

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Ms Jane Hills a prisoner at HMP Cardiff on 25 January 2019

**A report by the Prisons and Probation Ombudsman**

## 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.

Ms Jane Hills died in hospital on 25 January 2019 of chronic obstructive pulmonary disease (COPD) while a prisoner at HMP Cardiff. She was 66 years old and identified as a transgender woman. I offer my condolences to Ms Hills' family and friends.

My investigation found that, during the month she spent at Cardiff, Ms Hills' clinical care was not equivalent to that she could have expected to receive in the community. Staff failed to keep proper clinical records and failed to put a care plan in place to manage Ms Hills' COPD.

I am also concerned that Ms Hills was restrained when she was taken to hospital. The decision to authorise the use of restraints failed to take account of Ms Hills' poor mobility and medical condition.

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

**Sue McAllister CB**  
**Prisons and Probation Ombudsman**

**July 2019**

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# Summary

## Events

1. On 8 November 2018, Ms Jane Hills (formerly known as Mr Frank Hills) was remanded in prison custody, charged with possessing an imitation firearm, and sent to HMP Cardiff.
2. Ms Hills had chronic obstructive pulmonary disease (COPD – an umbrella term for respiratory diseases), asthma, arthritis and a history of high blood pressure. A prison GP prescribed Ms Hills with appropriate medication, including inhalers for her COPD.
3. On 9 December, an officer asked for healthcare staff to see Ms Hills as she was short of breath and thought she had a chest infection. Healthcare staff attended and found that Ms Hills' oxygen saturation level was low. They consulted a prison GP, who advised them to call an ambulance. Ms Hills was taken to hospital and restrained with an escort chain (which was removed the next day).
4. Ms Hills was treated in hospital for pneumonia, but she did not recover and died on 25 January 2019.

## Findings

5. Ms Hills' medical record contained no details at all about the events that took place on 9 December that led to her admission to hospital. The clinical reviewer had concerns that other interactions between prison healthcare staff and Ms Hills might not have been recorded. She was unable to say on the information available whether Ms Hills' admission was due to a sudden deterioration or whether there had been previous consultations on the same issue.
6. The clinical reviewer was also concerned that Cardiff had no formal protocols in place for the management of chronic conditions, such as COPD. She found that this aspect of Ms Hills' care, along with the lack of record keeping, was not equivalent to the care she could have expected to receive in the community.
7. We are concerned that the medical section of the escort risk assessment did not fully reflect Ms Hills' poor mobility and state of health, which meant that she was restrained inappropriately when taken to hospital on 9 December.
8. There was an unacceptable delay in the prison providing information to the PPO investigator.

## Recommendations

- The Head of Healthcare should ensure that all staff understand their professional requirement to maintain clear, accurate, contemporaneous healthcare records.
- The Head of Healthcare should ensure that staff put in place appropriate chronic disease management plans.
- The Head of Healthcare should ensure that staff complete the medical section of the escort risk assessment fully and accurately, so that custodial staff have the

information they need to make an informed decision on the appropriateness of restraints.

- The Governor and Head of Healthcare should ensure that information requested by the PPO after a death in custody is provided promptly.

## The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Cardiff informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
10. The investigator obtained copies of relevant extracts from Ms Hills' prison and medical records.
11. Health Inspectorate Wales commissioned a clinical reviewer to review Ms Hills' clinical care at the prison.
12. We informed HM Coroner for Bridgend and Glamorgan Valleys of the investigation. The coroner gave us the cause of death. We have sent the coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted Ms Hills' son to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond.
14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

## Background Information

### HMP Cardiff

15. HMP Cardiff holds around 800 men, mostly from south-east Wales. Many of the prisoners come from local courts on remand. Cardiff and Vale University NHS Health Board is responsible for delivering primary, physical and mental health services at the prison. The prison healthcare department has a 22-bed inpatient facility for prisoners with increased healthcare needs, with 24-hour nursing care.

