Investigation into the circumstances surrounding the death of a man whilst in the custody of HMP Full Sutton on in 2010

Report by the Prisons and Probation Ombudsman for England and Wales

June 2010

This is a report into the death of a man at HMP Full Sutton on in January 2010. The man died from natural causes and was 76 years old. A post mortem showed that he died from acute left ventricular failure (failure of the left side of the heart) caused by hypertensive heart disease.

I offer my sincere condolences to his family and friends for their loss. The Senior Family Liaison Officer, contacted the man's family at the start of the investigation.

The investigation was carried out on my behalf by my colleague,. Both he and I would like to thank the Governor and his staff particularly one of his governors for their co-operation during the course of our enquiries.

I also thank East Riding of Yorkshire Primary Care Trust for appointing a doctor to review the man's clinical care.

As the man died from natural causes, the findings of the clinical review play an essential part in my report. The review shows that he received good care whilst in custody that was equitable to that which he could have expected in the community.

I make no recommendations and recognise the efforts made in the family liaison.

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

CONTENTS

SUMMARY

On 19 September 2003 the man was convicted of sexual offences and sentenced to 12 years in custody. He was sent to HMP Liverpool where he had a health screen assessment with a nurse. The man had a significant past medical history which included previous heart attacks, (the last in 2002), ischaemic disease and angina.

The man was transferred to HMP Full Sutton on 9 January 2004. He stayed in a single cell on the ground floor in the vulnerable person's wing. He had regular contact with healthcare staff for monitoring his medication and routine blood tests.

On 9 February 2005 the man was diagnosed with diabetes. He refused to take this medication despite the implications of his decision being explained to him. In the years that followed he continued to have regular contact with both nurses and prison doctors at Full Sutton. However he often refused to have blood samples taken, failed to attend appointments with healthcare staff and refused to take his medication, despite encouragement and advice.

On 26 January 2010, at approximately 10.20am, the man used his cell bell and told uniformed staff that he had chest pains and was having difficulty breathing. Healthcare staff responded, and following a quick assessment, moved him the short distance to healthcare using a wheelchair.

Once in healthcare he was assessed by the prison doctor and an emergency ambulance was called. The ambulance arrived and the paramedics took over his care and stabilised his condition before transferring him to York District Hospital. The man received treatment from hospital staff, but went into cardiac arrest. The hospital staff attempted resuscitation but the man was pronounced dead at 12.38pm.

The man's next of kin was recorded as his sister who lived some considerable distance away. Due to the distance involved, the decision was taken to contact the nearest establishment to the family, HMP Liverpool, to break the news of his death that same afternoon.

I am satisfied that the care and attention he received at Full Sutton was equitable to that he could have expected to receive in the community. The man did on several occasions exercise his right to refuse treatment. I make no recommendations but recognise the good practice adopted by Full Sutton in family liaison.

THE INVESTIGATION PROCESS

1. The investigation was opened on 27 January 2010 when the investigator issued notices announcing the investigation to staff and prisoners. No prisoners came forward as a result.

2. The investigator visited HMP Full Sutton on 1 February. During his visit he was also given copies of all documentation relating to the man. My investigator returned on 23 February and interviewed eight members of staff.

3. East Riding of Yorkshire Primary Care Trust asked a doctor to review the man's clinical care. The investigator and the clinical reviewer jointly discussed aspects of the man's treatment with healthcare staff at Full Sutton.

4. The investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and request a copy of the post mortem report. Upon completion, the report will be sent to the Coroner to assist his enquiries into the man's death.

5. The Senior Family Liaison Officer contacted his next of kin about the investigation and invite them to ask any questions about his case. A copy of my report will be sent to them.

KEY FINDINGS

6. The man was born on June 1933 in Birkenhead, and lived in the Manchester area prior to his conviction. He had been married but divorced some years previously.

7. On 19 September 2003 a man was convicted of sexual offences and sentenced to 12 years in custody. He was sent to HMP Liverpool where he underwent a health screen assessment with a nurse. The man told the nurse that he had previously suffered heart attacks, the last in 2002, and had been in hospital a few months before entering prison. He also said that he suffered from asthma and deep vein thrombosis (DVT) (formation and migration of blood clots). He said that he had been a smoker for 60 years and had no intention of giving up.

8. Healthcare staff at Liverpool contacted the man's community doctor to confirm his medication and the details of a recent hospital admission. The doctor confirmed that the man had been in hospital from 24 January to 4 February 2003 under the care of a consultant physician at the Manchester Royal Infirmary. The man had a history of hypertension (high blood pressure), left ventricular failure (failure of the left side of the heart) and angina (chest pain caused by lack of blood supply to the heart). Whilst at hospital the diagnosis was also made that he also had mild chronic obstructive pulmonary disease (COPD - narrowing of the airways in the lungs) and arterial fibrillation (abnormal heart rhythm).

9. As a result of his medical conditions the man was prescribed Frusemide (for the treatment of heart failure), Pravastatin (for the treatment of high cholesterol), Ramipril (for the treatment of high blood pressure and heart failure), Isosorbide Mononitrate (for the treatment of angina), Digoxin (for the treatment of artrial fibrillation), Spironalactone (for the treatment of heart failure) Warfarin (for the treatment of DVT) and aspirin.

