A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Full Sutton in June 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 investigation report into the death of a man at HMP Full Sutton in June 2013. He died from ischaemic heart disease and malignant lymphoma. He was 73 years old. I offer my condolences to his family.

A review of the clinical care the man received in custody was carried out. The prison cooperated fully with the investigation.

The man had been in prison for 31 years. He had a long history of cardiac problems and suffered from a number of other chronic health conditions. In April 2013, he moved to the prison's healthcare unit as his health had deteriorated, but he refused medical tests to find out a diagnosis. His health continued to deteriorate, and in May he was placed on an end of life care plan. Later that month, after he had agreed to a blood test, he was diagnosed with a blood cancer, which medical staff had suspected for some months. He died in June from an associated cardiac failure.

I am concerned that the use of restraints when the man was taken on a visit to hospital was not justified by a fully considered risk assessment, a matter I have raised with Full Sutton before. In all other respects, I consider that he received good care and I share the clinical reviewer's view that the standard of healthcare was at least equal to that which he could have expected to receive in the community. Staff at the prison continued to encourage him to engage with medical investigation and treatment despite his reluctance and he received an exemplary standard of palliative care and support at the end of his life.

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 **January 2014**

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SUMMARY

1. The man was sentenced to life imprisonment on 29 January 1982. After several prison moves, he arrived at HMP Full Sutton on 28 February 1994 and lived there for the rest of his life.

2. During his time in prison, the man suffered from a number of chronic health complaints, including cardiac, respiratory and rheumatic problems. He was reluctant to have any medical investigation which made it difficult to provide an accurate diagnosis and treatment, although staff frequently encouraged him to engage with his healthcare.

3. In November 2012, healthcare staff became concerned that the man had a serious disease as he had lost a lot of weight but he was reluctant to discuss this with them. He frequently refused blood tests, but he agreed to have an ultrasound scan in January 2013 which showed an enlarged spleen, a possible sign of cancer. However, he continued to refuse any active medical investigation.

4. Over the following months, the man's health continued to deteriorate and, in April, he moved from his wing to a cell in the healthcare centre. In May, he was moved to the prison's palliative care suite and was placed on an end of life care plan where he received multi-disciplinary support from staff. On 13 May, he finally agreed to provide a blood sample and 10 days later he was diagnosed with a cancer. After his diagnosis, staff discussed possible treatment options with him, but he refused to engage with them.

5. The man died in June 2013, after a suspected heart attack the day before. The post-mortem report states that he died of ischaemic heart disease (IHD, a disease where narrowed or blocked vessels affect the flow of blood to the heart) and malignant lymphoma (a cancer which affects the blood cells).

6. We conclude that the man received appropriate medical care in prison and this view is supported by the clinical reviewer. We do not consider that the use of restraints when he attended hospital towards the end of his life was justified by a fully considered risk assessment and we make one recommendation about this.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Full Sutton informing them of the investigation and inviting anyone with any relevant information to contact him. No responses were received.

8. A clinical reviewer was commissioned to review the man's medical care in prison.

9. The investigator and a colleague visited Full Sutton on 13 June. They visited the healthcare wing where the man lived and met with staff there. They also met the Governor, Deputy Governor, a member of the Independent Monitoring Board (IMB) and the prison family liaison officer. The investigator obtained copies of the man's prison and prison healthcare records.

10. On 19 and 21 August, the investigator interviewed staff at Full Sutton. He informed the Deputy Governor of the initial findings of the investigation.

11. HM Coroner for East Riding and Kingston upon Hull was informed of the investigation and provided a copy of the post-mortem report. The Coroner has been sent this investigation report.

12. One of the Ombudsman's family liaison officers contacted the man's niece to explain the investigation and invite his family to identify relevant matters they wished the investigation to consider. The man's niece asked whether a normal prison wing was appropriate for her uncle and whether he should have moved to the healthcare unit (or a hospital) sooner. She was also concerned about the timeliness of his medical care. She also asked whether it would have been possible to have a family liaison officer allocated who knew him well, although she was happy with the support provided by the assigned officer.

