Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr George Gore a prisoner at HMP Hull on 1 July 2019

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

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 we oversee can improve their work in the future.

Mr George Gore died in hospital of heart failure on 1 July 2019, while a prisoner at HMP Hull. He was 67 years old. I offer my condolences to Mr Gore's family and friends.

I am satisfied that the standard of care Mr Gore received at Hull was equivalent to that he could have expected to receive in the community.

However, I am concerned that staff did not discuss with Mr Gore how he wanted to be cared for at the end of his life. I have recommended that healthcare staff at Hull receive training in Advance Care Planning.

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 **December 2019**

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Summary

Events

1. On 27 May 2016, Mr George Gore was sentenced to 21 years imprisonment and taken to HMP Hull. He had type 2 diabetes, ischaemic heart disease, heart failure, chronic kidney disease and high blood pressure.

2. Initially Mr Gore remained relatively stable but, as was expected, his health deteriorated as his conditions progressed. He became incontinent and increasingly unsteady on his feet.

3. In February 2019, Mr Gore was admitted to hospital with worsening heart failure, renal failure, dehydration and anaemia. He was discharged back to Hull but returned to hospital three days later with a distended umbilical hernia. In March, Mr Gore was moved to the prison well-being unit and then, on 6 June, to the palliative care suite.

4. On 17 June, a nurse called an ambulance when Mr Gore's clinical observations gave serious cause for concern. Mr Gore was admitted to Hull Royal Infirmary.

5. Mr Gore's condition did not improve and he died in hospital on 1 July.

6. A post-mortem examination showed Mr Gore died from congestive cardiac failure caused by hypertensive heart disease and chronic kidney disease.

Findings

7. The clinical reviewer found that the care Mr Gore received at HMP Hull was equivalent to that he could have expected to receive in the community.

8. However, despite Mr Gore's deteriorating health there was little evidence of Advance Care Planning (discussions with the person about their future wishes and priorities for care).

Recommendations

- The Head of Healthcare should ensure that within 12 months all healthcare staff receive training in Advance Care Planning.

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 Gore's prison and medical records.

11. NHS England commissioned an independent clinical reviewer to review Mr Gore's clinical care at the prison.

12. We informed HM Coroner for East Riding and Kingston Upon Hull of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

13. We shared our initial report with HM Prison and Probation Service (HMPPS). They did not identify any factual inaccuracies. They provided an action plan which is annexed to this report

14. We sent a copy of our initial report to Mr Gore's daughter. She did not make any comments.

Background Information

HMP Hull

15. HMP Hull is a local prison that holds up to 1,056 men in ten wings. City Healthcare Partnership provides health services at the prison. The prison has a wellbeing unit to support 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 hours 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 reducing violence, 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 healthcare services had deteriorated since the last inspection. The team offered an appropriate range of primary care clinics within an acceptable time frame. Social care assessments were timely and the provision was reasonably good.

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 ending 28 February 2018, the IMB judged that there was equivalence of healthcare at the prison, with a medical assessment within 24 hours of arrival. Elderly prisoners had told the IMB of the speedy way in which they had been referred for a social care assessment.

Previous deaths at HMP Hull

19. Mr Gore's death was the 12th at Hull since July 2017. Of the previous deaths, eight were from natural causes, one was drug-related, and one was self-inflicted. There were no similarities between Mr Gore's death and the previous deaths.

Key Events

20. On 7 December 2015, Mr George Gore was remanded in prison custody, charged with sexual offences, and sent to HMP Hull. He was convicted on 27 May 2016, and sentenced to 21 years imprisonment.

21. Mr Gore had type 2 diabetes, ischaemic heart disease, heart failure (he had a pacemaker fitted) and chronic kidney disease (he had had a kidney transplant in 2007). He also had gout, needed a stick for walking and had regular falls.

22. Mr Gore's condition fluctuated throughout 2016. He attended planned renal and cardiology appointments and was referred to the mental health team when he began to get memory problems that caused him to forget to take his medication. He also experienced and was seen for chest pain, shortness of breath, high blood pressure and swelling in his legs. He had a chest scan and various changes to his medications.

23. In October 2016, a prison GP reviewed Mr Gore after recent tests identified a significant drop in the iron in his blood. Mr Gore was not short of breath or tired. The GP wrote to his consultant and in December, Mr Gore attended hospital for iron infusion treatment.

24. During 2017, Mr Gore continued to receive specialist renal and cardiology care. He attended hospital for iron infusion treatment and his health remained relatively stable. In September, with help from smoking cessation staff, Mr Gore attempted to give up smoking. In October, he told staff that he had not smoked for several weeks and no longer needed help.

