

**Investigation into the circumstances surrounding the  
death of a man at hospital  
while in the custody of HMP Full Sutton  
in April 2011**

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

**July 2012**

The man subject to this investigation died at 1.13pm in April 2011 at hospital while in the custody of HMP Full Sutton. He was 51 years old. I offer my condolences to those affected by his death.

A clinical review of the man's healthcare was undertaken by a clinical reviewer on behalf of the local PCT. I am grateful for his review. Staff at Full Sutton cooperated fully with the investigation. I apologise for the delay in the publication of this report.

The man had been in custody since 2009. Although he had a number of health problems which were regularly monitored, there was no indication that he had any life threatening illness until March 2011 when he reported non-specific symptoms. Initial tests indicated a lowered blood count and liver function problems. He was cared for in the healthcare in-patient unit at Full Sutton until 4 April when he was transferred to hospital because of concern about his lowered oxygen levels. Hospital staff were unable to diagnose his underlying condition before he died. The pathologist subsequently found that he died from a malignant lymphoma.

There do not appear to have been any signs that the man was in danger of dying in late March and early April 2011 and neither I nor the clinical reviewer find any fault in the response of Full Sutton healthcare staff. His rapid decline and death was an unexpected event which I do not believe could have reasonably been foreseen or prevented. However, there remains scope for learning in two other areas. First, the man was in a very weak state when he arrived in hospital and it is not clear that restraints were necessary. Accordingly, it is recommended that the governor ensures the appropriateness of escort risk assessments in such cases. Second, while it is fortunate that the man's family were able to be at his bedside when he died, they should have been informed earlier of his serious condition in hospital, and a recommendation is made accordingly.

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.

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**July 2012**

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## SUMMARY

1. The man was remanded into custody in 2009. He was charged with serious offences and, following conviction, sentenced to 12 years imprisonment in April 2010. He arrived at HMP Full Sutton the following month. His initial health screen identified that he had a range of health problems including asthma, arthritis, epilepsy and mental health issues. These conditions were managed during his time at Full Sutton and did not cause healthcare staff to have serious concerns.
2. The man smoked and was overweight and, despite staff encouragement, was not interested in changing his lifestyle. Because he had difficulties getting around, he was allocated a cell on a lower level landing to make it easier for him to collect his food. His mental health was managed by anti-depressant medication and did not decline to any significant extent while he was at Full Sutton.
3. In March 2011, the man complained of feeling unwell. Prison healthcare staff thought that this might have been caused by both a chest infection and a urinary infection. A blood test indicated some problems with his liver function and his blood count. His medication for epilepsy was withdrawn as a possible cause and he was admitted into the healthcare unit on 1 April for monitoring. On 4 April, the man became more unwell and staff were concerned about the decrease in his oxygen levels. He was transferred to hospital where he later died, with the cause of his illness still not identified.
4. After his death, the pathologist found that the man died from malignant lymphoma (a malignant tumour of the lymph glands).

## THE INVESTIGATION PROCESS

5. The investigation was opened on 18 April 2011 when the investigator met senior prison managers and took copies of the relevant documentation relating to the man. Notices of the investigation were issued to staff and prisoners, inviting those who wished to provide information regarding his death to make themselves known to the investigator. No-one came forward in response to the notices. The investigator wrote to the Governor of Full Sutton in May 2011 to provide initial feedback on the progress of the investigation. Regrettably, the investigation and production of this report was then seriously delayed by competing workload pressures in this office.
6. The local PCT asked a clinical reviewer to carry out a review of the care received by the man while he was at Full Sutton.
7. One of the Ombudsman's family liaison officers contacted the man's family at the beginning of the investigation. She explained the investigation process and offered them the opportunity to raise any questions or concerns they would like addressed. They did not raise any specific concerns about his care.

## **HMP FULL SUTTON**

8. Full Sutton opened in 1987 as a purpose-built maximum security prison and holds up to 608 category A and B prisoners serving a minimum of four years. (Category A prisoners are those who would be highly dangerous to the public, police or national security if they were to escape. Category B prisoners are the next security level down. The man was a category B prisoner.) All cells are single occupancy.
9. Healthcare services are commissioned through the East Riding of Yorkshire Primary Care Trust (PCT). Two doctors provide daily medical cover. The inpatient healthcare unit is staffed by qualified nurses, healthcare assistants and prison officers and has six beds, with an additional two safer cells and a crisis suite. There is also a palliative care suite for prisoners in the last days of their life

## **Her Majesty's Chief Inspector of Prisons**

10. The most recent report of an unannounced inspection by Her Majesty's Chief Inspector of Prisons in November 2010 found that the prison was generally clean and well maintained. Relationships between staff and most prisoners had improved, supported by a good personal officer scheme. Health services were judged to be good and inspectors described the inpatient unit as well managed with good activities for patients and excellent interactions between officers and patients.

