Investigation into the circumstances surrounding the death of a man at HMP Full Sutton on 13 February 2009

Report by the Prisons and Probation Ombudsman for England and Wales

October 2009

This is the report of an investigation into the death of a man who died on 13 February 2009 at HMP Full Sutton. He had collapsed in his cell and despite efforts by prison and healthcare staff, was pronounced dead. The man had a long history of illness and a number of serious underlying medical conditions. He was 79 years old when he died.

A post mortem was held at the request of Her Majesty's Coroner for the District.. It found that the man died of natural causes resulting from intrathoracic haemorrhage due to ruptured thoracic aortic aneurysm consistent with severe atherosclerosis (the progressive narrowing and hardening of the arteries over time).

I offer my sincere condolences to everyone touched by the man's death.

The investigation was started by one of my colleagues but later completed by another colleague. In addition, a review of the man's healthcare was commissioned from the local Primary Care Trust (PCT). I am grateful to Ms A who carried out the review. I would like to thank the governing Governor of Full Sutton and his staff for their help and assistance. I am particularly grateful to the liaison officer, Governor A.

I endorse the four recommendations taken from the clinical review for the attention of the Head of Healthcare and the Informatics Development Manager for local PCT. The recommendations include reviewing the long term conditions policy, training for healthcare staff in the use of the computerised medical records, ensuring the role of the person updating records is recorded and formal medicine reviews to be documented at least annually.

The man made a number of complaints about his medical care during his detention at Full Sutton and these were all resolved locally by healthcare staff.

Jane Webb
Deputy Prisons and Probation Ombudsman **October 2009**

CONTENTS

Annexes

SUMMARY

A man was sentenced to eight years imprisonment on October 2005 at the Crown Court. He was held at HMP Altcourse where his medical history and life style (he drank and smoked heavily), made him a frequent visitor to the healthcare centre.

In December 2006, the man transferred to HMP Full Sutton where he was reviewed by healthcare staff. He continued to have regular contact with healthcare staff who also saw him on the wing. He had a number of chronic health problems which were controlled by self-medication. In addition he was under the care of a cardio vascular consultant at the local hospital. In November 2008, the man was diagnosed with abdominal and aortic aneurysms (an aneurysm is a sac formed by the dilation of the wall of an artery, vein or the heart). The consultant indicated that nothing further could be gained from additional investigations and he was discharged.

Throughout January 2009, the man complained of various pains and discomfort which resulted in visits to or from healthcare. On 7 February, the man complained of chest pains and feeling light headed and was attended to by healthcare staff. Two days later he again complained of feeling unwell, reporting feeling dizzy and sick. He was immediately transferred to healthcare for further observations. The following day the man reported feeling slightly better, was up and about and wanted to return to the wing. He did the next day.

However, on 13 February at 1.36pm, healthcare staff received a telephone call from the wing that the man was complaining of chest pains which he had had for about an hour. The man believed that they were muscular pains. The nurse discussed with Dr A who suggested that the man be admitted to healthcare. However, 20 minutes later the nurse went to the wing and observed the man walking to collect his canteen (items from the prison shop). She noted that he did not appear to be in pain and asked if he still had chest pains. He said that he did not, but had back pains. She asked if he wished to go to healthcare and he signed a disclaimer saying he did not wish to attend.

At 3.44pm a prisoner told wing staff that the man had collapsed in his cell. They responded immediately and found him slumped over his bed. Healthcare staff started cardio pulmonary resuscitation (CPR). Dr A arrived at 3.55pm and three minutes later pronounced the man dead.

The man was treated for various medical conditions for the two years he was at Full Sutton. The clinical review makes some recommendations regarding the healthcare systems and processes. I judge that the man received good medical, personal and emotional care from healthcare and discipline staff.

THE INVESTIGATION PROCESS

1. The investigator, Mr B, opened the investigation by letter. He received copies of all of the man's prison and medical records. The Ombudsman's notice of investigation and terms of reference had been sent. Full Sutton has previous experience of death in custody investigations. No members of staff or prisoners responded to the notices of investigation.

2. Following a review of the man's records, Mr B arranged a number of interviews with prison and healthcare staff through the liaison officer, Governor A.

