

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

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

April 2012

This is the report of an investigation into the death of a man, a prisoner at HMP Full Sutton, who died in September 2011 at hospital after suffering from a heart attack. He was 67 years old. I offer my condolences to his family and many friends for their loss.

The investigation was undertaken by a senior investigator. A clinical review was commissioned by the local Primary Care Trust (PCT) and I am grateful to the clinical reviewers for their review. I would also like to express my thanks to the Governor at Full Sutton and his staff for their co-operation.

The man had been at Full Sutton since 2008. He was relatively healthy, only seeing staff from healthcare twice before September 2011, but had also been diagnosed with osteoarthritis. He chose to continue working in the textile workshop even though, given his age, he was not required to work.

In September 2011, the man was in the textile workshop when he developed chest pain. He told staff that he had been experiencing this for a few days and had felt unwell the night previously. He said that he did not want to bother healthcare staff because he thought it was just a cold. However, healthcare staff were called and they took blood tests and a chest x-ray. The blood tests were sent to hospital for immediate analysis. At 3.45pm the same day the results indicated that he had been suffering from a cardiac event over the past five days. He was immediately taken by ambulance to hospital but died three days later.

This investigation has found that the man was treated in timely and effective manner by healthcare staff. In addition, his attendance at hospital and support for his family were managed in an appropriate and compassionate way. Accordingly, I make no recommendations in this report but I do commend one example of good practice.

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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SUMMARY

1. The man was born in 1944. He was 67 years old when he died, following a heart attack, at hospital in September 2011.
2. The man was sentenced to life imprisonment on 13 February 2008 and was transferred to HMP Full Sutton on 19 May 2008. He was noted to be a smoker but had little contact with healthcare apart from routine appointments for osteoarthritis. Although he was 67 years old and was not required to work in the prison, he chose to and enjoyed machine work in the textile workshop.
3. On 5 September, the man went to work as usual but when he was there he told staff that he was suffering from chest pains. Healthcare staff were called and suspected he was having a possible heart attack. They subsequently took blood tests and a chest x-ray and sent them to hospital for immediate analysis.
4. The results were received back at Full Sutton at 3.45pm. They indicated that the man had suffered from a coronary (heart) event. An emergency ambulance was called and he was immediately taken to hospital. Various tests were carried out but surgeons believed him to be too ill for further investigation or treatment. All treatment was stopped at 4.12 pm and he died at 4.25pm. His family were informed and had visited him the day before.
5. We make no recommendations but commend one example of good practice.

THE INVESTIGATION PROCESS

6. The man died in September 2011. A senior investigator opened the investigation on 14 September, when she visited the prison. She received copies of all his prison and clinical records. She spoke to the Deputy Governor and Head of Decency. She also met with the Head of Healthcare and interviewed four members of staff, three from healthcare and one discipline officer.
7. Notices were posted to staff and prisoners informing them of the investigation and inviting anyone who had relevant information to contact the investigator. No one contacted the investigator in response to the notices.
8. A clinical review of the healthcare provided to the man was commissioned by the local Primary Care Trust. We are grateful to the clinical reviewers for their review.
9. Our senior family liaison officer contacted the man's family to explain the investigation process and ask if they had any concerns or issues they wished to be considered. The family raised no concerns and we hope this report answers any questions they might have about the man's care before his death.

HMP FULL SUTTON

10. HMP Full Sutton is a purpose built, high security prison for category A and B male prisoners in a rural location ten miles from York. (All adult male prisoners are classified on reception into prison and put into one of four security categories based on the likelihood of escape and the risk to the public if they did escape. Category A prisoners would be highly dangerous to the public, police or national security if they were to escape. They must be held in the tightest security conditions. A small number of prisons in England and Wales are suitable for holding category A prisoners. These prisons form the high security estate. Category B prisoners are those for whom the highest security conditions are not necessary, but for whom escape needs to be made very difficult.) It opened in 1987 and was later extended when two further wings were built, making a total of seven wings. There is an operational capacity of 608 prisoners.
11. The prison has 24 hour healthcare cover and 6 inpatients beds. Healthcare is provided by the East Riding of Yorkshire Primary Care Trust. (PCT)

Her Majesty's Inspectorate of Prisons

12. The most recent report of an unannounced inspection was in November 2010. HM Chief Inspector said:

“The prison remained generally clean and well maintained. Relationships between staff and most prisoners had improved, supported by a good personal officer scheme, regular consultation and an impressive mediation initiative.

