Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Andrew Hamlin, a prisoner at HMP Hull, on 31 July 2020

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 Andrew Hamlin died from multiple organ failure as a result of heart failure and a blood clot in the heart on 31 July 2020 while a prisoner at HMP Hull. He was 42 years old. He also had Type 1 diabetes and obesity which contributed to but did not cause his death. I offer my condolences to his family and friends.

The clinical reviewer found that the clinical care that Mr Hamlin received at Hull was satisfactory and equivalent to 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.

Sue McAllister CB
Prisons and Probation Ombudsman **January 2022**

Contents

Summary

Events

1. In January 2013, Mr Andrew Hamlin was sentenced to 14 years in prison for sex offences. In April 2019, he was released on licence. His licence was revoked on 28 November 2019, and he was sent to HMP Hull.

2. On 29 November, a nurse carried out Mr Hamlin's initial health screen and noted that he had Type 1 diabetes, asthma and an emotionally unstable personality disorder. He was also obese.

3. On 20 March 2020, Mr Hamlin had a six-monthly diabetes review. A nurse noted that Mr Hamlin's understanding of diabetes was limited and he consumed high-sugar content foods and drink. Healthcare staff planned to supervise his insulin intake and to persuade him to reduce the high-sugar content drinks and snacks.

4. On 1 June, a nurse saw Mr Hamlin because he said that he was feeling unwell. She noted that Mr Hamlin had a National Early Warning Score of 4 which indicated that his condition had deteriorated, and she planned for nurses to monitor him throughout the day.

5. On 2 June, a prison GP reviewed Mr Hamlin and arranged urgent blood tests. These returned on 3 June and were abnormal and showed that Mr Hamlin may have heart failure. On 3 June, Mr Hamlin also had an echocardiogram (ECG, a scan of the heart) which was abnormal. The prison GP told Mr Hamlin that he should be referred for an urgent cardiology appointment but, on 5 June, Mr Hamlin declined to attend the appointment.

6. On 18 July, a nurse saw Mr Hamlin because he had been vomiting for an hour. Mr Hamlin was ashen, cold and clammy, his blood pressure was low, his pulse rate was raised, and his blood sugar level was high. The nurse sent him to hospital where hospital staff treated him for unstable diabetes. On 19 July, Mr Hamlin returned to Hull.

7. On 29 July, a nurse saw Mr Hamlin because a prison officer said that he looked unwell. Mr Hamlin said that he had not been able to keep food or water down for some days. The nurse noted that he had a NEWS of 8 and sent him urgently to hospital.

8. On 31 July, Mr Hamlin died in hospital. A post-mortem established that he died from multiple organ failure as a result of heart failure and a blood clot in the heart. He also had Type 1 diabetes and obesity which contributed to but did not cause his death.

Findings

Clinical care

9. The clinical reviewer found that the clinical care that Mr Hamlin received at Hull was satisfactory and equivalent to that which he could have expected to receive in the community, and that care plans were in place to manage his long-term conditions.

10. On 3 June 2020, Mr Hamlin's blood test results and ECG were abnormal and a prison GP referred him urgently to the heart failure clinic in line with NICE guidance.

11. The clinical reviewer made three recommendations which are not directly related to Mr Hamlin's death but which the Head of Healthcare will need to address.

12. We found no non-clinical issues of concern.

The Investigation Process

13. 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.

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

15. The investigator interviewed a prisoner by telephone on 4 September 2020.

16. NHS England commissioned a clinical reviewer to review Mr Hamlin's clinical care at the prison. They jointly interviewed five members of staff by video link between 5 October and 5 November 2020.

17. 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.

18. The Ombudsman's family liaison officer wrote to Mr Hamlin's partner to explain our investigation. She had no specific questions.

19. We shared the initial report with the Prison Service. There were four factual inaccuracies in two interview transcripts which have been amended accordingly. Three reported factual inaccuracies in a signed interview transcript have not been amended.

20. Mr Hamlin's partner received a copy of the initial report. She raised a number of questions regarding Mr Hamlin's clinical care which have been dealt with by separate correspondence.