### HM Inspectorate of Prisons

16. The most recent inspection of HMP Cardiff was in August 2016. Inspectors reported that overall healthcare was good. There were regular meetings with the Governor and relationships were good. The health centre, including the inpatient unit, was clean and had excellent facilities. Healthcare professionals had excellent access to training and were considered up to date with requirements.

### Independent Monitoring Board

17. 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 latest annual report for the year to 31 August 2018, the IMB reported a cooperative relationship between healthcare and custodial staff. They commended healthcare staff's efforts to provide a high standard of care for prisoners. They considered bedwatches were generally well managed.

### Previous deaths at HMP Cardiff

18. Ms Hills' was the fifth death at HMP Cardiff since January 2017. Of the previous deaths, two were from natural causes, one was drug-related and one self-inflicted. We have made a recommendation about restraints before. There have been two deaths since, both from natural causes.

## Key Events

19. On 8 November 2018, Ms Jane Hills (formerly known as Mr Frank Hills) was remanded in prison custody, charged with possessing an imitation firearm, and sent to HMP Cardiff.
20. A nurse carried out Ms Hills' reception screen. He recorded she had chronic obstructive pulmonary disease (COPD – an umbrella term for respiratory diseases), asthma, arthritis and a history of high blood pressure. He also noted that she identified as transgender. Routine clinical observations were within normal range.
21. On 9 November, a nurse carried out Ms Hills' second reception screening. She noted that Ms Hills used oxygen when required.
22. A prison GP prescribed Ms Hills with a range of medication including inhalers for her COPD. Ms Hills kept her inhalers in her possession.
23. On 12 November, the prison received a letter from the Department of Respiratory Medicine at a hospital in Newport, saying that it was unsafe for Ms Hills to have oxygen cylinders in her possession as she had threatened to blow herself up using the cylinders during her arrest. It had been decided that all her oxygen cylinders should be recalled. The next day, the supplier of the oxygen cylinders telephoned the prison to say they had been instructed to collect all Ms Hills' oxygen cylinders.
24. On 17 November, Ms Hills was moved to a cell on the 'Therapeutic Landing' for vulnerable prisoners.
25. On 28 November, a nurse recorded that Ms Hills was not collecting her medication as she was struggling with the stairs due to her COPD and arthritis. The Head of Healthcare arranged for nurses to take Ms Hills her medication but it was recognised that in the long-term she would need relocating.
26. On the morning of 9 December (the time is unknown as no contemporaneous records were made), an officer saw Ms Hills standing in the doorway of her cell. Ms Hills told the officer she was short of breath and thought she had a chest infection. The officer contacted healthcare staff and asked them to see her.
27. A Healthcare Officer (HCO) and a nurse attended Ms Hills' cell. Ms Hills was sitting upright on the bottom bunk and speaking in short sentences but was having difficulty breathing. They took observations and realised Ms Hills' oxygen saturation level was very low, even for someone with COPD.
28. The nurse gave Ms Hills oxygen, which raised her saturation level slightly but not enough in her opinion. She rang a prison GP for advice and gave her the observation readings. The prison GP advised her to call an ambulance and the nurse said she asked prison staff to do this.
29. A second nurse arrived at the cell and said she would sit with Ms Hills while they waited for the ambulance. The nurse said she handed the second nurse her notes, which included the observation readings, and said she would need them

for the ambulance and 'note entries'. Neither nurses nor the HCO made any entries on Ms Hills' medical record.

30. At 11.34am, Ms Hills was taken to hospital. She was escorted by two members of staff and restrained with an escort chain. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.)
31. On 10 December, at approximately 1.15pm, escort staff removed the escort chain after hospital staff asked them to withdraw from Ms Hills' room because they thought she might have tuberculosis (TB). Restraints were never reapplied.
32. On 17 December, a TB test came back as negative and Ms Hills was treated for pneumonia. Her condition deteriorated, and she became incontinent and unable to self-care. She frequently refused her medication even though the importance of it was explained to her. On 25 January 2019, Ms Hills died. Her death was declared at approximately 5.15pm.

