# Investigation into the circumstances surrounding the death of a man while in the custody of HMP Full Sutton in February 2011

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

**July 2012**

This is the report of an investigation into the circumstances surrounding the death from pneumonia of a man, a prisoner at HMP Full Sutton. He died at 3.15pm in February 2011. He was 66 years old. I extend my condolences to his family.

The investigation was carried out by an investigator and a clinical review into the man's healthcare at the prison was commissioned by the local Primary Care Trust and carried out by a clinical reviewer. Full Sutton co-operated fully with the investigation. I apologise for the delay in the publication of the report.

The man was serving a 17 year sentence. He suffered from diabetes, arthritis and asthma. Throughout 2010 and 2011, he suffered from persistent breathing problems and was treated with inhalers and antibiotics. He was diagnosed with an underlying lung disease in 2010. He was susceptible to chest infections and told his prognosis was poor. In February 2011, he was admitted to hospital with breathing difficulties. He was diagnosed with pneumonia and died in February, with his family at his side.

Although there were some inadequacies in medical record keeping and in the initial assessment of the man's lung condition, his long term and acute illnesses were generally well managed at Full Sutton. I also note that his family were informed of his admission to hospital in a prompt and timely manner. However, while all restraints were removed when he became seriously ill in hospital, the investigation was not able to conclude that the initial level of restraints used was justified by the risk assessment and a recommendation is made to ensure proportionality in such cases.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

**Nigel Newcomen CBE**
**Prisons and Probation Ombudsman** **July 2012**

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## SUMMARY

1. The man arrived at HMP Full Sutton in December 2009, shortly after being convicted of serious offences and given a 17 year sentence. During his reception health screen, he said that he suffered from type 2 diabetes, arthritis and asthma, and was only able to walk short distances with the assistance of a walking stick. His diabetes was managed effectively, although he sometimes did not attend his medical appointments because he did not like to wait to be seen.

2. The man was seen by medical staff on many occasions because of his breathing difficulties. Anxiety intensified his breathing problems and he was advised how to best manage these episodes.

3. A persistent cough resulted in the man undergoing a chest X-ray in February 2010 which suggested that he would benefit from seeing a chest physician. Although there is no specific entry in his medical record to show this was followed up, later entries indicate that he was diagnosed with chronic obstructive pulmonary disease (COPD). It is not clear exactly when this diagnosis was made.

4. Tests in March showed that the man was suffering from interstitial pulmonary fibrosis (lung disease) and the diagnosis was confirmed in April, The medical record does not have an entry to show what care was required for this chronic condition. Throughout the rest of 2010 and 2011, he continued to suffer with shortness of breath. This appeared to be partly due to his condition, made worse by anxiety. He received appropriate support and medication to control his breathing difficulties.

5. On 15 February 2011, the man was admitted to hospital. He had breathing difficulties and had become distressed. Investigative tests carried out in hospital showed that he was suffering from pneumonia. His condition continued to decline and he was moved to the intensive care unit (ICU) on 20 February. Due to the gravity of his condition, handcuffs were removed and the prison officers escorting him distanced themselves from his bedside.

6. Towards the end of February, hospital doctors spoke with the man’s family about his condition and prognosis. The following day, with his families consent, active treatment was stopped. He died at 3.15pm that afternoon.

## THE INVESTIGATION PROCESS

7. The investigation into the man's death was opened by an investigator on 1 March 2011, on behalf of the lead investigator. Notices were issued to staff and prisoners at Full Sutton informing them of the investigation and inviting them to contact the investigator if they had information regarding the investigation. No-one came forward in regard to the notices.

8. The investigator met the Governor of Full Sutton, the deputy governor and another senior manager and arranged for relevant documentation to be sent to the lead investigator.

9. The lead investigator conducted interviews at the prison on 11 and 12 May 2011 with staff and one prisoner. She wrote to the Governor on 18 May and provided preliminary feedback. She also wrote to the Governor and Coroner on 13 June and 27 January 2012, to apologise for the delay in issuing this report. Initially the report was delayed because of the need to wait for the clinical review, which was not received until September 2011. Subsequently the report became part of a backlog of cases in the office which we are striving to clear.

