Investigation into the circumstances surrounding the death of a male prisoner at HMP Full Sutton in May 2009

Report by the Prisons and Probation Ombudsman for England and Wales

June 2010

This is an investigation into the circumstances surrounding the death of a man who died at HMP Full Sutton on 26 May 2009. The man died of ischaemic heart disease. I would like to extend my condolences to the man's mother for her loss. I apologise for the delay in issuing this report and any additional distress this may have caused.

The man had suffered from mental health problems for many years but he died, unexpectedly and at an early age, from ischaemic heart disease (heart disease caused by a reduced blood supply).

This investigation was carried out on my behalf by two of my colleagues. An independent review of the man's clinical care was conducted by a Clinical Reviewer from East Riding Primary Care Trust. I am grateful for her assistance.

I would like to thank the Governor and his staff at Full Sutton for their full and ready cooperation during the course of my investigation. I am particularly grateful to the Liaison Officer for his assistance.

I make one recommendation in regard to adhering to the principles and spirit of Prison Service Order 2710 (Follow Up to Deaths in Custody) when Full Sutton informs the next of kin following a death in custody. I am pleased to see that Full Sutton has accepted my recommendation in full.

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.

Jane Webb
Acting Prisons and Probation Ombudsman **June 2010**

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SUMMARY

The man was convicted of manslaughter and sentenced to two life sentences on 30 July 1992. He had a troubled youth and suffered from mental health and substance misuse problems for many years, both before coming into prison and during his time in prison.

During the man's 18 years in prison he was frequently of concern to prison staff. He struggled to cope because of his mental health problems and self harming behaviour. The man's mental health deteriorated to such a degree that on two occasions he was transferred from prison to hospital under the Mental Health Act 1983.

The man had no medical history of significance apart from his long psychiatric history. He smoked a great deal. The forensic pathologist, said in his report that "death resulted from the effects of ischaemic heart disease" and that "the degree of heart disease was such that death could have occurred suddenly at any time".

Early on the morning of 26 May 2009, the man was found slumped in a chair in his cell by prison staff who were conducting their routine check at the end of a night shift. The staff went into his cell and tried to help him by placing him on the floor and attempting emergency aid. Healthcare staff were called and arrived promptly. They immediately commenced cardio pulmonary resuscitation (CPR) and defibrillation (electric shock given by a defibrillation machine to attempt to start the heart). They also tried to administer oxygen, but all without success.

The staff called an emergency ambulance while they continued with their life saving attempts, but sadly the man had already died. The paramedics soon arrived and, at 7.30am, confirmed that he had died.

I make one recommendation to the Governor about the need to ensure that the principles and spirit of Prison Service Order 2710 Follow Up to Deaths in Custody, specifically the supplementary guidance 4.13 which states "using the telephone is too impersonal to use in delivering news of a death to the family and should be used only as a last resort" are adhered to by his prison family liaison officers. I am pleased to see that the Governor has accepted my recommendation in full.

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THE INVESTIGATION PROCESS

1. The investigation was opened on 27 May 2009. The investigator issued notices announcing the investigation to the staff and prisoners of HMP Full Sutton. The notices included an invitation to those who wished to contribute to the investigation to make themselves known.

2. The Investigator visited the prison and met the Governor, the Chair of the local branch of the Prison Officers' Association, and the Chair of the Independent Monitoring Board. The Head of Business Change assisted the Investigator as his liaison officer.

3. The Investigator made a tour of the prison and visited B wing to see cell B1-32, which had been the man's room. He talked to a number of staff and prisoners who had known him.

4. The man's prison and health records were made available to the Investigator. He reviewed all relevant documents, which included the man's core record, clinical record, wing documentation, care plans, lifer review reports and other custodial and clinical documents.

5. East Riding of Yorkshire Primary Care Trust (PCT) was asked to organise a clinical review of the healthcare the man had received whilst in prison. The PCT commissioned the Assistant Director of Clinical Governance to carry out the review. I am grateful to her for completing her work expeditiously.

6. One of the Ombudsman's Family Liaison Officers contacted the man's mother to explain the investigation process and to offer an opportunity for her to be involved in the investigation.

