

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Brian Hogg a prisoner at HMP Full Sutton on 29 October 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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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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 Brian Hogg died of sepsis due to peritonitis on 29 October 2015, while a prisoner at HMP Full Sutton. He was 73 years old. I offer my condolences to Mr Hogg's family and friends.

Mr Hogg was in generally poor health and suffered from chronic obstructive pulmonary disease for which he received appropriate care and treatment. I am satisfied that Mr Hogg received a generally good standard of healthcare at the prison, equivalent to that he could have expected to receive in the community, but I do not consider that the use of restraints when Mr Hogg went to hospital was justified by fully considered risk assessments.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

May 2016

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Summary

Events

1. In 2002, Mr Brian Hogg was sentenced to life imprisonment for sexual offences. Mr Hogg suffered from chronic obstructive pulmonary disease (COPD – a collection of lung diseases including bronchitis and emphysema). When he first arrived at HMP Full Sutton in July 2015, after transferring from HMP Frankland, a nurse noted Mr Hogg was frail and in poor health and admitted him to the prison's inpatient unit for monitoring. In September, he moved to a standard prison wing when his condition improved. He had a prisoner carer to help with daily living tasks.
2. On 17 October, Mr Hogg had stomach pain and a nurse gave him pain relief. The next morning, he was still in pain. A nurse assessed him using the National Early Warning Score System, (NEWS) which indicated that he might be acutely ill, but he refused to be admitted to the inpatient unit. A GP diagnosed a urinary tract infection and prescribed antibiotics. Nurses monitored Mr Hogg in his cell.
3. On 20 October, Mr Hogg told a GP he was feeling better. The next day, his condition deteriorated and a nurse found he had not been taking his antibiotic medication as prescribed. Assessments again indicated an acute condition and a GP sent Mr Hogg to hospital by ambulance with suspected sepsis.
4. Doctors considered Mr Hogg might have a perforated organ in his abdomen but active intervention was not possible because of his COPD and Mr Hogg received antibiotic treatment. Mr Hogg's condition deteriorated and he died in hospital on 29 October. A post-mortem examination found the cause of death was sepsis caused by an infection following a rupture in his large intestine.

Findings

5. We are satisfied that, overall, Mr Hogg received a good standard of care at Full Sutton, equivalent to that he could have expected to receive in the community. The clinical reviewer has made recommendations in her review about response to National Early Warning Scores, which the Head of Healthcare will need to address but it is very unlikely in Mr Hogg's case that this would have affected the outcome. We are concerned that managers authorised the use of restraints when Mr Hogg went to hospital when he was very frail and there was a clear statement from a prison GP that his mobility was poor.

Recommendation

- The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Investigation Process

6. The investigator issued notices to staff and prisoners at HMP Full Sutton informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
7. The investigator obtained copies of relevant extracts from Mr Hogg's prison and medical records.
8. NHS England commissioned a clinical reviewer to review Mr Hogg's clinical care at the prison.
9. We informed HM Coroner for East Riding and Kingston upon Hull of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
10. One of the Ombudsman's family liaison officers wrote to Mr Hogg's sister to explain the investigation. She did not to reply with any specific matters for the investigation to consider.
11. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly.
12. Mr Hogg's sister received a copy of the initial report. She did not make any comments.

Background Information

HMP Full Sutton

13. HMP Full Sutton is a high security prison near York, which holds up to 600 men. Spectrum Community Health provides healthcare services with registered general and mental health nurses, as well as a nurse who is qualified to prescribe medication. There is daily GP cover. There is a healthcare inpatient unit with six beds and 24-hour nursing cover.

HM Inspectorate of Prisons

14. The report of the most recent inspection of HMP Full Sutton in January 2016 has not yet been published. At the time of the previous inspection, in December 2012, inspectors reported that clinical governance arrangements were satisfactory and the range and quality of healthcare services were good. Inspectors described the healthcare inpatient unit as satisfactory and found that patients were positive about the quality of care they received.

Independent Monitoring Board

15. 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 most recent annual report for the year to October 2014, the IMB noted that healthcare staff provided a comprehensive service in all areas of primary care. However, uncertainty about a change in healthcare provider had led to some healthcare staff shortages.

Previous deaths at HMP Full Sutton

16. Mr Hogg was the fourth prisoner to die of natural causes at HMP Full Sutton since the start of 2015. Our investigations into the other deaths found that the men received a good standard of care at the prison.