Background Information

HMP Hull

21. HMP Hull is a local prison which holds up to 1056 men in ten wings. City Healthcare Partnership provides health services and there is a wellbeing unit to support prisoners with complex needs. 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.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Hull was in July 2021. Inspectors found that healthcare services had been weak before the pandemic and were failing in some critical areas. Inspectors were not confident that partnership working with healthcare was providing sufficient oversight and governance and there were staffing vacancies across all clinical disciplines. They found that mental health services were not properly resourced, and that there were significant risks and unmet needs which required immediate attention. Inspectors noted that prisoners waited too long for some primary care services and there was no oversight of waiting lists. They noted that healthcare staff had good relationships with prisoners and were caring. However, prisoners with long-term conditions did not always receive person-centred, holistic care.

Independent Monitoring Board

23. 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 March 2021, the IMB reported that the prison was a safe place. They found that healthcare staff had worked hard to maintain healthcare provision under extreme pressure. However, they concluded that the management structure of healthcare provision and its communication with prison management needed to improve.

Previous deaths at HMP Hull

24. In the two years before Mr Hamlin's death there were five deaths from natural causes, six self-inflicted deaths and a drug-related death at HMP Hull. There have been six deaths from natural causes (three of which were related to COVID-19), one drug-related death and a self-inflicted death at Hull since Mr Hamlin's death. There are no significant similarities between our findings in this investigation and those of the other deaths.

Key Events

25. In January 2013, Mr Andrew Hamlin was sentenced to 14 years in prison for sex offences. He was released on licence on 26 April 2019. His licence was revoked on 28 November and he was sent to HMP Hull.

26. On 29 November, a nurse carried out Mr Hamlin's initial health screen and noted that Mr Hamlin had Type 1 diabetes, asthma, emotionally unstable personality disorder (sometimes referred to as borderline personality disorder) and was obese. The nurse referred him to mental health services and created care plans to manage his diabetes, asthma and personality disorder. He had a second health screen on 30 November.

27. On 30 November, a mental health social worker carried out a mental health assessment and noted that Mr Hamlin had anxiety, depression and post-traumatic stress disorder.

28. On 18 March 2020, Mr Hamlin told a nurse that his blood sugar reading was high. After administering eight units of insulin, Mr Hamlin's blood sugar reduced but remained high. A prison GP planned to discuss Mr Hamlin's case with the specialist diabetes team at the Hull Royal Infirmary. A diabetes nurse, recommended that Mr Hamlin should reduce his insulin and increase his carbohydrate intake.

29. On 20 March, Mr Hamlin had a six-monthly diabetes review. Healthcare staff noted that his understanding of diabetes was limited and that they would supervise his insulin intake and encourage him not to consume food and drinks with a high-sugar content. They planned to send him to hospital if his blood sugar levels remained high.

30. On 1 June, a nurse saw Mr Hamlin because he said that he was feeling unwell. She noted that his pulse rate was high, his blood oxygen saturation was low and his temperature was slightly raised. She did not record a blood sugar level but noted that Mr Hamlin remained alert. She recorded that Mr Hamlin's National Early Warning Score (NEWS) was 4 which indicated that his health had deteriorated. (NEWS is a tool to detect and respond to clinical deterioration. A NEWS above 0 indicates a deterioration in clinical condition, with a score above 7 indicating high clinical risk. The NEWS guidelines say that a score of 0 to 4 requires a community-based – that is, not hospital - response.) The nurse planned for nurses to monitor him throughout the day.

31. A nurse monitored Mr Hamlin for the rest of the day and noted that his NEWS was 2. The nurse said that she did not take Mr Hamlin's blood sugar level because she did not consider that the change in his condition was as a result of his diabetes.

32. On 2 June, a prison GP reviewed Mr Hamlin who told him that he had been using his asthma inhaler more frequently for shortness of breath and felt that he had put on weight in the past two weeks. The prison GP examined Mr Hamlin's chest which was normal, with clear breathing sounds and no wheezes, and noted that his heart sounded normal. The prison GP noted that Mr Hamlin had low blood oxygen saturation and arranged for urgent blood tests.

33. On 3 June, the prison GP reviewed Mr Hamlin's blood test results which were abnormal and showed that he may have heart failure. Mr Hamlin had an ECG which was abnormal. The prison GP told Mr Hamlin that he should be referred for an urgent cardiology appointment but on 5 June, Mr Hamlin declined to attend the appointment. The prison GP prescribed him bisoprolol, ramipril and atorvastatin for heart failure.