25. On 6 June 2018, Mr Gore attended a planned appointment at the renal transplant unit. The next day a nurse from the unit contacted the prison and told them that Mr Gore needed monthly injections to treat his low blood iron. The nurse outlined the procedure and made the necessary arrangements. In July, Mr Gore attended a planned cardiology appointment and in September, another appointment at the renal transplant unit.

26. On 5 December, a prison GP examined Mr Gore who had swollen legs and complained of breathlessness, abdominal pain and sickness. The GP arranged for blood tests but the next day, after a routine hospital appointment, Mr Gore was admitted to hospital for treatment and tests. Prison healthcare staff kept in regular contact with the hospital where Mr Gore's condition gradually improved. On 22 December, he was discharged back to Hull.

27. On 5 February 2019, Mr Gore told a nurse that he felt unwell and short of breath. He had blood on his nose from an earlier nose bleed. Staff helped him back to his cell and kept him under observation. Mr Gore later said he felt better and his clinical observations were more stable.

28. A prison GP examined Mr Gore the next day and again on 8 February. She noted worsening heart failure, renal failure, dehydration and anaemia and arranged his admission to hospital. Mr Gore was discharged back to Hull on 11 February with a diagnosis of acute renal failure. The possibility of kidney dialysis was considered.

29. On 14 February, Mr Gore was again admitted to Hull Royal Infirmary, this time with a distended umbilical hernia. He was restrained with single handcuffs but these were removed on 18 February. (He was not restrained on any subsequent visits to hospital.) On 20 February, after treatment to repair the hernia he was discharged back to Hull. While in hospital Mr Gore had a catheter fitted.

30. On 8 March, a prison GP examined Mr Gore after he fell out of bed and could not remember what had happened. Mr Gore did not want to go to hospital but agreed to a move to the prison's well-being unit for observation. On 12 March, he attended a planned appointment at the pacemaker clinic.

31. On 5 April at 9.36am, a nurse examined Mr Gore who reported extreme breathlessness. She told a prison GP who saw him approximately 20 minutes later. Mr Gore said he felt tired, he looked pale and his urine was cloudy. The GP diagnosed a suspected urine infection and prescribed antibiotics. Mr Gore had his catheter removed two days later and afterwards said he felt much better. However, the removal of the catheter caused incontinence.

32. On 16 April, Mr Gore told a prison GP he felt tired and his feet and legs were swollen. The GP advised he wear below knee support stockings.

33. On 18 April, a nurse examined Mr Gore after he reported abdominal pain near his left kidney, blood in his urine and swollen legs. The nurse arranged for him to go to hospital. Mr Gore returned to Hull the next morning with planned follow up appointments for further tests.

34. Mr Gore continued to suffer with urine infections. His mobility was poor and he was unsteady on his feet. He was treated with antibiotics and healthcare staff saw him regularly. On 28 May, a nurse referred him to the primary care mental health team when his worsening kidney failure started to affect his mood.

35. On 31 May, despite still being short of breath, Mr Gore told a prison GP that he felt better in himself. However, his condition continued to deteriorate and on 6 June, after suffering a fall and for his own comfort, he was moved to the palliative care suite.

36. On 9 June, healthcare staff attended to examine Mr Gore after he fell when walking from the toilet. He was not injured and staff helped him into bed.

37. On 10 June, Mr Gore attended the renal clinic for a planned appointment and the next day his condition was discussed at a multidisciplinary team meeting. A full review of his care needs and necessary interventions was requested, including a Waterlow risk assessment (for pressure sores), and nutrition and mobility assessments.

38. On 16 June at about 6.30am, an officer raised concerns and contacted healthcare staff after finding Mr Gore sitting in his chair cold and wet, with his dressings in need of changing. A nurse attended and Mr Gore told her he was fine. Later that morning staff gave Mr Gore a bath and changed his clothes. They changed his bedding and cleaned his cell. Healthcare staff changed the dressings on his feet. An officer later noted that Mr Gore seemed more settled but highlighted his increased confusion.

39. Healthcare staff saw Mr Gore regularly. He remained very unwell. On 17 June, a nurse described him as confused and jaundiced. He considered his vital signs gave serious cause for concern and arranged for an ambulance to be called. Mr Gore was admitted to Hull Royal Infirmary for further investigation and assessment.

40. Healthcare staff kept in regular contact with the hospital regarding Mr Gore's condition. On 19 June, Mr Gore's family agreed to put a do not attempt cardiopulmonary resuscitation (DNACPR) order in place. On 20 June, one of the bedwatch officers at the hospital told prison healthcare staff that Mr Gore had been put on 24-48 hours of antibiotics and if they had no effect, then Mr Gore would be put on end of life care. Mr Gore continued to deteriorate and he died in hospital on 1 July at 10.16pm.