3. A clinical review of the healthcare provided to the man was commissioned by local Primary Care Trust. I am grateful to Ms A for her comprehensive review.

4. In June the investigation was passed to Mr C to complete. In early July he conducted a number of interviews with prison and healthcare staff at Full Sutton to ascertain the emergency response to the man's collapse.

5. One of my family liaison team, Ms B, spoke to the man's next of kin, his step daughter. Ms B asked if she had any concerns that she wanted to be considered as part of the investigation. She said that prison staff had been good, helpful and sympathetic and had paid for the funeral. She mentioned that the man had complained about one doctor whom he felt was unhelpful. She did not want any of the man's property returned to her.

6. On 10 August, an inquest was held into the man's death at Hull. The inquest found that he had died from natural causes.

HMP FULL SUTTON

7. Full Sutton is a high security prison. It was opened in 1987 and is a modern, purpose built maximum-security jail for male category A and B prisoners. The man was a Category B prisoner.

8. The four original residential units are of a square design: A wing holds main wing prisoners and B, C and D Wings hold vulnerable prisoners. E and F wings, which were added later, are of an improved design and both hold main wing prisoners. Half of F wing is the segregation unit. G wing is used for induction and holds some vulnerable prisoners.

9. Healthcare services are commissioned through local Primary Care Trust (PCT). Full Sutton has an inpatient healthcare unit that is staffed by qualified nurses, healthcare assistants and discipline officers. The nursing staff have a range of skills including mental health and there is a nurse prescriber. Medical cover is provided by two doctors on a daily sessional basis. An electronic records system has been introduced for patients' notes.

10. Nurse led clinics for ongoing conditions and vaccinations are held regularly, and a dentist, physiotherapist and optician hold sessions in the unit. A walk in centre for prisoners is available everyday along with a practice nurse clinic for appointments.

11. Her Majesty's Chief Inspector of Prisons' most recent inspection of Full Sutton was in 2007. An extract from that report, commenting on healthcare services says:

> "There was evidence of individual patient care on the wings, with a multidisciplinary approach involving the prisoner, discipline staff and nurses and a joint care plan. This allowed a sick man to remain on the wing at his request with at least twice daily support from health services staff."

12. The Independent Monitoring Board noted in their Annual Report of 2008:

> "2008 has been another successful year for the HCC (Health Care Centre). The Mental Health Nursing Team achieved a 'Best Practice Nursing Award' from within the High Security estate. This is a notable achievement coming as it does, after last year's 'Best Practice Award' for healthcare within European prisons. Both awards reflect a very positive attitude towards continuous improvement, innovation and striving for excellence."

13. In April this year, in recognition of the growing number of older prisoners the Head of Healthcare, Ms C reviewed and updated the establishment's strategy for the Management of Older Offenders. This strategy brings together a number of disciplines within a co-ordinated framework and, when fully implemented it is intended to make a difference to the lives of older offenders.

14. There have been four previous deaths at Full Sutton since the Ombudsman's office started investigating all deaths in prison custody in 2004. Two of the deaths were self-inflicted. The others were due to natural causes and did not have any similarities to that of the man.

KEY FINDINGS

15. The man was 79 years old when he died. He was convicted of sexual offences against children committed when he was a younger man. He suffered from a number of chronic illnesses and diseases for some time prior to his imprisonment. He was a heavy drinker and smoker.

16. The man appeared at a Magistrates Court on 12 July 2005 and was remanded into custody at HMP Altcourse that day. The first reception health screen, completed by the prison's nursing staff recorded that the man had previously suffered from a heart murmur and angina, for which he was taking medication. He had previously been admitted to a psychiatric hospital, having attempted to harm himself by taking an overdose in 1999.

17. Because of his medical history the man was admitted to the healthcare centre for observations. Staff took the precaution of opening the Assessment Care in Custody and Teamwork (ACCT).ACCT is a procedure used to support and monitor prisoners thought to be at risk of suicide or self harm. It was closed a week later as he was not judged to be at risk.

18. On 7 October, the man was sentenced at the Crown Court to eight years imprisonment. In October and November the man reported to healthcare on a number of occasions, suffering from chest and abdominal pain and complaining that his medication had no effect. On 4 and 14 November, the man reported that he had fallen during his sleep and had been injured which were treated.