10. The independent clinical review was undertaken on behalf of the local Primary Care Trust (PCT) by a clinical reviewer. He received all medical and prison documentation relating to the man, upon which he based his findings.

11. HM Coroner for East Riding and Kingston Upon Hull was informed of the investigation and a copy of this report will be sent to the Coroner. .

12. One of the Ombudsman's family liaison officers contacted the man's wife and provided her with the opportunity to raise any questions or concerns. She said she was concerned that more could have been done for her husband if he had been admitted to hospital earlier.

13. On receipt of the draft report, the man's wife made the following comments:

    - She was disappointed that she was not informed of her husband's admittance to hospital earlier, and that she was unaware she was allowed to stay in the hospital overnight.

    - She said that she tried to keep up to date with how her husband was by telephone, but had difficulty obtaining updates and found it hard to reach the prison's family liaison officer.

    - She said she did not realise how ill her husband was, and did not think that he did either, otherwise they would have discussed this

    - She remains concerned that her husband would still be alive had he been admitted to hospital sooner

    - The man left the doctor's waiting rooms because his problems with his hip and back meant he was unable to sit for long periods of time

- She felt that the prison showed a lack of compassion because her husband remained double cuffed and in restraints while in hospital.

## HMP FULL SUTTON

14. Full Sutton is a maximum security prison near York. It holds up to 608 category A and B male offenders serving sentences of over four years, in single cells. Healthcare services are commissioned through the East Riding of Yorkshire Primary Care Trust (PCT). The nursing staff have a variety of skills, including mental health, and there is a nurse prescriber[1]. Two doctors provide daily medical cover. There is a six bed in-patient-unit.

### HM Inspectorate of Prisons

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 with a well qualified nursing team. The skill mix was very good with registered general nurses (RGNs) and RMNs providing support to patients. Two RGNs were also nurse prescribers. Nurses were trained in general competencies, including asthma and diabetic nursing.

### Independent Monitoring Board

16. Each prison is monitored by an Independent Monitoring Board (IMB), whose members are drawn from the local community. They have full access to prisoners and every part of the establishment. In its latest annual report for the year ending October 2011, the IMB were positive about health care services at the prison and particularly commended staff for the level of care and compassion provided to terminally ill prisoners.

### Previous deaths at Full Sutton

17. In the last two years, there have been seven deaths due to natural causes at Full Sutton, including that of the man. There are no direct similarities between any of the previous investigations and the investigation into his death.

[1] A nurse who is qualified to prescribe medication

## KEY EVENTS

18. The man was remanded into HMP Preston on 14 October 2009. Due to the nature of his offence, he was separated from the general population and held in the vulnerable prisoner unit. On 11 November, he was sentenced to 17 years imprisonment and moved to HMP Full Sutton, on 8 December. After a short period on the induction wing he moved to the vulnerable prisoner wing. .

19. The man told medical staff at his reception health screen at Full Sutton that he suffered from type 2 diabetes, arthritis and asthma, and was only able to walk short distances with the assistance of a walking stick. He listed the medication he was taking, which included metformin[2], losec[3], co-codamol[4], avandia[5], aspirin[6], glimepride[7], artovastatin[8] telmisartin[9] and fluoxetine[10]. It was noted in his medical record that a referral to a nurse regarding his diabetes was required.

20. On 14 December, the man was reviewed by a mental health nurse about his prescription for fluoxetine, an anti-depressant he had taken since January 2009. A doctor reviewed this consultation the following day and agreed to maintain the prescription for two months, which continued to be reviewed regularly.

21. The man's medical record shows that he was referred to the diabetes nurse on 18 December. The entry notes that he was "receiving intervention" but it is not clear from the records whether he was assessed by the nurse, or what intervention he received. On 24 December, because of security concerns, he was required to take his co-codamol supervised by staff.

22. Entries in the man's medical record show that he missed several appointments with a prescriber and one with the doctor during January and February 2010. There is nothing to explain why or whether staff followed this up. A prisoner on his wing, who knew him well, told the investigator that the man did not like to waiting for appointments and he had seen him leave the healthcare waiting room a couple of times without being seen.

23. On 4 January, the man saw the disability liaison nurse, who explained her role. He said he was fine and managed to walk to the healthcare centre everyday for his medications, using his walking stick. He said his current pain relief prescription was appropriate to manage the pain in his hip.