7. The man's mother did not have any specific concerns about the investigation but asked to receive the draft report when it was ready. She also asked to see copies of the man's psychiatric reports from the Hospital and HMP Wakefield. The Family Liaison Officer facilitated this process and offered support to the man's mother as she was concerned that reading the reports might be upsetting. The man's mother also asked if he had received regular medical checks whilst in prison.

8. The Investigator went on sick leave in late 2009 so I asked another of my colleagues to take over the investigation. The second Investigator constructed a chronology of significant events from his review of the man's case files and reviewed all relevant records. He considered that it was not necessary to interview staff or prisoners. He followed up the enquiries that had already been commenced and drafted this report.

9. After seeing the draft report, the man's mother provided a number of comments about the report. As a consequence, I have made some revisions to the chronology of events.

HMP FULL SUTTON

10. HMP Full Sutton is one of five dispersal prisons in England. It holds prisoners who have committed serious offences resulting in lengthy sentences and who need to be held in conditions of high security.

11. Full Sutton is a purpose built, high security prison for Category A and Category B male offenders situated a few miles outside the city of York. It was opened in 1987 and holds 595 men. It comprises three wings for mainstream prisoners and three wings for vulnerable prisoners.

12. Healthcare services at Full Sutton are commissioned by East Riding of Yorkshire Primary Care Trust. Services are classified as Type 4 Healthcare, which means that there is provision for 24 hour access to healthcare services within the establishment. Healthcare recently introduced an electronic clinical information system, called SystemOne, which records and manages prisoners' clinical information.

HM Chief Inspector of Prisons' inspection in 2007

13. HM Chief Inspector of Prisons last inspected Full Sutton in an announced inspection in November 2007. In her report she commented:

> "This inspection charts considerable progress at Full Sutton since the last inspection, particularly in the areas of activity and resettlement. Given its population, the prison had remained a commendably stable and largely safe environment. There is still work to be done to ensure more positive and proactive staff-prisoner relationships as an essential part of dynamic security. In addition, the forthcoming cuts to prisoners' regime, as part of the Prison Service's overall efficiency cuts, will be a significant challenge to managers and staff seeking to maintain stability and activity levels."

14. HM Chief Inspector of Prisons also wrote:

> "Recent changes in the delivery of health services to reflect provision in the outside community had not been well received by prisoners, who felt they had less access to the healthcare team. The introduction of some in-possession painkillers had not been well explained to prisoners, who could wait up to a week for a supply. There were reasonable clinical governance arrangements, and good staffing levels with some excellent skills, knowledge and competences. The new clinical IT system was well used. There was a range of primary care clinics, but these were not regular. The care of older prisoners was

managed innovatively, combining social care with physical and mental healthcare. Dental services were clinically sound, but the management of applications and the waiting lists was poor. Inpatient beds were used to accommodate prisoners with disabilities. Primary and secondary mental health services were integrated, which appeared to work well.

"The health services department had introduced an electronic clinical information system in the previous month, SystemOne. This system managed all prisoners' clinical interventions, waiting lists and arrangements for clinics, but prisoners' previous clinical records had yet to be added. Staff were enthusiastic about the new system, which still had a few minor problems with the management of caseloads and waiting lists.

"There were nurse-led clinics for lifelong conditions and vaccinations, and sessions for allied health professionals, such as the dentist, optician and physiotherapist. While the latter sessions were on fixed days, the nurse-led clinics were only arranged when a clinical room was available and the relevant nurse was on duty. Nursing staff followed national service frameworks and National Institute for Health and Clinical Excellence (NICE) guidance for prisoners with lifelong conditions, although some diabetic patients had not had retinopathy screening."

The Independent Monitoring Board (IMB) Annual Report 2007/08

15. The Prisons Act 1952 requires every prison to be monitored by an independent board appointed by the Secretary of State for Justice from members of the community in which the prison is situated. The Board must satisfy itself as to the humane and just treatment of those held in the prison it monitors.

16. Full Sutton IMB's most recent annual report was published in April 2009. The executive summary contains the following remarks:

"The Director General is asked to note the Board's concern relating to the Primary Care Trust's (PCT's) involvement in the delivery of healthcare in Full Sutton prison. The Board recognises the very pro-active and conscientious healthcare support provided by the prison's healthcare team which continues to evolve and improve. The proposal to channel the Prison's healthcare requirements and funding through the local PCT was implemented in recognition that there would be the opportunities for healthcare improvements within the Prison through an economy of scale and good practice as well as the opportunity for further efficiencies and possible savings. With the exception of the MRI scanner initiative, the Board is not

aware that the PCT linkage is providing any dividends in the form of healthcare improvements and savings.

