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

Report by the Prisons and Probation Ombudsman for England and Wales

July 2012

This is the report of an investigation into the death of a man, a prisoner at HMP Full Sutton. He died in December 2011 of heart failure caused by severe narrowing of the arteries. He was 51 years old. I offer my condolences to his family and friends.

The investigation was carried out by one of my investigators. The local PCT commissioned an independent clinical review of the care the man received.

The man attended the prison gymnasium one afternoon. He returned to his wing and was locked in his cell at about 7.10pm. He was seen during a routine roll check at 8.00pm and appeared well. The following morning at 6.45am, during a roll check, he was found lying face down on his bed and was unresponsive. Attempts were made to resuscitate the man, but the doctor who attended his cell noted that rigor mortis was well advanced and it appears he had been dead for some time.

The man had showed no signs of ill health, was a regular gym user and his death was unexpected. He made little use of health services but, when he did, the care provided was of good quality. Only one concern arose; about the use of staff from another prison to inform his next of kin of his death. While it would have involved some travelling, I consider that it would have been better practice for a member of staff from Full Sutton to have personally conveyed such news and been in a position immediately to answer any questions about the circumstances and the prison.

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.

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Prisons and Probation Ombudsman **July 2012**

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SUMMARY

1. On 16 July 2007, the man was charged with serious offences and remanded to HMP Preston. He was convicted on 17 October, and was sentenced to 12 years in prison. On 19 February 2009, he was transferred to HMP Full Sutton.

2. The man had a reception health screen at Full Sutton, where he said that he took medication for hay fever and eczema, and that he was allergic to penicillin. He also said that he had previously received treatment from a psychiatrist after suffering with depression. He was assessed as fit for normal location, work and cell occupancy.

3. On 6 March, the man was seen by a nurse for a mental health assessment. The nurse felt that he was coping well on the wing and raised no concerns. While at Full Sutton, he was generally in good health and visited healthcare only for minor matters.

4. The man attended the prison gym one evening in December. When he was later escorted back to the wing at around 7.00pm, he appeared fit and well and raised no concerns with staff.

5. At 7.10pm, prisoners returned to their cells for lockup. An officer locked the man's cell, and said good night to him. An officer and an Operational Support Grade (OSG) conducted a roll check later that evening and no concerns were raised.

6. A prisoner, who was in the cell next to the man, told the investigator that during the night he heard a bang on the wall coming from his room. He said that he had not been concerned when he heard the noise as the man was a noisy person.

7. At 6.45am the following morning, the man was seen lying facedown on his bed and was unresponsive. Attempts were made to resuscitate him but the doctor who attended commented that "rigor mortis was well advanced" and that it was possible he had been dead for some time.

8. The man's ex-partner, his nominated next of kin, lived in Bury, Lancashire. Full Sutton arranged that someone from HMP Manchester would inform her of the mans death, rather than doing so themselves.

9. A post-mortem examination revealed that the man died of acute myocardial insufficiency (heart failure) caused by severe coronary artery atheroma (severe narrowing of the arteries). His death appeared unforeseeable. We make one recommendation about notifying the next of kin.

THE INVESTIGATION PROCESS

10. The investigation was opened on 12 December 2011, when the investigator attended HMP Full Sutton. Before her visit, notices were issued announcing the investigation to staff and prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to the investigator. No-one came forward.

11. The investigator collected copies of the man's prison files, including his medical records. She visited the healthcare unit, viewed his cell, introduced herself to the staff on the wing and talked to the prisoner who lived in the cell next door to the man. She met the Governor and the Family Liaison Officer.

12. The investigator returned to Full Sutton on 29 February 2012, to interview four members of staff. Throughout the investigation, feedback was given to the investigator's liaison officer at Full Sutton.

13. An independent clinical review of the man's care at Full Sutton was carried out by two clinical reviewers on behalf of the local PCT. The clinical review was received on 13 March 2012.

14. One of the Ombudsmans family liaison officers attempted to contact the man's next of kin, his ex-partner, (who remained a friend), to inform her of the investigation and to provide her with an opportunity to raise any issues about the care he received. After being unable to make contact by phone, she wrote to her on 13 January 2012, but received no response.

