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A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man at HMP Full  
Sutton in January 2013**

## ***Our Vision***

*'To be a leading, independent investigatory body,  
a model to others, that makes a significant contribution to  
safer, fairer custody and offender supervision'*

This is the report into the death of a man at HMP Full Sutton in January 2013. He died from pancreatic cancer. He was 44 years old. I offer my condolences to his family and friends.

A clinical reviewer was appointed to conduct a clinical review of the standard of healthcare the man received at Full Sutton. The prison cooperated fully with the investigation.

The man was diagnosed with pancreatic cancer on 5 March 2010. He had major surgery in May to remove a tumour from his pancreas, followed by six months of chemotherapy. In August 2011, it was discovered that the cancer had spread to his liver. He was given chemotherapy treatment again a year later, but this was stopped in November 2012 because of the side effects.

The clinical reviewer concludes that the man's cancer was diagnosed in a timely manner and he received appropriate care at Full Sutton. He remained living in his cell on his wing until 28 December, when he moved to the prison's healthcare inpatient unit. His condition continued to deteriorate and he died in January 2013. I am satisfied that he received an appropriate standard of healthcare at Full Sutton. However, I am concerned that he was in a cell alone on the night he died, with staff monitoring him behind a locked door. There is also no evidence that the possibility of compassionate release was pursued and the use of restraints for hospital escorts was not always fully justified by the risk assessments.

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**

**November 2013**

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## SUMMARY

1. On 29 March 1999, the man was sentenced to life imprisonment for attempted murder. On the 6 August 1999, he was transferred to HMP Full Sutton.
2. On 3 March 2010, following a bout of diarrhoea and vomiting, the man was referred to hospital for blood tests. He was admitted to hospital the next day and diagnosed with pancreatic cancer on 5 March.
3. Following major surgery to his pancreas in May, the man had chemotherapy between August and February 2011. Officers used double cuffs to restrain him, and an escort chain when he was receiving treatment. (Double cuffing entails the prisoner having his hands cuffed in front of him and then having one wrist attached to a prison officer by an additional set of handcuffs.) He was re-categorised from security category A (the highest security category) to B (medium to high risk) on 19 April 2011. He continued to be double cuffed when he was taken out of the prison. In August 2011, a hospital scan showed the cancer had spread to his liver and a course of palliative chemotherapy was planned if his symptoms worsened. He refused to discuss his prognosis.
4. The man's condition was considered terminal, but there is no evidence that the prison considered the possibility of release on compassionate grounds. In September 2012, he began a course of palliative chemotherapy. In October he developed a blood clot in his lung that was treated with anticoagulant medication. He was admitted to the prison's inpatient unit several times, but preferred to remain on his wing. In November, chemotherapy treatment stopped due to increased toxicity levels in his body.
5. On 28 December, he was admitted to the prison's inpatient unit as his health had deteriorated further. He declined to move to the prison's palliative care suite, and remained in an adapted cell in the inpatient unit. He was placed on a care pathway for the dying in January 2013. He agreed that he would transfer to the palliative care suite the next day, but died in the early hours of the morning in a locked cell before he could be moved.
6. We are concerned that a dying man was left alone his cell after being placed on an end of life care pathway. The level of restraints for hospital visits was not always justified by fully considered risk assessments, and there is no evidence that compassionate release was ever considered, despite his terminal condition. Nevertheless, overall, we agree with the clinical reviewer that the clinical care he received during his time at HMP Full Sutton was equivalent to that he could have expected to receive in the community.

## **THE INVESTIGATION PROCESS**

7. The Ombudsman's office was notified of the man's death on 8 January 2013. The investigator issued notices informing staff and prisoners of the investigation and asking anyone with relevant information to contact her. No responses were received.
8. The investigator obtained copies of the man's medical record and relevant prison records. The local PCT appointed a clinical reviewer to conduct a review of the clinical care the man received at Full Sutton. She was given a copy of his medical record.
9. The investigator informed HM Coroner for Hull and East Riding of the investigation. A copy of this report has been sent to the Coroner to assist his enquiries.
10. One of the Ombudsman's family liaison officers contacted the man's sister to explain the purpose of the investigation. She did not have any specific concerns for the investigation to consider. She had the opportunity to comment on this report in draft before it was finalised.
11. The investigation has assessed the main issues in the man's care including his diagnosis and treatment, liaison with his family, his location and security arrangements, whether compassionate release was considered and whether appropriate palliative care was provided.