19. Throughout 2006 the man's health appears to have settled, however he continued to suffer a number of different ailments;

    - Ischemic Heart Disease (IHD is any group of acute or chronic cardiac disabilities resulting from insufficient supply of oxygenated blood to the heart).
    - Chronic Obstructive Pulmonary Disease (COPD is an 'umbrella' term for people with chronic bronchitis, emphysema or both)
    - Diverticulitis (occurs when small pouches bulge out from weak points in the instestines forming 'diverticula', which then become infected or inflamed. It is sometimes described as being similar to a balloon of air bulging out of a bicycle tyre.)
    - Anxiety (which was being treated by various medications. See annex 2.

20. The man saw the prison doctor in February because he was suffering from chest pains and in March and May healthcare staff were called to his cell and treated him for shortness of breath.

21. The man transferred to HMP Full Sutton on 13 December where he was reviewed by healthcare staff. As part of this review he was assessed by Dr A, the prison doctor and referred to the mental health in reach team (MHIRT) because of increased anxiety following his transfer.

22. In January 2007, the man saw the MHIRT who assessed that his mood was low because he was inactive. He was told about the older person services available at the prison and because he was not working, he was encouraged to use the library.

23. On 11 January, the man went to the Hospital for a chest x-ray which appeared to suggest that he was suffering from asbestos related lung disease. Four days later the man fell on the wing and staff arranged for him to be seen by the doctor. Wing staff were advised to keep an eye on the man and assist him, for example by collecting his meals whenever possible.

24. At the end of the month, Officer A reported that the man had settled into the prison regime but that his ailments and seniority of age limited him from getting around the prison, although he did his best to do so.

25. Two days later, the man saw Dr A, who noted that he continued to suffer from shortness of breath, related to his lung disorder. Dr A wrote to the consultant chest physician seeking advice for the long term management and/or further investigation of the man's medical conditions.

26. During February the man was referred back to the prison's MHIRT as a consequence of his poor self care, depression and feelings of helplessness. On 18 February, Officer A wrote that the man although infirm and unable to walk far without difficulty, did go out of his cell.

27. The man saw healthcare staff on the wing at the beginning of March. He said he was suffering from panic attacks and appeared unkempt. Another referral was made to the MHIRT. Over the subsequent months the man's mood lightened. Officer A reported that he appeared to be getting around the wing a little more than previously and was maintaining good spirits despite his health.

28. Although treated for his ongoing complaints over the summer, Officer A continued to report that the man remained in good spirits. He was smiling and joking and appeared well. He managed to get about more, including going on to the exercise yard.

29. During a sentence planning board chaired on 1 August, the man was set a target to participate on the Sex Offender Treatment Programme (SOTP). He said he had previously been unable to participate in due to his ongoing ill health. The man was also set the target of attending the over 60s group at the prison.

30. The man continued to have contact with the healthcare staff and, on 26 September, staff undertook a Coronary Heart Disease Risk Assessment. He was offered assistance to stop smoking but did not want to stop.

31. In October 2007, the man complained of tiredness and abdominal pain, for which a number of blood and urine samples were taken, but the results

proved negative. The man saw healthcare staff on a number of occasions during November as he felt unwell and was experiencing abdominal pain that he thought was due to his medication. He told staff that his health had suffered since he transferred to Full Sutton and he was unhappy with the care he was receiving. He said that he intended to seek legal action. The man continued to complain of abdominal pain throughout December. However nursing staff reported that, despite losing his appetite his weight had increased during the year. He was referred to a general/colorectal surgeon at York Hospital.

32. During January 2008, the man continued to complain of chest and abdominal pains. He was again encouraged to apply for the over 60s group in the prison, which he said he would. (The clinical reviewer said that at this time the man's blood pressure was extremely high which should have been identified and managed by healthcare, but according to the records he was not referred to the prison doctor.) The man was offered help to stop smoking but again told staff that he did not want to stop.