15. Following the issue of the draft report the man's next of kin contacted the family liaison officer requesting a copy of the draft report. The consultation period was extended to allow her time to consider the report. At the end of the consultation period another family liaison officer contacted the next of kin. After having the opportunity to consider the draft report she informed the family liaison officer that she no comments to make.

16. This report was forwarded to the coroner to assist in his enquiries.

HMP FULL SUTTON

17. 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, in single cells.

18. Healthcare services are commissioned through the local 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). Two doctors provide daily medical cover.

19. 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.

20. An Independent Monitoring Board (IMB) drawn from the local community is appointed to each prison by the Secretary of State for Justice to help ensure that standards of care and decency are maintained. In its latest annual report, for the year up to October 2011 the IMB were positive about health services at the prison.

21. This office has completed 14 previous investigations into deaths at Full Sutton since 2004. In September 2011, there was one other death due to a heart related disease. No similar issues of concern relating to heart disease were identified, but a similar issue about when to attempt to resuscitate arose in a previous investigation into a self inflicted death. In response to that case, a notice was issued, four days before the man's death, to say that if the nurse in attendance was satisfied that the person had died (with clear signs of rigor mortis of the limbs present); resuscitation did not have to be attempted. The nurse who attended his cell was not aware of this notice at that time.

KEY EVENTS

22. The man was convicted on 17 October 2008, and sentenced to 12 years in prison. On 19 February 2009, he was transferred to HMP Full Sutton from HMP Forest Bank. The same day he was seen by a Healthcare Support Worker (HCW), who completed a reception health screen. At this screening he told her that he was currently taking medication for hay fever and eczema and that he was allergic to penicillin. He explained he had previously received treatment for depression, but had chosen to stop taking antidepressants after feeling he no longer required them.

23. The HCW noted in his medical records that he had 'good eye contact with no thoughts of self harm or suicide'. In light of his previous depression, she referred him for a mental health assessment. He was assessed as fit for normal location, work and cell occupancy. During this reception screen his blood pressure, height or weight was not taken.

24. On 6 March 2009, the man was seen by a nurse for a mental health assessment. He explained that he had previously suffered from depression following his conviction, and that visits from his family were difficult as Full Sutton was quite a distance. He wanted to see if he could transfer to HMP Wymott to be near to his family. The nurse noted during his assessment that he was smart, clean and tidy in appearance and was pleasant in his mood and manner. The nurse felt that he was coping well in prison.

25. On 22 April 2009, the man saw a nurse after complaining of back pain. He worked in the prison kitchens and had been lifting kitchen equipment incorrectly. She said that his pain was muscular and gave him general back care advice, showing him how to lift correctly to avoid further injury. Later in 2009 and in February 2010, he was given treatment for minor injuries incurred at work.

26. On 20 May 2010, the man saw a doctor as he was worried that he was feeling depressed. He was seen by a mental health nurse four days later. In discussion with her, he explained that he felt that he had been misled by his legal team which had caused him some anxiety. She assessed him and noted in his medical record

    > "Copes well in prison and has a job that keeps him occupied for most of the week and also attends education. Offered ongoing support as he requires, does not want medication at the moment as he copes with his mood changes, no problems with sleep, diet or interactions".

    It appears that after this meeting the man was able to manage his depression himself as this was the last time he sought assistance from mental health services at Full Sutton.

27. While the man was at Full Sutton, further criminal charges were brought against him. He was required to attend Magistrates' Court on a number of occasions and, when necessary, was transferred to HMP Preston for a short

time. At Preston, he was seen for ‘well man’ checks there on 8 October 2010, and 5 January 2011, and no health problems were identified.

28. After a court appearance at Magistrates’ Court, the man returned to Full Sutton on 21 March 2011. He again saw the Healthcare Support Worker for his reception health screen. During this reception health screen the normal health related questions were asked, and his height, weight, body mass index (BMI) and blood pressure was taken.