10. The man transferred to HMP Full Sutton on 9 January 2004. A health screen check confirmed his medical history and medications. He was allocated a single cell on the ground floor. He had regular contact with healthcare staff to monitor his medication and have routine blood tests.

11. On 9 February 2005 the man was diagnosed with type two diabetes (non insulin dependant diabetes) and the prison doctor prescribed Metformin. He refused to take this medication due his interpretation of the effects of the medication upon the heart, even though the implications were explained to him.

12. Over the following two years the man continued to have regular contact with nurses and prison doctors at Full Sutton. However it was not uncommon for him to refuse to have blood samples taken and decline to take his medication, despite encouragement and advice from the healthcare staff. By March

2007,the doctor had added Salbutamol (for the treatment of COPD) and Beclomethasone (for the treatment of asthma) to his prescribed medications.

13. The prison doctor prison doctor, wrote to a consultant haematologist, at the York District Hospital on 12 March requesting an outpatient appointment for the man to review his level of Warfarin. An appointment was arranged for 28 June but, on the day the man refused to go to hospital. This was against the advice of the healthcare staff, and he signed a disclaimer to that effect.

14. On 17 October a nurse saw the man to review his asthma. He told the nurse that he had not been taking his medication as his asthma did not cause him any difficulties. The nurse advised him about the reasons and benefits of taking the medication and he agreed to resume taking it. The nurse also advised him about the effects of smoking on his health.

15. The man saw a nurse for a coronary heart disease review on 18 February 2008, to check his cholesterol levels. However he refused to have blood samples taken and told the nurse that he felt well. He also refused to have blood samples taken on 16 May and 9 June.

16. Between 19 June and 19 January 2009 the man failed to attend five appointments with healthcare staff. On 26 January, he saw another nurse for a coronary heart disease review. Yet again he refused to give his consent for blood samples to be taken. The nurse explained that blood samples were part of the process to manage his long term, potentially life threatening, conditions. They were needed to enable doctors to identify problems and make any necessary changes to his medication. He told the nurse that he felt fine and did not need blood tests, but he did agree to his weight and blood pressure being checked. His weight was recorded as 90kg and his blood pressure was 161/81. (The normal range for blood pressure is 100/70 to 140/90, although the pressure does vary throughout the day depending on the individual's activities. A blood pressure reading of greater than 140/90 is classed as high and a reading of 90/60 or below is classed as low.)

17. On 20 April the man saw the the same nurse, as he complained of a dry cough which was worse when he lay down. He told the nurse that he had not been using his inhaler medication. The nurse referred him to the prison doctor who prescribed Co-amoxiclav (antibiotic for treatment of respiratory tract infections) and advised the man to continue taking Salbutamol and Beclometasone.

18. Three days later he saw a different prison doctor, because he experienced heartburn at night. He also told the doctor that he had not taken the Metformin. The doctor prescribed Omeprazole (for treatment of heartburn) and encouraged him to have blood samples taken, to which he agreed. The doctor recorded his blood pressure as 160/80.

19. Three days later he saw another nurse for the blood samples to be taken. The man again refused to have any samples taken and said that he felt better without having them done. The nurse again explained the reasons for the

blood tests and the risks to his health. He also refused to have the flu vaccination, and declined the services of the chiropodist. The man asked to sign a disclaimer form to refuse all future blood tests and this was signed on 28 April.

20. On 24 July the man saw a nurse because he needed to urinate frequently during the night which concerned him. He also told the nurse that he had passed blood in his urine some five months previously but had not told anyone. He said he still had not taken the Metformin. The nurse advised him to take his medication as prescribed and see if his condition improved. He should contact healthcare straight away if he passed blood in his urine.

21. The man saw a nurse on Saturday 10 October because he passed blood with his urine. He told the nurse that this had been happening for about two weeks and he had hoped that it would have sorted itself out. He said that he had passed a clot of blood before he passed any urine that morning. The nurse referred him to see the doctor the following Monday, and told him to contact healthcare straight away if he felt unwell or was unable to pass urine. The nurse tested his urine which showed that blood was present and his glucose and protein levels were raised.

22. Two days later the man saw a prison doctor.. He had no fever or pain and he looked his usual self. He told the doctor that he had not passed as much blood in his urine that morning. The doctor wanted to refer him to the hospital but he refused any further intervention. The man said that he had a bad cough which produced green sputum for which the doctor prescribed a course of Amoxicillin (antibiotic for respiratory tract infections).

23. On 10 November the man saw the prison doctor to review his diabetes. He told the doctor that he was now taking his medication and also watching his diet. The doctor discussed the need for further investigation of the blood in his urine and the risks of not doing anything. He agreed. The prison doctor wrote a referral letter that same day to a consultant urologist, at York District Hospital, and asked for an urgent appointment in his clinic.

24. The man had an appointment with the consultant arranged for 7 December. On the day of the appointment the man refused to go to the hospital despite encouragement from healthcare and wing staff. The consultant wrote to the prison on 9 December to say that a future appointment would be made for the man.