33. An ultrasound was completed at second local hospital on 30 January. It showed that the man had multiple gallstones and a 4.5cm abdominal aortic aneurysm. (An aortic aneurysm is a thin, weakened section of the wall of your aorta that bulges outward. Most aneurysms occur in the section of the aorta that passes through the abdomen and are called abdominal aortic aneurysms.) The details were sent to Dr B, the consultant, who saw the man at the local hospital on 25 March.

34. In a letter dated 26 March from Dr B to Dr A, he described the man's history of abdominal discomfort. Upon examination there was no evidence of jaundice or anaemia, but the ultrasound showed many stones within his gall bladder. Dr B had asked for further tests including another CT scan of the abdomen and an endoscopy.

35. An appointment was received for the man to go for a CT scan on 16 April. However this appointment was cancelled and rearranged for 28 April. Another letter asked the man to attend for an endoscopy on 19 June.

36. On 15 April, nursing staff were called to the wing to treat the man for mild lacerations to his wrist which were caused by him falling out of bed.

37. During the first few months of 2008, the man was assessed on several occasions regarding his participation in the SOTP programme, and he said that he was too ill to participate.

38. The man again fell from his bed on 19 April, and was treated by staff. Arrangements were made for the disability nurse to review him. A decision was made that he should be admitted to healthcare overnight but he declined to move, signing a disclaimer to this effect. Staff then attempted to organise a bed support but were advised that this would be difficult. Discussions with the man suggested he move cells but again he declined although he appeared appreciative of the support offered by healthcare.

39. On 28 April the man refused to go to the CT scan citing that he did not want to be handcuffed as he found it humiliating. He saw prison doctor on 1 May who explained the seriousness of going the hospital appointment in order for confirmation to be made of his condition. The man was advised the most likely diagnosis was an aortic aneurysm.

40. During May the man reported feeling unwell on several occasions, suggesting that some symptoms may be due to anxiety. An appointment for another CT scan was made for 5 June.

41. The man fell out of bed again on 22 May. He again refused to move cells, saying that he was happy where he was.

42. The man went to the third hospital for his endoscopy on 19 June. In early July he and the prison doctor assessed his referral to the Cardio Vascular Consultant, Mr C. During July the man again reported to healthcare on several occasions because of abdominal pain and anxiety.

43. On 7 August, the man received his medication to hold in his possession. When it was checked by a nurse it was discovered that he had not been taking it correctly, with much having been taken out of its boxes and mixed up. The excess medication was removed.

44. Four days later the man was seen by the MHIRT at the request of wing staff. He was agitated after being interviewed to take part in SOTP and he firmly believed that he did not need the course because of his ill health and age.

45. During August the man was again seen by healthcare staff on a number of occasions as he was suffering from abdominal pain. He went to the third hospital on 18 August to see Mr C, Consultant Vascular Surgeon. Mr C reported that the man was suffering from separate thoracic and abdominal aortic aneurysms. Because of his age and ischaemic heart disease he was not a good candidate for surgery. As a consequence a decision was taken for the man to be kept under review and a follow up CT scan would be arranged in a year's time.

46. During the night of 27 August the man complained of stomach and leg pain and after intervention by nursing staff, agreed to be admitted to healthcare for an assessment. He was transferred to healthcare on 3 September as he was not coping well with day to day life and remained frail. He discharged himself several days later.

47. On 7 September, the man was told that his condition would not improve and was terminal. He was told to ask for staff if he required further support and although it was noted that his mood improved a little, he did not appear to be coping well. Throughout the remainder of September the man had numerous contacts with healthcare staff.

48. It was reported in early October, that the man was having difficulty showering and was unsteady on his feet. Provision was made for a chair in the showers. Although the man's conditions appear to have stabilised on 20 October, he reported bouts of dizziness but refused any intervention by nursing staff two days later.

49. At the end of October the man was again seen by the MHIRT. He reported his anxieties about his health and the pressure to undertake the SOTP, but did not report any feelings of depression.

50. On 3 November, the man went to the clinic at the third hospital with Dr B. Dr B confirmed in a letter to Dr A that the man had been diagnosed with abdominal and aortic aneurysms. The man reported that he had good days and bad. Dr B said that he did not think there was anything to be gained from further investigation and discharged him from the clinic.

