Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Brian Field, a prisoner at HMP Full Sutton, on 4 February 2024

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

Summary

1. 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.

2. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. Mr Brian Field died of advanced gastric cancer on 4 February 2024 at HMP Full Sutton. He was 87 years old. We offer our condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care Mr Field received at HMP Full Sutton was of a good standard and equivalent to that which he could have expected to receive in the community. The clinical reviewer noted that the medical care provided was appropriate, compassionate and responsive, and made no recommendations.

5. We found that the decisions to restrain Mr Field when he was taken to hospital on 19 January 2024, and subsequently while at hospital, were not justified given his advanced age, health condition and poor mobility. In addition, when escort officers asked for Mr Field's restraints to be removed on 24 January, the decision to do so was not made until over 24 hours later. This left Mr Field unnecessarily restrained, with bruising caused by the restraint, for a prolonged period.

Recommendations

- The Governor should ensure that decisions to remove restraints are made promptly, and where restraints are not removed, the decision is justified, and the rationale clearly documented.

The Investigation Process

6. HMPPS notified us of Mr Field's death on 4 February 2024.

7. NHS England commissioned an independent clinical reviewer to review Mr Field's clinical care at HMP Full Sutton.

8. The PPO investigator investigated the non-clinical issues relating to Mr Field's care. She interviewed five members of staff from HMP Full Sutton on 9 and 11 April 2024. Another PPO investigator took over the investigation in May 2024.

9. The Ombudsman's office wrote to Mr Field's daughter to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies, and this report has been amended accordingly.

Previous deaths at HMP Full Sutton

11. Mr Field was the eighth prisoner to die at HMP Full Sutton since 4 February 2021. Of the previous deaths, six were from natural causes and one was self-inflicted. In two recent investigations, we identified similar concerns to those we have identified in this investigation about the inappropriate use of restraints and made a recommendation to Full Sutton to address this.

Key Events

12. In 2001, Mr Brian Field was convicted of murder and was sentenced to life imprisonment. On 14 December 2001, he was transferred to HMP Full Sutton. He had multiple health conditions.

13. On 5 August 2021, a nurse saw Mr Field because he reported a poor appetite, loss of weight and trouble swallowing. She arranged for him to see a GP.

14. On 9 August, a GP operating at Full Sutton saw Mr Field and arranged for him to have a blood test, the results of which were abnormal.

15. On 16 August, a fast-track referral was completed for suspected lower gastro-intestinal cancer. Mr Field had a faecal immunochemical test (FIT, which indicates conditions, including bowel cancer), the result of which was negative.

16. On 3 September, Mr Field declined investigations for suspected lower gastro-intestinal cancer, including a computerised tomography (CT) scan and a colonoscopy.

17. On 9 August 2022, a nurse reviewed Mr Field due to recent complaints of chest pain. He had an electrocardiogram (ECG) which was normal. Mr Field declined hospital admission and was deemed to have mental capacity to make such decisions.

18. On 18 August, a GP operating at Full Sutton saw Mr Field about his chest pain. Mr Field declined to be referred to the hospital cardiology team and was assessed again as having mental capacity to make this decision. The GP told Mr Field to tell healthcare staff if he changed his mind or had further chest pain.

19. On 9 June 2023, a nurse saw Mr Field for his reported weight loss. He agreed to have a blood test and give a stool sample.

20. On 23 June, a GP operating at Full Sutton saw Mr Field as he had iron deficiency anaemia. Mr Field had another FIT test, the result of which was negative.

21. On 16 November, Mr Field had a blood test, the result of which was abnormal.

22. On 21 November, a prison GP reviewed Mr Field following his abnormal blood results. Mr Field wanted to be referred to hospital for treatment. Another FIT test was arranged to support referral for further investigations.

23. On 27 November, Mr Field’s FIT test results came back as positive.

24. On 12 December, a prison GP saw Mr Field and offered to refer him for a colonoscopy or CT scan for suspected cancer. Mr Field told the GP that he would prefer not to be referred for investigation. He said he knew that he may have cancer which could shorten his life.

