

**Investigation into the circumstances surrounding the
death of a man
at HMP Hull in April 2009**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

February 2010

This is the report of my investigation into the circumstances surrounding the death of a man at HMP Hull in April 2009. He was a life sentence prisoner aged 54 years and had been in Hull since January 2007. He suffered from a number of serious health problems for several years and required a high level of medical support. In March 2009, he was diagnosed with terminal cancer and his condition deteriorated quickly. He died while asleep during the night in the prison healthcare centre. A post mortem examination found that the cause of death was heart disease.

I would like to offer my condolences to the man's mother, children and wider family. At the time of his death, he was awaiting a Parole Board hearing and it was thought likely that he may have been judged suitable for release. In May 2008, he had been deemed suitable for open conditions but was unable to transfer to an open prison because of his poor health. Staff at Hull believed that he had made a genuine commitment to being fully rehabilitated into society and spending time with his children. Unfortunately his untimely death came at an otherwise hopeful time for him and his family.

My investigation was led by a senior investigator and a Family Liaison Officer was appointed.

An independent review into the clinical care received by the man was commissioned from the local Primary Care Trust. Clinical reviewers undertook the review and their reports are annexed to mine. I am grateful to them for their help and also to the Risk and Claims Manager for NHS Hull, for her liaison. I am also grateful to the Governor and staff at HMP Hull, especially a duty governor and a Principal Officer for their co-operation with this investigation.

I am disappointed that, despite being categorised as suitable for open conditions for almost a full year before he died, it was not possible to find an open prison able to take the man. I am pleased however that my investigation has found that the care he received at Hull was of a high standard and that he himself said that he was well looked after there.

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

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SUMMARY

The man was 54 years old and serving a life sentence at HMP Hull. He had a history of poor physical health and suffered from angina, diabetes and chronic obstructive pulmonary disease (COPD). He also suffered from depression and paranoid thoughts. Although a category C prisoner, he was transferred to Hull (a category B prison) in January 2007 because of his need for 24 hour healthcare support.

In May 2008, the Parole Board decided that the man was suitable for open conditions and he was re-categorised to category D. Unfortunately his medical needs meant that, despite efforts made by Hull staff, a suitable open prison could not be found.

In February 2009, the man told the doctor that he had a lump in his right thigh that was getting bigger and causing him pain. He was referred to the infirmary. A succession of scans and biopsies revealed the presence of a malignant tumour in his thigh and possible secondary tumours in his lungs. On 23 March, he was told that his disease was terminal. He had an operation to remove the tumour. A haematoma developed in the wound on his thigh and later became infected. He was treated on the wing and in the healthcare centre in Hull but his condition deteriorated rapidly and he died in April. A Home Office Consultant Forensic Pathologist undertook a post mortem examination of the man. The pathologist concluded that the cause of death was "hypertensive and ischaemic heart disease".

The clinical review of the treatment received by the man concluded that the care he received was at least equitable to that he would have received in the community. His physical and mental health needs were looked after promptly and to a high standard. Issues about the communication between the infirmary and the prison and housekeeping points concerning night records kept by healthcare staff are raised but I conclude that they did not affect his diagnosis and treatment.

The prison's response to the man's death was appropriate and timely and every effort was made to provide a high standard of liaison with his next of kin.

THE INVESTIGATION PROCESS

1. The investigation was led by a senior investigator. A Family Liaison Officer was appointed. Notices of the investigation were sent to staff and prisoners at HMP Hull inviting them to contact the investigator if they wished. No response was received to these notices. She visited Hull on 19 May. She read the man's prison record, clinical record and the documents associated with his death. She obtained copies of documents she considered relevant to the investigation. She visited the Healthcare Centre, spoke to staff and saw where he died.
2. An independent clinical review into the care received by the man was commissioned. A Registered General Nurse and a Consultant Physician in General and Respiratory Medicine undertook the review. Their reports appear at annex one. Both clinical reviewers visited Hull, read all of the clinical records and interviewed staff.
3. The Family Liaison Officer spoke to the man's brother by telephone. He said that the family were happy with the care offered to his brother by Hull.

