

**Circumstances surrounding the death of a man at a local
hospital, whilst in the custody of HMP Hull,
In March 2008**

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

October 2008

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.

This is the report of an investigation into the death of a man who was a prisoner at HMP Hull and who died from natural causes on 31 March 2008. He was 70 years old. Prior to his arrival in custody, eight months earlier, the man had been diagnosed with chronic renal failure. This meant that he needed to attend the local hospital for dialysis treatment three times a week.

I would like to add my personal condolences to those already expressed to the man's family on behalf of this office by one of the Ombudsman's Family Liaison Officers.

This investigation was undertaken by one of the Ombudsman's investigators. He and I would like to thank the Governor of HMP Hull and his staff for their assistance. A clinical reviewer was asked by Hull Teaching Primary Care Trust to undertake a review of the man's clinical care and I also much appreciate their help.

I have noted the clinical reviewer's conclusion that the quality of care the man received was in some instances better than that he would have received in a community setting. I have also noted the issues highlighted by the clinical reviewer and I endorse the recommendation made in the clinical review. The Primary Care Trust and the prison will need to develop an action plan to address the matters raised.

Jane Webb
Deputy Prisons and Probation Ombudsman

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SUMMARY

The man was 70 years old when he died at a local hospital on 31 March 2008. The man died from natural causes as a consequence of a gastrointestinal haemorrhage (bleeding in the tract that links the stomach and the intestine).

On 3 August 2007, the man was sentenced to seven years imprisonment. He arrived at Hull the same day and on arrival it was noted that he had been diagnosed with chronic renal failure which required him to have dialysis three times a week. The man had been diagnosed previously with chronic bronchitis, a duodenal ulcer, chronic obstructive pulmonary disease and coronary heart disease with congestive cardiac failure. He had also suffered from depression in the past. Due to his medical condition the man was located on the healthcare wing for the duration of his time at Hull.

During his first health screen interview the man told staff that he wanted to refuse all treatment. Accordingly, a self-harm observation and support regime was started. This involved regular checks being carried out and recorded. The regime was stopped on 13 August when the man agreed to attend his dialysis treatment. The self-harm observation and support regime was started again from 19 to 22 November, 2 to 5 December and 12 to 17 March 2008 when the man again refused treatment.

On 25 March 2008, the man was taken to a local hospital as he had been experiencing rectal bleeding, had low blood pressure and his complexion was pale.

Whilst the man was in hospital, a bedwatch was carried out by prison staff. The initial security risk assessment was that handcuffs were to be used and two officers needed to be at his bedside. This was later revised on 26 March and handcuffs were no longer used. Whilst the man was in hospital he was visited by his family.

At approximately 9:50am on 31 March, one of the officers on bedwatch duty noticed that the man had stopped breathing. The officers immediately informed hospital staff who established that the man had died. A doctor pronounced death at 11:10am.

The clinical review concludes that the man's clinical care was good and in some instances better than that available in the community. I have endorsed the clinical reviewer's recommendation and make no other recommendations.

THE INVESTIGATION PROCESS

1. One of the Ombudsman's investigators opened the investigation on 3 April 2008. He issued notices announcing the investigation to staff and to prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to my investigator. In the event, nobody came forward. The investigator also studied all relevant prison records relating to the man. These included his main prison record, bedwatch logs, medical records and statements made by staff.
2. The investigator visited Hull on 12 May and discussed aspects of the man's treatment with staff at the prison.
3. The Hull Teaching Primary Care Trust (PCT) commissioned the Clinical Governance Manager to carry out a review of the man's clinical care. I am grateful to the clinical reviewer for undertaking the review.
4. The investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist in his enquiries into the man's death.
5. One of the Ombudsman's Family Liaison Officers contacted the man's family. This gave them the opportunity to discuss the purpose of the investigation and to raise any concerns or questions they would like explored or addressed. The man's family did not wish to raise any specific concerns about the treatment he received while in custody. They asked the Family Liaison Officer to clarify whether anyone was with the man when he died. I can confirm that two prison officers were with the man at that time. The man's family also asked to see a copy of my report when complete. I hope that my report helps the family better understand the events leading up to the man's death.