29. On 21 June, the man attended healthcare for pain relief for backache.

30. One evening in December, the man attended the prison gym. Two Physical Education Officers (PEOs) were on duty that day. They were unable to recall what activity he took part in that day, but said that they did not remember him complaining of being ill or looking unwell. At approximately 7.00pm he and the other prisoners in the gym were escorted back to their wing.

31. At 7.10pm, a prison officer locked the man in his cell, and said good night. The officer confirmed that when he saw him that evening he appeared well, and showed no signs of distress.

32. Another officer arrived at 7.20pm to start his night shift. Shortly after his arrival, assisted by an Operational Support Grade (OSG), he conducted a roll check to ensure all prisoners were well and in their cells. The prison roll check was confirmed as correct at 8.46pm.

33. A prisoner was in the cell next to the man. He saw the man shortly before they were locked up for the night and he confirmed that all appeared to be OK. He said that later that night he heard a bang on the wall coming from the man’s room. He said the noise did not alarm him as he found the man a noisy person.

34. At 6.40am the following morning, the officer and OSG began the morning roll check. When the OSG opened the viewing hatch, he saw the man lying face down on his bed with his legs hanging off the side. He called the officer for assistance. The officer switched the cell night light on and off a few times to try and gain a response. He then knocked on his door and called his name but gained no response. The prison was still in ‘night state’ and all prisoners were locked in their cells. (During night state the number of staff is much lower than during the day. The night orderly officer is in overall charge of the prison and carries a set of keys that allow them to access all areas of the prison. Wing staff carry cell keys in a sealed pouch which they can use only in an emergency.)

35. The officer called the control room and spoke to a Senior Officer (SO), who advised that if he was happy to do so he could unlock and enter the man’s cell. The officer went into the cell, touched his on his left arm and called out his name. He explained in his witness statement that his arm felt “cold and solid”. After gaining no response and fearing he had died, he called a code blue on his prison radio requesting immediate medical assistance (this call

was timed at 6.45am; a code blue call indicates an emergency in which someone is having difficulty, or is not, breathing).

36. Healthcare staff do not carry prison keys at night. After hearing the alert on the radio, a nurse collected the blue resuscitation bag and waited to be collected from the healthcare centre. The Duty Governor arrived a minute or so later and escorted the nurse to the cell, arriving at 6.50am. With the help of Duty Governor, the nurse turned the man onto his back. She explained in her statement that, on examination “there was obvious pooling of blood in areas of his body, arms and legs”. He was rigid and she was unable to insert an airway into his mouth due to rigor mortis. Defibrillator pads were applied and it showed ‘asystole’ (no heart beat) and did not advise her to administer an electric shock. The Duty Governor called the control room at 6.54am asking that death in custody contingency plans be put in place and an ambulance be called. Despite the rigor mortis, the nurse started cardiac massage at 6.55am, continuing to monitor the defibrillator for any indications of a heart beat.

37. The prison doctor was just arriving for duty when the code blue was called. He went to the cell and, after examining the man, confirmed that “rigor mortis was well advanced with stiff extremities and clenched teeth”. At 7.20am he confirmed that the man he had died. Paramedics arrived at the prison at 7.14am, arriving at the cell shortly after the doctor’s arrival.

38. Before going off duty that morning, both the officer and OSG were seen by the employee support officer. Notices were put up around the prison advising all staff and prisoners of the man’s death, offering support to those who required it. The suicide prevention team were informed and prisoners in neighbouring cells were spoken to make sure they were alright.

39. The man’s next of kin, his former partner, lived in Bury, Lancashire. Full Sutton’s Family Liaison Officer contacted HMP Manchester to ask if they could break the news. A Principle Officer from Manchester went to the next of kin’s house to inform her of her former partner’s death. Full Suttons’ family liaison officer spoke to the mans next of kin by telephone the next day.

40. A post-mortem examination revealed that the man died of acute myocardial insufficiency (heart failure) caused by severe coronary artery atheroma (severe narrowing of the arteries).