13. The investigation has assessed the main issues involved in the man's care, including his diagnosis and treatment, family liaison, his location and security arrangements, whether compassionate release was considered and whether appropriate palliative care was provided.

14. The man's family received a copy of the draft report. They pointed out some factual inaccuracies. This report has been amended accordingly. They also raised issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

15. The Prison Service also received a copy of the draft report. Their response to our recommendations and action plan is included in the report.

HMP FULL SUTTON

16. Full Sutton is a maximum security prison near York holding around 600 Category A and B prisoners serving a minimum of four years imprisonment. Healthcare services are currently commissioned through the Yorkshire and Humber Area Team of NHS England (before April 2013, healthcare services were commissioned through the North Yorkshire and East Riding Commissioning unit). There are registered general and mental health nurses, as well as a nurse prescriber (a nurse who is qualified to prescribe medication), and daily General Practitioner (GP) cover. There is an inpatient healthcare unit with 6 beds and 24 hour nursing cover.

HM Inspectorate of Prisons

17. HM Inspectorate of Prisons (HMIP) conducted an announced inspection of Full Sutton in December 2012. The Inspectorate found that clinical governance arrangements were satisfactory and the range and quality of healthcare services was good, although prisoners were generally dissatisfied with these services. The inpatient healthcare unit was described as satisfactory and the Inspectorate found that inpatients were complimentary about the quality of care received. 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.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who monitor all aspects of prison life to ensure that prisoners are treated fairly and decently. In their latest published annual report, the IMB reported that terminally ill prisoners had been appreciative of the treatment they had received.

Previous deaths at Full Sutton

19. The man was the fifth prisoner to die at Full Sutton since 2012. Four of these previous deaths were as a result of natural causes. Since this investigation started, there has been one further death at the prison, also due to natural causes. We have previously made recommendations to Full Sutton about risk assessments and the use of restraints for hospital escorts and we do so again in this report.

ISSUES

The diagnosis of the man's terminal illness

Ischaemic Heart Disease

20. On 4 June 2012, a prison GP visited the man on the wing as he had been suffering from chest pains. He had a history of cardiac problems. He had previously suffered suspected transient ischaemic attacks (TIA's, small strokes causing minor and temporary symptoms) and had been diagnosed with angina and hypertensive disease (heart problems due to high blood pressure). He had experienced chest pain for some time, which was being treated with a glyceryl trinitrate spray (GTN, a chemical used to treat angina and heart failure). The GP noted that he was suffering from ischaemic heart disease. He encouraged the man, who was a life-long smoker, to try to reduce his levels of smoking. He refused to give a blood sample.

21. A visiting doctor from a hospital saw the man on 10 January 2013, who then had a chest X-ray on 14 January. The doctor reviewed the findings and noted that he had a pleural effusion (fluid next to the lung) which could signal underlying heart failure. He said that a pleural tap (sample of chest fluid) could provide a diagnosis. However, he would not consent to this investigation.

22. The prison GP told us that the man's heart disease was a long standing illness which had been present for at least ten years before his death, but it had been difficult to provide an exact diagnosis of his cardiac problems because of his lack of engagement. We are satisfied that his heart disease was appropriately diagnosed, taking into account the difficulties presented by his refusal to undergo further tests.

Malignant Lymphoma

23. On 8 November 2012, the man saw a prison GP. They discussed his ongoing health problems, including his recent weight loss. The man said that he probably had some diseases but would prefer not to know. The GP recorded that the man was happy with the healthcare and medication he was receiving and did not want any clinical intervention. He recommended that staff should continue to encourage him to engage with clinical investigations.