25. On 18 January 2024, a nurse saw Mr Field after the Disability Liaison Officer told healthcare staff that Mr Field had not left bed for two weeks. When she reviewed the wing observation book, she found that Mr Field had had a fall on 14 January

which had not been reported to the healthcare team. She reminded the wing's Senior Officer (SO) that all falls should be urgently reported. She took observations and advised Mr Field to rest. He was given a call bell to alert officers when he needed help, and a social care referral was submitted as his mobility had deteriorated.

26. On 19 January, a prison GP saw Mr Field as he had fallen over during the night and been incontinent. The GP diagnosed him with iron deficiency anaemia. He was admitted to hospital for an urgent blood transfusion. Before he left, the GP completed a medical risk assessment and ticked a box to indicate he had no medical objections to the use of restraints. An SO completed the security risk assessment and identified that Mr Field posed a high risk to the public due to his index offence. He also noted that Mr Field was a fully compliant prisoner with an enhanced Incentives and Earned Privileges (IEP) status, he had no history of disciplinary hearings, no behavioural concerns and there had been no incidents when he had previously attended hospital.

27. The SO recommended that an escort cable (a long metal cable with a handcuff at each end, one of which is attached to the prisoner and the other to an officer) should be used as Mr Field's health was deteriorating. As he was a category A prisoner, the Deputy Governor decided that Mr Field should be escorted by an SO and two officers. Mr Field was taken there in a wheelchair and restrained using an escort cable.

28. On 21 January, Mr Field was unsteady on his feet and fell while going to the toilet. A hospital doctor advised that he should not attend the toilet on his own. An escort officer on bed watch duty phoned an SO in the Security Department to ask for Mr Field's restraints to be removed due to his fragility and age. When the Head of Security visited the hospital that day, the escort officer raised her concerns with him, and he told her that this would be looked into. (There is no record of their conversation, but subsequent records indicate the restraints were not removed.)

29. On 22 January, a bed watch officer contacted the security team for authorisation to remove Mr Field's restraints for a CT scan. An SO phoned back after speaking to the healthcare team and said that the escort cable did not need to be removed. The records do not explain the rationale for this decision.

30. On 23 January, a hospital consultant told escort officers that Mr Field's results indicated possible terminal cancer, but they needed a biopsy to confirm this. During a management check, the Head of Special Units decided that the escort cable should remain in place. Escort records indicate that he considered Mr Field's category A status, age and current medical advice when deciding this.

31. On 24 January, a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order was put in place. An escort officer on bed watch duty asked for Mr Field's restraints to be removed due to his age, frailty, possible terminal cancer and bruising on his arm caused by the restraints. The restraints could not be moved to his other arm as he had a cannula in place.

32. On 25 January, an SO phoned the bed watch officers and told them that the escort cable could be removed, but they should consider reapplying it on Mr Field's return

to prison. A family liaison officer contacted Mr Field's next of kin to inform them of his condition.

33. On 26 January, a nurse visited Mr Field. She spoke to a hospital nurse, who told her that Mr Field had a mass in his liver and in his pancreas. Mr Field was offered palliative treatment but wanted to return to Full Sutton. He was discharged from hospital that day and admitted to the prison's inpatient palliative care suite. (We do not know for sure if restraints were reapplied for the journey from the hospital to prison, but one member of staff told us that they had been.)

34. On 27 January, an end-of-life care plan was created for Mr Field.

35. On 29 January, Mr Field's daughter and son visited him in prison.

36. On 30 January, a prison GP saw Mr Field to discuss his diagnosis. Mr Field told the GP that he would go back into hospital for a blood transfusion or for treatment of an infection but did not want further investigation or treatment of his cancer.

37. On 3 February, a nurse attended Mr Field's cell and found him unresponsive. She reported that Mr Field did not appear in distress or pain. Wing staff agreed to continue welfare checks and to tell healthcare staff if there were any changes in his presentation.

38. At approximately 8.40am on 4 February, Mr Field died.

Post-mortem report

39. The post-mortem report concluded that Mr Field died of advanced gastric cancer. Mr Field also had a liver abscess which did not cause but contributed to his death.

40. At inquest held on 1 October 2024, the Coroner concluded that Mr Field died of natural causes.

Non-Clinical Findings

Restraints, security and escorts

41. 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.

42. The Graham judgment in the High Court in 2007 made it clear that prison staff must 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 he has a serious medical condition. It stated 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.