## **Independent Monitoring Board**

11. Each prison has an Independent Monitoring Board (IMB) consisting of volunteers from the local community who monitor the day to day life of the prison. In its latest annual report, for the year up to October 2011, the IMB were positive about health care services at the prison and particularly commended staff for the level of care and compassion provided to terminally ill prisoners.
12. The Board confirmed that they had not had any contact with the man during his time at Full Sutton.

## **Previous deaths at Full Sutton**

13. There were four other deaths from natural causes at Full Sutton in 2011. There are no direct similarities with the circumstances of the man's death.

## KEY EVENTS

14. The man was born in March 1960.
15. He man entered custody in September 2009, charged with a number of serious sexual offences. He was convicted and sentenced to 12 years imprisonment in April 2010. He was allocated to HMP Full Sutton the following month.
16. As with any prisoners entering a new prison, the man went through an initial healthscreen where his medical history and concerns were discussed and noted. He had a number of medical conditions including asthma, arthritis, epilepsy and some mental health concerns. His arthritis particularly affected his back and hips and caused mobility difficulties. The pain was treated with analgesia.
17. The symptoms of asthma were controlled by an asthma and steroid inhaler and, when required, penicillin was used to treat any respiratory infections. Chest x-rays were undertaken in December 2010 and January 2011 because of his breathing difficulties but they did not reveal any significant concerns.
18. The man was prescribed carbamazepine (an anti-epileptic drug) which minimised the risk of him having fits in the day, although he continued to do so at night. His mental health also remained stable during his time at Full Sutton. He was prescribed moclobemide (an anti-depressant) to manage it and reviewed by a psychiatrist in the early weeks in prison who agreed this approach. He was reviewed by the mental health team on a number of occasions in early 2011, but no significant concerns about his mental health were identified.
19. The man was overweight and smoked 20 cigarettes a day. Staff offered advice on changing his lifestyle, but he turned down opportunities to get help with giving up smoking. Because of his limited mobility, he was allocated a cell on a lower landing to enable him to collect his food more easily.
20. During the summer of 2010, the man declined to attend a number of hospital appointments arranged due to a lesion on his lower lip. He was advised of the possible risk of oral cancer, but said he thought it was because of an injury at the dentist and did not wish to go to hospital.
21. In September 2010, the man's personal officer noted in his records that he had had some recent medical issues that were being dealt with by healthcare. In January 2011, there is a reference in his prison records that the man had not attended work as he felt ill.
22. During his time in custody, the man occasionally reported problems with bleeding while opening his bowels. This had begun before he came into prison and was thought to be due to piles. Blood tests were carried out in December 2010 following a particularly heavy bleed, but the test results did not reveal any abnormalities. Referrals were also made to hospital surgeons

in response to the same symptoms, but a colonoscopy undertaken in March 2011 showed normal results.

23. In March 2011, the man reported to healthcare staff that he felt generally unwell. Staff were unable to diagnose any particular complaint but, as he reported breathing problems, considered whether he might be suffering from a chest infection, but this was found not to be the case. A possible urinary infection was also ruled out.
24. Blood tests were carried out on 29 March which revealed that the man had problems with his liver function and blood count. The red and white cells and platelets in his blood were all reduced. Following discussion with hospital staff, his prescription for carbamazepine to treat his epilepsy was stopped, as it was a possible cause of the reduced blood count.
25. The man moved to the prison healthcare unit on 1 April to monitor the effects of ending his epilepsy medication. His condition remained stable until 4 April when his health deteriorated. He was tired and nauseous and had reduced oxygen levels. An electrocardiogram did not identify any immediate problems, but examination indicated wet sounds at the right lung base.
26. In view of these findings and the man's decline, he was transferred to hospital at 5.45pm on the same day, 4 April. Following a risk assessment, he was required to be supervised in the hospital by two officers and restrained by an escort chain (a long chain with handcuffs attached at each end for the prisoner and the officer.) On 7 April, larger ratchet cuffs were substituted for him as the usual handcuffs were too tight for his swollen wrists.
27. The man was initially diagnosed with pneumonia and prescribed antibiotics. However, he did not improve and, after further decline, he was admitted to the hospital's High Dependency Unit on 10 April. As he was heavily sedated, the restraints were removed. They were reapplied during a brief period of recovery but the instruction from the prison was to remove them again if his condition worsened. He was moved again to the Intensive Care Unit two days later as he continued to deteriorate and the cuffs were removed once more. No restraints were used for the remainder of his life.
28. The prison's family liaison officer contacted the man's family at around 4pm on 12 April to let them know that their relative was seriously ill in hospital. His mother and one of his sisters came to the hospital that evening and were able to remain with him until he died. After his death, his family were left alone in the room with him to allow them some privacy. The prison subsequently offered to contribute to the costs of the funeral and returned his personal possession to his family.
29. A debrief was held with staff after the man died. Staff were asked to produce statements and were reminded of the care and support available to them.

*Post-mortem report*

30. The pathologist wrote in the post mortem report that the man died from a malignant lymphoma (a tumour of the lymph glands). He explained that people suffering from lymphomas can have non-specific and relatively non-severe symptoms. This was the case with the man, whose breathing problems was also a symptom of his underlying illness. The post mortem report also noted that the man was in the most advanced stage of lymphoma and it had spread to his spleen and liver as well.