[2] An anti-diabetic drug
[3] Drug used for stomach conditions such as peptic ulcer and reflux disease
[4] A moderate form of pain relief
[5] An anti-diabetic drug. There is some controversy around this drug and the risk of cardiovascular events. It has been withdrawn in New Zealand and suspended in the European Union. In the United Kingdom, users should have been reviewed and transferred to another drug by 21 October 2010
[6] A form of pain relief. Also used to thin blood and is often prescribed to patients with cardiovascular disease
[7] An anti-diabetic drug
[8] A drug used to lower cholesterol
[9] Used to treat high blood pressure
[10] An anti-depressant

24. During January and February 2010, the man complained of chest problems and shortness of breath on a number of occasions. He was always reviewed by healthcare staff who checked his lungs and prescribed appropriate treatment. He was prescribed antibiotics for a chest infection and referred for an X-ray.

25. The man had a chest X-ray at hospital on 8 February. A letter from the radiology department outlined the findings as:

> "CTR 16.5/36 i.e. the heart is not actually enlarged. Not a good inspiration, certainly no over inflation. No pleural effusion is shown. There is a reticular nodular pattern in the lungs, it is difficult to exclude interstitial pulmonary fibrosis. Certainly no overt evidence of heart failure. I think this patient may benefit from a chest physician opinion."

26. The letter was filed in the man's medical record ten days later, but there is no entry to suggest a plan of care was created as a result.

27. On 16 February, a nurse wrote in the man's medical record that he had been seen at the request of the doctor as he had overused his inhaler when coughing. She advised him that the inhaler would not stop his coughing as it was to help breathlessness. She noted she suspected he might have chronic obstructive pulmonary disease (COPD) "as diagnosed recently", but there are no earlier entries in his medical record to suggest that he had been diagnosed with COPD. It was suggested he was to have a spirometry[11] test and routine blood tests which the nurse noted had previously been requested but so far no appointment had taken place. He was referred for a spirometry test the following day.

28. An emergency radio code blue[12] was called on the wing during the afternoon of 18 February as the man had shortness of breath and was hyperventilating. An examination showed that he had 'crackles' on both sides of his chest, but it was not clear if they were from his recent chest infection. He was upset that somebody had changed the name notice on his door and this seemed to make his condition worse. He was taken to healthcare and was assessed by a doctor. His emotional state was discussed as stress made his asthmatic attacks worse.

29. The following day, a nurse reviewed the man. She wrote in his medical record that he had calmed down since the previous afternoon and, as a result, felt much better with no shortness of breath. She discussed a mental health referral for support with his anxiety, which he appears to have welcomed. Entries in his medical record throughout February and March show that he had used the gym for remedial purposes in conjunction with the mental health in-reach team (MHIT) which indicates that a referral had taken place although this is not recorded. He said that he enjoyed using the gym, was able to move better and was able to walk longer distances without becoming breathless. However, as his condition worsened, he was advised not to use the gym.

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[11] Apparatus for measuring the volume of air inspired and expired by the lungs

[12] An alarm code which is called over the radio network to inform discipline and healthcare staff there is an emergency which needs immediate medical attention. Code blue signifies emergencies such breathing difficulties, unconsciousness and fits. A code red would signify an emergency that involves blood.

30. The man attended a spirometry screening test on 8 March. The results of the test were filed in his medical record four days later. These suggested he was suffering from interstitial pulmonary fibrosis, a condition which restricts breathing. The record did not indicate that any follow up actions were required.

31. The man complained of further chest problems throughout March. He saw a doctor on 24 March who noted his history of an "on and off cough for couple of years …" His recent chest X-ray was also noted, as was his diagnosis of interstitial pulmonary fibrosis. The doctor examined him and noted that there were fine crackles to the left lung, but no "sob (shortness of breath), no clubbing, no temp, no glands". The treatment plan was for him to have a computerised tomography (CT) scan[13] of his chest and a review by a chest physician. A prescription was made for carbocisteine[14].

32. On 9 April, a radiology report was sent to the doctor following the man's CT scan on 1 April. The letter confirmed that interstitial pulmonary fibrosis was present, although it did not suggest a treatment or action plan. There is no entry on the medical record that he had been for a CT scan, or to record the receipt of the letter with a diagnosis of a chronic illness.

