

**Investigation into the circumstances surrounding  
the death of a man  
at HMP Hull on 11 April 2006**

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

**October 2006**

This is the report of an investigation into the death of a male prisoner at HMP Hull on 11 April 2006, he was 58.

He had a long standing heart condition, and the post mortem comments that there was sufficient heart disease for him to die suddenly and unexpectedly. He was frail and needed extra assistance, and I am pleased that the prison was able to provide suitable accommodation for him. My colleagues and I would like to extend our condolences to this man's friends and family for their loss.

This office investigates all deaths of prisoners in custody, including those due to natural causes. In this case, the investigation was carried out by one of my investigators. The clinical review was carried out by the Director of Professional Development for Eastern Hull Primary Care Trust and the Clinical Adviser (Medical) for the Trust. I am most grateful for their help. Their reports are annexed to this one.

I would also like to thank a Principal Officer at HMP Hull for his help in ensuring all the relevant information was passed promptly to my investigator.

I make two recommendations, the first concerning arrangements for prisoners to attend out-patients appointments and the second regarding appraisals of the doctors working at Hull. I have also commended the man's cell allocation and access to a wheelchair as examples of good practice.

**Stephen Shaw CBE**  
**Prisons and Probation Ombudsman**

**October 2006**

## **Contents**

|  |    |
|--|----|
| Summary                                    | 4  |
| The man                                    | 5  |
| HMP Hull                                   | 6  |
| The investigation process                  | 7  |
| Key findings                               | 8  |
| Issues considered during the investigation | 11 |
| Recommendations and Good Practice          | 13 |

## SUMMARY

The man at the centre of this report died suddenly on 11 April 2006 at HMP Hull.

The man had been in custody since 5 November 2002. He had a long term heart condition, and had had previous operations. He regularly attended healthcare for appointments, and was an outpatient at Royal Hull Infirmary and Castle Hill Hospital.

An appointment was booked for 26 March 2006, but was cancelled because the man was assessed as lower priority than four other prisoners, and the prison is only able to facilitate four outpatient appointments each day. The appointment was re-scheduled for 13 April, but by that time the man had already died. The clinical reviewer is satisfied that, notwithstanding the missed appointment, the man's treatment and referrals were appropriate, but some concerns have been raised regarding his primary and preventative care.

The man was sensibly allocated a cell on the bottom landing of J wing, which is also where the food servery and treatment hatch are located. This meant that he did not have to use stairs to get his meals or medicines. He took part in 'in-cell' education and had gained several qualifications. (He had previously attended classes, but had found it physically demanding and so opted to work 'in-cell'.)

To help with mobility, prisoners have access to wheelchairs. There were a good number of these for I and J wings, and the man had access to them if he needed to move elsewhere within the prison.

The man had a group of friends with whom he associated regularly on the wing. It is these friends who found him on 11 April and called for the assistance of officers. All those to whom my investigator spoke said that the response was immediate.

## The man

1. This man was born in Nottingham. He left school at the age of 15 with no qualifications. He was self-employed, working at car boot sales, auctions and taxi driving. He described himself in reports as a “jack of all trades, master of none”. He had three children, two daughters who lived with his ex-wife and a son who had lived with him.
2. The man misused alcohol. It was recorded in prison assessments that this misuse had led to some of his offending and poor money management. However, he said that it was under control before coming to prison and did not, therefore, engage in any work to address this. He also declined to attend other offending related courses, but did attend education classes and had achieved certificates in history and computers. He initially attended education classes on another wing in the prison, but changed to ‘in-cell’ education as it was physically easier for him.
3. The man had a history of health problems including blocked arteries in his legs and groin and was waiting for an operation. He smoked and had tried on several occasions to stop or cut down. He attended smoking cessation classes which had varying degrees of success, and appears to have stopped smoking in late 2005. He had access to a wheelchair if he needed to get from one area of the prison to another during ‘freeflow’ (the movement of prisoners to and from work, education, etc.).

## HMP HULL

4. In the late 19<sup>th</sup> century, HMP Hull was a prison for both men and women. It was used as a military prison in 1939 and later as a Civil Defence Depot. It reopened in 1950 as a closed male borstal and in 1969 became one of the first maximum security dispersal prisons. In 1986, its role was changed again to the current role as a male local prison/remand centre.
5. The prison was expanded in 2002 to include four new wings and a new healthcare centre amongst other facilities. Refurbishment was also carried out to existing areas. The prison now has nine residential units. It holds remand, sentenced and convicted adult males (except category A) and young offenders. As of 31 January 2006, the operational capacity (maximum crowded capacity) was 1,000.