Prisoners spent a reasonable amount of time out of their cells. The importance of keeping long term, serious offenders busy and engaged was fully recognised and it was therefore commendable that the quantity and quality of purposeful activity had continued to improve. Educational and vocational achievements were high. Work was plentiful, if sometimes mundane. Access to PE and the library was satisfactory.”

Independent Monitoring Board (IMB)

13. Each prison has an IMB whose role it is to monitor the prison and to report any concerns that they have regarding the prison, or how prisoners are treated. Board members (who are members of the community who are independent of the prison) visit any area of the prison at any time and have direct access to any prisoner who they wish to see, or who asks to see them. The Board holds regular meetings in the prison, with the Governor attending for part of the meeting. The Chair of the Board produces an annual report to the Secretary of State for Justice.
14. In the section on healthcare in their annual report, covering the period for the year ending 30 November 2010, the IMB mentioned a specific incident which

bears a striking similarity to the events leading to the man's death, although, on this occasion, the prisoner survived his heart attack. Given their independent role in the prison, it is worth recalling this incident as it has been reported in the IMB report:

"it is also important to highlight a specific incident in January when a prisoner returned to his wing from work complaining of chest pains and asking to be allowed back to his cell to lie down. Rather than allow him to return to his cell, the staff placed him on a chair outside the wing office whilst healthcare support was called. A few moments later, the prisoner was found slumped on the floor and did not appear to be breathing. An emergency was called and the healthcare staff were able to resuscitate the prisoner using the defibrillator equipment. He was taken to the local hospital and he has since made a full recovery. The prisoner's life was saved, to a large degree, by the alert wing staff who did not allow him back to his cell to lie down. The healthcare staff were therefore able to react in a more timely fashion to the emergency and resuscitate the prisoner. This was an excellent example of alertness and professionalism. The prisoners on the wing expressed their admiration for the staff's quick reactions; they found it very reassuring."

Previous investigations at Full Sutton

15. This office has completed nine previous investigations into deaths at Full Sutton since 2004. Of these, one prisoner died of ischaemic heart disease. We found, on that occasion, that the emergency response was "timely, efficient and professional".

KEY EVENTS

16. The man was convicted on 13 February 2008 at Crown Court. He was sentenced to life imprisonment and was transferred from HMP Holme House, where he had been on remand from September 2007, to Full Sutton on 19 May 2008.
17. He suffered from osteoarthritis of his knees and shoulders and visited healthcare rarely apart from to obtain medication for this and on some occasions, minor illnesses. He had only attended healthcare on two occasions prior to his death. (The Clinical Review contains a précis of the healthcare delivered while he was at Holme House. It was noted that he had osteoarthritis but otherwise he only saw healthcare staff for medication or minor illnesses.) One appointment on 15 June 2011 was for attendance at the well man clinic. (A well man clinic is designed to offer a range of health checks to men.) The clinical record states that he smoked 15 cigarettes a day, his blood pressure was 135/68 and his pulse 68. He was given an electrocardiogram (ECG, a test which looks at electrical activity in the heart) reading, which was normal. The other appointment was on 23 August, when he was examined by the optician.
18. On 5 September, the man went to his machining job in the textiles workshop and told the instructor that he did not feel very well. At approximately 8.30am, the instructor telephoned for an appointment for him to attend the walk-in clinic, which is close to the textile workshop, later that morning. However, Healthcare Assistant (HCA) A told our investigator that she received another telephone call at around 9.45am, when she was told that he was experiencing chest pains.
19. The investigator spoke to the officer who was on duty in the textiles workshop that morning. He recalled that he was with a colleague when an instructor said that the man was unwell. The two officers went to see him. The officer, who had previously worked as an Ambulance Technician, said that the man said he was having chest pains and looked a little cyanosed (was bluish in colour) in his face. He took his pulse and thought, because of his symptoms, that he might be having a heart attack. The other officer telephoned the control room and asked that a "code blue" emergency call be put over the prison radio network (a code blue is used at Full Sutton, and many other prisons, to denote that a prisoner is having respiratory difficulties.)
20. At interview, the Charge Nurse said that she was in healthcare when she also received a call about the man at about the same time. As she was the designated emergency response nurse for that day, she went to the textiles workshop area with HCA A, taking the emergency trolley with her. As they went, they heard the code blue emergency call over the prison radio network.
21. HCA A said that she immediately grabbed the emergency bag (which contains various medical equipment), locked the clinic and went to the man. She said it took her about two minutes to get to him. She described him as looking poorly and grey in colour and said he was holding his chest.

