Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Hubbard, a prisoner at HMP Altcourse, on 27 July 2020

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*

Summary

1. 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.

2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

3. Mr Anthony Hubbard, who was 56 years old, died of an exacerbation of emphysema and pulmonary fibrosis on 27 July 2020, while a prisoner at HMP Altcourse. We offer our condolences to Mr Hubbard's family and friends.

4. The clinical reviewer concluded that the care Mr Hubbard received at HMP Altcourse was not equivalent to that which he could have expected to receive in the community because consultations were being conducted by the prison's pharmacy technicians and they did not discuss their findings with a registered nurse or refer Mr Hubbard for review by a GP as they should have done. She made four recommendations.

5. We did not find any non-clinical issues of concern.

Recommendations

- The Head of Healthcare should ensure that all prisoners are assessed and reviewed by suitably qualified staff.
- The Head of Healthcare should ensure that all healthcare staff are trained to use the National Early Warning Scores (NEWS) system.
- The Head of Healthcare should ensure that when a member of healthcare staff documents that they will add a prisoner to a waiting list to see a GP, that they complete that action.
- The Head of Healthcare should reiterate the importance of ensuring that referrals are made as documented.

Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Hubbard's clinical care at HMP Altcourse.

7. The PPO investigator has investigated non-clinical issues, including Mr Hubbard's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

8. One of the PPO's family liaison officers wrote to Mr Hubbard's next of kin, his sister, to explain the investigation. She did not respond to our letter.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at Altcourse

10. Mr Hubbard was the 13th prisoner to die at Altcourse since July 2018. Of the previous deaths, nine were from natural causes, two were self-inflicted deaths and one was a drug-related death. There are no similarities between our findings in the investigation of Mr Hubbard's death and the previous deaths.

Key Events

11. On 21 December 1992, Mr Anthony Hubbard was sentenced to life imprisonment for the murder of his stepchild. On 16 December 2019, he was released on life licence from HMP Altcourse to Wordsworth House Approved Premises (AP), Lincoln.

12. On 10 February 2020, Mr Hubbard was recalled to prison after breaching the conditions of his licence after returning to the AP 45 minutes after his agreed curfew time and having consumed alcohol. Mr Hubbard was sent to Altcourse.

13. At an initial health assessment, a nurse recorded that Mr Hubbard had a history of substance misuse and was being treated for drug addiction using a strictly controlled dosage of methadone (an opiate substitute). Mr Hubbard's prescribed medications were reviewed and careplans created. He was referred to the prison's drug treatment services and mental health team for review and support. Mr Hubbard was also noted to be a smoker and offered smoking cessation advice, which he accepted. He had little further significant contact with healthcare staff over the months that followed.

14. On 26 May, a pharmacy technician noted that Mr Hubbard had complained of a rash and skin blisters which he thought was due to Naproxen (which was prescribed for arthritic pain) and was feeling breathless. She recorded that Mr Hubbard would be referred to a GP for review. There is no evidence in his medical records that this was done or that her consultation with Mr Hubbard was discussed with a prison nurse.

15. On 30 June, Mr Hubbard was seen by another prison pharmacy technician, after he reported a feeling of breathlessness. She took his observations (checks of a patient's breathing, pulse, temperature, blood pressure and oxygen levels to give an indicator of their physical condition) which showed no concerns. His condition improved and he was told to contact healthcare staff if he felt unwell again.

16. On 2 July, a pharmacy technician reviewed Mr Hubbard after he reported experiencing shortness of breath. He told her that he had been feeling unwell for a number of weeks. He also said that he had a family history of COPD (chronic obstructive pulmonary disease). She noted that she would refer Mr Hubbard to a prison GP for review. There is no evidence in Mr Hubbard's medical records to indicate that a referral was made or that she discussed her findings with a prison nurse.

17. The pharmacy technician reviewed Mr Hubbard again on 10 July, after he reported feeling breathless again. She referred him to a prison GP for further review. A prison GP reviewed Mr Hubbard by telephone on 13 July. He told her that he had been experiencing shortness of breath for a number of weeks. The GP considered that he would benefit from having a full blood test and that the results should be reviewed in person by a prison GP the following day.

18. On 14 July, another prison GP reviewed Mr Hubbard after he complained of shortness of breath. He told the GP that he had been feeling breathless for the previous 12 months and that it had been steadily getting worse. The GP noted that Mr Hubbard appeared comfortable and could talk in full sentences, had not experienced any chest pains and there was no evidence of blood when he coughed or a worsening of his symptoms when he was lying down. However,

the GP noted a crackling sound when breathing. He referred Mr Hubbard for a chest X-ray and ECG. Later the same day, the results of the blood tests were reviewed by another prison GP. The test results indicated possible renal failure and anaemia. The GP referred him to Aintree Hospital, Liverpool for further review.

19. On 15 July, Mr Hubbard complained of breathlessness. A pharmacy technician took his observations and noted his oxygen saturation level was low. She referred him to a prison GP for urgent review. The GP reviewed him the same day. The results of the earlier ECG test showed that Mr Hubbard had developed an increased heart rate which could lead to a cardiac arrest. The GP considered that although Mr Hubbard had not been feeling faint, had no chest pain and was alert and talkative, he needed to be reviewed at the hospital. He sent Mr Hubbard to Aintree Hospital by emergency ambulance. Mr Hubbard was accompanied by two escort officers and restrained using an escort chain which was removed shortly after his arrival at hospital.

20. Following a review by hospital staff, Mr Hubbard was placed on oxygen therapy and given a course of intravenous antibiotics. Over the days that followed, Mr Hubbard's condition continued to deteriorate. Each time the oxygen therapy was removed, his oxygen saturation level would drop and could not be stabilised.

21. On 23 July, hospital staff told Mr Hubbard that he was very unwell and that he had developed a lung infection, emphysema and scarring in his lungs. Mr Hubbard told hospital staff that he did not wish to be resuscitated if his heart or breathing stopped and signed a do not attempt cardiopulmonary resuscitation (DNACPR) order to that effect. The following morning, hospital staff told the prison staff accompanying Mr Hubbard that his condition was critical and that he would receive end of life care.

22. Mr Hubbard's condition continued to deteriorate, and at 8.20pm on 27 July, Mr Hubbard died. A hospital doctor confirmed Mr Hubbard's death at 9.30pm.

23. The Coroner concluded that Mr Hubbard died of exacerbation of emphysema (lung disease) and pulmonary fibrosis (lungs become damaged and scarred making breathing difficult).

Lisa Burrell **May 2021**
Assistant Ombudsman