## ISSUES

### Clinical care

#### *Overall care*

31. The man entered custody with a number of significant health problems including asthma, arthritis and epilepsy for which he continued to receive appropriate treatment from the time of his arrival at Full Sutton. The clinical reviewer recognised this in his report and concluded that :

“ ... all his long term disease management was given appropriately ... in view of the appropriate care given the Clinical Reviewer does not have any specific recommendations to make.”

#### *The man's final illness*

32. When the man began to appear unwell, it was unclear what the cause of his health problems was. Healthcare staff initially considered that he was suffering from a chest or a urinary infection. The blood tests on 29 March 2011 indicated concerns about his liver function and blood count, and were discussed with hospital staff. He was admitted into the prison healthcare in-patient unit on 1 April to ensure that his condition could be effectively monitored. However, his health continued to decline and he was transferred to hospital on 4 April.
33. With regard to the man's decline in health during March and his eventual hospitalisation in April 2011, the clinical reviewer writes:

“ ... he had blood tests done in December 2010 which did not show any liver or blood problems ... The decline in his oxygen level suggested some serious changes happening within his lungs on 4 April. This was not noted before and the Clinical Reviewer fully agrees that immediate hospitalisation was the correct course of action. ... The Clinical Reviewer does not feel that the GPs could have anticipated this change and did act upon it appropriately.”

#### *Use of restraints*

34. When a prisoner is sent to outside hospital a risk assessment is made to consider the appropriate level of officer escort and what restraints, if any, should be applied. If restraints are appropriate, their subsequent removal in hospital can only be authorised by a senior prison staff member, or in an emergency situation (such as if hospital staff demand their removal to enable them to provide treatment). The assessment of the risk the man posed and the level of restraint was reviewed on a number of occasions. His restraints were removed on 10 April when he was admitted to the High Dependency Unit. However, the restraints were reapplied when his condition improved slightly. The restraints were removed, finally, two days later.

35. It is understandable, due to the nature of the man's offences, that restraints were used when he was initially taken to hospital. The decision to remove the restraints on 10 April was the correct one. However, it is questionable whether there was any necessity to maintain the restraints during his time in hospital, given his weak health and the two bedwatch officers who accompanied him. Prisons should take into account the medical condition of the prisoner when determining the risk posed, and level of restraints necessary. We therefore make the following recommendation:

**The Governor should ensure that escort risk assessments are regularly reviewed and fully take into account the medical condition of the prisoner.**

*Contact with the man's family*

36. The man's family were contacted and notified of his serious condition at about 4pm on 12 April. Fortunately, members of his family were able to be with him in his final hours.
37. Prison Rule 22 requires governors to inform the prisoner's spouse or next of kin when a prisoner 'becomes seriously ill'. While any admission to hospital could be seen as a serious illness, the man was clearly very unwell when admitted to the High Dependency Unit on 10 April. In view of this, it is unclear why his family were not informed of his stay in hospital at least at that stage. We therefore make the following recommendation:

**The Governor should ensure that next of kin are notified as soon as possible when a prisoner becomes seriously ill.**

## CONCLUSION

38. The clinical reviewer finds nothing inappropriate about the medical care provided to the man. Other than his general health issues and long term conditions, there was nothing to indicate any immediate and serious health concerns until March 2011.
39. The pathologist's post mortem report states that the man presented with non-specific symptoms and the cause of his illness was not identified until he had died. Due to the difficulty the hospital had in diagnosing his illness, there is nothing to suggest that the prison healthcare staff should have been able to do anything differently. All the evidence suggests that they acted appropriately when the man reported feeling ill, and acted quickly when his symptoms worsened.
40. While the investigation found that the man received a good quality of healthcare, it also identified scope for improvement in a small number of other areas and about which recommendations are made. First, it is not clear from the available evidence that a prisoner in such a weak state of health required restraints during his time in hospital and the governor needs to ensure the appropriateness of escort risk assessments in these circumstances. Second, while it is fortunate that the man's family were able to be at his bedside when he died, they should have been informed earlier of his serious condition in hospital.

## RECOMMENDATIONS

The following recommendations were made in the draft report. The Service responses are included in italics following each recommendation:

1. The Governor should ensure that escort risk assessments are regularly reviewed and fully take into account the medical condition of the prisoner.

***Recommendation accepted***

*Escort risk assessments take into account the risk an individual poses. These not only include the risk of escape but the risk to prison staff, nursing staff and the public. The man was at an early stage of a long sentence. However, the escorting staff and managers could highlight deterioration and the Risk Assessment should reflect this.*

*With immediate effect all security staff to review the suitability of arrangements.*

2. The Governor should ensure that next of kin are notified as soon as possible when a prisoner becomes seriously ill.

***Recommendation accepted***

*Full Sutton will appoint a Family Liaison Officer representative whose role will be to contact the next of kin when a prisoner is diagnosed with serious illness.*