22. She asked the man how long he had been in pain and he replied that he had been having chest pains since the previous Thursday, four days earlier. He said that he had not contacted anyone from healthcare because he did not want to bother anyone. He told her that the previous night he had felt cold and sweaty and felt nauseous and was short of breath. She tried to take his blood pressure, but was unable to do obtain a reading. At this time he was responding normally and could speak in full sentences.
23. A few minutes later, the Charge Nurse and HCA B arrived and they decided to take the man to a more private room. He was able to walk to the room unaided. The Charge Nurse asked him how he was feeling and he said that he had central chest pain radiating down his left arm and upper back. He told her that he had been vomiting and had a chesty cold and had struggled to breathe the previous night but had not told anyone.
24. The Charge Nurse subsequently assessed the man and his blood pressure was 195/95, his pulse 81 and his temperature 36.5. She told the investigator that although there was nothing that would obviously point to a heart attack; she decided that she wanted to do some more tests.
25. The Charge and prison doctor examined the man and completed a chest x-ray, an ECG and took some blood tests, including a troponin I blood test (troponin is released into the blood when heart muscle cells die, and this test gives a clear indication if someone is having a heart attack). The blood tests were sent straight to the hospital for analysis. At this point, his breathing and pulse were normal, the chest x-ray was clear and the ECG did not show anything abnormal. The clinical reviewers have noted that the doctor recorded that the most likely cause of pain was epigstric (the epigastrium is in the upper part of the abdomen, and is part of the digestive system). He was speaking normally but still feeling unwell. The doctor allowed him to return to his cell rather than back to work.
26. The blood test results were returned at 3.45pm on the same day. They indicated that the man had had a coronary event (heart attack or similar) during the past five days. An emergency ambulance was called to take him to the Coronary Care Unit (CCU) at hospital. Due to the risk posed to the community by him, and following a risk assessment, it was agreed that there should be a two person escort and that he should be double handcuffed when in transit and when moving around the hospital. (Double handcuffing means that a prisoner has both hands handcuffed and is also handcuffed to an officer.)
27. At 3.00pm on 6 September, hospital staff telephoned the prison to inform healthcare staff that the man had had an angiogram which indicated that there was a narrowing of an artery in his heart. (An angiogram is a procedure where a doctor puts a thin tube into an artery and then into the heart to see if there is a blockage or narrowing.) During this time, the Governor agreed that his risk had reduced and his restraints were changed to a closeting chain. (A

closeting chain is a long chain where the prisoner is handcuffed at one end and a prison officer at the other.)

