PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man in October 2011 at HMP Full Sutton

Report by the Prisons and Probation Ombudsman for England and Wales

September 2012

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This is the report of the investigation into the death of a man in October 2011 at Full Sutton. The man, who was 56, was diagnosed with cancer after a lump on his neck was discovered in July 2011. The cancer was inoperable and too advanced to be treated with radiotherapy. The man died in the prison's healthcare unit with nursing staff and two members of the chaplaincy team at his bedside.

The man did not want his family to be told that he was terminally ill, and his wishes were respected. I extend my condolences to his family and friends.

Her Majesty's Coroner for East Riding and Kingston upon Hull ordered a post-mortem examination, which concluded that the man died of natural causes.

A review of the man's healthcare was commissioned by East Riding of Yorkshire Primary Care Trust. Full Sutton prison cooperated fully with this investigation.

I agree with the clinical reviewer that the man received care at Full Sutton at least equivalent to that he would have received in the community. He was encouraged to undertake medical tests to determine the cause of his symptoms, despite a reluctance on his part. During his illness, thoughtful arrangements were made for him to be looked after in the healthcare unit in the daytime and return to his wing at night so he could be comfortable in familiar surroundings and have the support of his friends. While I am satisfied that the decision not to release on compassionate grounds was justified, the investigation found that in reaching this conclusion the prison placed too much emphasis on the man's historical risk factors rather than fully considering his physical condition and the effect this had on his risk. One recommendation is made to address this.

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 **September 2012**
Prisons and Probation Ombudsman

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SUMMARY

1. The man was diagnosed with a personality disorder in 1982, while being treated at a secure hospital. In 1983, he was sentenced to life imprisonment with a minimum period to serve of five years. During his custody, he was a challenging prisoner and spent time in a number of different prisons. In March 2010, he returned to Full Sutton from HMP Frankland where he had spent some time for assessment. The Parole Board considered the man's suitability for release on several occasions, but he failed to demonstrate that his risk had reduced sufficiently and he remained in custody. He has served 14 years beyond his minimum tariff.

2. In May 2011, the man was seen by a doctor because he had a lump on his neck which he said had been there for around eight months. The doctor arranged for a scan, which indicated a growth. The man underwent further medical investigations at outside hospital.

3. The man originally refused a biopsy but with the encouragement of the doctor agreed to undertake one on 12 July. This established that he had an adneocarcinoma (a tumour originating in the gland). Further tests showed that his cancer was inoperable. On 26 July, a doctor, two nurses and a specialist Macmillan cancer nurse explained his prognosis and reassured him that he would receive full nursing care during his illness. An application for compassionate release was rejected, as his proposed accommodation was deemed unsuitable to continue his care.

4. As his illness progressed, the man also suffered from deep vein thrombosis in his arm and later in his leg which was an added complication to his advancing cancer. For some time he was nursed in the healthcare unit during the day but, in compliance with his wishes, arrangements were made for him to spend nights on the wing in familiar surroundings with his friends.

5. On 3 September, the man's health declined and he became dependent on oxygen therapy to assist his breathing. He then remained in the healthcare unit and received palliative care. On 10 October, he was moved to the unit's palliative care suite (a room designed and equipped for terminally ill patients). Nursing staff stayed at his bedside and he was given morphine to relieve the pain. He died shortly thereafter. Two nurses and two members of the chaplaincy department were with him.

6. We note that the man received good end of life care, although we make one recommendation about compassionate release applications. The investigation found that too much emphasis was placed on the nature of his index offence and his behaviour in custody, rather than the risk he presented at the time of the application.

THE INVESTIGATION PROCESS

7. The investigation into the man's death was opened on 14 October when the investigator visited Full Sutton, reviewed the man's prison file and arranged to receive copies of relevant documents. The investigator visited the man's wing, and spoke briefly to a senior officer (SO). The investigator also visited the healthcare unit and met the Head of Healthcare.

8. The Ombudsman's terms of reference and notices of investigation were sent to Full Sutton before the investigator's visit. No-one came forward in response.