## THE INVESTIGATION PROCESS

6. My investigator requested all the relevant prison records relating to the man who had died. These included his medical records and core prison record. She also visited the prison and interviewed several members of staff and prisoners.
7. The Director of Professional Development at Eastern Hull PCT and the Clinical Adviser for the Trust undertook the clinical review on behalf of the PCT. They both made themselves readily available to my investigator to answer any queries, and their assistance was much appreciated.
8. HM Coroner for East Riding and Kingston upon Hull was informed of the Prisons and Probation Ombudsman's investigation. He kindly provided my office with the post mortem report. The Coroner received a copy of this report when it was completed.
9. One of my Family Liaison Officers spoke to a family member to ask if they had any comments or concerns. Nothing was raised, although the family have asked to see a copy of this report so that they have more information about what happened to their relative.
2. Notices to staff and prisoners were supplied and displayed by the prison. These invited anybody with information to talk to my investigator. In this instance, only those staff and prisoners already identified by my investigator made contributions.
11. When one prisoner was interviewed, his account of the sequence of events differed considerably from others. However, he has subsequently amended his interview transcript and it is now consistent with what other prisoners and staff had to say.
12. A draft copy of this report was issued to the man's family and to HMP Hull for them to make any comment. The family has not made any comments. Hull has commented on the recommendations made.

## KEY FINDINGS

13. The man was remanded on 5 September 2002 by Nottingham Crown Court to HMP Leicester. He spent most of his time at Leicester in the segregation unit, at his own request and for his own protection, because of the nature of his offence.
14. He transferred to HMP Hull on 5 November 2002 and was located on the Vulnerable Prisoner Wing. His wing records do not offer a lot of information about him, but from speaking to staff and other prisoners it appears he was a quiet, polite individual. He had a circle of friends with whom he associated during most of his time at Hull.
15. The man attended education classes and had gained several qualifications. He had initially attended classes on I wing which runs opposite J wing, where his cell was located. However, he later opted to continue with 'in-cell' education as it was less physically demanding.
16. There are many medical events throughout the man's time in custody, and these are detailed more fully in the clinical review. It is clear that he had existing health problems prior to his imprisonment. This included claudication in his legs (a cramp-like pain usually caused by blockage or narrowing of arteries). Intermittent claudication is pain in the calves which can be felt after walking certain distances.
17. J and I wings have several wheelchairs for prisoners' use. The man had access to these if he needed to move around the prison for example to Healthcare or to work. He was himself located on the bottom landing. This made getting his meals and medication easier as the servery and medical hatch are also located on the bottom landing.
18. The man's prison medical records show that he had a history of peripheral vascular disease (disease of the arteries in the extremities). A letter from his consultant vascular surgeon, dated 30 January 2004, suggests that there was disease and that the man would be suitable for an aorto-bifemoral graft (bypass).
19. The man continued to be seen at Hull Royal Infirmary under the care of another consultant vascular surgeon. There are regular letters filed between this surgeon, the man and the Medical Officer at Hull outlining the man's health problems.
20. These included the claudication and blocked arteries and, in late October 2004, a hugely distended stomach. Arrangements were made for the man to have an ultrasound before treatment for his blocked arteries.
21. In January 2006 the medical officer at Hull asked the consultant physician at Hull Royal Infirmary to review the man for heart failure. An appointment was offered

for 28 March. However the man did not attend this appointment as the prison has a policy of allowing only four prisoners out at one time. On this occasion, the allocation was already full so the appointment was rebooked for two weeks later on 13 April. The clinical reviewer comments that, had the man attended this appointment, it might have led to changes in his medication which in turn could have improved his prognosis.

22. A more detailed report of the man's health and treatment is given below. This report shows that although the referrals to specialists and subsequent treatments were appropriate, there were failings in the man's primary and preventative care. Areas such as treatment for high blood pressure and cholesterol levels have been highlighted as not being appropriately dealt with, thereby not reducing his risk of cardiac events.

### **11 April 2006**

23. April 11 was the man's birthday, and in the morning another prisoner took him a birthday card. In interview, this prisoner described the man as looking pale. He saw him again at lunchtime and said he looked better. The prisoner commented that the man had looked like this in the mornings for about the previous nine or ten weeks, but looked better as the day went on. A second prisoner, who was in the cell next to the man's, also commented that over the past few weeks the man had not looked well and was grey in pallor.

24. During the association period that afternoon, the first prisoner and a second prisoner went to see the man. The three men had been friends for some time in the prison and would often play cards and associate together. Just prior to this, a third prisoner was returning from his work and looked through the man's observation panel. He saw what he thought was the man bending over to pick something up. The second prisoner did not say anything and continued to his cell. Shortly afterwards, he went back to see if the man had some cigarette papers.

25. The first prisoner and second prisoner arrived at the man's cell first, followed by the third prisoner. They report going to the cell and immediately realising that the man was not well. The second prisoner, who has some knowledge of first aid, shouted to the others to get the officers. He then tried to put the man into the recovery position.

26. Two officers were in different areas on the landing, but heard the calls for help and responded immediately. They initially thought they were attending a fight. When the officers arrived at the cell, they could see that the man was in a serious condition. The first officer checked for a pulse and breathing, and a call went out over the radio for medical assistance. The officers commenced cardiopulmonary resuscitation (CPR), and shortly afterwards a nurse responded to the radio call.