28. Hospital staff told healthcare staff at Full Sutton that while the man was in recovery his chest pain became worse. They took him back into the angio room to see if they could insert a stent to settle his pain. (A stent is a small balloon which is placed in an artery to unblock or expand it so that blood can be pumped through it.) His blood pressure was low and the narrowing of the artery was getting worse and nursing staff said that he may need urgent bypass surgery.
29. The man remained very poorly and, at 10.15am the next day, suffered a heart attack. He was given oxygen and cardiac inotropes. (Cardiac inotropes are drugs which affect the strength of the contractions of the heart muscles.) A CT (computerised tomography, a technique which produces a 3D image of the body) scan had also found a bleed in his duodenum (which is part of the intestine). At that stage, the hospital told a nurse at Full Sutton that they had no plans to move or transfer him back to the prison. The surgeon said that he was too unwell for any further investigation or surgery. His family had been informed of his condition and the Governor allowed them to visit him in hospital. He was not handcuffed during the medical interventions.
30. The security risk assessment for the man was reviewed. A governor decided that, given the state of his health, he was a low risk to the public or of escape and said that no handcuffs should be applied. He remained very poorly and the prison chaplain visited him and spent approximately 20 minutes talking to him.
31. The man deteriorated throughout the day, and hospital staff were unable to move him to investigate the duodenal bleed further. Staff said that over the period of the day, the consultant made the decision that his heart was too damaged to continue treatment. At 4.12pm the consultant and hospital staff made a decision to withdraw all treatment as there was nothing further that could be done to benefit him.
32. The man passed away 13 minutes later at 4.25pm. His family had asked that the prison contact them by telephone if he died. The prison family liaison officer contacted them by telephone at 4.40pm to inform them of his death. She visited them at home the next morning. The prison also assisted the family financially and practically with funeral arrangements.
33. Prisoners on the wing where the man had lived before his death were informed of his death by a Senior Officer. They were offered the service of Listeners (Listeners are prisoners trained by the Samaritans to provide support to their peers in times of crisis) and the use of the Samaritans' telephone for support and all prisoners at risk of suicide or self harm were reviewed. The chaplain also held a memorial service for him on the wing. We understand that this was well attended.

34. After the man's death, the Governor held a hot debrief with the staff who were involved in his care when he died. (A hot debrief is a meeting to discuss emerging issues). No issues were identified and the duty care team offered support to staff.

ISSUES

Clinical Care

35. Although the man was known to have osteoarthritis when he arrived in prison in 2007, he had very little interaction with healthcare staff over the next few years. The clinical reviewers, however, have commented on the medication used to treat this condition (non steroidal anti inflammatory drugs) and have commented that this prescription was appropriate as he had no history of duodenal ulcers or gastroesophageal reflux disease (which is also known as acid reflux). They have also noted that he was given smoking cessation advice and that, although his cholesterol levels were high, it was appropriate not to offer treatment at that time.

36. In discussing the events leading to the man's death, a clinical reviewer has examined the results of ECG tests conducted at Full Sutton on 15 June and 5 September 2011. He concludes that the interpretation of the results by both the computerised system and the prison doctor was appropriate.

37. The reviewers summarise their findings as follows:

“The man was seen appropriately and timely by medical and nursing staff. This was a difficult clinical case as the history and symptoms were atypical and the ECG was normal. The prison doctor had the right differential diagnosis and organised appropriate investigations which included troponin levels. The troponin levels were very high and it is this that gave the diagnosis. “

38. The clinical reviewers made no recommendations and consider that the practice by healthcare staff at Full Sutton was of a good standard. We commend the staff for carrying out the troponin blood test even though the man's symptoms did not match those of a heart attack. The efficient way that the tests were taken and the timely response meant that he could be taken to hospital speedily. Sadly, although this was the case he died a short time after admission to hospital.

Use of restraints

39. When the man was taken to hospital on 5 September, a risk assessment was conducted to establish the level of restraint that was appropriate in the circumstances. The use of double handcuffs, and a two man escort, was authorised. This seems to be appropriate as, although it is clear that he was unwell, he was still conscious and able to move around.

40. However, when his condition deteriorated, the risk assessment was reviewed and the level of restraint to the use of a closing chain. This was removed during any medical procedures.

41. We have investigated many deaths, in which we have criticised the continued use of restraints when it might have been appropriate to reduce the level or

type of restraint. We are pleased to see that, on this occasion, the level of restraint was quickly reviewed when the man's health deteriorated.

CONCLUSION

42. The man was 67 years old when he complained of chest pains. He was treated by healthcare staff in a timely and effective way and was subsequently transferred to hospital after his blood tests indicated that he had suffered from a heart attack. He suffered from another heart attack whilst in hospital and died three days later. We are satisfied that the man's family were informed of his death appropriately and that all security assessments were suitable given the risk he posed.