9. A family liaison officer wrote to the man's mother, his nominated next of kin, to inform her of the investigation and invited her to raise any issues she would like the report for consider. The man's mother did not raise any concerns.

10. A review of the man's healthcare while at Full Sutton was commissioned by East Riding of Yorkshire PCT.

11. On 5 December, the investigator and a colleague visited Full Sutton and interviewed prison staff and prisoners. A meeting was held with the Head of Healthcare and members of the healthcare team to discuss the man's care. The following day the investigator wrote to the Governor with the initial findings of the investigation.

12. The investigation assesses the following aspects of the man's care and treatment:

- Whether his diagnosis was made in a timely fashion?
- Whether he was told about his condition and the treatment which followed?
- Whether he was treated properly and attended hospital appointments as necessary?
- Whether the liaison with the family was appropriate?
- Whether he was accommodated in the most appropriate part of the prison?
- Whether consideration was given to compassionate release from prison?
- Whether appropriate palliative care was provided?

HMP FULL SUTTON

13. 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. All cells are single.

14. The prison's inpatient healthcare unit has six beds and is staffed by qualified nurses, healthcare assistants and prison officers. There are an additional two safer cells, a crisis suite and a palliative care suite. Healthcare services are commissioned through the East Riding of Yorkshire Primary Care Trust (PCT). There are registered general and mental health nurses, as well as a nurse prescriber (a nurse who is qualified to prescribe medication). One doctor provides daily medical cover.

15. The most recent report of an unannounced inspection by Her Majesty's Chief Inspector of Prisons in November 2010 found that relationships between staff and most prisoners had improved, supported by a good personal officer scheme. Health services were judged to be good. Inspectors found that the inpatient unit was well managed with good activities for patients and excellent interactions between officers and patients. The Inspectorate also noted that there were excellent links with local cancer organisations including Macmillan nurses.

16. Each prison has an Independent Monitoring Board (IMB) who are 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 services at the prison and particularly commended staff for the level of care and compassion provided to terminally ill prisoners.

17. This office has completed ten previous investigations into deaths at Full Sutton since 2004. In 2011, there was one other death due to a cancer related disease and one from heart disease. No similar issues of concern from those deaths have been identified.

ISSUES

18. The man was 56 and unmarried. From 1977-1982, he was an inpatient at a secure hospital receiving treatment for a severe psychopathic personality disorder. In 1983, he was convicted of rape and received a discretionary life sentence with a minimum period to serve of five years. He moved between eight prisons in the 18 years he spent in custody. On 22 March 2010, he returned to Full Sutton from Frankland after being assessed as unsuitable for the dangerous and severe personality disorder unit at Frankland.

19. The man was found guilty of many disciplinary offences during his time in prison, including for inappropriate behaviour and conduct towards female officers. He did not engage in any offending behaviour work and failed to demonstrate that he had reduced his risk to the public. His next parole board review was due in November 2011.

The diagnosis of the man's terminal illness

20. On 13 May 2011, a nurse examined a lump on the man's neck and made an appointment for him to see a doctor. Six days later he saw a doctor and said he had first noticed the lump about eight months previously. The doctor arranged for the man to have an ultrasound scan.

21. An entry in the man's medical record on 25 May indicated that the scan showed evidence of a large growth on his neck. The following day, the doctor told the man that he was referring him urgently to outside hospital for further medical tests and that he had a suspected malignant (cancerous) growth. On 6 June, the man attended outside hospital for an x-ray, which showed that there was a swelling next to his lung, near to the lymph nodes. (The lymph nodes are organs of the immune systems and are found all through the body, including in the neck.)

22. The clinical reviewer notes that patients suspected of having cancer are usually referred for medical investigations at a hospital under the "two-week waiting referral pathway." The doctor used a standard urgent referral letter and he was seen quickly at the hospital in ten days. However, the clinical reviewer has suggested that in future the prison should consider using the two-week waiting referral to ensure a smoother referral process.

23. The man refused to attend an appointment in the Ear Nose and Throat department on 21 June at outside hospital and signed a witnessed disclaimer form. An entry in his medical record by the

doctor shows that he discussed the man's refusal to attend hospital and the possibility of a cancer diagnosis, with a palliative care nurse specialist. It was agreed that when all outstanding medical tests results were received they would talk to him.