33. On 2 May, wing staff called for the assistance of healthcare staff, as the man was lying on his bed shaking and crying. A nurse recorded that when she saw him he was able to talk in full sentences. She did not observe any evidence of chest pain or a wheeze, although he said he felt cold and had started shivering. He had had a recent bereavement and did not feel he was coping very well.

34. The nurse recorded the man's medical observations and that she was unsure of the cause of the symptoms he displayed. She offered him an admission to healthcare for observation, which he declined. He was advised to take paracetamol every four hours in case of a temperature and she noted that she would arrange a urine sample in case he was suffering from an infection. The chaplaincy was asked to provide support and she said she would inform the mental health team of his distress so they could also consider providing support. Later that day, the healthcare department was called again as he was hyperventilating and shaking. The nurse again suggested he move to healthcare for observation, but he declined.

35. Shortly after, he changed his mind. When he arrived at healthcare, he had a high temperature. A doctor was informed and suggested oral fluids, paracetamol and a urine test. The doctor asked to be contacted again if he became more unwell. He was monitored through the rest of the day and night. His urine test results were negative for infection. The doctor thought he had a viral infection and recommended that he continued to drink plenty of fluids.

36. The man suffered from cellulitis[15] and a slightly raised temperature between 4 and 7 May and was admitted to hospital. He returned to prison on 10 May and

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[13] Use of x-rays and a computer to create detailed images of the inside of your body
[14] Used to help loosen sputum and to help relieve symptoms of COPD
[15] A common skin infection caused by bacteria.

remained in healthcare overnight for a review with the prison doctor the following day. He returned to the wing on 11 May after signing a disclaimer stating that he did not want to stay in healthcare any longer.

37. Through the rest of the year, the man was seen by healthcare staff for a variety of matters including diabetes control and cellulitis, shortness of breath, medication reviews and a dermatology referral to outside hospital. A staff nurse told the investigator during an interview that:

> "I saw him for his diabetes plan occasionally if I happened to be the nurse on duty here if he had any problems. He was always very polite, very pleasant appeared to be compliant; his blood sugars were reasonably well-controlled. He did miss a few appointments and he had an appointment with specialist consultant in diabetes which he refused to wait to see him because of his levels we tried to get him reviewed but he refused to wait. But otherwise he was compliant and polite and there were no real issues with him."

**2011**

38. Entries in the man's medical record for January 2011 suggest that he had begun to experience shortness of breath again. On 24 January, a nurse examined him, whose breathlessness appeared to have been brought on by anxiety, as he said he was bullied on the wing but would not say more. She advised him to speak to the Senior Officer on the wing about this. He asked to see a nurse from the mental health team. His personal officer agreed to follow this up and he said he felt better having talked about things.

39. A mental health nurse saw him the next day. He told her that he felt "things were getting on top of him on the wing and other prisoners had been making comments about his size and mobility issues". He said that he would not let it affect him too much and found that relaxation techniques and talking his problems through helped.

40. On 31 January, the man complained of shortness of breath and an on-going cough which he said he had had for the previous seven weeks. He was examined by a nurse who noted that that after approximately five minutes, he was no longer short of breath and talked in full sentences. She recorded that he did not have a fever and, although a slight wheeze could be heard on his left side, there was good air entry. He told the nurse that it was not anxiety related, although his symptoms were similar to previous anxiety related episodes. The nurse said she would ask for his condition to be reviewed the next day. The following day another nurse diagnosed a chest infection and prescribed antibiotics for seven days.

41. An entry in the man's medical record on 8 February noted that he had weekly baths in healthcare. The cellulitis on his legs was much improved, but he still complained of shortness of breath on exertion. He told the nurse that he did not think the antibiotics he had been prescribed worked. A doctor was consulted, who said he would re-prescribe an alternative antibiotic. The nurse said she

would request a member of the nursing team to review him the following Thursday. There is no record to confirm if he was reviewed or not.

42. The man reported sick on 14 February. A nurse examined him in his cell and she did not observe any shortness of breath. She noted that he had moved to a different landing so that it was easier for him to collect water and other everyday items. She recorded that he was due to have his bath in healthcare the following day and she would put him on the list to see the doctor. He was reminded that he was to let healthcare know if he felt worse before seeing the doctor.