24. On 3 January 2013, the man agreed to have a blood test after a nurse noted he had lost weight and had a rash. However, on 8 January, he declined the tests despite encouragement from the nurse. In a disclaimer letter, he said that he did not want the prison to be aware if he had a serious illness as he feared this information would be used to disadvantage him. A prison GP told the investigator that the man often said he felt that the authorities were trying to prevent his release.

25. On 10 January, the hospital doctor told the man that, without further investigation, it would be impossible to provide a definitive diagnosis. He was

prepared to have an X-ray and an electrocardiogram (ECG, a test that measures the electrical activity of the heart), but he was unwilling to have any form of blood test. The doctor said that the man seemed to be particularly fearful of finding out that he had cancer.

26. On 29 January, the man had an ultrasound scan in the healthcare unit which showed he had an enlarged spleen. A prison GP discussed the results with the hospital doctor on 1 February and suggested that a CT scan (which gives more detailed images) might help obtain a diagnosis if he was still unwilling to have a blood test. Nurses discussed these options with him and he agreed to have a CT scan which took place on 18 April. However, he said he did not want to know what was wrong with him. The results of the CT scan highlighted the enlarged spleen and the hospital doctor advised that a biopsy would provide further information and a potential diagnosis. He declined any further clinical investigation.

27. On 13 May 2013, the man eventually agreed to blood tests. A sample was sent to hospital and later that month he was diagnosed with mantle cell lymphoma (a cancer of the lymphatic system affecting the white blood cells). The post-mortem report confirmed the cause of death as malignant lymphoma. This causes pernicious anaemia (a lack of red blood cells due to the body not absorbing vitamin B12), which would have triggered the cardiac event which he eventually died from.

28. The clinical reviewer notes that the man refused multiple appointments for tests and eventually consented to the blood test which confirmed the diagnosis of his illness almost four months after his initial consultation. We are satisfied that a diagnosis could not have been provided any earlier because of his reluctance to have the blood tests required to identify his condition.

Informing the man about his condition and treatment

Ischaemic Heart Disease

29. The man had a long history of cardiac problems and had been diagnosed with angina and hypertensive disease in 2007. In June 2010, he was put on a chronic heart disease management plan due to his multiple health problems and to monitor any cardiac changes. His heart disease was a long-standing condition with multiple symptoms which was discussed with him frequently. We are satisfied that he was aware of his heart condition and the further tests and treatment available.

Malignant Lymphoma

30. On 22 April 2013, a prison GP told the man that recent weight and muscle-mass loss, and the results of the CT scan indicated a potential cancer. In a further discussion on 7 May, the GP said that his symptoms could indicate leukaemia (cancer of the blood), but he declined any clinical investigation.

31. After the man agreed to a blood test, later in May 2013, a probable lymphoid malignancy (cancer of a blood-forming organ) was diagnosed. The prison GP informed him and explained that he needed a blood transfusion and that if he did not have one he risked dying of a heart attack. After considering the options available to him, he refused the blood tests which would have allowed cross-matching for a transfusion.

32. On 23 May, a diagnosis of mantle cell lymphoma was confirmed. A prison GP saw the man on 3 June to discuss his prognosis and treatment options and explained that he would need a blood transfusion followed by chemotherapy. He was not keen to have this treatment but initially agreed to a blood test later that week. However, he changed his mind and declined a transfusion.

33. It is clear from the medical records that healthcare staff discussed with the man the likelihood of serious illness on many occasions. We are satisfied that he was informed of his illness in a timely manner, following the eventual diagnosis, and was made aware of the treatment options available to him, which he declined. He was seen by mental health services during his time in the healthcare unit and they did not identify any concerns about his mental capacity. We are satisfied that he had the mental capacity to understand the implications of refusing treatment.

The man's medical appointments and treatment

34. The man had a significant amount of contact with healthcare staff because of his multiple health problems, but he attended only one hospital appointment in 2013 for a CT scan. He refused all other appointments. A prison GP told the investigator that he had frequently refused hospital appointments and treatment throughout his time in prison.