24. On 29 June, the doctor spoke to the man about his refusal to attend the biopsy test that could determine whether he had cancer. The man was worried about the test, and the doctor reassured him that whatever the outcome of the biopsy, he would receive appropriate medical help and support. He eventually agreed to the procedure and on 12 July, the man attended outside hospital for his biopsy. The following day, a nurse spoke to the man about the biopsy. He asked the nurse if the doctor could explain the results to him when they were available.

25. The biopsy results were received on 22 July. They showed that the man had adneocarcinoma of the lung (a type of lung cancer), and that it was inoperable.

26. The man did not report the lump on his neck for eight months. As soon as he brought it to the attention of healthcare staff, appropriate diagnostic tests were arranged. Staff spoke to him about his reluctance to discover the extent of his illness. Although the formal two week referral pathway was not followed, this did not adversely affect his access to the necessary medical investigations. We agree with the clinical reviewer's assessment that the diagnosis of the man's terminal illness was timely and carried out in an appropriately supportive manner.

Informing the man about his condition and treatment

27. After receiving the biopsy results on 22 July, the doctor spoke to the man in the healthcare unit to explain the results, as he had requested. Two nurses were with the doctor for additional support. The doctor told him that the biopsy result had shown that he had adneocarcinoma of the lung and that the cancer cells had spread into his neck. It was most likely that the cancer was inoperable and further medical tests were being arranged. The man said he would like to carry on as normal as far as he could and stay on his wing rather than going to the healthcare inpatient unit.

28. The doctor saw the man on 26 July, with a Macmillan Nurse and two further nurses. The man told the healthcare staff he was concerned that his care might be compromised because he was a prisoner. He was reassured that he would be well looked after and have access to appropriate services, including Macmillan nurses, as if he were in the community. The man repeated that he would like to carry on as normal as far as possible, and stay on his wing. He was told that medication would be available to manage his pain as his illness progressed. It was recorded in his medical notes that he found it

difficult to accept his diagnosis of terminal cancer despite support from the healthcare staff and a Macmillan nurse.

29. The man was appropriately told that his cancer was inoperable and that he was terminally ill by the doctor and nursing staff at Full Sutton. He was understandably anxious about his condition but was well supported throughout his illness by healthcare staff and a Macmillan nurse, who ensured that any questions he had about his illness were answered

The man's medical appointments and treatment

30. Other than the man refusing the biopsy on 21 June, he attended all his hospital appointments. He was referred for secondary medical investigations appropriately and these included ultrasound scans and x-rays. He was prescribed paracetamol and ibuprofen for pain relief in the first stage of his illness.

31. After further investigation, the man's cancer was deemed inoperable and on 7 September, a referral was made for him to be assessed for palliative radiotherapy which helps to delay the onset of cancer symptoms. However, he became too weak and his cancer was too advanced for the treatment.

32. Because of the cancer symptoms, the man was also being treated for a DVT in his arm, and later in his leg. He attended hospital appointments for ultrasound scans and was treated with Fragmin injections to prevent further blood clotting. Later, the blood-thinning medication to prevent DVT was changed to Warfarin. He had regular blood tests to check for blood clotting and his medication was adjusted accordingly.

33. Multidisciplinary meetings were held to discuss the man's treatments and care plans. A Macmillan attended those meetings to offer her expertise and advice. She spoke to the man to explain the treatments and answer any questions.

34. The clinical reviewer concludes, and we are satisfied, that the man received appropriate treatment for both his cancer and DVT. He was closely monitored by healthcare staff including taking blood tests to regulate his treatment for the DVT. Hospital appointments were facilitated and staff worked with him to ensure that his initial reluctance to engage with treatment did not compromise his treatment in the long term.

The man's pain relief and medication

35. A nurse saw the man on 3 July, and recorded that his right arm was swollen to double its size. A prison doctor examined him and noted that he should be referred for an urgent ultrascan on the arm. The

doctor asked the nursing staff to take the man's temperature every 30 minutes and an urgent blood test was taken for analysis. The doctor prescribed Fragmin injections, (used to thin blood in order to prevent deep vein thrombosis, or DVT).