Emergency escort on 19 January

43. When Mr Field went to hospital on 19 January 2024, a prison GP completed a medical risk assessment, but ticked a box to indicate that he had no medical objections to the use of restraints. He told us that this might have been an error on his part as Mr Field was very pale and weak and looked severely anaemic. As this was a one-off, human error, we make no recommendation about this.

44. Although an SO recognised Mr Field's deterioration in health, he recommended the use of an escort cable on the basis of his perceived high risk. While the escort assessment indicated that Mr Field was a compliant prisoner with no recent behavioural concerns, the assessment of high risk appears to have been based on his historic index offence. We identified that Mr Field also had a personal emergency evacuation plan (PEEP) in place as he had limited mobility, he was taken to the ambulance by wheelchair, and he had not left his bed for two weeks. There is therefore no evidence that the decision to restrain Mr Field was based on the actual risk he presented at the time of his admission to hospital or that the Graham judgment was followed.

45. In a recent investigation, we identified similar concerns about the assessment of risk during escorts. We made a recommendation to the Governor of Full Sutton to ensure that staff understand the legal position on the use of restraints and take into account a prisoner's current level of risk. We therefore do not repeat this recommendation but await the prison's response.

Restraints during hospital admission

46. Escort officers repeatedly asked for Mr Field's restraints to be removed between 21 and 24 January. However, it was not until 25 January that an SO told them to remove the escort cable. Despite Mr Field complying with all instructions, behaving well throughout his hospital admission and a doctor advising of his poor mobility, Mr Field remained restrained in hospital for six days. We consider that the decision to maintain the restraints was not justified.

47. The Head of Security told us that he discussed the possibility of removing Mr Field's restraints with a colleague on 21 January, and they agreed that the restraints did not need to be reduced as Mr Field's risk had not reduced and he was not that poorly at the time. He could not confirm whether this decision was communicated to an SO and there is no record of any further action being taken.

48. The Head of Special Units told us that on 23 January, he decided that Mr Field's restraints should remain in place because they did not interfere with his medical treatment and due to the risk he presented to the public as a category A prisoner. Prison staff told us that as Mr Field had not completed any offender behaviour programmes, his risk and category had not decreased since his offence. While we recognise this, the index offence (while incredibly serious) had taken place in 1968, some 55 years earlier. Mr Field's behaviour in prison was good and his age, frailty, health condition and poor mobility significantly reduced his risk. There is no evidence that prison staff took these factors into account in their decision-making.

49. Decisions to remove restraints should be made promptly. Over 24 hours had passed between the escort officer's request on 24 January for Mr Field's restraints to be removed and the decision being taken to do so on 25 January. Although we appreciate that this decision required input from various internal and external teams, the request should have been prioritised and actioned quickly to avoid Mr Field remaining restrained for an unnecessarily prolonged period, particularly as he had bruising caused by the restraints.

50. It is unclear from the paperwork whether Mr Field was restrained on his return to the prison but one of the escort officers told us that he believed the escort cable was applied as a precaution. There is no evidence that Mr Field's condition had improved and no record of any rationale for the decision to reapply restraints.

51. During Mr Field's hospital admission, escort officers asked for his restraints to be removed on three occasions. There is a lack of justification recorded for the decision to keep the restraints in place, despite clear evidence that the restraints should have been removed. We make the following recommendation:

    The Governor should ensure that decisions to remove restraints are made promptly, and where restraints are not removed, the decision is justified, and the rationale clearly documented.

Governor to note

52. When Mr Field fell on 14 January 2024, a F213 form (which records injuries to prisoners) was not completed, and the healthcare team was not notified until 18 January. The officer who recorded Mr Field's fall in the wing observation book told us that he did not complete a F213 form as Mr Field had declined healthcare intervention. He is now aware that he should nonetheless have completed one and told the healthcare team.

53. Records consistently indicate that an escort chain was used to restrain Mr Field, but Full Sutton told us that this was an escort cable (which has been introduced more recently). It would be helpful for records to indicate with accuracy which type of restraint was used.

Good practice

54. HMP Full Sutton provided the information we needed for our investigation and responded to our further questions in a very timely manner.

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Prisons and Probation Ombudsman **July 2024**

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