HMP HULL

4. HMP Hull is a category B local prison holding remand and sentenced adult male prisoners and young offenders. Since 2002 it has undergone a period of expansion and now holds over a thousand prisoners. The expansion included a purpose built healthcare centre offering 24 hour healthcare and a multi-bedded in-patient ward and cellular accommodation. This year a terminal care suite has been adapted. Medical services are contracted out to the local Primary Care Trust.
5. The prison accepts indeterminate (life) sentenced prisoners sentenced in the interests of public protection (IPP – known as the ‘two strikes’ system) as well as the conventional mandatory life sentence. Hull runs a number of offence-related courses and category B prisoners are often re-categorised to lower security categories once they have completed them.
6. The 2008 report of the Hull Independent Monitoring Board (IMB) highlighted the problem that an overcrowded prison system poses in terms of moving these prisoners around the system. In common with other category B prisons Hull also contains a number of category C and even category D prisoners who are waiting for spaces at lower category prisons. The man was a category C prisoner when he arrived at Hull in 2007 and was re-categorised to category D (deemed to be suitable for open conditions) in May 2008. He remained in Hull because it was not possible to find another lower category prison that could manage his medical needs.
7. In late 2008 Hull scored positively in Measuring Quality of Prisoner’s Life (MQPL) survey and attained ‘Best in class for Diversity’. It was rated as a “safe and decent prison”. The Prison Service raised its rating to level four – awarded to “excellent establishments that are delivering exceptionally high performance”.
8. Her Majesty’s Inspector of Prisons last inspected Hull in an announced inspection in November 2008. Her report, published in March 2009, complimented Hull on staff prisoner relations, activities, diversity, resettlement and time out of cell. The healthcare offered was judged to have “improved considerably” since the previous inspection.

KEY EVENTS

9. The man suffered from a number of physical and mental health problems for many years. These included chronic breathing difficulties, heart disease and diabetes. The clinical reviews at Annex 1 offer a very detailed account of the nature of his illnesses and chronology of care he received from prison healthcare staff. In this section I concentrate on significant events from February 2009 until his death.
10. On 16 February 2009, the man asked to see the prison doctor about a lump on his right thigh that he said had been there for about one month and was increasing in size. He said it had started to become painful and cause numbness down his leg. He was examined by a prison doctor and referred to hospital for an ultra sound scan.
11. Three days later, on 19 February, another prison doctor examined the man because he said the lump had increased in size and was spreading towards his lower thigh. The doctor sent him to the infirmary the same day to exclude a haematoma (a collection of blood outside the blood vessels as the result of internal bleeding) or abscess. An urgent ultra sound scan was carried out on his right thigh but the prison was not contacted. Staff made several calls to the infirmary to find out the results.
12. On 21 February, the man reported that he had “blacked out” out in his cell and fallen, hurting his ankle. He attended the infirmary the same day for an x-ray of his ankle which revealed a sprain. He had a follow up appointment on 25 February but was able to walk normally at this point and had no further ankle problems.
13. The hospital faxed the prison on 24 February referring to the lump as highly suspicious and possibly malignant. The man was referred for a formal musculoskeletal review.
14. On 1 March, the man complained of chest pains and pins and needles down his right arm. He was taken to the infirmary by emergency ambulance and was given a chest x-ray that revealed a possible infection.
15. The man returned to the infirmary for an appointment on 9 March with a Consultant Plastic Surgeon. The consultant decided to undertake an MRI scan of the man’s right thigh and core biopsies of the lump. The scan and three biopsies took place on 13 March. At the same time he was given chest x-rays and scans of his abdomen, thorax and pelvis.
16. The man saw the consultant again on 23 March. He was told that the scan and biopsies had revealed that the lump was suggestive of a high grade sarcoma (malignant tumour of the muscle). The diagnosis was not definitive but the scans of his abdomen, thorax and pelvis had revealed

