

**Prisons &
Probation**

Ombudsman
Independent Investigations

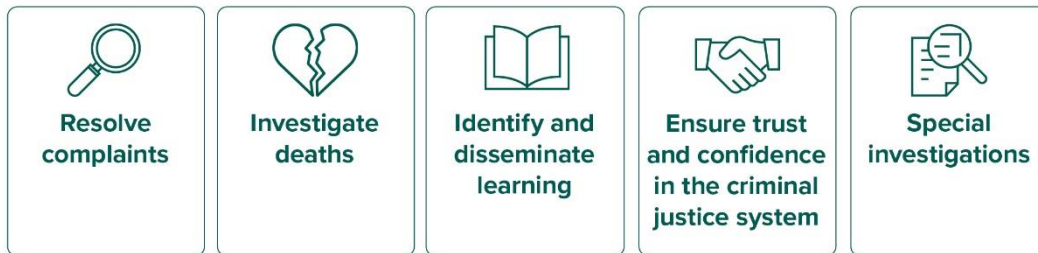
Independent investigation into the death of Mr Anthony Pulami, a prisoner at HMP Hull, on 28 April 2022

A report by the Prisons and Probation Ombudsman

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



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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 Anthony Pulami died of a retroperitoneal haemorrhage on 28 April 2022 at HMP Hull. He was 76 years old. I offer my condolences to his family and friends.

The clinical reviewer concluded that the healthcare Mr Pulami received at HMP Hull was only partially equivalent to that which he could have expected to receive in the community.

She was concerned that there was no evidence to indicate that risk assessments were completed in respect of Mr Pulami's pressure ulcers, risk of malnutrition or his risk of falls. She was also concerned that there was no evidence of care planning while Mr Pulami was at Hull.

She did, however, consider that the care Mr Pulami received when his condition had deteriorated, and also in respect of his social care provision, was equivalent to that which he could have expected receive in the community.

I also note that healthcare staff commenced CPR even though Mr Pulami displayed signs of rigor mortis, which is not in line with European Resuscitation Council Guidelines.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Kimberley Bingham
Acting Prisons and Probation Ombudsman

March 2023

Contents

Summary	1
The Investigation Process.....	2
Background Information.....	3
Key Events.....	4
Findings	8

Summary

Events

1. On 27 September 2021, Mr Anthony Pulami was remanded to HMP Hull charged with historic sexual offences. He was 76 years old.
2. Mr Pulami had some pre-existing medical conditions, including high blood pressure (hypertension) and in 2019, he had a stroke.
3. During his initial health screen at Hull, a nurse noted Mr Pulami's medical conditions. She reviewed his prescribed medications and updated them accordingly.
4. At 9.10am on 28 April 2022, a prison officer went to Mr Pulami's cell to make sure he had taken his prescribed medication. When he entered the cell, he found him lying on his bed, unresponsive. He attempted to gain a response from Mr Pulami but noted that he was cold to the touch and he could not find a pulse. The officer was not carrying a radio, so he called for staff assistance. A supervising officer responded immediately and radioed a medical emergency code. Control room staff telephoned for an emergency ambulance immediately.
5. A nurse responded and noted that Mr Pulami was unresponsive, cold to the touch and there were signs of stiffness in the joints indicating possible rigor mortis. He attempted cardiopulmonary resuscitation (CPR). The prison's Health Service Manager brought a defibrillator. They attached it to Mr Pulami's chest, but no shockable rhythm was found. A second nurse arrived shortly afterwards, she reviewed Mr Pulami and advised that CPR should stop because Mr Pulami was clearly dead.
6. At 9.31am, paramedics arrived at the cell and confirmed Mr Pulami's death at 9.38am.
7. The post-mortem report gave Mr Pulami's cause of death as retroperitoneal haemorrhage caused by a ruptured abdominal aortic aneurysm and severe atheroma.

Findings

8. The clinical reviewer concluded that the healthcare Mr Pulami received at Hull was partially equivalent to that which he could have expected to receive in the community.
9. She was concerned that there was no evidence in Mr Pulami's medical records to indicate that healthcare staff completed appropriate risk assessments for Mr Pulami's pressure ulcers, risk of malnutrition or his risk of falls, which is not in line with NICE (National Institute for Clinical Excellence) guidance. She was also concerned there was no evidence of care planning while Mr Pulami was at Hull.

