Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Norman Hill

a prisoner at HMP Channings Wood on 9 January 2018

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

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

Mr Norman Hill died on 9 January 2018 of pneumonia while a prisoner at HMP Channings Wood. He was 90 years old. I offer my condolences to Mr Hill's family and friends.

We are satisfied that the care Mr Hill received at Channings Wood was equivalent to that which he could have expected to receive in the community. He was well cared for, and his wishes were respected throughout.

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 **August 2018**

Contents

Summary

Events

1. Mr Norman Hill was serving a life sentence for murder. He had been at HMP Channings Wood since 1991.

2. Mr Hill had a number of health concerns during his time in prison. In early 2016, his condition deteriorated and he spent some time in hospital. On his return to Channings Wood, he was moved to a cell with better access to healthcare. Nursing staff monitored and treated him as required.

3. Mr Hill remained relatively stable for the next 18 months but, in November 2017, his condition deteriorated further. On 22 November, a prison GP sent him to hospital with suspected sepsis. Mr Hill did not have sepsis but was treated for pneumonia. On 27 November he was discharged back to the prison. Shortly after his return, a nurse reviewed him and sent him back to the hospital as an acute admission.

4. Three days later Mr Hill was returned to Channings Wood. He declined the option to move to another prison and was relocated to a ground floor cell which had a medical bed. The prison applied for release on compassionate grounds for Mr Hill. It also investigated nursing home options for him.

5. During December, Mr Hill steadily lost weight but his condition was otherwise stable. Early in January his condition deteriorated daily. On 7 January, Mr Hill confirmed that he still wanted to be resuscitated if his heart or breathing stopped.

6. On 9 January at 1.10pm, a social care worker spoke to Mr Hill while he was in bed. At 1.43pm, a nurse responded to an emergency call and found Mr Hill unresponsive in his cell. He noted that Mr Hill had the early signs of rigor mortis, had no pulse and no respiratory effort. Due to this, he did not attempt resuscitation. At 1.56pm, a prison GP pronounced Mr Hill dead.

Findings

Mr Hill's clinical care

7. The clinical reviewer concluded that the care Mr Hill received was equivalent to that which he could have expected to receive in the community. His health concerns were effectively managed, and he was referred to external specialists as required.

Mr Hill's location

8. We are satisfied that Mr Hill was appropriately located during his time at Channings Wood. While we accept that he would have had access to better healthcare facilities elsewhere, the prison respected his wishes to remain there.

Restraints, security and escorts

9. Mr Hill was not restrained when escorted during his last year at the prison, and we consider this appropriate.

Liaison with Mr Hill's family

10. We are satisfied that the prison acted appropriately in its contact with Mr Hill's family. Mr Hill had no next of kin recorded on his record, but the prison located and informed his son in person of his death. It then respected his son's wishes regarding future involvement.

Compassionate release

11. We consider that the prison acted appropriately by applying for release on compassionate grounds when it did. Unfortunately, Mr Hill died before this application could be fully considered.

Recommendations

- We make no recommendations.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Channings Wood informing them of the investigation and asking anyone with relevant information to contact him. No one responded

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

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

15. We informed HM Coroner for Plymouth and South Devon of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.

16. The investigator wrote to Mr Hill's son to explain the investigation and to ask whether he had any matters he wanted the investigation to consider. He did not respond to our letter.

17. The investigation has assessed the main issues involved in Mr Hill's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

18. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HM Prison Channings Wood

19. HMP Channings Wood is a medium security prison near Newton Abbot in Devon. It holds over 700 men. Care UK provides health services at the prison. There is one permanent GP, with locum GPs running additional clinics. Nurses are on duty every day and there is an out of hours GP service.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Channings Wood was conducted in October 2016. Inspectors reported that, overall, the prison had deteriorated since their last inspection. The healthcare unit was clean and tidy and inspectors observed that staff were caring and professional. There were gaps in record-keeping and a lack of care-planning for prisoners with complex health needs. There were no nurse-led clinics for prisoners with long-term conditions and no effective recall system to maintain ongoing care. Such prisoners were managed through the GP. This affected GP waiting times, which at six weeks were too long.

Independent Monitoring Board

21. 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 August 2017 the IMB reported that, despite staff shortages and poor morale, prisoners were overall treated fairly and humanely. The Board recognised that since the change in healthcare provider in March, there was a gradual but marked improvement in healthcare provision.

Previous deaths at HMP Channings Wood

22. Mr Hill was the sixth prisoner to die of natural causes since January 2015. There were no significant similarities with the circumstances of the earlier deaths.

Findings

The background to Mr Hill's health concerns

23. On 2 February 1973, Mr Norman Hill was sentenced to life imprisonment for murder. He had been at HMP Channings Wood since 1991.

24. Mr Hill had a history of Bowen's keratosis (a form of skin cancer). He also suffered with related blood and fluid loss from lesions on his buttocks which were monitored and dressed as required. He had no other relevant health concerns until October 2013, when he was diagnosed with hypertension, and suspected as suffering with atrial fibrillation (AF), a common abnormal heart rhythm. In February 2014, he was diagnosed with poor peripheral circulation, and an electrocardiograph (ECG) confirmed that he had AF. Mr Hill declined medication intended to reduce his risk of stroke.

