Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Barry Hastings, a prisoner at HMP Elmley, on 11 July 2021

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

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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 Barry Hastings died of a haemorrhage (blood loss) as a result of a ruptured abdominal aortic aneurysm (a bulge in the main blood vessel running from the heart), systemic hypertension (high blood pressure) and atherosclerosis (thickening or hardening of the arteries) on 11 July 2021 at HMP Elmley. He was 76 years old. I offer my condolences to those who knew him.

The clinical reviewer found that the clinical care that Mr Hastings received at Elmley was equivalent to that which he could have expected to receive in the community. While the clinical reviewer found that it would not have made a difference to the outcome for Mr Hastings, we are concerned that healthcare staff relied on a hospital order for him not to be resuscitated and did not put in place a new order for him when he returned to prison, with his explicit consent not to be resuscitated.

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 **July 2022**

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Summary

Events

1. On 16 August 2019, Mr Barry Hastings was sentenced to seven years in prison for sex offences and was sent to HMP Elmley. He had several long-term health conditions.

2. On 10 September, Mr Hastings went to hospital for a CT scan which showed that he had an abdominal aortic aneurysm (a bulge in the main blood vessel from the heart). A prison GP reviewed the results of the CT scan and referred him urgently to a vascular surgeon.

3. On 15 November, a vascular surgeon assessed Mr Hastings' abdominal aortic aneurysm and decided that he did not need treatment, but advised aspirin and a statin, which a prison GP subsequently prescribed.

4. On 1 February 2021, Mr Hastings went to hospital because he had abnormal blood test results. While in hospital, an order was put in place for Mr Hastings not to be resuscitated if his heart or breathing stopped.

5. On 13 April, Mr Hastings went to hospital for an ultrasound scan to re-assess his abdominal aortic aneurysm. There is no record of the outcome of the scan.

Events of 11 July 2021

6. At about 8.30am on 11 July, a nurse saw Mr Hastings in his cell to give him his medication. Mr Hastings was sitting in his bed. He was alert and told the nurse that he had slept well.

7. At about 9.30am, an officer went into Mr Hastings cell and saw that he had breathing difficulties and did not look well. The officer radioed a medical emergency code blue (which indicates that a prisoner is unconscious or having difficulty breathing), asked for a defibrillator and for someone to check if Mr Hastings had signed an order not to be resuscitated.

8. Two nurses went into the cell and confirmed that Mr Hastings had signed an order not to be resuscitated. When Mr Hastings stopped breathing, staff did not try to resuscitate him.

9. At 10.03am, ambulance paramedics pronounced that Mr Hastings had died.

10. A post-mortem examination established that he had died of a haemorrhage caused by a ruptured abdominal aortic aneurysm, systemic hypertension and atherosclerosis.

Findings

Clinical care

11. The clinical reviewer concluded that the clinical care that Mr Hastings received at Elmley was equivalent to that which he could have expected to receive in the community.

12. On 11 February 2021, Mr Hastings returned to prison from hospital, with an order in place not to be resuscitated. This had been completed in hospital. The clinical reviewer found that the order was invalid in a prison setting, and a new order should have been completed.

13. The clinical review made a number of recommendations which did not directly relate to Mr Hastings' death, but which the Head of Healthcare will need to address.

Recommendations

- The Head of Healthcare should ensure that when a prisoner returns from hospital with an order not to be resuscitated, healthcare staff confirm with the prisoner that his wishes remain the same and complete a new order to that effect.

The Investigation Process

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

15. The investigator obtained copies of relevant extracts from Mr Hastings' prison and medical records.

16. NHS England commissioned a clinical reviewer to review Mr Hastings' clinical care at the prison.

17. We informed HM Coroner for Kent and Medway of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

18. Mr Hastings did not have a next of kin.

19. We shared the initial report with the Prison Service. There were no factual inaccuracies.

Background Information

HMP Elmley

20. HMP Elmley holds around 1,100 prisoners, who have been remanded into custody or sentenced. Oxleas NHS Foundation Trust provides 24-hour primary healthcare services. Oxleas NHS Foundation Trust provides mental health services and the Forward Trust drug treatment services.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Elmley was in April 2019. Inspectors reported that healthcare provision was reasonably good. They noted that there was a range of primary care services, although the wait for nurse triage appointments was too long. The inpatient unit was well-run, and a GP was available every day. Inspectors also found that the number of prisoners not attending appointments had reduced since the previous inspection.