The Investigation Process

10. 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.
11. The investigator obtained copies of relevant extracts from Mr Pulami's prison and medical records.
12. NHS England commissioned an independent clinical reviewer to review Mr Pulami's clinical care at the prison.
13. We informed the Coroner for Hull and East Riding of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
14. Mr Pulami did not identify a named next of kin. He had no contact with his family.
15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Hull

16. HMP Hull is a local prison that holds up to 1,056 men in ten wings. The prison has a wellbeing unit to support prisoners with complex needs, which are difficult to meet in the normal prison environment. City Healthcare Partnership (CHCP) provides health services at the prison. GP surgeries are held four days a week, with an out of hours service at other times.

HM Inspectorate of Prisons (HMIP)

17. The most recent inspection of HMP Hull was in April 2018. Inspectors found that health provision was reasonable, and governance was mostly effective, but some health services had deteriorated since the last inspection.

Independent Monitoring Board

18. 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 report for the year to February 2022, the IMB noted concerns that the current healthcare providers were failing to provide adequate healthcare services at the prison.
19. The IMB also noted that the contract to provide healthcare services had been put to tender but in the interim period, Spectrum Services had been tasked with providing healthcare services at Hull.

Previous deaths at HMP Hull

20. Mr Pulami was the twelfth prisoner to die at Hull since April 2020. Of the previous deaths, seven were from natural causes and four were self-inflicted. There have been two further deaths since Mr Pulami's death, one from natural causes and one that was drug related.
21. In two previous investigations into the deaths of prisoners at Hull in June 2021 and May 2022, we made recommendations about the management of long-term conditions, and the appropriate use of care plans. The prison accepted our recommendations made in the investigation in June 2021 and said that prisoners with long-term conditions were identified during the reception process and referred to long-term condition clinics at the prison. They also said that the system was reviewed every month to ensure compliance. It is very disappointing that we are raising this issue again in this report.

Key Events

22. On 27 September 2021, Mr Anthony Pulami was charged with historic sexual offences and remanded into prison custody. He was sent to HMP Hull.
23. The nurse manager carried out an initial health screen. She noted that Mr Pulami had been diagnosed with high blood pressure at the age of eighteen, and that he had had a stroke in 2019 (a life-threatening condition that occurs when the supply of blood to the brain is reduced). She also noted that Mr Pulami had experienced incontinence following a surgical procedure to treat a brain aneurysm while in Nepal, where he had been living for the previous ten years. Healthcare staff reviewed and updated his prescribed medications and referred him to a prison GP for further review.
24. A worker from the prison's Mental Health Inreach Team (MHIRT) saw Mr Pulami later that day. She did not feel he would benefit from any further input from MHIRT but told him that he could refer himself for support should he feel the need.
25. On 15 October, a prison GP saw Mr Pulami. He noted Mr Pulami's previous diagnosis of high blood pressure, the stroke he had in 2019 and his ongoing issues with incontinence. He considered that Mr Pulami would benefit from full blood tests. However, despite his best efforts, Mr Pulami refused and said that the blood tests were unnecessary because there was nothing wrong with him.
26. On 16 November, a nurse reviewed Mr Pulami's blood pressure and it was extremely high. She referred him to a GP for an urgent review. A prison GP saw Mr Pulami the next day. He noted his blood pressure, which was still high. Mr Pulami told him that he had decided to stop taking his blood pressure medication because he was concerned that his blood pressure would then be too low. The GP told Mr Pulami that this was not a sensible course of action and reinforced the importance of him taking his medication as prescribed. Mr Pulami agreed to start taking his medication correctly. The GP also made a note in Mr Pulami's medical records asking healthcare staff to encourage him to take his medications as prescribed. There is no evidence that either the doctor or any of the nurses who saw Mr Pulami considered setting up care plans for any of Mr Pulami's long-term conditions.
27. On 23 November, prison officers were concerned that Mr Pulami had become withdrawn after he had been assaulted by another prisoner. A nurse from MHIRT went to see him. He told her that he felt fine and that he had been withdrawn since he had suffered a stroke two years previously. He declined the offer of support and said that he would be fine in a couple of weeks. She reminded him that he could refer himself to MHIRT at any time should he need to do so.
28. Later that day, a nurse saw Mr Pulami, after he was noted to be unsteady on his feet while collecting his lunch. She asked him if he felt his mobility had deteriorated. He told her that he had had a stroke two years earlier, and as a result, was occasionally unsteady on his feet particularly when he was tired. However, she was concerned that he may have suffered another stroke.