25. In June 2015, an x-ray suggested that Mr Hill might have chronic obstructive pulmonary disease (COPD - a range of lung conditions which causes breathing difficulties). In September, there was a note on his medical record that he might have asbestosis but there was no evidence of a confirmed diagnosis for this and no further investigations. Also in September, Mr Hill was diagnosed with left ventricular heart failure and suspected of having ischaemic heart disease. In November, a consultant cardiologist reviewed Mr Hill and diagnosed him with heart disease. At the same time, his diagnosis of COPD was confirmed.

Mr Hill's clinical care

26. On 18 February 2016, a prison GP reviewed Mr Hill after healthcare staff became concerned about his low temperature. She noted that he was pale, subdued, and looked unwell, so she sent him to hospital where he was diagnosed with left ventricular heart failure. On 9 March, he was discharged back to Channings Wood, with a Treatment Escalation Plan (TEP) and a Do Not Attempt Cardiopulmonary Resuscitation order, or DNACPR. A DNACPR means that in the event of cardiac or respiratory arrest no attempt at resuscitation will be made. All other appropriate treatment and care will continue to be provided.

27. On 11 March, Mr Hill informed officers that he did now wish to be resuscitated and his DNACPR was amended, pending a review by a GP. On his return to Channings Wood, Mr Hill was relocated onto a different wing where he could be more easily cared for by healthcare staff.

28. Mr Hill remained poorly and frail, and healthcare staff continued to monitor him on the wing. They treated and dressed his lesions as required, and gave him supplement drinks to enhance his diet. For the next 18 months, his condition remained relatively stable and he had no relevant health concerns.

29. On 1 November 2017, a prison GP reviewed Mr Hill due to concerns about his leg lesions. She noted that he was alert but pale and frail looking, with obvious weight loss. She diagnosed cellulitis (a common bacterial skin infection) and prescribed antibiotics to treat it. She also instructed staff to monitor his weight weekly. On 6 November, a prison GP reviewed Mr Hill after a high NEWS score was recorded. (National Early Warning Score (NEWS) is a clinical tool used to

alert healthcare staff to potential medical risks.) He noted that Mr Hill appeared clinically very well, but felt he might be sensitive to the antibiotics.

30. On 10 November, a prison GP reviewed Mr Hill in his cell. She noted that he had taken most of his antibiotics, but had stopped them because they were making him feel dizzy. She again discussed the DNACPR order with Mr Hill, and informed him that "he would almost certainly be disabled" if he was successfully resuscitated. Mr Hill confirmed that he still wanted to be resuscitated, and she noted that he had the mental capacity to make this decision.

31. On 22 November, a prison GP reviewed Mr Hill after healthcare staff became concerned at the deterioration in his leg lesions. She noted that his legs were not healing and suspected sepsis, so sent him straight to hospital. Mr Hill was diagnosed with pneumonia and kept in hospital as an inpatient. A hospital nurse informed a nurse at the prison that Mr Hill had experienced faecal incontinence, and had been hiding this from healthcare staff.

32. On 27 November, Mr Hill was discharged back to Channings Wood. Shortly after his return, a nurse reviewed him and noted that his NEWS score called for an immediate admission to an acute setting. He was sent straight back to hospital. Two days later, a nurse noted that the hospital wanted to discharge Mr Hill. Later that day, she recorded that he was to be discharged that day but that someone from the hospital would visit the prison to administer intravenous medication. On Mr Hill's return to Channings Wood, a prison GP reviewed him. He told her that he did not expect to live long, but still wanted to be resuscitated to allow him the opportunity to get out of prison.

33. For the next few weeks, healthcare staff continued to monitor Mr Hill's health, skin integrity and weight. On 1 December, a nurse manager saw Mr Hill and noted that he was moving around his cell, talking in full sentences, and did not appear breathless. He recorded Mr Hill's weight as 63kg. On 9 December a nurse recorded Mr Hill's weight as 58kg, but on 14 December a prison GP recorded it as 63kg. On 22 December, a healthcare assistant noted that Mr Hill refused to be weighed but, on 27 December, a nurse recorded his weight as 53kg.

34. In early January 2018, Mr Hill's condition continued to deteriorate. On 4 January, a social care worker noted that he was very quiet, had difficulty speaking, and had a dry throat and mouth. The next day, a nurse noted that he was deteriorating daily and was finding it increasingly difficult to swallow. On 7 January, paramedics attended, but declined to admit Mr Hill to hospital. The next day, a prison GP reviewed Mr Hill and noted that he had deteriorated rapidly over the last few days. The GP discussed DNACPR with Mr Hill, but he maintained that he wanted to be resuscitated.