"Healthcare staff are to be commended for the increased use of the telemedicine link with Airedale Hospital and for acting as consultants to another High Security prison in the installation and effective use of this complex equipment.

"Full Sutton's staff have performed well and have built on the very positive HMCIP Inspection report from last year with some very commendable progress in the key areas of Diversity, Safer Custody and in the Segregation unit."

Previous deaths in custody at Full Sutton

17. Since 2004, the Ombudsman's office has investigated eight deaths at Full Sutton, which have included seven deaths by natural causes and one homicide. One of the deaths occurred after that of the man who is the subject of this report. I am satisfied that there is no link between the circumstances surrounding this investigation and the other deaths, although a number of the deaths by natural causes were also associated with chronic disease and long term medical conditions.

18. The Ombudsman investigated a death by natural causes in February 2009 at Full Sutton. The clinical review found that there was some difficulty in identifying healthcare staff who had made entries in the clinical record and that healthcare interventions and care plans were not always clearly documented. The recommendation arising from that investigation was that there should be a review of documentation to ensure that evidence of care planning and designation of staff making the entries would be clearly evident. Much of the problem was that the use of SystemOne was still in its infancy and there had been some initial technical difficulties at the time. The prison's healthcare team accepted the recommendation with the response:

> "This is a systems error on the SystemOne clinical record system, which has been reported. Until the fault is resolved staff will enter information manually."

KEY EVENTS

19. The man was remanded into custody at HMP Lincoln on 19 July 1991 charged with murder. Following conviction of manslaughter in 1992, he was sentenced to two life sentences and sent to HMP Wakefield. On 5 August 1992, his Category A status was confirmed, which meant that he was assessed as a risk to the public if he escaped.

20. On 7 September 1999, he transferred to HMP Full Sutton. He was seen by healthcare staff on reception where a health assessment was undertaken. Healthcare staff noted that he was in good physical health although he was overweight and a heavy smoker.

21. In late 2000, healthcare staff wanted to carry out some clinical diagnostic tests due to concerns about the man's weight, excessive smoking and eating habits. He would not cooperate and discussion with a visiting psychiatrist on 4 January 2001 indicated that at that time he was refusing any clinical tests regarding his physical health.

22. However, five days later on 9 January 2001, he relented and had a cholesterol investigation. The subsequent biochemistry result indicated he had a high level of cholesterol. Clinical details at the time indicated that the man showed symptoms of depression and a suspected thyroid problem which was contributing to his weight problem. He was scheduled for an ECG test (electro cardiogram records and measures the functioning of the heart) but he declined to comply. His blood test for a thyroid function test showed the results as normal.

23. On 25 May 2002, healthcare staff called to see the man in his cell because he was complaining of feeling unwell. They carried out a clinical assessment but found there was nothing of concern. He was advised to rest and inform the staff if he became any worse.

24. Healthcare staff maintained their contact with the man, particularly to monitor his mental health. On 4 March 2005, he was reviewed by a senior registrar in psychiatry who noted that he was "emotionally flat and with poor hygiene". The man's long standing mental health problems were still an ongoing concern for both clinical and custodial staff. Concerns about his mental health and lack of insight in regard to his offending behaviour had been noted by a number of discretionary lifer panels (DLPs). Regrettably, the man's mental health and behavioural difficulties hindered his progress through his life sentence. At the time of his death, he had served nine years more than his tariff (the part of the life sentence a prisoner must serve before being considered eligible for release on licence).

25. More than a year later, on 4 June 2006, the man went to the healthcare centre after complaining of dizziness and nausea. He was assessed by healthcare staff who observed that he smelt strongly of alcohol but no medical intervention was required.

26. The man did not cooperate very well with advice from healthcare. On 9 June, he failed to attend the Practice Nurse Clinic. Failing to attend for healthcare appointments or to comply with healthcare advice was a common feature with him.