She asked him if he could get out of his bed and move to his chair unaided, and he said that he could. He also showed her that he was able to lift his arms and legs when asked to do so, was able to grip with both hands and with equal pressure and was able to smile and frown when asked to do so. She noted that he had no signs of facial drooping, weakness or loss of sensation.

29. The nurse asked another nurse for a second opinion. The other nurse noted that Mr Pulami was eating and drinking well, passing urine and opening his bowels without issue. However, she noted that during her review, there were occasions where he lost his train of thought and she had to repeat her questions. She referred him for a GP review, and also made a referral to MHIRT. She told Mr Pulami that if he had any concerns in the meantime, he should raise them with healthcare staff.
30. A prison GP reviewed him the following day. He carried out a urine test. The results indicated that Mr Pulami had a raised creatinine level (often an indicator of reduced kidney function). The GP prescribed him antibiotics and made a referral to the ultrasound department at the hospital for further review.

2022

31. On 23 January 2022, a nurse saw Mr Pulami after prison officers had raised concerns about his mobility. Mr Pulami told her that he also felt his mobility had worsened. Another nurse saw Mr Pulami a month later, after prison officers had found him on the floor of his cell. She noted that he was unsteady on his feet and she referred him for a GP review. There is no evidence in his medical records to indicate that a falls risk assessment was completed.
32. On 25 February, a prison GP saw Mr Pulami. He considered Mr Pulami may have developed a urinary tract infection and prescribed him antibiotics.
33. On 14 March, a worker from the prison's MHIRT saw Mr Pulami. She noted that he was pleasant during her review and reported no previous mental health concerns. However, she noted in his medical records that he had bouts of forgetfulness and needed support with daily tasks. She considered he would benefit from an Addenbrookes Cognitive Exam (ACE-III, a series of neuropsychological tests used to identify cognitive impairment in conditions such as dementia). She also made a referral for ongoing blood tests to look for signs of dementia.
34. On 23 March, a nurse noted Mr Pulami's incontinence was worsening and that his mobility was becoming increasingly limited. She also noted that he needed increasing levels of assistance from healthcare assistants at the prison. She considered he would benefit from additional support from social carers. The following day, a nurse completed a social care assistance referral.
35. During a routine review on 25 March, a Healthcare Assistant (HCA) noted that she considered Mr Pulami's memory was deteriorating and that he was not eating properly. She asked a nurse to review him. The next day, a nurse carried out a urine test. The test result showed that Mr Pulami had a urine infection, but his condition was much improved.

36. On 29 March, a prison GP saw Mr Pulami. He noted the results of the urine test and prescribed a course of antibiotics to treat the infection. He made a second referral to the ultrasound department at the hospital.
37. However, the following day, Mr Pulami's condition deteriorated, and he was taken to hospital by emergency ambulance. Hospital staff diagnosed him with a urinary tract infection, and he was given a course of intravenous antibiotics and fluids. He remained in hospital as an inpatient. His condition stabilised and he was discharged from hospital and went back to Hull on 16 April.
38. On his arrival at the prison, a nurse saw Mr Pulami. The nurse noted that Mr Pulami was unable to confirm the year or where he was. He considered that Mr Pulami was not actually fit for discharge from hospital and raised his concerns with hospital staff. Hospital staff told him that while Mr Pulami had been an inpatient he had not been confused and that despite being incontinent, was able to use the toilet. Following his review, prison healthcare staff checked Mr Pulami twice every hour.
39. On the 21 April, a nurse saw Mr Pulami after prison staff found him on the floor of his cell. He had no apparent injuries. She took a note of his observations and they were within a normal range.
40. On 25 April, a worker from MHIRT carried out an ACE-III test. The results indicated that Mr Pulami might have dementia. On 27 April, a nurse noted in Mr Pulami's medical records that he was still awaiting a decision in respect of the social care referral made on 24 March.
41. At 9.10am on 28 April, an officer went to Mr Pulami's cell to make sure that he had taken his prescribed medication. When he entered the cell, he found Mr Pulami lying on his bed, on his right-hand side, unresponsive. He attempted to gain a response from Mr Pulami by shaking his arm and noted that he was cold to the touch. He could not locate a pulse.
42. The officer was unable to call a code blue medical emergency (indicating a prisoner is unconscious or is having breathing difficulties) because he was not carrying a radio. He immediately called to another officer and asked him to use his radio to call a code blue emergency. However, before he could so a Supervising Officer (SO) arrived and radioed the code blue immediately.
43. A nurse and an HCA responded immediately and brought an emergency grab bag (a bag containing lifesaving equipment). The nurse noted that Mr Pulami was unresponsive, cold to the touch and there were signs of stiffness in the joints indicating possible rigor mortis. Despite this, he attempted CPR, assisted by the HCA.
44. The Health Service Manager also responded with a defibrillator. They moved Mr Pulami to the floor of his cell and cut off his clothing. The Manager attached pads to Mr Pulami's chest, but no shockable rhythm was found. The Nurse Manager arrived shortly afterwards. She reviewed Mr Pulami and advised that attempts at CPR should stop. Paramedics arrived at the cell at 9.31am and at 9.38am, confirmed that Mr Pulami had died.

