his bed with shallow breathing and called a medical emergency code blue (which indicates that a prisoner is unconscious or not breathing). A nurse arrived shortly afterwards and noted that Mr Allen had high blood pressure (155/85 mmHg) and a low oxygen saturation level (89%). She gave him oxygen and sent him by emergency ambulance to hospital. Two officers escorted Mr Allen without using restraints.
30. Hospital staff initially diagnosed a faint, but Mr Allen's condition deteriorated and he was admitted for a suspected heart attack. An echocardiogram confirmed severe aortic stenosis, heart failure and fluid in the lungs, but Mr Allen declined surgery. Considering Mr Allen's deteriorating physical and mental health, a hospital consultant decided that it would not be in his best interests to resuscitate him should he fall critically ill. Records show the consultant was not satisfied that Mr Allen had the mental capacity to make an informed decision and implemented a Do Not Attempt Cardiopulmonary Resuscitation order (DNACPR - which means no attempt at resuscitation will be made should the heart or breathing stop) under the provisions of the Mental Capacity Act 2005.
31. On 11 June, Mr Allen was returned to the prison's wellbeing unit for palliative care (a medical approach that specialises in care for life-limiting illnesses). The next day, a prison manager allowed Mr Allen's cell to be left unlocked so nurses had easy access. Healthcare staff monitored and reviewed Mr Allen frequently and he moved to the wellbeing unit palliative care suite on 14 July. Staff completed appropriate care plans, liaised with speech and language therapists regarding a suitable diet, attended regular multidisciplinary meetings and assisted with Mr Allen's personal hygiene needs.
32. On 19 August, a prison paramedic, went to give Mr Allen his morning medication and noticed that his condition had deteriorated. She noted that he looked grey, had shallow breathing and presented more confused than normal. Healthcare staff continued to monitor and review Mr Allen frequently over the next seven days and liaised with specialist palliative care nurses regarding his end of life care
33. On 26 August, at 8am, a nurse saw Mr Allen for a review and recorded that he was awake and able to nod his head in response to her questions. At around 11.55am, an officer noticed that Mr Allen appeared to have stopped breathing and called a medical emergency code blue. Officers alerted the nurse, who was present on the unit, and she attended immediately. She noted that Mr Allen had stopped breathing, did not have a pulse and was cold to touch. She did not start CPR because a DNACPR order was in place. Paramedics arrived and confirmed that Mr Allen had died, at 12.50pm.

Contact with Allen's family

34. There was no family involvement in the investigation. Mr Allen did not have a nominated next of kin.
35. The prison arranged and paid for Mr Allen's funeral, which took place on 11 September, in line with national policy.

Support for prisoners and staff

36. After Mr Allen's death, a prison manager, debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
37. The prison posted notices informing other prisoners of Mr Allen'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 Mr Allen's death.

Post-mortem report

38. The coroner gave Mr Allen's cause of death as coronary artery thrombosis (a blood clot in the heart) caused by stenosing coronary artery atheroma (a build-up of fatty deposits on the walls of arteries causing them to narrow).

Findings

Clinical care

39. Mr Allen was an elderly man who had several long-term health conditions including, severe aortic stenosis, dry macular degeneration and hearing and memory loss. The clinical reviewer considered that Mr Allen received a good standard of care at Hull. Healthcare staff attended regular multidisciplinary meetings to discuss his future management and his frailties were addressed accordingly. Staff liaised with palliative care specialists regarding his end of life care and made the correct decision not to start CPR. We are satisfied that the care Mr Allen received in prison was equivalent to that which he could have expected to receive in the community.

Restraints, security and escorts

40. 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.
41. When Mr Allen was taken to hospital between 20 November 2017 and 4 March 2018, the risk assessments said he presented a low risk of escape and harm to others. They recommended two officers escort him without restraints, due to his age and reduced mobility. On 4 April, a prison manager authorised two officers to restrain Mr Allen with an escort chain. There were no medical objections to the use of restraints and his level of risk remained the same. We can see no justification for the use of any form of restraint on a very elderly prisoner who required a wheelchair and posed little risk, and we consider this action was both unnecessary and undignified.
42. When Mr Allen was taken to hospital on 24 May, a prison manager, reviewed his risk assessment and authorised two officers to escort him without using any restraints due to the seriousness of his condition and lack of mobility.
43. We can see no justification for the use of an escort chain in April. The risk assessment used was based on the prison's view of his offence with little consideration of how his age, health and mobility affected his risk of escape, as the 2007 High Court judgment requires. Whenever restraints are used, the risk assessments must accurately reflect the risk posed at that time to ensure proportionality and to maintain human dignity.

44. We have previously expressed concerns about the inappropriate use of restraints on very sick and elderly prisoners at HMP Hull, and the prison has committed on each occasion to address these failings. In October 2018, we drew our concerns to the attention of the Prison Group Director for Yorkshire. In response, the prison said they would review the escort risk assessment and remind all relevant staff of the legal position on the use of restraints. They also said that they would monitor the use of restraints on a monthly basis and provide the PGD with the new risk assessment to test compliance. On that basis, we have not made a recommendation in this case.

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