27. Two days later, on 11 June, he was seen after he complained of feeling "depressed and being stressed with pain in his chest". Healthcare staff examined him but were not unduly concerned as their clinical observations showed that there was "no sweating, pallor or vomiting" (these are signs of acute heart problems). He was asked to attend healthcare later that day to see the doctor.

28. The man did not return to healthcare that day but he was seen the following day. He said that he felt "much brighter and no longer felt depressed" and, when healthcare staff examined him, the pain in his chest and abdomen had gone.

29. On 11 November, he was seen in healthcare at the request of wing staff due to increasing concerns over his physical health. He reported to staff that he had not eaten for a week due to nausea and vomiting and felt light headed. Healthcare staff examined him and advised him to drink more fluids. He was placed on the doctor's list for a full medical review.

30. He complained of a chest infection on 25 January 2008 and was given antibiotics by healthcare staff.

31. A substance misuse assessment took place on 5 February 2009. The assessment showed that the man had a history of drug or alcohol misuse or was known to have taken medication from others. He had a history of storing up or overdosing on medication although the assessment acknowledged that this had not happened during the previous five years. Also of concern was that the assessment identified that he was a target for bullying and self harming behaviour. He was not placed on Assessment, Care in Custody and Teamwork monitoring (the Prison Service system to identify and support those prisoners at risk of self harm or suicide). The risk assessment concluded the man was at "moderate risk of substance misuse so would have weekly drug assessments".

32. Prison staff observed the man talking loudly to himself, possibly responding to hallucinations, during the night of 11 May. He was subsequently referred to healthcare for mental health assessment. A few days later on 15 May, he was assessed by a psychiatrist who thought he was suffering a possible relapse of his mental illness. The psychiatrist treated the man's psychotic symptoms with anti-psychotic medication (for treatment of serious mental illness).

33. On the morning of 26 May, Officer A was conducting his final roll check on B wing at the end of the night shift and went to check the man. Officer A opened the observation panel of cell B1-32 at approximately 6.47am and saw the man slumped on his chair. The officer called out to him but there was no response. A member of Night Patrol came to assist and also called out to the man but again got no response. At that point Officer A raised an emergency code blue alarm on his radio (Bravo 2 – radio call sign).

34. At approximately 6.49am Officer A decided to go into the man's cell, at which point a prison officer dog handler arrived to assist him. Officer A tried again to gain a response from the man but to no avail. He could see no sign that the man was breathing. The Night Orderly Officer, Officer A and a Prison Officer with training in healthcare went into the man's cell at 6.50am and saw him slumped in a chair. They placed him on the floor and examined him, but could not find a pulse (which would indicate his heart was beating) or respirations (which would indicate he was breathing).

35. The staff immediately started cardio pulmonary resuscitation (CPR) and defibrillation (electric shock given by a defibrillation machine to attempt to start the heart) and tried to administer oxygen, but with no success. At 7.10am a Nurse arrived and CPR was attempted again. Healthcare staff were unable to insert an airway (a tube to clear the patient's airway to aid breathing) because, as the Nurse observed, "the man's jaw was locked and his body in a state of rigor". (Rigor mortis occurs after death and renders the body rigid.) They also observed that there was pooling of blood (haemostasis after death) on the right side of the man's face and body and he was cold to the touch. An emergency ambulance was summoned. The paramedics arrived and verified that the man was dead at 7.30am.

36. The prison's Family Liaison Officer telephoned the man's mother at 9.00am to establish if she would be available for a home visit that day. He broke the news that her son had died earlier that morning, apparently from natural causes. The man's mother accepted his offer to visit her at home.

37. That afternoon the prison's Family Liaison Officer, accompanied by the duty governor and a representative from the chaplaincy, visited the man's mother at home. The prison's Family Liaison Officer provided the man's mother with a letter of condolence from the prison and also an information booklet containing contact numbers, relevant procedures and other information.

38. The man's mother told the prison's Family Liaison Officer how she had had a good relationship with her son and regular contact over the years. She agreed that the man's funeral would take place near Full Sutton, rather than in his home area. The prison's Family Liaison

Officer assured her that he would be in contact regarding funeral arrangements.

39. The prison's Family Liaison Officer told the investigator that the man's mother seemed concerned that he had "died so young" but expressed the view that "after 17 years in prison he may just have given up".