Key Events

17. In November 2002, Mr Brian Hogg was sentenced to life in prison for sexual offences. He had spent most of his time in prison at HMP Frankland but was transferred to HMP Full Sutton on 14 July 2015.
18. When Mr Hogg arrived at Full Sutton, he was 73 and had been diagnosed with chronic obstructive pulmonary disease (COPD – a collection of lung diseases including bronchitis and emphysema) which meant that he was frequently short of breath. He had a history of urological problems and occasional urinary tract infections. At an initial health screen, a nurse found he was suffering an exacerbation of COPD (a sudden worsening of the condition often caused by an infection) and admitted him to the prison's inpatient unit to monitor him. A doctor prescribed antibiotics and steroids. He had a nebuliser (which administers medication in the form of a mist) and oxygen to help with his breathing. On 1 September, Mr Hogg moved to a standard prison wing, as his condition had improved. He had a prisoner carer to help with daily living tasks.
19. On 17 October, Mr Hogg complained of abdominal pain, which he thought had been caused by something he had eaten. A nurse gave Mr Hogg some paracetamol and advised him to ask for help if it continued or got worse. She checked him during the night and gave him some more paracetamol for pain.
20. On the morning of 18 October, Mr Hogg still had abdominal pain. A nurse took a urine sample for testing. The nurse took his clinical observations and used them to assess that he had a National Early Warning Score (NEWS) score of seven, which indicated high clinical risk. (NEWS scores are used to indicate the degree of acute illness and inform the response.) She referred Mr Hogg to a GP and wanted to admit him to the prison's inpatient unit for further assessment and monitoring but Mr Hogg refused and went back to his wing.
21. A prison GP saw Mr Hogg later that morning but had some difficulty examining his abdomen, as Mr Hogg could not lie flat because of his COPD. Mr Hogg told the doctor that he was constipated. The GP reviewed Mr Hogg's urine test results, which indicated a urinary tract infection and prescribed antibiotics, pain relief and laxatives.
22. On 20 October, a prison GP reviewed Mr Hogg who said he felt much better. The GP advised him to continue taking the antibiotics.
23. On the evening of 21 October, shortly before 7.00pm, a nurse went to see Mr Hogg, after wing staff reported that his health had deteriorated. She found some unused antibiotics in his drawer, which indicated he had not been taking them as prescribed. She took his clinical observations, assessed his NEWS score as seven and discussed him with a prison GP. They admitted Mr Hogg to the prison's healthcare unit for further assessment and monitoring.
24. The prison GP came to the prison and examined Mr Hogg at about 10.30pm. He noted that Mr Hogg had not been taking his antibiotics and was confused and appeared dehydrated. He suspected that Mr Hogg might have developed sepsis from the urinary tract infection and arranged his admission to hospital by ambulance. Two officers accompanied him and a prison manager decided they

should use an escort chain to restrain him. (An escort chain is a long chain with handcuffs at either end, one attached to the officer and the other to the prisoner.)

25. The hospital admitted Mr Hogg and prison healthcare remained in contact for updates on his condition. An X-ray showed that Mr Hogg had air trapped under his diaphragm (a sign of perforation of one of the organs in the abdomen such as the stomach and intestines). There was no sign of peritonitis when Mr Hogg was first admitted and doctors treated him with intravenous antibiotics. Doctors did not consider he needed surgery at the time, and in any event considered his severe COPD meant he would not be fit for any surgical intervention. After a slight clinical improvement in hospital, Mr Hogg's condition declined. On 28 October, the hospital considered he was dying and began palliative care. The hospital reported that Mr Hogg died in comfort in the early hours of 29 October.

Contact with Mr Hogg's family

26. On 22 October, hospital staff asked the prison for contact details for Mr Hogg's next of kin, his sister. The hospital informed his sister that he was seriously ill.
27. The same day, the prison appointed a family liaison officer. The officer phoned Mr Hogg's sister later that day and arranged for her to visit Mr Hogg at the hospital. He agreed to telephone Mr Hogg's sister to keep her informed of his condition and if he died. As agreed, the officer telephoned Mr Hogg's sister when he died and offered his condolences and support.
28. The officer helped to organise Mr Hogg's funeral, which was on 13 November. The prison contributed towards the costs, in line with national policy.