- multiple nodules in his lungs, which were thought to be lung tumours. The consultant told the man that the only way to obtain a definitive diagnosis was to remove the lump from his thigh. However, any further treatment given would be palliative and the disease was terminal. The man agreed to have the lump removed and is reported as saying that a definitive diagnosis might help him come to terms with what was happening to him.
17. The lump was removed at the infirmary on 25 March. On his return to the prison healthcare staff reviewed the man to check how he was coping with the diagnosis that he was terminally ill. They reported that he appeared relatively cheerful but that his wound was oozing blood on movement. On 31 March, it was recorded that his wound was bleeding when he moved about and he was only really comfortable while in bed. He was reviewed by the second prison doctor the same day and prescribed morphine for pain relief.
 18. The next day, the man went to the healthcare centre to have his wound dressed and it was noticed that it was leaking and large clots of blood had formed. He was sent to the infirmary by ambulance and he had a further operation to remove a large haematoma from the site of the operation. He was discharged back to prison on 4 April and said he did not want to be admitted to the healthcare centre. A third prison doctor agreed that he could remain on the wing and have his dressing changed twice daily. On 5 April, his morphine dose was increased. He remained on the wing but was seen twice daily by healthcare staff to dress his wound and review his pain management.
 19. On 8 April, the man asked to be admitted to the healthcare centre because his pain had increased. Staff completed the required paperwork to support his release on compassionate licence. He had a parole review date of 7 June but it was hoped to expedite this in the light of his now rapidly deteriorating condition.
 20. It was recorded on 11 April that the man's wound was showing signs of infection. The next day, he reported feeling very unwell and was given antibiotics. A note on his clinical record said that if he got worse then he should be taken to the infirmary. The following day he was seen to be in obvious distress due to his clinical condition and was taken to the infirmary by ambulance. The prison contacted his family to tell them. He was found to have an acute infection that had exacerbated his breathing problems and angina.
 21. On 14 April, the man discharged himself from the infirmary against medical advice. He attended an outpatient appointment at a hospital on 15 April and was reported to be in good spirits, despite the fact that his wound remained badly infected. He remained in hospital for his wound to

- be stitched and drained and was returned to the prison healthcare centre on 18 April.
22. The man complained of difficulty breathing three days later on 21 April. A fourth prison doctor examined him and recorded that he was losing weight and deteriorating quickly. The doctor increased the man's morphine to counteract his increasing pain. He went to an outpatient appointment at hospital the following day but was very sleepy on his return due to the amount of morphine in his system.
23. On 23 April, at about 7.40am, an officer began unlocking the prisoners in the healthcare centre. He unlocked room F1-4, which was shared by the man and his cellmate. In his statement the officer said that he spoke to the man through the door but he did not respond. He looked at the cellmate who said, "he's out for the count boss".
24. A nurse and the in-patient manager arrived at the cell and examined the man. They found that he did not respond. He appeared cyanosed (that is blue in colour because of lack of oxygen) and was not breathing. The in-patient manager asked the officer to radio for paramedics and the doctor, and to tell the orderly officer (the officer in charge of the operational management of the prison) and the Duty Governor. Cardio-pulmonary resuscitation (CPR) was attempted but the man's airways were blocked and his jaw was too stiff to be able to insert an airway. A defibrillator was applied but it advised not to shock. He was cold, clammy and not breathing. Paramedics arrived and, after further examination, he was pronounced dead at 8.19am.

ISSUES

Clinical care

25. The clinical reviews provided by two clinical reviewers are reproduced in their entirety at annex one of this report. The first clinical reviewer concludes that the general healthcare that the man received in Hull was comparable to that he would have received in the community. The management of his COPD, heart disease and diabetes was consistent with national recommendations and he was offered smoking cessation advice and lifestyle and dietary advice on a regular basis. He had suffered from mental health problems including depression. Following his diagnosis with a terminal illness, mental health staff spoke regularly to him to assess his mood. He was also spoken to when he discharged himself from the infirmary against medical advice.

26. The clinical reviewer is satisfied that the prison referred the man to secondary care in a timely manner once he reported the lump in his thigh. During interviews with staff at Hull it became apparent that they had found it difficult to obtain information from the infirmary about the type of treatment the hospital planned to give. Prison healthcare staff resorted to asking the man. He would in turn ask his solicitor to ask the hospital and then the solicitor would inform the prison of the answers by letter. This is clearly a ridiculous and unsatisfactory state of affairs and one that may seriously reduce the prison's ability to provide prisoners with the care they require. It is not within my remit to make a recommendation directly to the hospital, therefore I must ask the Head of Healthcare at Hull and the Primary Care Trust to pursue a memorandum of understanding or other policy to improve communication between secondary care and primary care in the prison.