40. The Forensic Pathologist wrote in his post mortem report that the man had "no medical history of significance apart from a psychiatric history and that the man's death was from natural causes". His death resulted from the "physiological effects of ischaemic heart disease and the degree of heart disease was such that death could have occurred suddenly at any time". The Forensic Pathologist added that "hypercholesterolaemia (high levels of cholesterol) and hypertension (high blood pressure) would have been contributing factors" to the development of the man's heart disease.

ISSUES

Clinical care

41. A Clinical Reviewer from East Riding PCT conducted a review of the man's clinical care in accordance with the PCT's Serious Untoward Incident procedure. She identified that there was a failure to undertake note summarisation of manually written clinical records onto the electronic SystemOne which resulted in the information about the man's raised cholesterol levels not being readily available to healthcare staff.

42. The clinical reviewer notes that there was poor record keeping until computerised records were introduced. Some earlier entries were illegible, or untimed, and the designation of the person making the entry was not always clear. She wrote that there was:

> "… poor clinical record documentation (prior to electronic health records being implemented in 2007); some healthcare staff signatures and parts of their entries in the clinical record are illegible; entries seldom timed and the professional status of the individual making the entry not always documented."

43. However, she noted an improvement in the man's records in that later entries were eligible and the name and designation of the staff member making the entry is apparent. The Clinical Reviewer viewed a number of recent clinical assessments in a random sample of clinical records complied by staff who looked after the man and was satisfied that the recording of clinical assessments had improved.

44. The Clinical Reviewer identified in her clinical review report that until note summarisation is undertaken the

> "probability that someone with a long term health condition can be lost in the system and is thereby not offered the opportunity to participate in a clinical management programme remains."

45. The clinical reviewer also identified the absence of a plan to address the man's cholesterol levels:

> "There was no documented management plan supported by a systematic approach to the management of his high cholesterol to ensure he was reminded to attend for his blood tests and given appropriate health promotion advice and support
> When paper healthcare records were changed to electronic records this was not supported with a process of note summarisation to ensure key previous health information was inputted onto the new electronic heath record."

46. The Clinical Reviewer adds:

> "Prior to the move to electronic health records in 2007 the system in place to ensure patients who required management of a long term health condition relied in part upon the patient presenting to healthcare rather than being called in for a review. It appeared from the records that the man was reluctant to attend healthcare for blood tests which could be the reason why there are no further entries in relation to management of his high cholesterol after 2006.
>
> "Had note summarisation been undertaken when electronic health records were introduced it is likely that the man's previous raised cholesterol levels would have been identified and this information could have been transferred to his electronic records prompting healthcare to request that he attended for a blood test."

47. She concludes in her clinical review:

> "(There was) no systematic approach to the management of patients with a long term health condition prior to 2007. Had there been a systematic approach it is highly likely that this would have resulted in the information being automatically entered onto the electronic patient record when it was introduced.
>
> "There is no documented evidence to suggest that the man was experiencing chest pains which could have alerted healthcare staff to his coronary heart disease and led to his subsequent management. (The man's mother has, however, reminded me of references to chest pain in June 2006 which I made at paragraphs 27 and 28 of this report.)
>
> "The man's reluctance to communicate and comply at times with the proposed management plan in terms of monitoring his cholesterol levels will have impacted on the ability of the prison healthcare team to appropriately and systematically monitor and manage his raised cholesterol level. Had the man's raised cholesterol been known to the healthcare staff he would have been identified and thereby managed by the 'Long Term Conditions' prison nursing team which was established in 2006. He would have had a Coronary Heart Disease (CHD) management plan in place and would have automatically been called for an annual review and offered health promotion advice and information.
>
> "In the man's case although it is probable that he would not have engaged with any active management of his raised cholesterol

the opportunity to participate was unable to be offered as the information relating to his raised cholesterol was not readily available for healthcare staff."

48. The Clinical Reviewer made the following recommendations, which I am pleased to report have already been addressed by the Primary Care Trust and Full Sutton:

> "A plan for the summarisation of paper based patient notes is developed and implemented with the information being entered onto the electronic health record without delay.
>
> "The Prison Healthcare staff should mitigate against this risk until note summarisation has been undertaken by exercising increased vigilance when taking medical histories from prisoners in conjunction with a review of their paper held records where this is reasonably practicable."