36. The following day, the doctor examined the man's arm and wrote that he should continue taking ibuprofen to manage the pain, as well as having Fragmin injections. Ten days later, an ultra sound scan at outside hospital confirmed that he had a DVT in his arm and that he should continue with the Fragmin medication. Regular blood tests were to be taken from him to assess his blood clotting and any adjustments to his medication. On 21 July it was noted that the swelling in his arm was reducing. He continued to receive daily injections of Fragmin and on the 11 August the medication was changed to Warfarin, used instead of Fragmin.

37. The doctor prescribed the man Tramadol, an opiate-based pain relief on 22 August. Two days later, Fortisips (a nutritional drink) was added. The man's medication was reviewed when he told staff that Tramadol made him nauseous and that his appetite was diminishing. Anti sickness medication was prescribed on 24 August.

38. On 3 September, the doctor prescribed Fentanyl patches for pain relief (these are patches of morphine placed on the skin so the medication can be absorbed.) Five days later, a further prison doctor prescribed liquid Oramorph, (morphine) for the man to take daily. On 11 September, the doctor also prescribed morphine tablets to help with pain relief.

39. The man was fitted with a syringe driver on 10 October to deliver diamorphine (an opioid painkiller) and midazolam, (a sedative). The clinical reviewer noted that the man was prescribed appropriate pain relief as his illness progressed which included medication for his DVT. The man's medication was reviewed regularly and we are satisfied that healthcare staff responded appropriately when he experienced pain and discomfort.

The man's location

40. The man lived on D wing and was employed as a wing cleaner until the onset of his illness. At his own request, he remained on the wing until 2 September, when his health deteriorated. He was then admitted to the healthcare centre so that his pain control could be monitored more closely and to help with his personal hygiene.

41. The man preferred to be on D wing because he had friends on the wing and he was familiar with the surroundings. Following a meeting with a prison doctor and two nurses on 23 September, it was agreed that he could return to D wing in the evening for association periods

and stay in his cell overnight. Appropriate arrangements were made between the healthcare and wing staff to facilitate this.

42. Prisoners on D wing assisted the man by helping get his meals and making him drinks. One of those friends told the investigators that the prisoners on D wing did what they could for their fellow prisoner but he did not tell them what his illness was. His friend said that the man became increasingly weak and it was obvious that he was seriously ill.

43. The investigators spoke to a D wing manger. She said that when the man first went to the healthcare unit for nursing care he seemed to ”pick up”. When he returned to D wing to sleep, his friends supported him and made him comfortable. His friends helped to push him in his wheelchair around the wing and it was the support of his friends that it made it possible to care for him in his cell.

44. We commend the care afforded to the man by his friends on D wing and the sensitive arrangements made by both healthcare and wing staff for him to spend nights in his cell as he requested.

45. A prison doctor saw the man on 3 September and noted his frailty and declining health. He was now taking oxygen therapy and it was agreed that he should remain in the healthcare unit for continuous nursing care. The following day, he was transferred to outside hospital for a medical assessment and returned to the healthcare unit on 5 September, for palliative care nursing. There was no record that his friends from the wing were able to visit him in the healthcare centre during that time.

46. The man moved into the palliative care suite in the healthcare unit on 10 October. He was nursed by staff until his death shortly thereafter. Two nurses and two members of the chaplaincy staff were at his bedside when he died.

47. We acknowledge the sensitive care given to the man during the final hours of his life. The clinical reviewer writes:

> “It was very good that the prison had a dedicated palliative care suite which allowed for the correct level of care to be given in the proper environment at the end of his [the man’s] life.”

Thanks to the effort of staff and prisoners, the man was able to spend the last weeks of his life in familiar surroundings, in accordance with his wishes.