35. The medical records show that the man had agreed to non-invasive procedures in the past, such as CT scans, but had always been reluctant to undergo more invasive procedures including blood tests which severely limited his treatment options. Although he finally consented to blood tests in May 2013 which helped to provide a diagnosis of his illness, he continued to refuse blood transfusions which would have been necessary to treat his cancer successfully and prevent his eventual heart failure.

36. In April, the man began oxygen therapy (breathing high concentrations of oxygen from a cylinder or machine) to help with his breathing difficulties and continued this treatment for the rest of his life. Although he gradually became reliant on the additional oxygen, it ensured that he was able to remain fairly mobile and could undertake tasks such as going to the toilet independently until near the end of his life. A prison GP told us that his palliative care, unusually for a cancer case, was centred on treating breathlessness rather than pain.

37. The clinical reviewer comments that the man's historic refusal to access health care and non-attendance at appointments made it difficult to treat his

general symptoms but concludes that his chronic conditions were managed correctly, in line with national guidance.

The man’s pain relief and medication

38. The man had suffered from chest pains caused by angina related to his IHD for many years and had been prescribed with a GTN spray to control the symptoms. He also took simvastatin, a cholesterol-lowering medication used to lower the risk of heart attacks and furosemide to treat heart failure. Most of his pain resulted from his ankylosing spondylitis (chronic arthritis affecting the spine) and lower limb problems rather than his terminal illness. His chronic back pain was managed through painkillers including tramadol, gabapentin and paracetamol and he was given compression stockings to reduce the risk of DVT. Adjustments were also put in place such as a ‘lazy-boy’ chair in his cell to help with chronic back pain and modifications to the shower opposite his cell to aid mobility.

39. A prison GP told the investigator that he believed the man took his analgesic medicine appropriately most of the time and it became easier to manage his pain relief when he moved to the healthcare unit.

40. When the man began to find it difficult to take medication orally shortly before his death, he was given injections of midazolam (a sedative) to provide pain relief. A syringe driver (a small pump which administers pain relief under the skin) was set up to give him diamorphine (a strong painkiller) but he died before it could be used.

41. We are satisfied that the man’s pain relief and medication was appropriately managed in prison. He was prescribed with a range of medications to control the symptoms of heart disease and this, along with his other co-existent diseases such as ankylosing spondylitis, were managed in line with national guidelines according to the clinical reviewer. We are content that his pain relief and oxygen therapy was correctly managed at the end of his life to ensure that he remained comfortable and this view is shared by the clinical reviewer.

The man’s location

42. The man was frequently offered a move from his residential wing to the healthcare unit by but always declined. While living on the wing, he had the help of another prisoner to assist him with various daily tasks.

43. On 2 April, a case conference of staff responsible for the man’s care concluded that it was no longer appropriate for him to live on a residential wing as his safety and security were at risk due to his declining health. Staff discussed a move to the healthcare unit with him and also asked other prisoners to try to persuade him to move. However, his health deteriorated quickly and, on 4 April, he was moved to the healthcare inpatient unit.

44. The man was initially disappointed to have been moved and staff agreed that he could go back to his cell on the wing after a few weeks once his health and mobility had been further assessed. However, his health continued to deteriorate and, on 8 May, he was moved to the palliative care suite, a specialist room which allowed more space for medical equipment and better staff access. He briefly moved back to a standard healthcare cell on 6 June as his condition stabilised, which he preferred. However, he returned to the palliative care suite three days later when his health deteriorated again.

45. It is appropriate that terminally ill patients are involved in decisions about their location. Although staff frequently encouraged the man to move to the healthcare unit to help with his medical care and treatment, he was allowed to remain on a residential wing in accordance with his wishes until it was no longer possible for him to safely remain there. We are satisfied that he was properly involved in discussions about his location and the decision to move him to the healthcare unit was appropriate at the time.