HMP HULL

6. HMP Hull opened in 1870 and is now a category B adult male and young offender local prison serving the courts in East and North Yorkshire and North Lincolnshire. There are eight residential units and a healthcare centre. The maximum number of prisoners that can be held is 1,044 and the certified normal accommodation is 723.
7. Provision of healthcare is the responsibility of Hull Teaching Primary Care Trust with the General Practitioner (GP) service being provided by a local GP practice. The healthcare centre has 18 beds and provides 24 hour nursing care.
8. Medication is administered on a weekly and/or monthly basis to those prisoners who have been risk assessed as suitable for holding it in their own possession. It is administered on a daily basis to other prisoners, when either they are judged to be at risk or the medication is considered unsuitable to be held in their possession.
9. Her Majesty's Chief Inspector of Prisons, Ms Anne Owers, carried out her last full inspection in November 2005. Hull has changed considerably since the time of that inspection due to the closure of a much-criticised unit. At that time, Ms Owers found that "the healthcare centre provided a good service".
10. The Measuring the Quality of Prisoner Life (MQPL) survey, carried out in November 2007, found a small majority of prisoners negative about relationships between prisoners and staff. This was in contrast to the Independent Monitoring Board's finding, in its annual report for 2006/7, who found staff "dedicated and loyal". A number of prisoners who participated in the MQPL survey expressed frustration at the lack of employment opportunities. The Inspectorate found "the overall quantity of purposeful activity remained insufficient, with prisoners spending too long locked up in their cells".
11. Since 2004, the Ombudsman's office has investigated nine deaths through natural causes at HMP Hull. There was no link between the circumstances surrounding this investigation and the previous deaths at Hull.

KEY EVENTS

12. The man arrived at Hull on 3 August 2007. On first reception in prison, it was noted that he had a number of health issues and that he was a smoker. The man had suffered for a number of years from chronic renal failure which required him to have dialysis three times a week. The dialysis sessions would last four hours. As the man's own kidney function was virtually non-existent, he required the dialysis sessions in order to remain alive. The man also had a long history of chronic bronchitis, chronic obstructive pulmonary disease and coronary heart disease with congestive cardiac failure. It was recorded that he had previously been diagnosed with a duodenal ulcer and that he suffered from depression from time to time. The man was offered support to help him stop smoking but he chose not to take up this offer. Due to his health problems the man required a special diet and needed to have his fluid intake restricted to one litre per day. The man was prescribed a range of medication to treat his various conditions and was allowed to keep some medicine in his possession.
13. During his first health screening interview the man told staff that he wanted to refuse all treatment so he could die. It was noted that he was upset at his prison sentence. The consequences of refusing treatment were explained to the man and a referral also made to the mental health in-reach team. As he was refusing treatment, an Assessment, Care in Custody and Teamwork (ACCT) self-harm observation and support regime was started. (ACCT is used to monitor and support those prisoners who are felt to be at risk of suicide or self-harm.) The ACCT was to remain open until there was an improvement in the man's mood and he cooperated with his medication and dialysis. A three day psychiatric assessment was also carried out which did not identify a need for any further mental health intervention. After his health screening interview, the man was admitted to the prison's healthcare centre.
14. Three days after his arrival at Hull, on 6 August, the man attended the local hospital for dialysis. The ACCT document was closed a week later on 13 August as staff felt that the man had come to terms with his situation and was complying with his medical treatment.
15. The man was an enhanced prisoner and he was compliant with the regime in the prison. (The Incentives and Earned Privileged Scheme (IEPS) is a scheme that is designed to encourage and reward good behaviour in prisons. There are three tiers – Basic, Standard and Enhanced, the top level. Incentives include access to in-cell televisions, more private cash to spend, wearing own clothes, more time out of cell and community visits.)
16. He continued to accept treatment until 19 November, when an ACCT document was opened as the man again refused all medication and dialysis treatment. The man duly attended the local hospital again for dialysis on 21 November. The ACCT document was closed the following day as the man resumed his medical treatment.
17. During the evening of 25 November, the man was found crying on his knees on the floor of his cell. He was helped up by a nurse. The man said he felt so

unwell that he was finding it difficult to care for himself anymore. He was worried about his personal hygiene and he hated being unshaven. The man's clinical observations were taken and they were within normal limits. He was given a slice of buttered toast and a cup of tea. The man insisted that he felt better afterwards. The following day, another nurse tried to assist with the man's personal hygiene needs but was told that his help was not needed.