22. Inspectors also carried out a short scrutiny visit at Elmley during the COVID-19 pandemic in April 2020. They reported that there had been a good leadership and management response to a fast-changing situation and management oversight of healthcare services was effective. They noted that most routine healthcare provision, such as external hospital appointments, had stopped temporarily due to the risks of COVID-19 but there had been an increased focus on oversight and supporting those most at risk.

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 31 October 2021, the IMB reported that healthcare staff were unsettled because of the ending of the Integrated Care 24 contract. They noted that health provision was patchy due to staff leaving the profession and difficulties in employing agency staff. The IMB reported that outpatient appointments had been impacted by the COVID-19 exceptional delivery model and a high number of hospital appointments were cancelled due to the pandemic, but that the inpatient unit was well maintained.

Previous deaths at HMP Elmley

24. In the two years before Mr Hastings' death, eight prisoners have died from natural causes at Elmley, one as a result of COVID-19. Two prisoners have died from natural causes at Elmley since Mr Hastings' death, one of which was as a result of COVID-19. There are no significant similarities between our findings in this investigation and those of the other deaths.

Key Events

25. On 16 August 2019, Mr Barry Hastings was sentenced to seven years in prison for sex offences and was sent to HMP Elmley.

26. He had many long-term physical and mental health concerns, including hypertension and an abdominal aortic aneurysm (a bulge in the main blood vessel from the heart to the chest and stomach). He used a wheelchair.

27. On 19 August, a prison GP saw Mr Hastings because he had told healthcare staff that he had a shadow on his lung. He noted that Mr Hastings had a history of weakness and weight loss. He found no abnormal physical findings but noted that he may have an irregular pulse and slightly raised blood pressure. He arranged for blood tests, a chest x-ray and an ECG.

28. On 20 August, Mr Hastings had an ECG which showed some abnormalities. Mr Hastings said that he was short of breath and had chest pain. A prison GP sent him to hospital, where he was diagnosed with a left-sided chest infection. Hospital staff sent Mr Hastings back to Elmley with antibiotics and asked that healthcare staff arrange a CT scan. Another prison GP saw Mr Hastings the next day and referred him for physiotherapy and a CT scan.

29. On 10 September, Mr Hastings went to hospital for the CT scan which indicated that he did not have lung cancer but showed that he had an abdominal aortic aneurysm, a saccular aneurysm (a blood vessel wall weakness), chronic lung changes and enlarged adrenal glands. A prison GP reviewed the CT scan results and arranged for Mr Hastings to be referred urgently to a vascular surgeon.

30. On 2 October, a prison GP saw Mr Hastings who told her that he had increased back pain. She referred him for physiotherapy and noted that a social services referral was already in place.

31. On 6 October, a prison GP saw Mr Hastings about his back pain. She increased the dose of his buprenorphine pain relief patches and prescribed him a single dose of morphine sulphate (also pain relief medication).

32. On 25 October, a prison GP saw Mr Hastings and increased his dose of amlodipine because his blood pressure was raised.

33. On 15 November, Mr Hastings saw a vascular surgeon who assessed his abdominal aortic aneurysm and common iliac artery aneurysm. The surgeon noted that Mr Hastings did not need treatment but should be prescribed aspirin and a statin, which a prison GP prescribed.

34. On 9 December, a prison GP reviewed Mr Hastings and noted that he had raised blood pressure and increased his amlodipine dosage. On 29 December, a nurse saw Mr Hastings because he had a painful and swollen right leg. He sent him to hospital because he thought that he might have a deep vein thrombosis. Hospital staff found that he had cellulitis (a skin infection) and gave him intravenous antibiotics. He returned to the inpatient unit at Elmley the next day. On 31 December, a prison GP prescribed tablet antibiotics because the cellulitis had not cleared.

35. On 6 May, a prison GP changed Mr Hastings' pain relief medication. He increased the dose of the buprenorphine patch and decreased the dose of oral morphine sulphate. On 22 May, a prison GP noted that a carer found Mr Hastings to be over-sedated and less able to use his wheelchair. He asked for the pain team to review Mr Hastings urgently. That day, a nurse reviewed Mr Hastings' medical records and recommended reducing the buprenorphine patch dose and to discontinue the oral morphine sulphate.

36. On 27 August, a prison GP saw Mr Hastings because he had an ulcer on his left leg. She prescribed antibiotics and arranged for him to see specialists. Healthcare staff applied a dressing and planned to replace it every 72 hours. On 26 September, a prison GP prescribed more antibiotics.

37. On 12 November, Mr Hastings tested positive for COVID-19 and was sent to hospital on 25 November, with low blood oxygen saturation levels. While in hospital, Mr Hastings had spinal surgery. On 2 December, Mr Hastings returned to the inpatient unit at Elmley.