Palliative care

46. The NHS document 'The route to success in end of life care – achieving quality in prisons and for prisoners' sets out how an end of life care pathway might be implemented in prisons. Among the benefits of an end of life pathway is that it helps carers plan when and how care will be delivered and helps patients make choices about how they are cared for towards the end of their lives.

47. On 1 May, the man discussed with a nurse resuscitation options, in the event of a respiratory or cardiac arrest. He had previously said that he did not want resuscitation, but now said he would want to be resuscitated unless he had not been breathing or had been without a heartbeat for some time.

48. On 8 May, a multi-disciplinary team of staff responsible for the man's care in prison met to discuss his deteriorating health. After this meeting, he agreed to move to the palliative care suite and was placed on a care pathway (this is a multi-disciplinary care plan covering all aspects of a patients care and treatment).

49. On 9 May, a doctor discussed the possibility of resuscitation following a cardiac arrest with him and said that any attempt to provide cardiopulmonary resuscitation (CPR) would be medically futile due to his condition. He agreed and signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order. In the week before his death, he appeared to have changed his mind and told nurses that he wanted to be resuscitated following a cardiac arrest. However, the DNACPR order does not appear to have been withdrawn.

50. A prison GP said that Full Sutton provides bespoke care plans for prisoners, based on their specific needs, with input from a range of staff including Macmillan cancer-specialist nurses. The man was regularly monitored by medical staff through appropriate care plans to ensure that pain relief and treatments were provided where necessary and his condition and care were

discussed with him. He was also supported by a designated family liaison officer and chaplaincy staff. Visits from friends from his wing were arranged. As his mobility decreased, extra staff were located close to his room at night to ensure his safety.

51. When the man returned to a standard cell in healthcare on 6 June, his care plan was updated to monitor the signs and symptoms of his illnesses. He was placed on a care pathway for the dying patient (usually put in place during the last days and hours of a patients life) when his condition deteriorated and he returned to the palliative care suite.

52. On 9 June, after a suspected heart attack, a prison GP decided that resuscitation was not appropriate as this would involve defibrillation (electric shock) treatment and a follow up blood transfusion. He had discussed this with the man earlier, who made it clear that he did not want any treatment which would have required a transfusion. The clinical reviewer is satisfied that this was managed correctly. He was not suitable for resuscitation and it would not have been in his best interests, due to his acute medical condition and co-morbidities. In addition, he made clear that he did not want a blood transfusion, which would have been necessary if resuscitation had been carried out. The healthcare professionals involved were satisfied that he had the capacity to make this decision.

53. We agree with the clinical reviewer's conclusion that the man's palliative care at Full Sutton was exemplary and that his end of life was managed sensitively and compassionately through excellent multi-disciplinary support, with his wishes respected. The clinical reviewer commends the use of additional staff to support him at night as his condition deteriorated.

Contact with the man's family

54. Prison Service Instruction (PSI) 64/2011 says that prisons should encourage terminally ill prisoners to engage with their families and must ensure that arrangements are in place for an appropriate member of staff to liaise with the next of kin or nominated person and, with the prisoner's agreement, keep them updated on the prisoner's condition.

55. The man had not been in contact with his family for some time. However, from June 2012, his niece started writing to him for the first time. He told staff that she was aware of his health problems.

56. A trained family liaison officer (FLO) was assigned as the main point of contact for the man's family on 8 May due to his declining health. On 9 May, the FLO introduced himself to the man, who said that he did not want the prison to contact his niece without his consent. In line with his wishes, the prison did not have any further contact with his niece until after his death.

57. On the morning the FLO was informed that the man had died he attempted to contact the man's niece. As he was unable to find a phone number for her,

he contacted the man's solicitor and also asked the local police to help. The police contacted the man's niece and informed her of his death.

58. At the request of his niece, the funeral was arranged by Full Sutton. It took place on 2 July and was attended by staff from the prison. In line with national guidance, the prison contributed towards the costs of the funeral. A memorial service for him was held at the prison the following day.

