Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David May, a prisoner at HMP Hull, on 16 September 2021

A report by the Prisons and Probation Ombudsman

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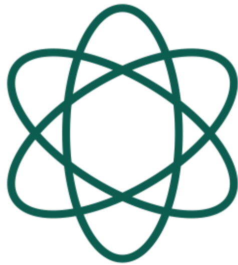
Our vision

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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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 David May, who was 57 years old, died in hospital of heart failure on 16 September 2021, while a prisoner at HMP Hull. We offer our condolences to Mr May's family and friends.

4. The clinical reviewer concluded that the clinical care Mr May received at Hull was of a reasonable standard and equivalent to that which he could have expected to receive in the community. She made a number of recommendations about the need for healthcare staff to accurately record clinical observations using the NEWS2 tool, ensuring that specialist services are updated when a prisoner's health deteriorates and that staff complete appropriate assessments when a prisoner returns from hospital. We repeat the recommendations below.

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

Recommendations

- The Head of Healthcare should ensure that when clinical observations are being undertaken and recorded, these are complete and include all the observations required for an accurate NEWS2 score and that the NEWS2 score is documented.
- The Head of Healthcare and Prison GP services should ensure that communication with outside consultants and hospital departments is timely and accurate and includes information about any deterioration or concerns in the prisoner's presentation.
- The Governor and the Head of Healthcare should ensure that all prisoners returning to the prison via Reception are seen and assessed by healthcare staff on return from hospital in a timely manner.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr May's clinical care at HMP Hull.
7. The PPO investigator has investigated the non-clinical issues in Mr May's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. Our family liaison officer wrote to Mr May's next of kin to explain the investigation. He 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 HMP Hull

10. Mr May was the 14th prisoner to die at Hull since September 2019. Of the previous deaths, five were from natural causes, seven were self-inflicted and one was drug related. There were no significant similarities between the findings in our investigation into Mr May's death and our findings from the investigations into the previous deaths.

Key Events

11. In November 2019, Mr David May was sentenced to five years in prison for sexual offences and was sent to HMP Hull.

12. Mr May did not have any significant physical health concerns. He had a history of anxiety and depression, which had led to instances of self-harm in the community. He engaged with mental health services when he arrived at Hull until July 2020. He was prescribed appropriate medication for his anxiety and depression.

2021

13. In January 2021, Mr May told healthcare staff that he had a persistent cough and chest pain. COVID-19 tests were negative. A prison nurse organised blood tests and an ECG (electrocardiogram is a test of the rhythm and pace of the heart). A prison GP reviewed the results and noted that the chest pain appeared to be muscular, and he prescribed pain relief. Mr May's blood test results were abnormal, and the prison GP asked for all the tests to be repeated.

14. On 29 January, Mr May told the prison GP that he felt better as the chest pain had stopped and his cough had reduced. All his observations were normal, and his blood test results had improved. The prison GP requested repeated blood tests. The results were reviewed on 12 February and showed that Mr May had a chest infection. The prison GP prescribed antibiotics.

15. On 14 April, Mr May asked to see a prison GP about a persistent cough he had for several weeks. Repeated COVID-19 tests were all negative. The next day, a prison GP saw Mr May. Mr May told him that he was producing yellow sputum and had constant pain in the right side of his chest. The GP examined him and noted there were abnormal crackles in the right lung. The GP requested more blood tests and another ECG. Another prison GP reviewed the results and made immediate arrangements for Mr May to go to Hull Royal Infirmary.

16. While Mr May was in Hull Royal Infirmary, scan results showed that he had widespread cancer. The primary site of the cancer was identified as his testes. On 25 April, he transferred to St James's University Hospital, where he was diagnosed with testicular cancer. He was treated with a combination of chemotherapy medication. On 25 July, Mr May was discharged from hospital and was taken back to Hull. He was due to have a hospital follow-up appointment within the next two days.

17. On 29 July, Mr May became unwell in his cell. Prison officers radioed a code blue medical emergency (indicating that a prisoner is unconscious or is having breathing difficulties). A nurse attended and noted that he had had chemotherapy the previous day and his current symptoms were usual for him post treatment. His temperature and respiratory rate were normal. The nurse considered that he was settled, so no further action was taken.

18. On 3 August, Mr May told a healthcare assistant that he felt weak and had been vomiting. His NEWS2 score was 2. (NEWS2 is a nationally recognised tool to facilitate the early detection of a deterioration in health. A NEWS2 score of 7 or higher indicates emergency assessment by critical care team is required.)

Healthcare staff sent Mr May to hospital for review. After being assessed, he was well enough to return to Hull.

19. The next day, the Leeds Oncology Department asked a prison GP to review Mr May to assess if he was fit enough for further chemotherapy. A GP noted no recent changes in Mr May's condition and had no concerns about his observations. The GP tasked a member of the healthcare team to telephone the Leeds oncology team to update them, but the prison administrator was unable to get through to them on the telephone. The next day, a healthcare operations manager spoke to the consultant oncologist at Leeds. The consultant expressed concerns about the lack of communication and updates from prison healthcare staff about Mr May's condition.

20. Mr May continued to attend hospital for chemotherapy and scans. When he returned to Hull on 12 August, healthcare staff did not record any clinical observations.

21. At 10.12am on 25 August, the healthcare operations manager saw Mr May in his cell and noted that he had chest pains, was short of breath and weak. She took his observations and recorded a NEWS2 score of 6. Mr May said he did not want to go to hospital but wanted to speak to his oncologist. Healthcare staff spoke to his oncologist at 2.28pm, who advised them to transfer Mr May to hospital for assessment.

22. Healthcare staff called an ambulance but were told that there was a four hour delay for a non-emergency ambulance. During this time, Mr May's NEWS2 score had increased to 8. The ambulance request was then upgraded to an emergency ambulance, and it arrived at 2.35am the next morning. Mr May was taken to St James's University Hospital and he was treated for community acquired pneumonia. His health continued to deteriorate in hospital.

23. On 16 September, it was confirmed that Mr May had died in hospital.

Post-mortem report

24. The pathologist gave Mr May's cause of death as acute cor pulmonale (heart failure) caused by bleomycin toxicity (a recognised complication that can occur with the use of a chemotherapeutic drug, bleomycin). He also had disseminated germ cell tumour of testis (testicular cancer), which did not cause but contributed to his death.

Lisa Burrell **April 2022**
Assistant Ombudsman

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