## **HMP FULL SUTTON**

12. Full Sutton is a maximum security prison holding more than 600 category A and B prisoners serving a minimum of four years. Healthcare services are commissioned through the NHS North Yorkshire and East Riding Commissioning Unit. There are registered general and mental health nurses, as well a nurse prescriber (a nurse who is qualified to prescribe medication) and daily General Practitioner (GP) cover. There is an inpatient unit with six beds and 24 hour nursing cover.

## **HM Inspectorate of Prisons (HMIP)**

13. HMIP conducted a full announced inspection of Full Sutton in December 2012. The Inspectorate found that the healthcare nursing team was well qualified with a good skill mix. There was a palliative care policy, a dedicated palliative care room in the healthcare unit, and good links with local Macmillan cancer patient support services.
14. The Inspectorate found that HMP Full Sutton had the foundations of a generally safe environment and prisoners were treated as decently as the necessary constraints allowed.

## **Independent Monitoring Board (IMB)**

15. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. In their annual report for 2011- 2012, the IMB reported that terminally ill prisoners had been appreciative of the treatment they received and the arrangements to allow family members to visit them in the healthcare centre.

## **Previous deaths at Full Sutton**

16. Since February 2011, there have been nine deaths at Full Sutton six of which have been due to natural causes. In a report into a death from cancer in September 2012, we also found that the prisoner had received care at least equal to that he could have expected to receive in the community.

## **ISSUES**

### **The diagnosis of the man's terminal illness**

17. On 2 March 2010, the man saw a doctor because he had diarrhoea and sickness. Blood tests were arranged, the results of which showed abnormalities. He appeared jaundiced and he was admitted to hospital on 4 March for further tests. The next day, a computerised tomography scan (CT) scan found a mass to his pancreas. The hospital confirmed the diagnosis of pancreatic cancer in letters written to the prison between 17 March and 21 April 2010.
18. In August 2011 the man had another CT scan, after which he was told that the cancer had spread to his liver.
19. As soon as he presented with symptoms, the prison referred the man to hospital where he was diagnosed with pancreatic cancer. The clinical reviewer concludes, and we agree, that the prison responded quickly to his symptoms and the diagnosis of his condition was timely and appropriate.

### **Informing the man about his condition and treatment**

20. Hospital staff told the man about his diagnosis of pancreatic cancer in 2010 and gave him a booklet to explain the condition. When he returned to Full Sutton on 11 March 2010, he told staff that he understood his diagnosis and he planned to tell his family when he had received the full test results. He understood that he would be referred to hospital for major surgery. Although the clinical reviewer notes that there is no clear entry in his medical record that he was told about the correspondence which confirmed his diagnosis, he appears to have been fully informed about his condition.
21. On 19 July a GP at Full Sutton went through the man's care plan with him and explained that he would have chemotherapy. On 18 August, he told another prison GP that he was positive about the potential outcome of his chemotherapy treatment.
22. On a visit to hospital on 25 August 2011, hospital doctors told the man that the cancer had spread to his liver. They explained that his condition would be monitored, but he would not benefit from more treatment at that time. The man's personal officer spoke to him about this and noted that he seemed to have taken the bad news well and was grateful for the support of his friends and the staff on the wing.
23. A prison GP visited the man in his cell on 4 October to tell him that he had an embolism (blood clot) in his lung, and he would need daily injections to thin his blood. The doctor noted that he responded positively considering the seriousness of the situation, but he did not want to talk about his life expectancy.

24. Although it would have been preferable to have a clear note in his medical record that the man was told when his diagnosis was confirmed we are satisfied that the evidence indicates that he was informed of his diagnosis and treatment options.