41. A post-mortem examination showed Mr Gore died from congestive cardiac failure caused by hypertensive heart disease, which had been caused by chronic kidney disease.

Contact with Mr Gore's family

42. On 19 June, Mr Gore's daughter, his named next of kin, telephoned the prison because her father had not been in recent contact with her. An officer told her that Mr Gore was in Hull Royal Infirmary and it was arranged that she would visit him that evening.

43. On 20 June, after prison staff were told that Mr Gore would be placed on end of life care if antibiotics had no effect, the prison appointed a family liaison officer (FLO). The Head of Residence and Safety telephoned Mr Gore's daughter and told her that the FLO would contact her the next day.

44. The FLO tried to contact Mr Gore's daughter on 21 June but was unsuccessful. She eventually managed to speak to her on 24 June. Later that day, the FLO visited Mr Gore in hospital and afterwards updated his daughter about her father's condition. The FLO stayed in regular contact with Mr Gore's daughter.

45. On 2 July at 6.30am, when the FLO arrived for work, a senior prison manager told her that Mr Gore had died late the previous night. A member of staff from the hospital had contacted Mr Gore's family when his condition deteriorated the previous evening, but he died before they got to the hospital. The FLO telephoned Mr Gore's daughter to offer her condolences and then she and the Head of Residence and Safety visited her home address and spoke to the family.

46. The FLO kept in contact with Mr Gore's daughter. She arranged the return of Mr Gore's property and assisted with the funeral arrangements. Mr Gore's funeral was held on 18 July. The prison contributed towards the cost in line with Prison Service instructions.

Support for prisoners and staff

47. After Mr Gore's death, a senior prison manager debriefed the staff involved in the hospital bedwatch to ensure they had the opportunity to discuss any issues arising, and to offer support.

48. The prison posted notices informing other prisoners of Mr Gore'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 Gore's death.

Post-mortem report

49. A post-mortem examination showed that Mr Gore died from congestive cardiac failure, which had been caused by hypertensive heart disease and chronic kidney disease.

Findings

Clinical care

50. The clinical reviewer was satisfied that the care Mr Gore received at Hull was of a good standard and equivalent to that he could have expected to receive in the community.

51. Mr Gore had complex health conditions including chronic kidney failure and heart failure. He was assessed and reviewed in a timely manner and received regular specialist consultant care. National Institute for Health and Care Excellence (NICE) guidelines were followed as appropriate and there were many examples of good practice, including regular reviews of pain control, nutrition and mobility. Communication between prison healthcare staff and hospital specialists was of a good standard.

52. However, the clinical reviewer found that despite Mr Gore's deteriorating health, there was little evidence of Advance Care Planning (the term used to describe the conversation between the person, their family and carers about their future wishes and priorities for care). There was no recorded discussion with Mr Gore about how he wanted to be cared for at the end of his life. There is no evidence that prison healthcare staff discussed with Mr Gore his wishes regarding resuscitation if his heart or breathing stopped. A DNACPR order was not signed until 19 June 2019, when hospital staff agreed this with his family.

53. We make the following recommendation:

    The Head of Healthcare should ensure that within 12 months all healthcare staff receive training in Advance Care Planning.

Contact with Mr Gore's family

54. Mr Gore's daughter was concerned that the prison had not told her on 17 June that her father had been admitted to hospital. She only found out because she telephoned the prison on 19 June when she did not hear from her father as usual.

55. Section 22(1) Prison Rules 1999 states that if a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of mental disorder, 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.

56. Prison Service Instruction 64/2011, Chapter 11, states that where prisoners have a terminal illness or suffer an unpredicted and/or rapid deterioration in their physical health, prisons must have in place procedures for supporting the prisoner, engaging with their next of kin or nominated person and providing support for staff.

57. While we recognise that there was a delay in Mr Gore's daughter finding out about her father's admission to hospital, we consider that the prison was not required to tell her at that stage. Although Mr Gore was in poor health on 17 June, he had been admitted to hospital on previous occasions for short periods

and there was no reason at that point to consider that he would not improve in hospital and return to the prison again as he had in the past.

58. As soon as Mr Gore's daughter telephoned the prison and found out about his hospital admission, the prison arranged a visit for her. When Mr Gore's condition deteriorated in hospital on 20 June, the prison appointed a family liaison officer in line with prison guidance.

59. We consider that the prison's contact with Mr Gore's family was acceptable and we make no recommendation.

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