35. On 9 January at 1.10pm, the social care worker noted that she saw Mr Hill in his cell. He was still on his bed and told her that he was very tired. At 1.43pm, an officer found Mr Hill collapsed in his cell, and called a code blue. (A code blue call is an emergency radio code which indicates someone is unconscious or having problems breathing and immediately alerts healthcare staff and the control room to call for an ambulance.) A nurse arrived at Mr Hill's cell in response and observed that Mr Hill was unresponsive and exhibited the early

signs of rigor mortis. The nurse noted that he had no respiratory effort, no pulse, his pupils were fixed and dilated, and his hands were cold to the touch. He recorded that CPR was not attempted due to how Mr Hill presented.

36. A prison GP was asked to attend and, at 1.56pm, she pronounced Mr Hill dead. An ambulance had also been called when Mr Hill was first discovered but arrived after she had pronounced Mr Hill dead and was therefore no longer required.

37. The post-mortem confirmed that Mr Hill died from pneumonia, with heart disease as a secondary cause of death.

38. We agree with the clinical reviewer that the care Mr Hill received at Channings Wood was equivalent to that which he could have expected to receive in the community. His complex health and care needs were appropriately managed and he was referred to external specialists as required.

39. We are satisfied that the decision not to start CPR when Mr Hill was discovered on 9 January was correct based on his presentation. The prison respected Mr Hill's wishes regarding CPR throughout his time at Channings Wood, with prison GPs periodically discussing this with him and giving him all the information necessary to make an informed decision.

Mr Hill's location

40. Mr Hill had been resident at Channings Wood for 25 years when his condition deteriorated in early 2016. In March, following his discharge from hospital, he was relocated to a cell with better access to healthcare facilities. He was given a personal emergency evacuation plan (PEEP) due to his poor mobility and frailty. Initially he was not happy about being moved, but settled after a few weeks.

41. On 1 November 2017, a prison GP discussed the idea of a nursing home with Mr Hill and he appeared amenable to this idea. On 30 November, she spoke to Mr Hill about a potential move to HMP Exeter, but he refused this. The following day, a nurse recorded that Mr Hill needed to go to Exeter because of the prison's superior social care facilities. He noted that he would liaise with healthcare staff there.

42. The same day, Mr Hill was relocated to a ground floor cell which was fitted with a medical bed. An officer recorded that Mr Hill was not happy at being moved but that the new bed would help him. On 5 December, Mr Hill met social workers who were investigating a residential placement for him in a nursing home. Unfortunately, he died before any move could be arranged.

43. We are satisfied that the prison managed Mr Hill's location appropriately. While we acknowledge that he was not happy relocating within Channings Wood on either occasion, these decisions were made with his best interests in mind. The prison respected his decision to decline a transfer to Exeter, and did not force this on him despite Exeter having better healthcare facilities.

Restraints, security and escorts

44. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints.

The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility.

45. Mr Hill was not restrained during his final few months at Channings Wood. We consider the prison's decision not to restrain Mr Hill was appropriate.

Liaison with Mr Hill's family

46. Mr Hill had no next of kin recorded on his prison record. On 7 December 2017, a chaplain located a telephone number for his son and left a message for him to contact the prison. There is no record of Mr Hill's son returning this call.

47. On 9 January 2018, the prison appointed a family liaison officer. She noted that she would take over family liaison duties once the governor had contacted Mr Hill's son, and that the prison did not know what the situation would be, since they were not in contact with each other.

48. On 10 January, an address was found for Mr Hill's son. At 7.10pm, a governor and an officer visited Mr Hill's son at his home and informed him of his father's death. The governor informed Mr Hill's son about the funeral arrangements. The chaplain continued to liaise with Mr Hill's son and kept him updated with details of his father's funeral arrangements.

49. Mr Hill's funeral was held on 6 February 2018. The prison contributed to the cost of this in line with national guidance. Mr Hill's son did not attend the funeral.

50. We are satisfied that the prison acted appropriately in its dealings with Mr Hill's son. He was not listed as Mr Hill's next of kin, and was not in contact with his father. However, the prison informed him in person and respected his wishes about the contact and involvement he wanted to have.

Compassionate release

51. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 4700 for prisoners serving indeterminate sentences. Among the criteria is that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of the Her Majesty's Prisons and Probation Service (HMPPS).

52. Mr Hill was refused parole on several occasions during his time in prison. At an earlier parole hearing in 2015, the Parole Board did not support his application for release because they felt his risk could not be safely managed under licence conditions. However, they indicated that they would be prepared to consider his release in the future, subject to a suitable release and risk management plan. Mr

Hill was due to have a renewed parole review by the end of 2017. By early November, the prison focused on compassionate release rather than parole for Mr Hill.

53. On 7 November, Mr Hill's offender supervisor informed a probation officer that a governor had requested that a compassionate release application be started for Mr Hill. The application was completed within a couple of weeks, and Mr Hill was assessed for his suitability for a nursing home placement. On 14 December, an officer recorded that Mr Hill's compassionate release documents had all been sent through to the PPCS for consideration.

54. We consider that the prison acted appropriately in making an application for compassionate release when it did. Unfortunately, Mr Hill died before this process could be completed.

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