### **The man's medical appointments and treatment**

25. The man had pancreatic surgery at hospital on 9 May 2010, and remained in hospital for 12 days. When he returned to Full Sutton he was admitted to the inpatient unit for treatment to his surgical wound, observations and postoperative care. He had a number of scheduled hospital appointments for chemotherapy.
26. After hospital staff told the man in August 2011 that the cancer had spread to his liver, he attended regular meetings with healthcare staff to discuss his treatments and medication, although no active curative treatment was possible.
27. On 10 September 2011, the man started palliative chemotherapy at hospital, but it was stopped on 16 November because the side effects were making him very unwell. A week after the chemotherapy was stopped, it was noted in his medical record that he was feeling better. At a hospital appointment on 29 November, he was told that he would not have any more palliative chemotherapy. A follow up appointment was scheduled for January 2013. He died before the appointment could take place.
28. We agree with the clinical reviewer that the man's treatment was appropriately facilitated by the prison, in line with his hospital consultant's advice.

### **The man's pain relief and medication**

29. Following the man's major surgery at hospital, he was prescribed medication for to aid digestion and balance pancreatic enzymes. He took diclofenac (an anti-inflammatory), paracetamol and ibuprofen, for postoperative pain.
30. In October 2012, the man was diagnosed with a blood clot and had daily injections of fragmin (an anticoagulant) to thin his blood. He was prescribed an oral solution of morphine on 19 October, a stronger medication, to manage his increasing pain. As he was losing weight, he was prescribed therapeutic food supplement drinks from 27 November.
31. On 2 January 2013, the man's condition deteriorated and he began to receive end of life care. A prison GP prescribed diamorphine, an opiate painkiller and midazolam, a sedative.
32. The clinical reviewer noted that, "there are frequent notes made by HCC staff asking whether the man requires analgesia (pain relief) and although he frequently refuses, health staff continue to ask, this demonstrates a caring approach".

33. We agree with the clinical reviewer that the man's pain was managed appropriately and his medication was adjusted when his condition changed.

### **Palliative care plans**

34. On 25 May 2010, a multidisciplinary team (MDT) meeting was held with a Macmillan nurse to discuss treatments and care for the man after his surgery at hospital. Over the following two years, MDT meetings were held regularly, so that his care was monitored and updated accordingly.
35. At a case review on 13 March 2012, the man told healthcare staff that he was in touch with his family and was keeping them up to date about his health problems. He continued to be positive and was thankful for the support he was receiving. At a further case review on 22 May, he was still positive although he was described as thinner and paler.
36. On 19 October 2012, a care plan was developed in response to the man's increased pain and deteriorating condition. A week later, at an MDT meeting it was noted that he did not want to discuss his prognosis and did not want to know what his life expectancy was. A Macmillan nurse visited him regularly and oversaw his palliative care. On 26 October, he told the Macmillan nurse that he was aware that he had incurable cancer but did not want to discuss his prognosis.
37. As part of his palliative care plan a chaplain provided spiritual and pastoral care. She contributed to the MDT meetings during the last few weeks of his life.
38. On 2 January, a prison GP spoke to the man about whether he wanted to be resuscitated if his condition became critical. The GP agreed with him that he would be resuscitated, unless his health failed significantly and he was put on the care pathway for the dying. Just five days later, on 7 January, his health had deteriorated so significantly that he was placed on the Liverpool Care Pathway (used by doctors and nurses in the last days or hours of life), and a 'Do Not Attempt Resuscitation' order was activated, with his agreement.
39. The clinical reviewer considers that the man's palliative care was well coordinated and regularly updated. We agree that his palliative care was managed, and informed by specialist palliative care nurses.

### **The man's location**

40. The man wanted to remain on his residential wing for as long as possible where he had the support of friends and staff he knew. On more than one occasion, he was admitted to the healthcare centre when his condition deteriorated, but as soon as he recovered he chose to go back to the wing.
41. With the man's agreement on 4 October 2012, the prison GP told a senior officer and an officer on his wing about his condition. The officers increased

the number of his observations and other prisoners were appointed as carers to clean his cell, collect his meals and support him.