Events of 26 January 2010

25. A staff training day took place on 26 January 2010. This meant that the prison was on “patrol state” and prisoners were in their cells rather than being involved in other activities. At approximately 10.20am an officer responded to the cell bell from the man’s cell. Through the observation hatch the officer could see the man sitting on his bed. He told the officer that he had chest pains and was having difficulty breathing. The officer ran to use the telephone in the cleaner’s office and contacted the control room to make a Code Blue

call (the code for a medical emergency when someone is experiencing difficulty breathing).

26. An officer returned to the man's cell and was joined by a Principal Officer (PO) and Senior Officer (SO).. The officers went inside and reassured the man that healthcare staff were on the way. Within one minute two nurses arrived and, following a quick assessment, used a wheelchair to take him the short distance to the healthcare centre.

27. Once in healthcare he was assessed by a prison doctor and an emergency ambulance was called at 10.56am. Whilst waiting for the ambulance the man talked to the doctor and the nurses. The ambulance arrived at 11.16am and the paramedics took over the man's care. They stabilised his condition before transferring him to York District Hospital at 11.42am.

28. An escort risk assessment was completed, and the man was accompanied to hospital by two officers but no restraints were in place. He arrived in the emergency department at 12.05pm. The man received treatment from hospital staff; however he went into cardiac arrest. The hospital staff attempted resuscitation but the doctor pronounced him dead at 12.38pm.

29. The man's next of kin was recorded as his sister, who lived some considerable distance away. Due to the distance involved, Full Sutton telephoned the nearest prison to the family, HMP Liverpool, to ask for the help of their family liaison officer. Liverpool agreed and an officer, Family Liaison Officer, went to visit his sister that afternoon to break the news of his death.

30. A debrief was held later that day for the staff involved in the emergency response, with appropriate support offered by the Care Team. The wing staff completed incident reports, but none were completed by the healthcare staff.

31. In accordance with the family's wishes, Full Sutton made the arrangements for his funeral and disposal of his property and belongings. The funeral took place on 8 February and was conducted by the prison chaplain.

ISSUES

Clinical Care

32. The man had long standing medical conditions, which were correctly identified when he entered custody. The clinical review specifically commentated:

> "The man had significant past medical history which included that of previous myocardial infarctions, angina, hypertension, poor left ventricular function, mild chronic obstructive pulmonary disease and type 2 diabetes mellitus."

33. The clinical care reviewer judges that the care he received at Full Sutton was equitable to what he could have expected in the community. The clinical review made the following comments about healthcare services at Full Sutton:

> "HMP Full Sutton has got facilities for managing long term conditions which are comparable to the care expected to be provided in the community."

34. There were many occasions where he declined medical treatment, missed or refused appointments. It seems that staff made considerable attempts to engage with him, and encourage him to take his medication. They included occasions where nurses and doctors outlined the importance and potential risks of declining blood tests, medical investigations, and non compliance with medication. The clinical review said;

> "It is very clear from review of medical records that his compliance with medication was extremely poor. This was despite repeated attempts by the medical and nursing staff to explain to him the importance of taking medication."

Use of restraints

35. Unfortunately there have been too many reports where the Ombudsman has been critical of the use of restraints when prisoners are under escort in outside hospital. It is pleasing therefore to recognise that Full Sutton ensured that the man was treated with dignity and respect during the emergency response and treatment in hospital.

Incident reports and hot debrief

36. There are a number of rules, regulations and guidelines by which prisons are run. They are outlined in Prison Service Orders (PSOs) and Prison Service Instructions (PSIs). PSO 1400 "Incident Management Manual and PSO 8150 "Prison Service Post Incident care for Staff detail the procedures to follow after a death in custody has occurred. Uniformed staff involved in the emergency response correctly provided individual incident reports. However healthcare staff did not provide reports despite being asked to by the Deputy Governor. At the time that Mr Piercy was taken to hospital the prognosis

would have been uncertain. However, as he died so shortly after arriving at hospital, there was an expectation that healthcare staff would provide incident reports when asked. Full Sutton appropriately followed PSO 8150 by ensuring a debrief took place and support was available for staff.

Family Liaison

37. I am pleased to note that Full Sutton contacted HMP Liverpool to ask their family liaison officer to contact the man's next of kin. As Liverpool was closer to the family home, it meant the news was broken face to face in a timely matter and by an appropriately trained member of Prison Service staff. It is therefore pleasing to see that Full Sutton followed this guidance, and Liverpool readily agreed.

38. In addition, Full Sutton also took responsibility for arranging the man's funeral and handling all external communications. This was compassionate and in line with the family's wishes.

CONCLUSION

39. During his time at Full Sutton, the man had well documented regular interventions with doctors and other healthcare staff. I am satisfied that the care that he received at Full Sutton was equitable to that expected in the community. He had a responsibility for his own health and could have accepted medical attention but often exercised his right to refuse treatment.

40. I believe that the man was treated with dignity and respect during the time he was at Full Sutton. Following his death Full Sutton appropriately followed the guidance given in PSO 2710, “Follow up to death in custody”.