34. On 23 June, a healthcare administrator telephoned the Heart Failure Clinic and re-sent the cardiology referral because the hospital had not contacted her to make the appointment.

35. A prisoner shared a cell with Mr Hamlin and said that he ate 'biscuits and drank pop'. He said that about 20 days before he died, he saw a doctor who told him that 'he was too fat, that he should diet and stop eating rubbish'. He said that Mr Hamlin followed the advice.

36. On 18 July, a nurse saw Mr Hamlin because he had been vomiting for an hour. She saw that he was ashen, cold and clammy. The nurse noted that his blood pressure was low, that his pulse rate was raised, that his blood sugar level was high but that he remained alert and was talking freely. Mr Hamlin had a NEWS of 5 and she sent him to hospital by ambulance. Hospital staff treated him for unstable diabetes.

37. On 19 July, Mr Hamlin returned to Hull. Mr Hamlin did not have a discharge summary but told the nurse that the hospital had given him fluid, food and insulin.

38. On 29 July, a nurse saw Mr Hamlin because he looked unwell. Mr Hamlin was fully conscious and able to talk but looked grey and pale and was slightly unsteady on his feet. Mr Hamlin said that he had not been able to keep food or water down for some days. The nurse noted that Mr Hamlin had a NEWS of 8 and sent him urgently to hospital by ambulance.

39. When Mr Hamlin went to hospital, prison and healthcare staff completed an escort risk assessment, and restrained him with a single handcuff. At 10.05pm on 29 July, when Mr Hamlin's condition deteriorated, a prison manager reviewed the level of restraint and authorised that the restraint should be removed.

40. Mr Hamlin died in hospital on 31 July.

Contact with Mr Hamlin's family

41. On 30 July, the Head of Residence and Safety appointed an officer as the family liaison officer (FLO). The FLO telephoned Mr Hamlin's partner and told her that he was seriously ill and had been taken to hospital.

42. At 1.15am on 31 July, the Head of Residence and Safety telephoned Mr Hamlin's partner and told her that it was likely that Mr Hamlin would die within a couple of hours. At 2.55am, Mr Hamlin's partner arrived at the hospital but Mr Hamlin had died a short while earlier. At 10.30am, the FLO telephoned Mr Hamlin's partner and offered her condolences.

43. Mr Hamlin's funeral took place on 10 September. The prison contributed to its cost in line with national instructions.

Support for prisoners and staff

44. After Mr Hamlin's death, the Head of Residence 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.

45. The prison posted notices informing other prisoners of Mr Hamlin'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 Hamlin's death.

Post-mortem report

46. A post-mortem examination established that Mr Hamlin died of multi-organ failure as a result of acute congestive cardiac failure (heart failure) and left ventricular thrombosis (blood clot of the heart) due to coronary artery disease (narrowing of the arteries around the heart). He also had insulin dependent diabetes mellitus (Type 1 diabetes) and obesity which contributed to but did not cause his death.

Findings

Clinical care

47. The clinical reviewer found that the clinical care that Mr Hamlin received at Hull was satisfactory and equivalent to that which he could have expected to receive in the community. Even though Mr Hamlin's behaviour was challenging at times, the clinical reviewer found that the way that healthcare staff managed him was confident and competent.

48. Mr Hamlin's asthma was monitored in line with National Institute for Health and Care Excellence (NICE) guidance, and care planning was in place to manage his long-term conditions appropriately. The clinical reviewer found that a prison GP frequently reviewed Mr Hamlin and provided him with impressive continuity of care. He also appropriately referred him urgently to the heart failure clinic on 3 June 2020 but Mr Hamlin died before his assessment.

49. The clinical reviewer found that healthcare staff gave Mr Hamlin dietary advice and encouraged and promoted good nutritional intake, which he was reluctant to accept, and advised him of the risks of a poor diet with diabetes.

50. The clinical reviewer has made three recommendations which are not directly related to Mr Hamlin's death but which the Head of Healthcare will need to address.

Prisons & Probation Ombudsman
Independent Investigations

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