18. The man refused dialysis treatment for a third time on 30 November. An ACCT document was opened two days later after his condition started to deteriorate. When staff spoke to the man he was coherent but also quite emotional. Due to the deterioration in his health, arrangements were made for him to be admitted to the local hospital. Around 4:00pm on 2 December, the man was taken by ambulance to hospital. He returned to healthcare at Hull early the following day as he had continued to refuse all treatment and had been acting aggressively towards hospital staff. The man was located in a cell where he could be observed by staff via closed circuit television. Around 9:00am on 3 December, the man told staff that he would now attend dialysis treatment and he was taken around midday to the local hospital. He returned to healthcare in the early evening of the same day. The ACCT document was closed on 5 December as the man's mood had improved and he was compliant with his medical treatment.
19. Treatment continued until 12 March 2008, when another ACCT was opened as the man had again refused to attend the local hospital for dialysis and he had also asked not to be resuscitated. The ACCT document was closed on 17 March as the man had resumed dialysis and seemed much happier.
20. Whenever the man refused treatment staff would complete incident and disclaimer forms. They also continued to liaise with the man with regard to his choices and staff were able to persuade him to continue with his treatment. His request asking not to be resuscitated was properly recorded and documented by staff at Hull.
21. When interviewed, the Head of Healthcare at Hull confirmed that she had been in liaison with the service manager of Hull and East Yorkshire Hospital Trust. They had been investigating whether Hull could bring dialysis equipment into the prison with individual external and internal support provided for the man. This would make it easier for the man's treatment regime to be accommodated and would have meant that he did not need to leave the prison for dialysis. However, this was hindered by the man's refusal to comply with his medical treatment. The Head of Healthcare said that they were exploring whether an external private company could provide the equipment when the man died.
22. On 25 March, the man was again taken to the local hospital as he had been experiencing rectal bleeding, had low blood pressure and his complexion was pale. A gastroscopy (a gastroscope is an instrument which is used to examine or view the interior of the stomach) was performed and the man was diagnosed with a gastrointestinal haemorrhage (bleeding in the tract that links the stomach and the intestine). An endoscopy was also performed. (An endoscopy is a test

that looks inside the body. The endoscope is a long flexible tube that can be swallowed. It has a camera and light inside it.)

23. Whilst the man was an in-patient at the hospital and attending dialysis, a bedwatch was carried out by prison staff. The initial security risk assessment identified that an escort chain should be used and two prison officers should be in attendance. The risk assessment was revised on 26 March and restraints were no longer used. Staff on bedwatch duty maintained a log of activities whilst the man was an in-patient. During his stay in hospital, the man was visited by his family.
24. At approximately 6:45am on 31 March, an officer commenced his bedwatch duty and he was joined at around 7:05am by another officer. When interviewed by the Ombudsman's investigator, the first officer said that the man was receiving fluids and that the hospital staff had washed him and made him comfortable. The officer said that the man's breathing was erratic and he seemed very agitated but was still speaking to the hospital staff.
25. When the doctor did his rounds at 9:15am, he told the staff on bedwatch duty that the man would be re-assessed on a daily basis and that his family would be informed that he was very poorly. Someone from the healthcare centre at Hull rang the hospital for an update on the man's condition. They were told that the man's condition was not good, his blood pressure was dropping fast and his oxygen saturation levels were falling even though he was receiving oxygen. A staff nurse told the first officer that she would be contacting the man's family to advise them of the gravity of his condition.
26. The man's condition continued to deteriorate and at approximately 9:50am the first officer noticed that he had stopped breathing. The officers immediately informed hospital staff who established that the man had died. The man was pronounced dead at 11:10am by a hospital doctor. It is not clear why there was such a delay before this happened.
27. Prisoners on the healthcare wing were told what had happened. Each prisoner was asked whether they required anything or wanted to speak to a Listener (a prisoner who has been trained by the Samaritans to give support to their peers). When the officers who had been on bedwatch duty returned to Hull they were offered support from the prison's care team.
28. At around 1:00pm, a residential governor met the man's family at the local hospital. A senior officer was appointed as the prison's family liaison officer. She contacted the family the day after the man's death to offer condolences and support. The senior officer maintained contact with the family and assisted with the arrangements for the funeral. The prison offered financial assistance with funeral costs.

29. The post mortem report records the man's death as being due to natural causes as a consequence of gastrointestinal haemorrhage caused by a duodenal ulceration (bleeding in the tract which links the stomach and the intestine) and lobar pneumonia end stage renal failure.

ISSUES CONSIDERED

Clinical care

30. A review of the man's medical care was undertaken by a clinical reviewer on behalf of Hull Teaching Primary Care Trust. The review found that the man had suffered from significant long-term chronic diseases. From the medical records, it was clear that the man was seen regularly by healthcare staff and, when necessary, referred to secondary care services.
31. The clinical reviewer recognises that, due to being in custody, the man was unable to exercise the same choices as other patients in the wider community. However, a review of his medical record indicated that the man was allowed to choose options within these constraints. The clinical reviewer finds that the man was able to request reviews of his medical needs by healthcare staff and was also able to choose to be nursed in the main ward of the healthcare wing. She concludes that the quality of care the man received was broadly similar and in some instances superior to that he would have received in a community setting. The clinical reviewer notes that referrals were made to appropriate health care professionals and the man had access to advice regarding medical issues on request. The clinical reviewer concludes that appropriate actions regarding follow up and opening of ACCT documents were completed by staff. She judges that if the man had been in the community, follow up of this nature might not have been completed in such a timely manner.
32. The man was able to receive quick and convenient quality care for mental health problems and learning disabilities. He was immediately referred to the in-reach mental health team for review after his first reception health screen. The man was able to access the mental health services which are available at Hull. He was seen by a medical officer on many occasions due to his fluctuating mood. The renal physicians at the local hospital told the clinical reviewer that mood fluctuations and mild depression are a common symptom of chronic renal failure.
33. The clinical reviewer observes that when the man arrived at Hull it was noted that he was a smoker. He was offered smoking cessation advice but continued to smoke. The clinical reviewer believes that this could have severely affected the man's quality of life due to his existing health conditions and may also have increased the possibility of gastric ulcer disease.

