Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Hughes a prisoner at HMP Usk on 25 April 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 we oversee can improve their work in the future.

Mr David Hughes died on 25 April 2018 of an upper gastro-intestinal bleed, while a prisoner at HMP Usk. He was 71 years old. I offer my condolences to Mr Hughes' family and friends.

Mr Hughes had persistent symptoms of vomiting, nausea and abdominal pain, for which he saw nursing staff. There were three missed opportunities to refer Mr Hughes to a GP for review. Although it is not possible to say whether earlier intervention would have changed the outcome for Mr Hughes, we consider that the standard of clinical care he received at Usk fell below that which he could have expected to receive in the community.

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
Deputy Prisons and Probation Ombudsman **December 2019**

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Summary

Events

1. On 26 January 2018, Mr David Hughes was sentenced to five years imprisonment for historic sexual offences. He was transferred to HMP Usk on 15 February. Mr Hughes took various medications for high blood pressure, high cholesterol, overactive thyroid and arthritis.

2. On 6 April, Mr Hughes was prescribed an antacid (usually prescribed for symptoms associated with indigestion). There is no recorded reason for this in his medical record.

3. On 11 April, Mr Hughes saw nursing staff and told them that he had been vomiting since the previous evening. He saw nursing staff on two further occasions, on 12 and 13 April, complaining of nausea and abdominal pain but this did not prompt the nursing staff to refer Mr Hughes for a review with a prison GP.

4. On 20 April, Mr Hughes' weight was recorded after returning from court. He had lost nearly 10kg in two months. No further action was taken.

5. At about 10.30am on 21 April, Mr Hughes told a prison manager that he felt nauseous, but he said that he would be fine. At 4.00pm, he went to the wing office, upset and in discomfort. He told the prison manager that he felt sick and had pain in his stomach. As it was a weekend and there was no healthcare cover, the prison manager arranged for Mr Hughes to go to the Accident and Emergency department at the local hospital via taxi, secured to officers by a chain and handcuff.

6. While in hospital, test results identified that Mr Hughes had a stomach ulcer with a prominent pulsating blood vessel. There was no current bleeding but the vessel looked arterial, so there were no plans to treat Mr Hughes. The tissue surrounding the ulcer appeared 'very abnormal' and a plan was made for a biopsy. Hospital staff anticipated that Mr Hughes would be discharged from hospital and transferred back to Usk in the coming days.

7. Mr Hughes remained in hospital and at about 2.30am on 25 April, he vomited a large amount of blood. Nursing staff increased his intravenous fluids and he had a blood transfusion. The escort chain was removed at this point. The on-call surgeon advised that Mr Hughes might need to be admitted to the high dependency unit or intensive care.

8. About an hour later, Mr Hughes had a respiratory arrest followed by a cardiac arrest. Hospital staff made resuscitation attempts but a hospital doctor pronounced Mr Hughes dead at 4.11am.

Findings

9. Nursing staff did not refer Mr Hughes to a prison GP for review on three occasions, after Mr Hughes complained of persistent symptoms of nausea, vomiting and abdominal pain. Mr Hughes was prescribed an antacid, which

should have also prompted a review by a GP, especially given his age, but healthcare staff did not make an appointment. We are concerned that there is no automatic system in place at HMP Usk to refer a patient to a GP for review after repeated consultations with the nursing team.

10. We are also concerned that despite Mr Hughes reporting on-going symptoms to nursing staff, his weight was not recorded to provide an accurate picture of his symptoms. Healthcare staff did not recognise that Mr Hughes had lost 10kg in weight over a period of two months and his weight loss was not investigated further in line with NICE guidelines. Weight loss for a person over the age of 55 coupled with symptoms of indigestion should have prompted an urgent referral for an endoscopy for suspected oesophageal cancer. Healthcare staff did not refer Mr Hughes for a GP review and therefore an urgent referral was never made.

11. The clinical reviewer concluded that Mr Hughes' death was not foreseeable and it is not possible to say definitively if a GP review would have changed the outcome. However, we are not satisfied that the clinical care Mr Hughes received while at Usk was equivalent to that which he could have expected to receive in the community.

12. We were concerned that restraints were used, in addition to Mr Hughes being escorted by two officers. HMPPS provided us with evidence of its decision-making process when deciding to use restraints. We are now satisfied that the prison fully considered the medical implications for use of restraints and took account of the Graham Judgement throughout the decision-making process.