Support for prisoners and staff

29. After Mr Hogg's death, a prison manager debriefed the prison escort staff who had been with Mr Hogg in hospital to give them the opportunity to discuss any issues arising, and to offer support.
30. The prison posted notices informing prisoners and staff of Mr Hogg's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Hogg's death.

Post-mortem report

31. A post-mortem examination concluded that Mr Hogg had died of sepsis due to acute purulent peritonitis (an infection of the tissue lining the inner wall of the stomach), which was the result of a perforated diverticular disease of the rectum (a rupture of a diseased part of the large intestine).

Findings

Clinical Care

32. We are satisfied that Mr Hogg received appropriate treatment when he first arrived at Full Sutton. A nurse identified that he was suffering an exacerbation of COPD and he was treated in the prison's inpatient unit until he was well enough to go to a standard residential wing. He received appropriate medication for his conditions and was well cared for.
33. On 18 October, the day after Mr Hogg first began to report abdominal pain, a nurse referred Mr Hogg to a GP after noting a National Early Warning Score of seven. This would usually indicate a serious acute condition and should have prompted a care plan for more frequent observations and his compliance with taking his antibiotic medication. However, the clinical reviewer was satisfied that in the absence of any other symptoms, initial treatment for the clearly indicated urine infection was the correct course of action and at first his condition appeared to improve. Earlier admission to hospital was very unlikely to have changed the outcome for Mr Hogg, as his general standard of health was very poor, did not allow any active intervention, and the mortality rate for acute purulent peritonitis, from which Mr Hogg died, is extremely high.
34. In her review, the clinical reviewer made recommendations about the use of care plans and NEWS scores, which the Head of Healthcare will need to address. However, we are satisfied that overall Mr Hogg's care in prison was of a good standard and the clinical reviewer considered it was equivalent to that he could have expected to receive in the community.

Restraint, security and escorts

35. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.
36. On 21 October, when Mr Hogg went to hospital from Full Sutton, a risk assessment indicated that Mr Hogg was 'high' risk to the public and 'low' risk of escape. In the medical information section of the risk assessment, a prison GP recorded that Mr Hogg had impaired mobility due to severe COPD. A prison manager recorded that 'Mr Hogg is a frail 72 year old man in poor health' but decided that escort officers should use an escort chain to restrain him in hospital.
37. On the morning of 22 October, a member of the prison escort staff in the hospital recorded that Mr Hogg had appeared confused. Less than an hour later, at 9.25am he recorded that Mr Hogg 'made a lunge for the open window'. He

called the prison to request an additional member of staff on the escort. At 10.05am, a prison manager agreed a third member of staff for the escort. Later that day, the Governor decided that, despite Mr Hogg's behaviour, he was elderly and infirm so a third officer was not necessary. He decided, after considering the risks that Mr Hogg presented and the decency implications, that officers should continue to restrain Mr Hogg with an escort chain.

38. After this date, prison managers reviewed the level of restraint for Mr Hogg on a daily basis. During these reviews, the managers considered whether the restraint level was appropriate to Mr Hogg's health, though there was no record that a healthcare professional had any input into these reviews.
39. Mr Hogg remained restrained, until 28 October, when his condition deteriorated significantly and he was unresponsive. Managers then decided that officers should remove the escort chain. Mr Hogg died in the early hours of 29 October.
40. On 21 October, when Mr Hogg went to hospital, he was frail, had been in poor health for some time and needed a wheelchair to get about on the wing. He was suffering from a urinary tract infection and healthcare staff had noted that he was confused as a result. A prison GP had recorded his poor mobility on the risk assessment and a prison manager recognised that he was frail, in poor health and a low risk of escape. It is difficult to see, at that point, how an objective assessment could have concluded that restraints were necessary to prevent Mr Hogg's escape. After we issued our initial report, the Governor confirmed that he had considered the 2007 High Court judgment; though he accepted that there should have been better clarification around Mr Hogg's medical condition. Without this clarification, we do not consider that the prison was able to properly apply the tests given in the 2007 High Court judgment. We also do not see that the daily checks by prison managers between 23 and 28 October were able to comply with the judgment without formal, recorded input from a healthcare professional.
41. Although an officer recorded the next day that Mr Hogg had made a "lunge" for a window, this appears to have been caused by confusion from his infection rather than a credible escape attempt. The presence of two officers should have been sufficient security for a frail, elderly man with poor mobility. There is no record that the decision to restrain Mr Hogg was reviewed again until very shortly before his death. We make the following recommendation:

The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

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