42. On 28 December 2012, the man moved to the inpatient unit. His friends from the wing visited him there, and he went to the wing to join his friends during association time, when prisoners are unlocked and able to socialise with each other.
43. At the beginning of January 2013, healthcare staff asked the man if he wanted to move to the palliative care suite, attached to the healthcare unit. The palliative suite is adapted for prisoners in the late stage of a terminal illness, and the cell in which they live is not locked. He told staff that he did not want to go into the suite and preferred to remain in his cell on the healthcare unit. His cell in the inpatient unit was locked at certain times during the day and throughout the night.
44. The day before he died it was recorded in his medical notes that the man agreed to go into the palliative care suite the following day. He died the following morning, just hours before he was due to be moved.
45. A nurse recorded in the man's medical notes that he spent the hours before his death wandering around the cell and sitting on the edge of the bed. As he was in a locked cell the nurses had to observe him through the door. When he was checked at 1.15am, he was lying down, asleep. Half an hour later, at 1.45am the nurse recorded that his breathing had become shallow. Five minutes later, the nurse noticed that he had stopped breathing, so he contacted the night orderly officer to come to open the cell so that healthcare staff could attend to him. When the cell was opened it was found that he had died.
46. It is appropriate that terminally ill patients should be involved in decisions about their location. We are satisfied that the man was consulted and his wishes respected about his location in the prison. However, we share the clinical reviewer's concern that a man was allowed to die on his own while members of staff watched from the other side of a locked cell door. Although he had previously declined to move to the palliative care suite, we do not consider this was appropriately humane treatment of a dying man.

**The Governor should ensure that prisoners who are acknowledged to be dying are not held in locked cells so that healthcare staff are able to support them at the end of their lives.**

### **Restraints, security and bed watch**

47. The Prison Service has a duty to protect the public when escorting prisoners to hospital and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health. A judgement in the High Court

in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that a medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process. It deemed that handcuffing a prisoner receiving chemotherapy (and, by implication, other life saving treatment) was degrading and that such restraint would be likely to be regarded as inhumane unless justified by other relevant considerations.

48. The investigator reviewed the escort risk assessments for the man's hospital visits. Until 19 April 2011 he was a standard Category A prisoner and officers used double cuffs to restrain him during the escort. It was recorded that he was violent, with a history of sexual offences against children and adults and he was considered a high risk to the public and of escape. No individual medical assessments were recorded on the risk assessment, as the High Court Judgement requires, and there was no mention of his actual state of health at the time of the escort.
49. On 19 April 2011, the man was re-categorised to B. At that stage his risk of escape was assessed as low and his risk to the public was reduced to medium. However, officers still used double cuffs for all his hospital visits. An escort chain was used when he was receiving chemotherapy. (An escort chain is a length of chain with a handcuff at each end one of which is attached to the prisoner and the other to an officer.)
50. Although it is recorded on the man's escort record that several members of healthcare staff saw him just before he left Full Sutton for his hospital visits, the medical section of his escort risk assessment was never fully completed.
51. We acknowledge that public protection is paramount, but security measures must be proportionate to a prisoner's individual circumstances. As there is no evidence that the man's serious medical condition was taken into consideration when assessing his level of restraints, we cannot be satisfied that his risk was properly assessed. It is a particular concern that he was restrained during chemotherapy, even after his risk of escape was assessed as low.

**The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.**

#### **Liaison with the man's family**

52. The man was in contact with his sister and family members during his sentence. He told his family when he was first diagnosed with probable pancreatic cancer and kept in touch by telephone and letters.