Recommendations

- The Head of Healthcare should ensure there is a robust system in place to refer patients to a GP after repeated consultations with nursing staff.

- The Head of Healthcare should ensure all staff are aware of the need to weigh prisoners when there is a clinical need, specifically prisoners over the age of 55, who present with on-going symptoms, and a robust, simple system is implemented to record and monitor weight of prisoners over the age of 55.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Usk informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

14. The investigator obtained copies of relevant extracts from Mr Hughes' prison and medical records.

15. Healthcare Inspectorate Wales (HIW) commissioned a clinical reviewer to review Mr Hughes' clinical care at the prison.

16. We informed HM Coroner for Wales Gwent District of the investigation who informed us of the cause of death. We have sent the coroner a copy of this report.

17. One of the Ombudsman's family liaison officers contacted Mr Hughes' wife, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mrs Hughes wanted to know if Mr Hughes had received appropriate and timely clinical care at Usk because he appeared to be very unwell for some time. We have addressed her concerns in this report.

18. We shared our initial report with HM Prison and Probation Service (HMPPS). They identified some factual inaccuracies about the use of restraints. The report has been amended accordingly.

Background Information

HMP Usk and Prescoed

19. HMP Usk holds up to 273 men convicted of sexual offences. The prison is managed jointly with nearby HMP Prescoed. The Aneurin Bevan University Health Board delivers healthcare services at Usk. Nurses are on duty from 8.00am to 4.30pm, Mondays to Fridays. There is a GP surgery every weekday morning and doctors are on call until 6.30pm each weekday. Out of hours and weekend services are provided through the Gwent Out of Hours Cover, which provides telephone triage by a nurse or doctor.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Usk was in October 2017. Inspectors noted that governance of health care was satisfactory and leadership was good. Prisoners were very positive about their access to and the quality of GP and nursing care. The health care environment was clean. The population at Usk contained a high proportion of older men. Despite the environment's limitations, good work was undertaken to support them, including the best provision relating to the Care Act inspectors had seen. Healthcare provision overall was reasonably good.

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 31 March 2017, the IMB reported that in general, prisoners appeared to feel that their health needs were being met and that the service they received was at least as good as they would have expected to receive in the community. The IMB agreed with this view.

Previous deaths at HMP Usk

22. Mr Hughes was the second prisoner to die from natural causes at Usk since January 2017. This is the second time we have made a recommendation about the use of restraints since April 2015.

Key Events

23. On 26 January 2018, Mr David Hughes was sentenced to five years imprisonment for historic sexual offences and was sent to HMP Cardiff.

24. Mr Hughes was over 70 years old and took various medications for high blood pressure, high cholesterol, overactive thyroid and arthritis.

25. On 31 January, Mr Hughes was transferred to HMP Parc before being transferred to HMP Usk on 15 February.

26. During Mr Hughes' reception screen at Usk, a nurse noted that Mr Hughes' blood pressure was elevated and his weight was 86.4 kilograms (kg). The nurse made an appointment for Mr Hughes to see a prison GP.

27. On 16 February, at a follow-up reception screen, Mr Hughes told a nurse that he had fallen about five days before at HMP Parc. He said that he had bruised and hurt his left ribs. The nurse completed an injury report and noted that Mr Hughes could cough and take deep breaths in and out. A note was made of his medical conditions and medications, and his weight was recorded as 87kg. An appointment was made for Mr Hughes to have an 'age sensitive assessment', which included assessing memory, mobility, falls risk and records weight, height and blood pressure. The assessment took place a few days later and no concerns were raised. Mr Hughes' blood pressure was slightly elevated and his weight was recorded as 84.6kg.

28. A prison GP reviewed Mr Hughes on 19 February. She noted that Mr Hughes needed routine monitoring of his high blood pressure and referred him for a blood test, which he had the next day. On 21 February, she reviewed the results, without Mr Hughes being present. A note on the blood test results said that Mr Hughes' thyroid test was 'marginally abnormal' and he needed to see a GP, however no a follow-up appointment was arranged for a face to face review.

29. There were no further significant entries in Mr Hughes' medical record during February and March.

30. On 6 April, a prison GP prescribed an antacid. As it was an over the counter medication, she did not see Mr Hughes in person and there is no information in the medical record to explain why Mr Hughes was prescribed it, but antacid medication would normally be prescribed for symptoms associated with indigestion.