43. On 15 February, the man was reviewed by a doctor. He arrived at healthcare in a wheelchair and was breathless but able to talk in full sentences. The doctor recorded in his medical record "an exacerbation of asthma" and recommended that he stay in healthcare for further care and observations. He transferred to healthcare but became distressed in the holding cell. The doctor put him on a nebuliser and his breathing stabilised. He was then moved to a cell in healthcare where he rested on the bed. However, he became distressed again and the doctor advised a transfer to hospital by ambulance for an opinion on his respiratory condition.

44. A risk assessment was carried out and the man was assessed as being a medium risk to the public and it was noted that should he escape he would be a risk to the public, especially children. However, his risk to hospital staff, risk of hostage taking, risk of escape and likelihood of outside assistance were all recorded as low. He was "double cuffed" while he moved from healthcare to hospital. When he arrived at hospital this was changed to a standard single cuff and also an escorting chain. Double cuffs were used when he had to move from his hospital room for various tests. This means that both his hands were handcuffed together and, additionally, another set of handcuffs were used to cuff him to a prison officer. He was escorted by two officers at all times. The close handcuff to an officer was removed when he ate meals, needed treatment or used the toilet but at all times the escort chain was still applied. (An escort chain is a long chain with handcuffs attached at each end, one secured to the prisoner and one to an officer.)

45. During an interview with the investigator, an Anglican chaplain explained that:

> "When he went in first, I went to see him almost immediately and he obviously wasn't very well and he asked me if I would ring his wife which I did and he was grateful, as she was, and eventually she came, I think she came several times to visit him. I spoke to her several times over the telephone and then when he became obviously very much more ill I visited him several times."

46. Healthcare staff contacted staff on the man's ward at hospital on 16 February. He had been diagnosed with pneumonia and was treated with intravenous (IV) antibiotics. It was thought that he would need to remain in the hospital for at least another two to three days, if not longer. He was given oxygen therapy and some of his diabetic medication was reduced as it was felt they might interfere with the medication he was receiving at the hospital.

47. The man underwent a bronchoscopy[16] at the hospital on the morning of 16 February. When healthcare staff spoke to the hospital, they were told that the results had not yet arrived and they were still treating him for pneumonia. His condition was said to be stable at the time. On 19 February, he transferred to a different ward. He remained "very unwell". There were no plans to discharge him at the time.

48. On 19 February, a further risk assessment was carried out regarding the use of restraints. The assessment noted that the man had difficulty wearing the cuffs while receiving treatment. His wrists were swollen and he had several drip lines in the back of his hand, which made wearing the cuffs impractical. The duty governor authorised the removal of the cuffs for treatment, but instructed that they must be re-applied as soon as practicable. It was noted that there was no change in the risk he potentially posed.

49. The next day, 20 February, the man was transferred to the intensive care unit (ICU) as the level of oxygen in his blood was decreasing. It was believed that he was near to death. He had been intubated[17] and ventilated[18] and was unconscious. His family had been contacted and his wife was with him. The prison chaplaincy had also been informed.

50. A risk assessment carried out on 20 February noted the deterioration in the man's condition and authorised the removal of all cuffs. The escort chain was also removed at this stage and restraints were not reapplied at any point before his death. The chaplain explained to the investigator that he:

> "Definitely was not cuffed in the intensive care and the officers were not right on him, they were a little bit further away, obviously in sight of him but they weren't sort of right on top of him… And there were two officers. Each time I went I have to say they were obviously very professional and very genuine and gentle with him and his wife."

51. On 21 February, the prison's family liaison officer (FLO) contacted the man's wife to give her his contact details. She said that she had been unable to stay over when visiting him. The FLO told her that he was stable. Later that day he contacted her again because he had undergone dialysis[19] treatment to remove fluids as his kidneys were not working properly. It was noted that he was otherwise "fairly stable". His condition remained the same for the next few days.