Compassionate release

48. Prisoners who are suffering from a terminal illness and for whom death is thought likely to occur soon can be released from prison by early release on compassionate grounds. Arrangements for prisoners

such as this man who was serving an indeterminate sentences are set out in PSI 29/2010 which amended PSO 4700 – The Indeterminate Sentence Manual. Before exercising the power to release a prisoner on compassionate grounds, the Parole Board has to be consulted unless the circumstances make this impracticable. Each case is considered on its own individual merits. For life sentenced prisoners decisions for release have to be approved personally by a Minister and such decisions are not delegated to officials.

49. The criteria for compassionate release on medical grounds for all indeterminate sentence prisoners (ISP) are as follows: -

> "The prisoner is suffering from a terminal illness and death is likely to occur very shortly (although there are no set time limits, 3 months may be considered to be an appropriate period for an application to be made to Public Protection Casework Section [PPCS]), or the ISP is bedridden or similarly incapacitated, for example, those paralysed or suffering from a severe stroke; and the risk of re-offending (particularly of a sexual or violent nature) is minimal and further imprisonment would reduce the prisoner's life expectancy; and there are adequate arrangements for the prisoner's care and treatment outside prison; and early release will bring some significant benefit to the prisoner or his/her family."

50. On 17 September, the man told a nurse that his solicitor would be making an application for compassionate release. He told the nurse that he would like to spend some time with his family and his elderly parents would appreciate this. Five days later, his offender supervisor at Full Sutton wrote in the man's file that while talking to him he told her that he was in regular contact with his father and his family were supportive of a compassionate release. Apparently, he was telling different information to staff regarding his family contact. His family told Full Sutton's family liaison officer, that there had been no contact between them for a long time.

51. The man's application for release on compassionate grounds was started in September. The medical practitioners involved in the man's care were consulted and it was agreed that his prognosis was between two and 12 weeks. He was described in the report as "frail and suitable for palliative care only". Although he was not bedridden at the time of the assessment, the report suggested that "his mobility would reduce" and he would eventually become confined to his bed. Finally, the medical report recognised that he needed assistance with "daily activities of living".

52. The man's community probation officer completed a report for the application for compassionate release on 28 September. Although the man indicated that he could stay with his parents if he were to be granted compassionate release, his probation officer recognised the

limitations of this arrangement, given his complex medical needs. The man's offender supervisor concluded her assessment that "he is still considered at the moment physically capable of committing an offence should he want to", and noted that he had acted inappropriately towards female staff. She was also concerned about securing accommodation that would appropriately meet the man's medical needs.

53. A Governor completed the application for compassionate release on 4 October. It was his view that "the primary concern when considering release on compassionate grounds is the safety of the public". The Governor concluded that the man's risk of reoffending remained high, based on his index offence and his behaviour in the prison. He also recognised the difficulty of securing appropriate accommodation to manage the man's healthcare needs. The Governor concluded that he "did not meet the criteria due to a 'very high' risk of sexual reoffending".

54. Much weight was attached to the nature of the man's index offence throughout the application for compassionate release. The medical report identified him as a "frail" man, but did not describe him as bedridden. However, the application was completed when the man was living in the palliative care suite in the healthcare centre, so serious was his medical condition. Risk is not static and, in cases such as these, the risk to the public needs to be judged taking into account the reality of the prisoner's physical condition. He would not have been able to secure appropriate accommodation so his application was unlikely to have been successful. Nevertheless, it appears that too much weight was attached to his static risk, and not enough account was taken of the actual risk he presented taking into account his physical condition at the time of the assessment.

The Governor should ensure that applications for compassionate release appropriately reflect the risk that the prisoner presents at the time of the application.

55. On 7 October, a Governor visited the man in the healthcare unit and told him his application had not been approved. The Governor discussed with him the reasons for the refusal, namely a lack of appropriate accommodation to deliver his adequate care and treatment outside of the prison. Furthermore, it was noted that he still posed an ongoing risk to the public, because he had failed to address his offending behaviour and his history of psychopathy.

56. The man thanked the Governor for speaking to him and said he would appeal the decision through his solicitor. He then went on to tell the Governor that he was being well cared for in the healthcare unit and this care was, "second to none". There was no evidence that he took his appeal any further.