Contact with Mr Pulami's Family

45. On 28 April 2022, the prison appointed a Family Liaison Officer (FLO).
46. The FLO noted that Mr Pulami had no next of kin listed on prison records. She telephoned his community probation officer to ask if she had any details of family that she could contact. His probation officer told the FLO that his family had disowned him when his offences had come to light. She told the FLO she would contact local police to see if they could offer any assistance.
47. On 9 May, the police informed the FLO that they had traced Mr Pulami's nephew, but he wanted no further involvement.
48. The prison paid for Mr Pulami's funeral in line with national guidance.

Support for prisoners and staff

49. After Mr Pulami's death, a prison manager debriefed the staff who were involved, giving them 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 Pulami'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 his death.

Post-mortem report

51. The post-mortem report gave Mr Pulami's cause of death as retroperitoneal haemorrhage (bleeding in the retroperitoneal space) caused by a ruptured abdominal aortic aneurysm (leaking blood vessel) and severe atheroma (a fatty substance that is deposited into the walls of the heart). He also had chronic kidney disease and hypertension (high blood pressure), which were listed as contributory factors.

Findings

Clinical care

52. The clinical reviewer concluded that the care Mr Pulami received at HMP Hull was only partially equivalent to that which he could have expected to receive in the community.
53. She noted that Mr Pulami was appropriately reviewed by the prison GP at times of concern regarding his high blood pressure. However, she was concerned that there was no evidence in his medical records to indicate that his long-term conditions were appropriately managed during his time at Hull, including that there was no evidence of care planning. She considered that was not in line with NICE clinical guidance. We recommend:

The Head of Healthcare should review the pathway for long-term conditions to ensure compliance with NICE clinical guidance.

Other matters

54. The clinical reviewer also made recommendations about the lack of risk assessments for malnourishment, falls or ulcers to support Mr Pulami's care, which we do not repeat in this report but which the Head of Healthcare will need to address.

Emergency response

55. Guidance to support the decision-making process about when not to perform cardiopulmonary resuscitation in prisons states that 'CPR must be started on all patients who are found not breathing and/or pulseless unless certain conditions exist. In the prison estate, the primary judgement that needs to be made is whether rigor mortis is present'. The European Resuscitation Council Guidelines state that in such cases, a non-clinician might make a diagnosis of death but is not certifying death. CPR that has no chance of success in terms of survival is pointless and may violate the right for dignity in death.
56. Staff should not have attempted to resuscitate Mr Pulami when he was found unresponsive in his cell. Mr Pulami's body was stiff when staff moved him to carry out CPR, which was a strong indication that rigor mortis had set in. Rigor mortis normally occurs several hours after death. We recommend:

The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances where resuscitation is and is not appropriate, in line with national and European guidelines.

**Kimberley Bingham
Acting Prisons and Probation Ombudsman**

March 2023

Inquest

The inquest, held on 1 June 2023, concluded that Mr Pulami died from natural causes.

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