The three members of staff continued to try and resuscitate the man. The nurse used the defibrillator, a machine that can administer electric shocks.

27. In the meantime, an ambulance had been called and the nurse asked for a doctor to attend in case intravenous medication might be required. The doctor arrived at the same time as the paramedics. After several more attempts by the paramedics to administer CPR, it was decided not to continue and the man was pronounced dead at 4.30pm.

## ISSUES CONSIDERED DURING THE INVESTIGATION

### *Access to healthcare*

28. The clinical reviewer states that there appears to have been reasonable access to primary care provided by doctors and nurses at the prison. However, there are only a few blood pressure readings recorded each year. Given that these were almost all high, indicating poor control, then best practice would have been more intensive and regular monitoring.
29. The reviewer also considers that the man was promptly and appropriately referred to specialists in relation to his dyspepsia, peripheral vascular disease and suspected heart failure.
30. The exception was the difficulty taking the man to an outpatient appointment at the heart failure clinic in March 2006. The clinical reviewer is of the opinion that, had the man attended, it might have led to changes in his medication which could possibly have improved his condition and influenced subsequent events.
31. My investigator discussed the arrangements for prisoners to attend outpatient appointments with a governor at HMP Hull. The governor said that every day the prison is staffed to escort up to four prisoners to planned appointments (emergencies are dealt with separately). There is a protocol with Healthcare staff that they prioritise all the appointments and re-arrange those which have to be re-scheduled. Appointments for life threatening conditions are deemed to be high priority and take precedence over routine appointments. On this occasion, the man's appointment was cancelled and replaced with a date two weeks later. He died before the appointment could take place.
32. I understand the need for predictable arrangements to cover outpatient appointments. However, it is important that the policy is kept under review, both in respect of prisoners with routine conditions who may regularly be pushed to the back of the queue, as well as those with serious conditions.

**I recommend that the Governor and Primary Care Trust review the policy for escorts to outpatient appointments, balancing prison and hospital resources to provide the best healthcare for prisoners.**

### *Quality of Clinical Care*

33. The man had high blood pressure, but there does not appear to have been any attempt to reduce it by changing his medication. It would have been best practice to adjust his medication to attempt to achieve better blood pressure control.

34. For patients like this man, with a diagnosis of peripheral vascular disease (hardening and blockage of the arteries), it is usual practice to attempt to reduce other risk factors. In this man's case, this included smoking. The clinical reviewer notes that he was offered support and did manage to reduce the habit.
35. The man's records show that his cholesterol level was raised, specifically the proportion of the cholesterol which was of the harmful (LDL Cholesterol) type, which would be of particular concern for patients with peripheral vascular disease. It would have been best practice to have offered cholesterol lowering treatment, which could have reduced his risk of a heart attack.
36. In summary, the clinical reviewer concludes that the clinical care of the man's blood pressure and the risks he was exposed to did not meet best practice standards. He considers that appropriate care and treatment was provided by the community doctors and specialists, but that there are concerns about the quality of the primary and preventative care, and improvements might have increased the man's life expectancy. The Clinical Adviser for the Trust believes that the prison's reliance on locum staff and the lack of clear management protocols and guidelines has led to these failings. He comments that a revalidation process began in 2004 which requires prison GPs, like others, to be subject to appraisals which should address any deficiencies in their practice. The clinical reviewer also comments that the prison's Healthcare Centre relies on locum doctors, which does not assist the provision of thorough and consistent care for prisoners.

**I recommend that the Primary Care Trust ensures that prison doctors, including locums, are appraised and work to clear protocols and guidance.**

37. I am pleased to note that HMP Hull has recognised the need to develop healthcare provision. It has improved the treatment room facilities, and recruited a dedicated support team to work within the medical clinics and with visiting consultants. The prison has also established a better appointment and recall system. A dedicated GP to undertake general medical services is to be appointed to work four sessions a week, and an Emergency Care Practitioner is also being introduced. Finally, a system has been set up to agree any changes of out patient appointments with the prison.

## RECOMMENDATIONS

1. **I recommend that the Governor and Primary Care Trust review the policy for escorts to outpatient appointments, balancing prison and hospital resources to provide the best healthcare for prisoners.**

HMP Hull has accepted this and the PCT have now introduced a system where all prisoners who leave the establishment for hospital appointments are seen by Healthcare staff prior to leaving and on their return from the hospital. Forthcoming appointments are reported to the relevant discipline department to allow adequate notice and covering of escorts.

2. **I recommend that the Primary Care Trust ensures that prison doctors, including locums, are appraised and work to clear protocols and guidance.**

HMP Hull has accepted this recommendation and an information pack for doctors has now been produced and is inclusive of prescribing protocols and formulary.

## GOOD PRACTICE

1. **The prison ensured that the man's social and mobility requirements were met. His cell was on the first floor landing, close to the food servery and medical treatment hatch, which meant that he did not face the physical demands of using the stairs. He had the use of a wheelchair when he needed to get from one part of the prison to another.**