51. Throughout November and December the man's contact with healthcare staff continued. He complained of stomach pain during the night on several occasions. Nursing staff noted that the man's complaints appeared to be aggravated by irrational anxieties. They also noted that he had lost weight but that his health appeared to have improved slightly. On 31 December, the man attended a care of the elderly session and appeared to enjoy chatting and socialising with others.

52. The first two weeks of January 2009 were quiet for the man. However he complained again of abdominal pains after eating on 15 January. Officer A wrote on his wing sheet that, although the man's health had not improved, he was leaving his cell more often.

53. On 21 January, a note by healthcare staff said that the man complained of poor sleep and abdominal pain. In another entry for the same date he reported increased anxiety, expressing thoughts that he was falsely accused and had been wrongly imprisoned. A member of the MHIRT team was asked to investigate due to his agitated state. On 23 January, they reported that the man became agitated when discussing the SOTP programme and although frustrated, exhibited no thoughts of harming himself.

54. Nursing staff were called to see the man on 25 January who again reported pain to his abdomen. It was difficult to ascertain the problem as the man moved the conversation from subject to subject. He did not appear to be in discomfort and was being observed standing up and bending down. On 27 January, the man was given medication for his symptoms of sickness.

55. The man complained of chest pains and feeling light headed on 7 February. Healthcare staff attended and he was told to ask for them again if he experienced further problems.

56. Two days later the man again complained of being unwell, reporting feeling sick and dizzy and said that he had not eaten for several days. He was immediately transferred to healthcare for further observations. The man ate

later that day. It was noted that he had settled in healthcare and looked the best that he had been in a long time. The following day the man reported feeling slightly better, was up and about and wanted to go back to the wing, which happened later that day. There was no further contact between the man and healthcare staff until the day of his death.

13 February

57. On 13 February, the man reported having some chest pains. Healthcare staff recorded that although his vital signs were normal, they wanted him to be admitted to healthcare for observations. The man signed a disclaimer declining any further medical treatment.

58. At 10.00am that morning the man again saw a member of the MHIRT who reported no depressive thoughts. The man remained anxious and frustrated about his sentence and the SOTP course. He declined to partake in offending work.

59. At 1.36pm wing staff telephoned healthcare as the man had complained of chest pains, which he had had for about an hour. He said that he believed they might be muscular. The nurse discussed this with Dr A who in turn suggested that the man be admitted to healthcare.

60. The nurse returned to the wing at 1.56pm and saw the man collect his canteen. She saw him walking and recorded in EMIS (the computerised medical record) that he did not appear to be in pain. The nurse asked the man if he wanted to be admitted to healthcare, and he again declined, signing another disclaimer to that effect.

61. At 3.44pm another prisoner on the wing informed staff that the man had collapsed. The staff reacted immediately and found the man slumped over his bed. He appeared to be breathing. They moved the furniture and laid him on the cell floor. Healthcare staff had arrived by then and they commenced cardio-pulmonary resuscitation (CPR) using a defibrillator that instructed them not to administer an electric shock. (The defibrillator is used to start/monitor heart rates in people who have stopped breathing and it can provide an electric shock to try and re-start a heart.) Dr A arrived at about 3.55pm and he pronounced him dead at 3.58pm. No ambulance was called.

62. The man's next of kin was recorded as his step daughter. Efforts to locate her by the prison were unsuccessful as several different names and addresses were listed. As a result, Greater Manchester Police were asked to deliver the news of the man's death. This they did at about 11.31pm. The next day, the prison family liaison officer spoke to the man's step daughter and expressed the prison's condolences.

ISSUES

Clinical Care

63. In her clinical review Ms A concluded that healthcare staff at Full Sutton "actively managed a range of long term conditions that the man was suffering from and appeared to encourage healthy behaviours." She said that the man had an outpatient care plan for his chronic conditions which was used by healthcare staff to closely monitor him, given his choice that he did not want to leave the wing. Ms A said that it was evident that the man was supported and offered admission to inpatients on a number of occasions. However this was sometimes declined by the man, including in the hours before his death.

64. She found that healthcare staff responded quickly when the man was found collapsed.

65. Ms A said that the man's long history of multiple conditions were reviewed by healthcare and specialist opinion was sought by means of referrals to outside hospital. The man did not always comply with the medication prescribed. Had he done so, it may have resulted in him experiencing fewer symptoms, including abdominal pain. She said that his bowel symptoms, although masking a possible deterioration in the aneurysms, were unlikely to have had any effect on his death.