Palliative care plans

57. The man's palliative care plans were discussed with him on 26 July, following his diagnosis of his cancer. According to his records, the man was informed of his care, the Macmillan nursing team were involved in multidisciplinary meetings and care plans were drawn up in line with the palliative care pathway.

58. Following deterioration in his condition, the man moved to the palliative care suite on 10 October.

59. The clinical reviewer noted that the prison had a dedicated palliative care suite. He said,

> "This allowed the correct level of care to be given in the proper environment at the end of his life. I do feel that the staff in general should be complimented on their delivery of care to [the man] particularly in the palliative care phase of his life."

60. We agree with the clinical reviewer's comment that the palliative care provided to the man was of a high quality.

Liaison with the man's family

61. The man was not in contact with his family while serving his prison sentence. It was recorded in his prison file that his mother was his nominated next of kin. When he was diagnosed with cancer, the man told healthcare and wing staff that he did not want his family to be informed of his terminal illness and this wish was respected. His parents were elderly and he did not want them to worry about him. Despite this he told his offender supervisor that he could stay with his parents should he be released on compassionate grounds.

62. According to the man's medical records, healthcare staff spoke to him about informing his parents of his illness. On 3 October, he told a healthcare senior officer (SO), "I don't want them [the man's parents] to know what's going on with me." The senior officer assured the man that his wishes would be respected and no one would contact his family.

63. The man died on an evening in October and the prison's family liaison officer and a colleague visited his parents the following morning to break the news of their son's death. The investigator was told that the prison took into account that the man's family were elderly when making the decision to wait until the following morning to contact them. We agree that this was appropriate in the circumstances. The man's parents were naturally distressed by the news of their son's death. His brother arrived at the house while the family liaison team were there and confirmed that they had not been in contact with their relative for a long time.

64. Funeral arrangements were made by the prison on the family's behalf. On 23 October, the funeral service was held for the man. It was conducted by the prison chaplain and attended by staff from the prison.

65. The prison's contact with the man's family was conducted with sensitivity and we are satisfied that it was appropriate in the circumstances.

CONCLUSION

66. The man was diagnosed with terminal cancer in July 2011 and developed deep vein thrombosis, a common illness associated with cancer. The clinical reviewer writes in his review that the lump in the man's neck was cancerous and his prognosis was poor by the time he reported it to healthcare staff. He received appropriate care throughout his illness and staff facilitated his temporary return to his wing so that he could feel comfortable in familiar surroundings, with the company of his friends.

67. The application for compassionate release was completed in line with the guidance, but too much emphasis was put on the man's offending history. Although he was unlikely to have been granted compassionate release because of a lack of suitable accommodation, his physical condition should have had more bearing on the Governor's conclusion.

68. We note the sensitive approach taken to ensure the man was supported by healthcare staff and chaplains during the last few hours of his life. The clinical reviewer concludes that the man received care at Full Sutton to a standard comparable or better than he would have received in the community.

RECOMMENDATIONS

1. The Governor should ensure that applications for compassionate release appropriately reflect the risk that the prisoner presents at the time of the application.

   Accepted – While the response does not expressly mention adequate assessment of the physical condition of a prisoner when considering compassionate release, the prison responded as follows:

   This is already established practice at HMP Full Sutton.

   A review of the application for compassionate release indicates that at the time it was made (September 2011), the man was still manifesting his offending behaviour in prison. The Offender Manager/home Probation Officer report supported this with the following assessment:

   - *"Currently [the man] is considered to still have the physical capability to commit further offences should the opportunity arise and therefore his risk is considered too high to be managed within a residential care setting or a hospice. Any consideration of a placement within these settings will require full disclosure to relevant staff to ensure that they were aware of the risks and are appropriately able to manage this." 28th September 2011;*

   - *The man had not consented to full disclosure, so full risk assessment for appropriate accommodation could not be carried out.*

   This assessment confirmed and supported other assessments that the man still had the capacity to offend and continued to pose a risk to the public which is supported by his unwillingness to give permission for his offending history to be released to third parties as identified by his offender manager.

   When considering release on compassionate grounds the key factor is that of public safety. HMP Full Sutton considers that the decision made reflects a thorough assessment using the information available at the time and the risk that he posed at that time.