Liaison between the healthcare centre and the hospital

34. The clinical reviewer finds that communication between health staff at Hull and other external agencies was documented and that further action was identified and followed up. Although the outcome for the man would not have been affected, she concludes that it may prove beneficial in the event of similar situations in the future if multi-disciplinary team case conferences are held. The clinical reviewer suggests that the conferences could be between Hull, acute hospital specialists and the next of kin and the patient, with the aim of facilitating care planning.

HMP Hull should consider multi-disciplinary case conferences to assist in the clinical management of prisoners who have specialised health requirements.

Consent to treatment

35. The clinical reviewer also draws attention to the man's frequent refusals to consent to dialysis treatment despite the consequences of such action being explained. She says that staff would regularly complete incident forms and disclaimer forms and continue to liaise with the man regarding his choices. The clinical reviewer notes that on several occasions medical staff persuaded the man to consent to his treatment continuing. Staff at Hull recognised that the man's actions might have been a display of risk of self-harm and frequently opened ACCT documents so that he could be monitored for his own safety.
36. The clinical reviewer says that the man was not deemed to be lacking in capacity to consent by either staff at HMP Hull or the local hospital. The clinical reviewer judges that to treat the man against his wishes would have been an infringement of his human rights. A decision to cease his dialysis treatment was not made as the man frequently changed his mind and attended his dialysis sessions after previously refusing to consent. As already mentioned, depression and mood fluctuations are common symptoms of chronic renal failure. Following discussion with the nursing team at the renal unit in the local hospital, the clinical reviewer reports that it is common for patients to recommence therapy after previously declining treatment.
37. The clinical reviewer draws attention to the man's refusal to take his medication on a number of occasions. She says that it is not clear from the man's medical records whether he refused medication for prolonged periods. The clinical reviewer notes that one of the man's prescribed medications, Omeprazole, is used to prevent symptoms and complications of gastrointestinal ulceration and excessive stomach acid.
38. The clinical reviewer says that it is impossible to be certain if the man would have refused treatment so frequently if he had not been in prison. His refusal to consent was not consistent as the man regularly consented to treatment following initial refusal. The clinical reviewer judges that the man received appropriate treatments and therapeutic interventions.
39. The clinical reviewer is not critical of any actions of healthcare staff and says that all appropriate clinical procedures were followed. The clinical reviewer believes that the man's death could not have been avoided. The man had been placed on appropriate preventative medication and the proper clinical investigations were carried out.

Use of Assessment, Care in Custody and Teamwork procedures

40. Prison staff opened ACCT documents each time that the man withdrew his consent to treatment. Although this is not the customary reason for the

arrangements to be used, I consider it to have been a thoughtful and compassionate way to ensure that he was supported and monitored at a time when he felt distressed.

Restraints

41. I am also pleased to report that the man was properly assessed whilst he was in hospital and, as a result, the level of restraints was reduced and the escort chain removed. The bedwatch officers remained and I hope that it is a comfort to the man's family to learn that he was not alone when he died.

CONCLUSIONS

42. The man arrived at Hull in August 2007 and he died of natural causes in a local hospital in March 2008.
43. From the bedwatch log, I believe that the staff involved with the man's care behaved with compassion and sensitivity. The security arrangements at the hospital seem to have been suitable, and to have struck a good balance between public protection and respect for the man.
44. The man appeared to be a difficult patient to manage. On four occasions he refused treatment. This was a very dangerous course of action by the man as he needed dialysis regularly. I commend the action of staff at Hull in trying to support the man through these difficult times when he refused treatment.
45. In light of the findings of my investigation and the clinical review, I conclude that the care provided to the man was entirely appropriate. Indeed, I think that staff at Hull treated the man with sensitivity and professionalism. I am encouraged by the conclusion the clinical reviewer reaches in her clinical review - "The care the man received at HMP Hull healthcare was broadly similar and in some instances superior to that he would have received in a community setting." The clinical reviewer has made one recommendation, which I endorse. This will need to be addressed by the Hull Teaching Primary Care Trust in partnership with the Governor of Hull.

RECOMMENDATION

Clinical

1. HMP Hull should consider multi-disciplinary case conferences to assist in the clinical management of prisoners who have specialised health requirements.

Accepted - The Primary Care Trust are undertaking multidisciplinary meetings for those clients with complex health needs.