49. Full Sutton's Head of Healthcare has since responded that the project to summarise the clinical records is underway and ongoing but is likely to take a few months to complete.

First on the scene and emergency response

50. When the man was found in his cell, the response by discipline and healthcare staff was timely, efficient and professional. A healthcare officer quickly arrived to help him. Sadly, it appears that the man had already died some time earlier.

Contact with the man's mother

51. The Prison's Family Liaison Officer telephoned the man's mother at 9.00am to inform her of her son's death earlier that morning. Later that afternoon he visited the man's mother at her home with the prison's condolences and to offer support. The Prison Family Liaison Officer told the investigator that he recognised the need to inform the man's mother at the earliest opportunity and was keen to make a home visit on the day of the man's death. He said that the purpose of telephoning the man's mother was to establish whether she would be at home.

52. Prison Service Order 2710 (Follow Up to Deaths in Custody) states in Supplementary Guidance on liaison with bereaved families at section 4.13:

> "Using the telephone is too impersonal to use in delivering news of a death to the family and should be used only as a last resort. There may be no one nearby to support the family. If the family lives abroad, the consulate may be able to assist in breaking the news. However the news is broken and especially if this is not

done face to face by the prison, there should be an early follow up by the prison."

53. It is clearly best practice for either local prison staff or staff from a nearby establishment to inform the next of kin on a face-to-face basis of the death of their relative. The Prison Family Liaison Officer told the investigator that, in this case, he considered his options. He concluded that he should first establish whether the man's mother would be at home and available for him to visit. However he went on to notify her of her son's death during the telephone conversation.

54. The man's mother told the Family Liaison Officer from my office that although the Prison Family Liaison Officer had been supportive, she also found it "difficult to get hold of him and had given up trying" because the staff operating the prison switchboard never connected her to the Prison Family Liaison Officer or took any messages. It is most important that family members have confidence that they will receive a timely response to questions and messages left following the death of a loved one. I appreciate that because of shift working this can be difficult, but nevertheless the perception of the man's mother was that it was difficult to maintain contact with the prison, which is regrettable.

The Governor should ensure that the principles and spirit of Prison Service Order 2710 Follow Up to Deaths in Custody (particularly the supplementary guidance which states "using the telephone is too impersonal to use in delivering news of a death to the family and should be used only as a last resort") are adhered to by the prison's family liaison officers.

CONCLUSION

55. The man suffered from serious mental health problems for much of his life and they continued to hamper his progress whilst in prison. There is strong evidence which indicates that he frequently neglected his health and did not take heed of advice from healthcare staff which might have helped prevent his premature death. His mental health difficulties made it difficult for him to have good awareness of his problems.

56. The investigator found no substantial evidence to suggest that the man had experienced any regular symptoms of ischaemic heart disease, such as chest pains, which healthcare staff might have missed. This meant that healthcare staff were not alerted to his underlying and unknown coronary heart disease, which could have enabled them to intervene with preventative clinical measures.

57. The man had no medical history of significance apart from his long psychiatric history. He smoked a great deal which is likely to have had a deleterious effect on his health. The forensic pathologist said that "death resulted from the effects of ischaemic heart disease" and that "the degree of heart disease was such that death could have occurred suddenly at any time."

58. The man died unexpectedly and at a relatively young age. He had a close relationship with his mother who had visited him regularly in prison over the years. Under the circumstances, I would have hoped that the prison family liaison officer would inform the man's mother of her son's death face-to-face rather than by telephone, although I appreciate he followed up his call with a personal visit the same day. The man's mother lives less than an hour's drive away from Full Sutton and I feel that a prompt home visit, whether she proved to be at home or not, would not have been onerous for the prison.

RECOMMENDATION

1. The Governor should ensure that the principles and spirit of Prison Service Order 2710 Follow Up to Deaths in Custody (particularly the supplementary guidance which states “using the telephone is too impersonal to use in delivering news of a death to the family and should be used only as a last resort”) are adhered to by the prison’s family liaison officers.

   Full Sutton’s response was:

   All operational managers and Family Liaison Officers will be advised that delivering news of the death of a prisoner to family members should be made in person. If this poses problems due to long distances then the assistance of a FLO in another establishment shall be utilised. Wherever possible the use of a telephone for passing such news should not be used.