53. The prison chaplain told the investigator that she had been in contact with the man's sister since 2010 when he had surgery in Leeds. She stayed in frequent contact with her over the next 18 months.
54. As the man's condition deteriorated in December 2012, the chaplain and the duty governor arranged for his sister to visit him in the healthcare centre on 30 December.
55. A trained family liaison officer (FLO) was appointed as the main point of contact for the man's family on 2 January 2013. The FLO arranged a visit for 8 January 2013 for the man's sister from South Wales. Sadly, he died before the visit could take place. The FLO rang her to inform her of her brother's death.
56. Prison Service Instruction (PSI) 64/2011 says "Wherever possible, the FLO and another member of staff must visit in person the next of kin or nominated person to break the news of the death". However, we agree it was appropriate in these exceptional circumstances to tell the man's sister over the telephone before she started her journey to the prison.
57. The FLO and chaplain visited the man's sister at her home the next day. The funeral was held on 25 January in his home in South Wales and the prison offered a contribution towards expenses in line with national requirements. The service was conducted by a prison chaplain and attended by the FLO.
58. We are satisfied that the prison supported the family with sensitivity during the man's illness and after his death.

### **Compassionate release**

59. The man was sentenced to life imprisonment in March 1999 with a minimum of eight years to serve. He was five years over the minimum of his sentence when he received his terminal diagnosis. In April 2011, the Parole Board indicated that he was not ready for release and still posed a threat to the public.
60. The man was given palliative chemotherapy from September 2012. He did not want to discuss his prognosis and his life expectancy is not recorded in his medical record. There is no evidence that the prison sought to confirm his prognosis or that compassionate release was discussed at this point, despite him receiving palliative treatment for his terminal condition.
61. It was noted in the man's medical record on 27 November 2012 that he asked for a transfer to a Welsh prison to be nearer to his family. Healthcare staff said that they would look into this possibility, but there is nothing in his medical record or prison record that staff acted to facilitate this request. A note in the medical record on 24 December indicated that staff were still waiting for a decision on his request.

62. On 3 January 2013, prison officers, healthcare staff, operational managers and the man met to discuss his care. He asked again if he could be transferred to a prison near to his family or released on compassionate grounds. It was agreed to contact the Head of Healthcare at HMP Cardiff to see if he could be transferred there as his family lived in South Wales. On 4 January, the Head of Healthcare at Cardiff said he could not transfer to the prison, because it was their practice to refer terminally ill prisoners to either a local hospital or hospice.
63. There is no evidence that an application for compassionate release was ever started. We do not know whether the man would have met all the criteria for compassionate release. Nevertheless, we consider that the possibility of compassionate release should be considered when a prisoner is terminally ill.

**The Governor should ensure that the possibility of release on compassionate grounds is considered and documented for all terminally ill prisoners with a short time left to live.**

## **RECOMMENDATIONS**

1. The Governor should ensure that prisoners who are acknowledged to be dying are not held in locked cells so that healthcare staff are able to support them at the end of their lives.
2. The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.
3. The Governor should ensure that the possibility of release on compassionate grounds is considered and documented for all terminally ill prisoners with a short time left to live.

## ACTION PLAN: The Man – HMP Full Sutton

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Governor should ensure that prisoners who are acknowledged to be dying are not held in locked cells so that healthcare staff are able to support them at the end of their lives.	Accepted	All patients on the end of life pathway are already asked to consider moving into the palliative care suite where they are not locked in a cell and have ready access to a nurse. However, a patient's wishes should also be taken into consideration and in this case the man did not want to transfer into the palliative care suite despite knowing how ill he was and the consequences of being in his requested cell.	End of Life policy developed 2010	
2	The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.	Accepted	The assessment for suitability for medical appointments by Doctor or Healthcare Manager are managed through a standard set of prescriptive questions form the risk assessment which is now in place for all prisoners at Full Sutton. Management checks include an assessment of the prisoner's well-being which requires the manager visiting the patient to assess that the cuffing arrangements are proportionate to the risk posed of escape and to the public.		
3	The Governor should ensure that the possibility of release on compassionate grounds is considered and documented for all terminally ill prisoners with a short time left to live.	Accepted	Some work had been undertaken in preparation for the man's assessment for compassionate release however there was no completed assessment provided by his OM in the community. There was no indication from the Medical Practitioner of an imminent death which is difficult to assess. Offender Management will work closely with Healthcare regarding potential Deaths in Custody and will send out the appropriate requests when advised.	Systems and procedures in place	