52. On 23 February, the FLO telephoned the man's wife to tell her there was no change in his current situation. She said that she hoped to visit the hospital that

[16] An examination of the major air passages of your lungs using a flexible bronchoscope, which is made up of many small glass fibres which transmit light and allow your doctor to see clearly through the instrument. A channel in the bronchoscope allows small specimens to be taken from the bronchial tubes.
[17] The placement of a tube into the windpipe to maintain the airway in those who are unconscious or unable to breathe independently.
[18] Using a ventilator to assist or replace a patients breathing.
[19] A form of treatment that replicates many of the kidney's functions.

weekend and the FLO asked her to let him know if she was able to visit any sooner so that he could make the necessary arrangements.

53. The man's condition towards the end of February remained critical but "static", with no improvement. He remained on a ventilator. His family were due to visit later that day and the possibility of withdrawing treatment was going to be discussed with them.

54. A prison nurse spoke with the registrar of the ICU the following day. He was told that active treatment for the man would stop that afternoon as his chances of survival were considered poor. Hospital nursing staff discussed this with the man's wife and it was decided to wait until his daughter and son arrived. She asked the prison officers in the hospital if she could speak to the prison FLO as she had not heard from him. She spoke to him at 1.30pm about arrangements for when her husband died. The man's son and daughter arrived at approximately 2.25pm.

55. An officer who was in the hospital with the man at the time, completed a statement to say that the life support was removed at approximately 2.45pm. His family were with him when he died at 3.15pm.

**Support for the family**

56. The man's wife was informed of his admission to hospital on 21 February and arrangements were made so that his family could visit him there. The chaplain spoke to her several times on the telephone and also visited the man on the day he died while his wife was visiting.

57. The family liaison log shows that the prison FLO contacted the man's wife on 4 March to discuss the funeral arrangements. She confirmed that she would organise his funeral and the prison contributed towards funeral costs. The FLO offered her the opportunity to view her husband's cell, but she declined. He agreed to return his property to her.

**Support for staff**

58. Both bedwatch officers who had been present at the time of the man's death were spoken to when they returned from the hospital. They said that they were aware of what care and support was available and how to access the services.

**Support for prisoners**

59. A Prisoner Information Notice was issued on 1 March. It told prisoners who to contact if they felt affected by the man's death. These included the Samaritans, Listeners and members of staff. Also, all prisoners who were subject to self harm monitoring procedures were spoken to and had their documentation reviewed.

## Post mortem

60. A post mortem was carried out on behalf of HM Coroner on 1 March 2011. The post mortem report says that the man's death was caused by pneumonia, secondary to chronic obstructive airways disease.

## ISSUES

### Medical care

*Overall care*

61. Dr McPeake describes the development of the man's final illness and death as follows:

> "The man developed a chest infection during February 2011 which was initially treated aptly but which progressed and led to his hospitalisation on 15 February. He continued to receive intensive inpatient treatment but died on 28 February 2011 after active treatment was withdrawn following discussions with his family."

62. When the man went to Full Sutton, he suffered from type 2 diabetes, arthritis and asthma, and was only able to walk short distances with the assistance of a walking stick. The clinical reviewer writes that his diabetes was managed effectively: "During his custody he was assessed on a number of occasions and his glucose levels were generally normal. [There was] generally good control of his diabetic condition." His arthritis was controlled by a co-codamol prescription which he describes as "generally effective treatment for him".

63. Overall, the clinical reviewer considers that the man's medical conditions were managed effectively, with the exception of his lung disease (discussed below). He concludes that: "The man's long-term and acute onset illnesses were well managed with the exception of the assessment and management of his interstitial pulmonary fibrosis".

*Breathing conditions*

64. The man entered prison suffering from asthma. His condition was acknowledged and he was provided with inhalers to manage it. He also suffered from anxiety and this seemed to make his breathing problems worse. He was seen many times by healthcare staff and was given reassurance and advice on how best to manage these episodes.

65. A CT scan undertaken on 1 April 2010 confirmed the diagnosis of interstitial pulmonary fibrosis, but the clinical reviewer: "found no documented assessment for interstitial pulmonary fibrosis or change in the man's respiratory medication from that time". Although there is no evidence of such an assessment, he notes his view that: "The man's prognosis would not have been fundamentally changed by a specialist assessment … He may not have benefited from any active treatment and would always have been susceptible to poor outcomes from chest infections, a risk that would have increased over time." Furthermore, he notes that the post mortem report makes no reference to this condition in the cause of death.