I recommend that the Head of Healthcare and the PCT look at ways of formalising communication between secondary care and prison healthcare.

General clinical issues

27. Both clinical reviewers were satisfied that all emergency equipment was checked on a daily basis and counter checked weekly. The first clinical reviewer considers that training in basic and advanced life support and CPR should be standardised and restructured to take place in one or two days. I make no formal recommendation in this regard but draw the attention of the Governor and the Head of Healthcare at Hull for their consideration.

28. Both reviewers commented that the electronic clinical record notes were comprehensive and decipherable. They said however that notes kept by night staff were on paper and only written up electronically on an ad hoc basis. This led to gaps in the record. I am aware that the man was well known to staff and his case was necessarily the subject of much discussion. I do not feel therefore that any gaps in the record reflect a lack of communication or failing in his case. However, it is important that an accurate audit is kept and I make the following recommendation.

I recommend that the Head of Healthcare reviews the system of record keeping by night staff with a view to standardising practice among staff.

29. The first clinical reviewer also refers to the fact that Hull does not have a formal Do Not Resuscitate (DNR) policy for terminally ill prisoners. Such policies are common practice when caring for people who are terminally ill. The man's wishes in this respect were not discussed with him. I agree that the prison should formally adopt such a policy and endorse the clinical reviewer's recommendation that one be implemented.

I recommend that the Head of Healthcare and the PCT implement a formal Do Not Resuscitate policy for use in the care of terminally ill prisoners.

The prison's response to the man's death

30. Prison Service Order 2710 Follow up to deaths in custody, requires that prison staff inform the next of kin when a prisoner dies. In the man's case Hull decided that it would be quicker for staff from the prison nearest to his mother to visit the family in person, than for staff to travel to Middlesbrough from Hull. Contact was made with HMP Holme House and the Deputy Governor there visited the man's mother at home to break the news. I am satisfied that the decision for staff from Holme House to break the news to the family was sensible. A governor from Hull prison spoke to the man's mother by telephone later the same day and visited the family on 30 April to return his property. The governor also went to the funeral and the prison met the costs. I am satisfied that every effort to provide effective family liaison was made.

31. It is clear from the evidence of staff who saw the man on 23 April, that by the time his room was unlocked by the officer, he was already dead. The prisoner who shared the room appeared unaware that the man had died. I am satisfied that the response by staff was efficient and appropriate.

32. I am also satisfied that all the persons required to be informed of a death in custody were informed of the man's death in a timely manner. All

prisoners who were subject to the Prison Service's self-harm monitoring system (ACCT) were reviewed promptly. I am impressed with the notices issued to staff and prisoners by the Governor and have annexed them to this report. They were issued promptly and the tone and content are excellent. I draw them to the attention of the Prison Service as examples of good practice.

CONCLUSION

33. The man had been in poor health for a number of years. He was transferred to Hull in 2007 because he required access to 24 hour healthcare provision. His health was already challenging to manage by the time he was diagnosed with a terminal illness and suffered a major leg wound that would not heal. I am satisfied that the care he received in Hull was timely, appropriate and consistent with that he would have expected in the community.
34. I am however disappointed that, despite attaining category C and then category D status almost a full year before his death, an appropriate prison providing the man with the healthcare and resettlement support he needed could not be found. This is no reflection on Hull who made every attempt to find a place for him in a lower category prison. It should however be a subject of concern for the Prison Service as a whole. Whilst I make no recommendation, I draw the matter to the attention of the National Operating Officer.
35. The man was obviously popular with staff and his death, particularly its suddenness, was obviously upsetting for all those who looked after him. The way in which his needs were managed does credit to Hull prison.

RECOMMENDATIONS

1. The Head of Healthcare at Hull and the PCT should look at ways of formalising communication between secondary care and prison healthcare.
2. The Head of Healthcare should review the system of record keeping by night staff with a view to standardising practice among staff.
3. The Head of Healthcare and the PCT should implement a formal Do Not Resuscitate policy for use in the care of terminally ill prisoners.

Good practice

4. The content and tone of the Governor's Notices to staff and prisoners following the man's death are good practice.