38. On 26 January 2021, healthcare staff discussed Mr Hastings at a palliative care meeting. On 27 January, a prison GP saw Mr Hastings because he was concerned that he had abdominal swelling which the GP thought may be ascites (an abnormal build-up of fluid in the abdomen).

39. On 1 February, a prison GP reviewed Mr Hastings and sent him to hospital because his blood test results were abnormal. While in hospital, an order was completed to confirm that Mr Hastings did not want to be resuscitated if his heart or breathing stopped.

40. Hospital staff found that Mr Hastings had gastritis (inflammation of the stomach lining), duodenitis (an intestinal condition) and diverticular disease (a digestive condition that affects the large bowel). Hospital staff gave him a blood transfusion and medication for indigestion and heartburn. They also suspected that he may have a myocardial infarction (tissue death of the heart muscle) and damaged heart muscle. Mr Hastings returned to Elmley on 11 February.

41. On 13 April, Mr Hastings had an ultrasound scan in hospital to re-assess his abdominal aortic aneurysm. The clinical review does not set out the results of this.

Events of 11 July 2021

42. At 6.15am on 11 July, a Healthcare Assistant (HCA) noted that Mr Hastings had complained of stomach pain and constipation.

43. At about 8.30am, a nurse saw Mr Hastings in his cell to give him his medication. She saw him sitting in bed and noted that he was alert. He told her that he had slept well but was constipated. She gave him his prescribed medication and movicol (for constipation).

44. At about 9.30am, an officer went into Mr Hastings cell because the HCA had told him that Mr Hastings was short of breath and did not look well. The officer found that Mr Hastings' breathing was very shallow, and he was unresponsive. He radioed a medical emergency code blue. He asked for a defibrillator and for

someone to check if Mr Hastings had signed an order not to be resuscitated. He saw that Mr Hastings was gasping for air.

45. A nurse went into the cell with a colleague, who confirmed that Mr Hastings had signed an order not to be resuscitated. Mr Hastings stopped breathing, and staff therefore did not try to resuscitate him.

46. At 10.01am, ambulance paramedics were at his side and at 10.03am, pronounced that he had died.

Contact with Mr Hastings' family

47. On 30 November 2020, when Mr Hastings' health worsened, a Custodial Manager (CM) appointed a chaplain as the family liaison officer. Mr Hastings told prison staff at the hospital that he had no next of kin and did not want anyone to be told that he was ill. On 12 July 2021, a police officer visited Mr Hastings' ex-wife and told her that he had died. The chaplain telephoned Mr Hastings' ex-wife and offered his condolences. She told him that neither she nor Mr Hastings' daughter wanted to be his next of kin. Mr Hastings' funeral took place on 23 August. The prison paid for its cost in line with national instructions.

Support for prisoners and staff

48. After Mr Hastings' death, a CM 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.

49. The prison posted notices informing other prisoners of Mr Hastings' death and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Hastings' death.

Post-mortem report

50. A post-mortem examination established that Mr Hastings died of a haemorrhage caused by a ruptured abdominal aortic aneurysm, systemic hypertension and atherosclerosis.

Findings

Clinical care

51. The clinical reviewer concluded that the clinical care that Mr Hastings received at Elmley was equivalent to that which he could have expected to receive in the community. He made a number of recommendations which did not relate to Mr Hastings' death, but which the Head of Healthcare will need to address.

Orders not to be resuscitated

52. On 11 February 2021, Mr Hastings returned from hospital with an order in place not to be resuscitated if his heart or breathing stopped. The clinical reviewer noted that in a prison setting, this order was invalid but was still used in Mr Hastings case. He noted that expectations for such orders were very different in acute care and community settings. He noted that hospital orders could be written and agreed based on 'best interests' and did not need to take into account the views of a prisoner. He concluded that the situation in a prison setting was very different and an order had to be agreed and signed, with the prisoner's explicit consent. He said that while the order would have been valid in a hospital setting, it was not valid in prison and a new order not to resuscitate Mr Hastings should have been completed. Despite this, the clinical reviewer found that resuscitation in these circumstances would have been futile, and Mr Hastings' dignity was better maintained by not attempting it. Although it might not have made a difference in Mr Hastings' case, in another emergency, it may be possible to save a life. We therefore make the following recommendation:

    The Head of Healthcare should ensure that when a prisoner returns from hospital with an order in place not to be resuscitated, healthcare staff confirm with a prisoner that his wishes remain the same and complete a new order to that effect.

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