*Other clinical matters*

66. The man's medical record shows that he did not routinely attend for his medical appointments and this was said to be due to the fact that he did not like to wait. Again, the clinical reviewer says that he could find no evidence that this would have changed the outcome.

67. The man's wife said that she was concerned he had not been admitted to hospital soon enough. The clinical reviewer said that he was "initially treated aptly" for a chest infection, but his condition continued to progress, which led to his hospitalisation. From reviewing his medical records, we consider that his treatment was timely and appropriate.

**Restraints**

68. The man was subject to restraints when he visited hospital, which included being handcuffed to a prison officer and also attached to an escort chain. Double cuffs were used when he moved around the hospital. The removal of restraints can only be authorised by a senior prison staff member or in emergency situations (such as if hospital staff demand their removal to enable them to provide treatment). The assessment of the risk he posed and the level of restraint was reviewed on a number of occasions and finally a decision to remove all restraints was made on 20 February, when he moved to the intensive care unit (ICU). Due to the gravity of his condition and his poor prognosis, his handcuffs and escort chain were removed and the prison officers distanced themselves from his bedside.

69. While the man was assessed as medium risk to the public, his actual risk of escape and potential to do so was assessed as low. There is no explanation why, with this assessment, it was decided that two officers and the level and type of restraints used were needed, or that any alternative bed watch arrangement was considered. The only reason given is 'Cat B prisoner held in a High Security prison' which would apply to the majority of prisoners at Full Sutton, irrespective of their health or physical condition. No reason for the decision was given on the risk assessment document in the space provided for the senior manager taking the decision. While the prison kept the arrangements under review, appropriately removed restraints when he was in the intensive care unit and removed them permanently from 20 February, there is little evidence that his individual circumstances were fully considered before that. In the circumstances, this appears too risk averse an approach and taking into account his physical condition and lack of mobility it is hard to see how the original level of restraints used was justified.

    **The Governor should ensure that escort arrangements are proportionate to risk and that full account is taken of a prisoner's health and physical condition and the impact this has on his actual risk.**

**Liaison with the man's family**

70. The man's family were informed of his admission to hospital shortly after he was admitted. This enabled them to visit him in hospital and be kept fully informed of his condition and treatment by hospital staff.

71. A family liaison officer was appointed at an early stage and contacted the man's family. He explained his role and provided his contact details. A prison chaplain also offered support to him and his family and met them several times at the hospital. Following his death, his family were appropriately offered a contribution towards funeral expenses.

**Record keeping**

72. There were a number of oversights in the clinical record. Following a chest X-ray in February 2010, it was advised that the man might benefit from seeing a chest physician. Although the letter was filed in his medical record ten days later, there is no entry about his care needs and follow up action to be taken. Further entries suggest that he had been diagnosed with chronic obstructive pulmonary disease (COPD), although there is no clear information as to when or where this diagnosis was made. A spirometry test and CT scan in the following months diagnosed him as suffering from interstitial pulmonary fibrosis. Again, although the results were filed in his medical record, there is no entry in relation to the diagnosis of a chronic condition and the follow up care required.

73. In is important to record a patient's diagnosis, care needs and follow up appointments so that all other healthcare colleagues involved in a patient's care are aware of it. Although the clinical reviewer says in his clinical review that the clinical documentation was generally of a good standard, there were occasions when his interactions with healthcare were not appropriately documented.

    **The Head of Healthcare should ensure that all healthcare staff follow the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.**

## CONCLUSION

74. The man received an appropriate level of care while he was at HMP Full Sutton. This report concurs with the findings of the clinical reviewer: “The treatment of acute presentations of respiratory disease seems to have been entirely appropriate with good levels of support from the clinical team”.

75. However, it is evident from reviewing the man’s medical record that standard of record keeping was not always appropriate. His family were informed of his admission to hospital in a prompt and timely manner.

76. Finally, while the man’s handcuffs were removed when his condition deteriorated the initial level of restraints used did not seem to be supported by the risk assessment.

## RECOMMENDATIONS

1. The Governor should ensure that escort arrangements are proportionate to risk and that full account is taken of a prisoner's health and physical condition and the impact this has on his actual risk.

   **The prison accepted this recommendation.**

2. The Head of Healthcare should ensure that all healthcare staff follow the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

   **The prison accepted this recommendation.**