41. The man was cremated on 19 December 2011. Full Sutton contributed to the costs of the funeral.

ISSUES

The emergency response

42. The officer thought the man was dead when he found him unresponsive and called a code blue requesting immediate medical assistance. When the Duty Governor and nurse arrived at the cell they turned him over onto his back,

tried to insert an airway into his mouth and attached defibrillator pads. Although there were clear signs that he was dead, with rigor mortis present, the nurse started cardiac massage, and continued to monitor the defibrillator for any indications of a heart beat.

43. Full Sutton's 'death in custody – first on scene action sheet' instructs staff that, "If the prisoner is not breathing attempt resuscitation. If not breathing and/or no pulse is present, clear airway and attempt resuscitation, using a face mask with non return value, unless rigor mortis of the limbs <u>has clearly set in</u>".

44. The investigator asked the Healthcare Manager at Full Sutton what nursing staff had been instructed to do during an emergency response. She advised that, previously, nursing staff were required to continue resuscitation until death had been confirmed by a doctor or a paramedic regardless of whether they thought the person has died. However, in response to a previous investigation by this office in 2011 a notice had been issued to say that if the nurse in attendance was satisfied that the person had died (with the clear signs of rigor mortis of the limbs being present) resuscitation did not have to be attempted. However, she had advised her staff that any decision to attempt (or not to attempt) resuscitation must be an individual decision that they would be happy to defend if required.

45. The notice issued to staff on 2 December 2011, said,

> "A recent PPO Clinical Review into the suicide of a prisoner at Full Sutton made the recommendation to re-examine the nursing response and interventions delivered on finding a body.
>
> The PPO support the view that in cases where a prisoner has ended his life with the clear signs of rigor mortis of the limbs being present, no attempts at resuscitation are required in accordance with Annex 13C of PSO 2700.
>
> This applies only to clear cases. In all other circumstances upon finding a collapsed or unconscious body all attempts at resuscitation should be made until paramedic staff, GP or a suitably qualified clinician pronounces death".

46. At interview, the nurse (who attended the emergency response) explained that she was now aware of the new guidance, but at the time she had followed the previous guidance, to continue resuscitation until the death had been confirmed.

47. The clinical reviewer commented in his review that:

> "A situation such as finding a prisoner who has apparently died will always be anxiety-provoking and upsetting and attending nurses are expected at all times to act professionally and in the best interests of the patient. By attempting emergency life saving aid for the man, albeit he had already

died, [this] should not be seen as a detrimental criticism of the nurse's actions. Her actions were futile in actual fact, but no harm was done either".

Informing the next of kin of the man's death

48. PS02710, which deals with events following a death in custody, indicates that the preferred option for breaking news of a death is that the prison's Family Liaison Officer, and another member of staff, should visit the next of kin in person. However, the PSO also lists a number of other factors which can be taken into account when deciding how to break bad news. One of these is the location of the next of kin and distance from the prison.

49. Full Sutton is approximately 80 miles from Bury, under two hours driving time. In our opinion, this is not an excessive distance for staff to drive in these circumstances. While acknowledging that each case should be decided according to the specific circumstances, we make the following recommendation:

    The Governor should ensure that, except in exceptional circumstances, where the next of kin of a prisoner who dies lives within a reasonable distance of the prison, they are informed in person by a member of Full Sutton staff.

CONCLUSION

50. During his time in prison custody, the man had only a few minor health issues and little contact with Healthcare services. He worked in the prison kitchen, attended the gym regularly and appeared to all those around him to be fit and well.

51. He showed no signs of ill health the evening before his collapse and his death was entirely unexpected.

RECOMMENDATIONS

To the Governor

1. The Governor should ensure that, except in exceptional circumstances, where the next of kin of a prisoner who dies lives within a reasonable distance of the prison, they are informed in person by a member of Full Sutton staff.

   The National Offender Management Service responded with,

   Accepted - The local contingency plans for Handling a Death in Custody will be reviewed and amended to reflect that the distance and time from Full Sutton to the address of the deceased's NOK is *reasonable* and that there must be exceptional reasons when our own Family Liaison officer and staff are not deployed.