### **Contact with Ms Hills' family**

33. On 23 January, the prison appointed an officer as the family liaison officer (FLO). He went to the hospital to meet Ms Hills' family and explained his role and the support available. Ms Hills' family were with her when she died.
34. Ms Hills' funeral was on 26 February. No members of prison staff attended at the request of the family. In line with national policy, the prison contributed to the funeral costs.

### **Support for prisoners and staff**

35. A prison manager checked the escorting officers had the opportunity to discuss any issues arising and offered support. The staff care team also offered support.
36. The prison posted notices informing other prisoners of Ms Hills' 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 Ms Hills' death.

### **Cause of death**

37. The coroner accepted the cause of death provided by the hospital and no post-mortem examination was carried out. The hospital gave Ms Hills' cause of death as COPD, caused by type 2 respiratory failure. (Type 2 failure is caused by a build-up of self-generated carbon dioxide which the body cannot eliminate.)

# Findings

## Clinical care

### *Record keeping*

38. Ms Hills' medical record contained no details at all about the events that took place on 9 December that led to her admission to hospital. Retrospective statements show that three members of healthcare staff attended, but none of them made an entry in the medical record.
39. The Lead GP and the Nurse Manager said, 'There is nothing on the record to give an accurate chronological chain of events that led to Ms Hills being admitted to hospital. We recognise this is an issue and will take this forward to the safety and quality meeting that we hold within the establishment as a significant event.' The Lead GP added, 'There is ongoing work re coding and note keeping to improve this behaviour, and there is certainly an improvement but this is not of sufficient quality or quantity and we are addressing this.'
40. The clinical reviewer was concerned that the lack of records for 9 December might not have been an isolated incident and that other interactions between prison healthcare staff and Ms Hills might not have been recorded. She was unable to say on the information available whether Ms Hills' admission to hospital was due to a sudden deterioration in the hours leading up to the admission or whether there had been previous consultations related to the same issue that had not been recorded. She found that the lack of record keeping meant that Ms Hills' care at Cardiff was not equivalent to that she could have expected to receive in the community. We make the following recommendation:

**The Head of Healthcare must ensure that all staff understand their professional requirement to maintain clear, accurate, contemporaneous healthcare records.**

### *Management of chronic conditions*

41. The clinical reviewer was concerned that Cardiff had no formal protocols in place for the management of chronic conditions, such as COPD. She said that she would have expected a plan to have been in place to manage Ms Hills' COPD, although she concluded that it was unlikely it would have made much of an impact given the short time Ms Hills was at Cardiff. We make the following recommendation:

**The Head of Healthcare should ensure that staff put in place appropriate chronic disease management plans.**

## **Restraints, security and escorts**

42. 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.

43. Ms Hills was taken to hospital on 9 December and was restrained with an escort chain. A nurse completed the medical part of the escort risk assessment. She noted that Ms Hills needed to go to hospital because she was having difficulty breathing and that she had a history of heart issues and COPD. However, the section that should detail any physical concerns such as mobility, disability or frailty that might influence the escort, was left blank. (This is despite Ms Hills being unable to collect her own medication because of issues relating to her COPD and arthritis.)
44. A Custodial Manager (CM) completed the security risk assessment, stating that all risks (to public, of hostage taking, escape and outside assistance) were low. He recommended two escorts and an escort chain.
45. The authorising governor noted the form to say that he had taken Ms Hills' health and the risk she presented into account and agreed to the proposed escort and restraint arrangements. A nurse had not, however, given him all the information to enable him to make a fully informed decision.
46. Although restraints were removed on 10 December, we do not consider that Ms Hills should have been restrained at all given her poor health and mobility. We make the following recommendation:

**The Head of Healthcare should ensure that staff complete the medical section of the escort risk assessment fully and accurately, so that custodial staff have the information they need to make an informed decision on the appropriateness of restraints.**

#### **Delay in providing information to the PPO**

47. As Ms Hills' medical record gave no details about what had happened on 9 December, the investigator asked the prison to provide statements from the healthcare staff involved. The investigator requested this information on 26 February but did not receive the first of the statements until one month later and waited six weeks for the last statement. This delay was unacceptable. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that information requested by the PPO after a death in custody is provided promptly.**

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