31. On 11 April, Mr Hughes told a nurse manager that he had been vomiting since the previous evening. She advised Mr Hughes to drink fluids and eat a light diet. Later that afternoon, Mr Hughes told a healthcare support worker that he had stopped vomiting and was feeling better and was due to have a visit with his wife. The healthcare support worker noted that Mr Hughes had been seen by the nurse manager that morning and had planned to monitor him. Mr Hughes made an application to see a GP where he said that he was experiencing faint aches in his chest and left back pain. No appointment was made for Mr Hughes to be reviewed by a GP.

32. On 13 April, Mr Hughes went to the healthcare unit and told a nurse that he had stopped vomiting, but he had an ache to the left of his umbilical area, the pain was intermittent and had been there for about a week. He said that he could tolerate food and drink well, but the pain usually occurred after having a meal. The nurse examined Mr Hughes and noted that his abdomen was soft and not tender and his basic observations, such as blood pressure and temperature, were within the normal range. She advised Mr Hughes to drink plenty of fluids and take some pain relief. If he did not feel better after the weekend, he should contact healthcare staff. She did not refer Mr Hughes to a GP for review.

33. On 17 April, healthcare staff assessed Mr Hughes as 'fit to travel' to attend Cardiff Crown Court to be tried for further offences. He returned to Usk on 20 April.

34. On his return, Mr Hughes had a routine health screen and his weight was recorded as 77.5kg. Healthcare staff did not identify that Mr Hughes had lost nearly 10kg in weight in two months, so this weight loss was not followed up and he was not referred to a GP for review. A routine appointment was scheduled for 23 April, for a medication review only. Healthcare staff did not flag Mr Hughes' weight loss up for the GP's attention or that he had been experiencing chest and abdominal pain for several weeks.

Events of 21-25 April

35. On 21 April, a Custodial Manager (CM) spoke to Mr Hughes at about 10.30am. Mr Hughes said he felt nauseous and thought he had a stomach bug. The CM told Mr Hughes to let him know if he felt any worse, but Mr Hughes said that he would be fine. The CM did not see Mr Hughes again until later that afternoon.

36. At about 4.00pm, Mr Hughes went to the wing office. He was 'visibly upset and in obvious discomfort'. He told the CM that he felt sick and had pain in his stomach, but he had an appointment to see the prison GP on 23 April. The CM thought Mr Hughes needed to be seen as soon as possible. As there was no healthcare provision over the weekend, he arranged for officers to take Mr Hughes to a hospital by taxi. They left Usk at about 5.00pm.

37. The escort risk assessment showed that Mr Hughes was considered a high risk to children and a low risk to the public, staff and of escape. The CM authorised an escort chain and single cuff to be used, which could only be removed in medical emergencies.

38. When Mr Hughes arrived at the hospital, he had his bloods taken and an electrocardiogram (a test that monitors the electrical activity of the heart). Hospital staff noted that Mr Hughes had been presenting symptoms of abdominal pain, vomiting and increased acidity for three weeks. Physical examination showed no abnormality and Mr Hughes' observations were stable. Hospital staff noted his weight loss and gave a provisional diagnosis of gastro-oesophageal reflux disease (GORD).

39. The following day, Mr Hughes had another blood test, which showed a decrease in his blood count. A hospital doctor said that it was possible Mr Hughes had an upper gastro-intestinal bleed and would need an endoscopy (in which a thin

flexible tube with a camera on the end is used to examine the oesophagus, stomach and small bowel).

40. Mr Hughes had an endoscopy on 23 April, which showed a stomach ulcer, with a prominent pulsating blood vessel. There was no current bleeding and there were no plans for therapy because it was possible the vessel was arterial. The tissue surrounding the ulcer appeared 'very abnormal' and a plan was made for a biopsy. The escort risk assessment was changed to authorise use of an escort chain only.

41. Later that day, nursing staff witnessed Mr Hughes vomiting blood, with 'coffee ground' vomit. He was reviewed by the medical team and was given intravenous fluid. A further blood test did not show a drop in his blood count.

42. On 24 April, another blood test showed a slight drop in Mr Hughes' blood count and he was given a blood transfusion. One of the escort officers said Mr Hughes was in good spirits and was chatting with staff. The escort chain was still in place while Mr Hughes received a blood transfusion.

43. At about 2.30am on 25 April, Mr Hughes vomited a large amount of blood. He was seen immediately by nursing staff who increased his intravenous fluids and blood. One of the escort officers contacted the duty governor immediately who authorised the removal of the escort chain. The on-call surgeon saw Mr Hughes ten minutes later and advised that he might need to be admitted to the high dependency unit or intensive care before any surgical intervention could be considered.