66. She says that when the man refused to attend his CT scan, there was a delay until the GP explained the seriousness of the situation and importance of attending the scan. She says that patient information was key to ensuring that the man understood the care and management of his condition.

67. However, she reports that there was no uniform use of the Map of Medicine website. This is a national tool for evidence based practice and would be particularly supportive for practitioners operating in a closed clinical setting such as a prison. This mechanism can also be used to provide up to date patient information which can be printed off directly from the website.

68. Ms A says that the man had a number of small aneurysms as a result of widespread arthrosclerosis and was under review by a vascular surgeon. She said that there was always a risk with such a condition that a sudden and unpreventable deterioration would occur. The man refused an offer to return to healthcare in the hours leading to his death. However, she concluded that a return to healthcare at that time was still likely to have resulted in his death.

69. She said that the review of this case from a healthcare perspective concludes that a comprehensive range of care was offered to the man but it was unclear as to any formal review processes in place.

70. Ms A concludes that due to the sudden onset of chest pain the treatment plan and proposed admission to healthcare was reasonable. She says that the man had a lot of contact with healthcare and that this appears to have been

managed appropriately, however Ms A said that this had been difficult to establish due to the way healthcare records were presented.

71. She concludes by saying that it was unlikely that additional interventions in the days leading to the man's death would have resulted in a different outcome. She says that there are systems and processes which could be strengthened with regard to the management of prisoners suffering from long term conditions.

72. Ms A makes the following recommendations which I endorse.

Formal medicines reviews should be clearly documented in the patient record at least annually.

Training of healthcare staff to maximise the use of SystemOne to ensure more explicit recording of Reed referrals and patient contacts.

The role of people entering data on to SystemOne is clearly recorded

The Long term Conditions policy should be reviewed to include doctors also being directed to Map of Medicine to ensure practice remains current to the most recent clinical evidence.

Ambulance

73. My colleague interviewed the staff who dealt with the man following his collapse asking why no ambulance was called. No one could say why one was not called but all said it would have been the control room that were responsible for calling emergency services. There appears to be some confusion as to who should direct the control room to summon an ambulance. The non calling of an ambulance in this particular case proved not to be relevant however, it could be vital in the future.

74. I make no formal recommendation regarding this, but suggest the prison governor reviews the protocols for calling ambulances and ensure all staff are aware of them.

Post Incident Statements

75. The investigating officer found that prison officers making their incident statements appeared to have 'cut and pasted' parts from Senior Officer Y's statement into their own. This is not good practice and staff should be reminded to make a factual statement on what they recall and not to 'cut and paste' from other colleagues statements.

Family Liaison

76. The prison family liaison officer was asked why police and not the prison had contacted the man's next of kin. It was explained that although they had the name and address shown for his next of kin, they also had a number of different addresses for her and they felt it better to get police to check the relevant addresses and confirm to them the correct one, which is what occurred. I understand a balance needs to be struck between timeliness and sensitivity. Whilst I make no formal recommendation, I would encourage the Governor to satisfy himself that policies regarding breaking the news of a death are sufficiently robust and in line with Prison Service Order 2710.

First Aid Training

77. A number of prison officers also raised with the investigator the problem of prison officer staff not maintaining their first aid qualifications. This clearly has an impact on prison staff being 'qualified' to administer emergency first aid to prisoners should the need arise, but also to their colleagues who may suffer a medical emergency. It seems a waste of time and money to train staff in first aid and then not allow them to maintain their qualification via the refresher training. This is a matter the Governor and Head of Healthcare may wish to consider.

RECOMMENDATIONS

1. Formal medicines reviews should be clearly documented in the patient record at least annually.

2. Training of healthcare staff to maximise the use of SystemOne to ensure more explicit recording of Reed referrals and patient contacts.

3. The role of people entering data on to SystemOne is clearly recorded

4. The Long term Conditions policy should be reviewed to include doctors also being directed to Map of Medicine to ensure practice remains current to the most recent clinical evidence.