44. At 3.45am, Mr Hughes had a respiratory arrest, followed by a cardiac arrest. Hospital staff made resuscitation attempts, but this was hindered by large amounts of blood in his airways. A hospital doctor declared Mr Hughes dead at 4.11am.

Contact with Mr Hughes' wife

45. The prison contacted Mr Hughes' wife when he was admitted to hospital on 21 April. She visited Mr Hughes while he was in hospital.

46. After Mr Hughes' death, a prison manager called Mr Hughes' wife on the telephone at 8.00am to inform her of Mr Hughes' death. A senior prison officer was appointed as the prison's family liaison officer (FLO).

47. The FLO contacted Mr Hughes' wife and introduced herself at 9.25am and arranged to visit her home at 10.30am. She provided on-going support to Mr Hughes' wife, including returning Mr Hughes' property and advising on the next steps.

48. Mr Hughes' funeral was held on 10 May. The prison offered a financial contribution towards the cost of the funeral in line with national policy.

Support for prisoners and staff

49. After Mr Hughes' death, a prison manager debriefed the staff who were on the hospital escort to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

50. The prison posted notices informing other prisoners of Mr Hughes' death, and offering support. A prison manager reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Hughes' death.

Post-mortem report

51. The coroner did not conduct a post-mortem due to the nature of Mr Hughes' death. The clinical cause of death was recorded as an upper gastro-intestinal bleed caused by a duodenal ulcer with a pulsatile vessel. Significant factors noted, but not directly linked to Mr Hughes' death, were high blood pressure and high cholesterol.

Findings

Clinical care

52. Mr Hughes was an elderly man who had high blood pressure, high cholesterol and arthritis, for which he took appropriate medication. We are not satisfied that the care he received at HMP Usk was equivalent to that which he could have expected to receive in the community. Prison healthcare staff failed to refer Mr Hughes for a GP review on three occasions after he complained of persistent symptoms of abdominal pain and vomiting. Healthcare staff also failed to pick up that Mr Hughes lost 10kg in two months. This should have prompted further investigation and review by a prison GP, which might have led to an urgent referral under the two-week referral protocol.

Referral to GP for review

53. On 6 April, Mr Hughes was prescribed an antacid, which would normally be prescribed to alleviate symptoms of indigestion. Although the medication was prescribed by a GP, it is an over the counter medicine and the GP did not physically see Mr Hughes. Healthcare staff did not update Mr Hughes' medical records to confirm the reason why he was prescribed antacid. The clinical reviewer said that the prescribing of an antacid would have ordinarily prompted a review by a GP, especially given Mr Hughes' age, but healthcare staff did not make an appointment for Mr Hughes to be reviewed by a GP.

54. Mr Hughes did not report any significant concerns to healthcare staff until 11 April, when he told the nurse manager that he had been vomiting through the night. He also asked to see the GP after experiencing faint aches in his chest and left back pain. On 13 April, Mr Hughes saw another nurse and complained of abdominal pain to the left of his umbilical area. Healthcare staff had planned to monitor Mr Hughes but after three consultations with nursing staff in nine days about persistent symptoms, and despite Mr Hughes requesting to see a GP, no appointment was made for him to be reviewed by a GP.

55. A routine appointment was made for 23 April, for a review of Mr Hughes' medications, but healthcare staff did not highlight Mr Hughes' weight loss or persistent symptoms. Mr Hughes was admitted to hospital before this appointment took place.

56. NICE guidelines state that an urgent referral for an endoscopy for suspected oesophageal cancer should be made for any person over the age of 55 with symptoms of weight loss and indigestion. Being prescribed antacid and being seen on three occasions by nursing staff for persistent gastric symptoms should have prompted a review by a GP. The Head of Healthcare told the clinical reviewer that there is no automatic system in place at Usk to ensure that a person is referred to a GP for review after repeated consultations with the nursing team. It is at the nurses' discretion to refer a prisoner to the GP for review.

57. If Mr Hughes had seen a prison GP, a more detailed medical history would have been noted and reviewed, and a sudden on-set of indigestion and weight loss

would have been assessed. This might have triggered the GP to make an urgent referral for suspected cancer.

58. It is not possible to say definitively if a GP review would have changed the outcome for Mr Hughes, but the clinical reviewer concluded that the clinical care Mr Hughes received while at Usk was not equivalent to that which he could have expected to receive in the community. We make the following recommendation:

The Head of Healthcare should ensure there is a robust system in place to refer patients to a GP after repeated consultations with nursing staff.

Weight monitoring

59. On 20 April, a nurse recorded Mr Hughes' weight which indicated a weight loss of 10kg over two months. The nurse did not identify this as a concern and Mr Hughes was not referred to a GP for review.

60. Following his death, Mr Hughes' wife provided the investigator with a letter written to her by Mr Hughes, dated 21 April. He said that he had been feeling unwell for three weeks, had lost a lot of weight and was asking for help. Mr Hughes' wife told the investigator that when she visited on 11 April, she noticed how much weight he had lost. Mr Hughes eventually told prison staff how unwell he felt and was taken to hospital.

61. The Head of Healthcare said that patients are weighed when they enter the prison and over 55s are weighed annually as part of the age sensitive assessment. Other weights recorded would be opportunistic or due to clinical need. There is no policy in general practice for weight to be routinely recorded during a consultation.

62. Mr Hughes had his weight recorded during his reception screens at Usk and as part of the age sensitive assessment. On the three occasions he saw nursing staff with complaints of vomiting, nausea and abdominal pain, his weight was not recorded. His symptoms, along with his history of indigestion, would have highlighted a clinical need for a weight check. If his weight had been taken and noted alongside his symptoms, it would have provided a fuller picture of his symptoms, which would have indicated a 'red flag' for referral. We make the following recommendation:

The Head of Healthcare should ensure all staff are aware of the need to weigh prisoners when there is a clinical need, specifically those prisoners over the age of 55, who present with on-going symptoms, and a robust, simple system is implemented to record and monitor weight of prisoners over the age of 55.

Restraints, security and escorts

63. When prisoners have to travel outside 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.

64. A High Court judgement in 2007, highlighted a number of factors that prisons should consider when deciding on the use of restraints. These included addressing 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 suffering from a serious medical condition.

65. When Mr Hughes was sent to hospital, two members staff escorted him using an escort chain and single cuff (an escort chain is a long chain with a handcuff at each end, one of which is attached to a prison officer). A full risk assessment indicated that Mr Hughes presented a high risk to children and low risk to the public staff and of escape. It stated that the restraints could only be removed in medical emergencies.

66. Although the escort risk assessment was changed to authorise use of an escort chain only when Mr Hughes was diagnosed with an ulcer, restraints were not removed during his blood transfusion.

67. It is the Governor's responsibility to ensure that the risk assessment process is managed properly and that there is a clear justification for any use of restraints. We are not clear that the requirements of the High Court judgment were fully met, in particular that there was proper consideration of the impact of Mr Hughes' deteriorating condition on his risk to the public or of escape.

68. We query whether the use of restraints was appropriate given Mr Hughes was a 71 year old man in poor health, and we question why restraints were considered necessary and proportionate over and above the control already available through the escorting officers.

69. We acknowledge that when Mr Hughes vomited a large amount of blood and received intravenous fluids and blood, the duty governor immediately authorised the removal of the escort chain. We are satisfied that the prison's risk assessment on this occasion fully considered the medical implications for use of restraints.

70. HMPPS responded to our concerns and provided us with evidence detailing how and why decisions were made about the use restraints. They said that they were committed to complying with the Graham Judgment and would remind managers of the legal ruling to ensure that they set appropriate levels of restraint, proportionate to the perceived security risks and balanced by considerations of care and decency of the prisoner. They also said that they would update their escort paperwork to ensure that managers involved in the decision-making process for the use of restraints are reminded of the legal ruling in the Graham Judgment when considering the appropriate use of restraints.

71. HMPPS considered that managers and staff involved in the decision to use restraints and who were located at the hospital with Mr Hughes, made appropriate and considered decisions about the level of restraints to be used. Given the information prison staff were provided with by the hospital and the risk information available, HMPPS consider that appropriate decisions were made in this instance, specifically that the risk assessments were dynamic taking account of Mr Hughes' changing health condition. The use of restraints was kept under review and the officers took account of all actual risks. This is evidenced in the

decisions to change the level of restraints used. HMPPS are satisfied that they balanced the need for public protection against Mr Hughes decency throughout his hospital stay.

72. We are satisfied that the prison fully considered the medical implications for use of restraints and took account of the Graham Judgement throughout the decision- making process. We therefore make no recommendation.

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