59. Prison Service Instruction (PSI) 64/2011 says, "Wherever possible, the FLO (family liaison officer) and another member of staff must visit in person the next of kin or nominated person to break the news of the death". While it would have been preferable for a member of prison staff to visit the man's niece to inform her of his death in person, we are satisfied that she was informed in a timely manner taking into account her uncle's decision that the prison should have no contact with her before his death. However, we are surprised that the prison did not record any contact details for her, particularly as the family liaison officer had spoken to him about his wishes regarding contact.

60. The man's niece told us that she was happy with the support provided by the assigned officer, but asked whether it would have been possible to have a family liaison officer allocated who knew him well. The investigator was informed that Full Sutton has a pool of trained family liaison officers who are assigned as necessary. Where possible if a trained officer knows a prisoner well the prison aims to allocate that officer to the prisoner.

61. We are satisfied that an appropriate family liaison officer was appointed at the correct time in this case and that the man's wishes about family contact were taken into account by the prison.

Compassionate release

62. Release on compassionate grounds is a means by which prisoners who are seriously ill can be permanently released from custody before their sentence has expired. The criteria for early release for indeterminate sentenced prisoners are set out in Prison Service Order (PSO) 4700 and prisoners are usually expected to have less than three months to live. The criteria include that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and their family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) within the National Offender Management System (NOMS) and should be supported by the Governor.

63. The man submitted an application for early release on compassionate grounds on 15 April 2013, following advice from his solicitor. The Head of Offender Management forwarded the application to prison, probation and healthcare staff to complete on the same day.

64. An application for early release on compassionate grounds requires reports from all parties (as above) before it is submitted to the Governor for a decision on whether the request should be sent to PPCS for consideration. The man's application for early release was not completed before his death as reports from a medical professional and the offender manager had not been received. In an email dated 17 May, the Head of Healthcare at Full Sutton said that a prison GP would not be able to provide a "credible or meaningful" statement as there was no diagnosis due to the man's refusal of treatment. On 23 May, the man's Offender Manager sent an email indicating that she required information from healthcare in order to complete her submission.

65. A confirmed diagnosis of the man's terminal illness was not available to medical staff until 23 May, more than 6 weeks after the initial application was made. A prison GP telephoned and wrote to a consultant haematologist (a blood specialist) at hospital on 3 June for advice on a prognosis for mantle cell lymphoma with and without chemotherapy and taking into account the man's co-existent diseases. While a formal response from the consultant is not recorded in the medical record, the GP recorded that the prognosis was medium-term survival if he consented and responded well to treatment and a survival period of weeks if not.

66. It is our view that the man would have been unlikely to meet the criteria for early release on compassionate grounds as his continued reluctance to engage with medical investigation or treatment meant that it was impossible for medical staff to give an accurate prognosis of his life expectancy. We are satisfied therefore, that the application was progressed as far as it could be by the prison.

Restraints, security and bed watch

67. The Prison Service has a duty to protect the public when escorting prisoners to hospital and have a reasonable 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.

68. The man had three scheduled hospital appointments outside prison in April and May 2013, although he only attended one of these, on 18 April. The investigator reviewed the risk assessments for that visit.

69. The medical section of the risk assessment for 18 April, completed by a prison GP and a Full Sutton GP respectively, gave no medical objections to the use of restraints but did not give any further information about the man's condition, apart from noting the reason for the visit as a CT Scan. The remainder of the security information provided information regarding his historic offences and current intelligence. A security officer wrote 'He is in extremely poor physical health, he rarely leaves his cell and cannot navigate stairs at all'. He was considered to be a medium risk to the public and all other risks were considered low. There were no reports to indicate that he posed a risk to the public or hospital staff.

70. The Governor instructed that prison staff should use double-handcuffs (two pairs of handcuffs; one to cuff the prisoner's wrists together and one to cuff his wrist to that of an officer) during the escort. He noted that an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer) could be used in place of the single cuff between the man and an officer for some activities and treatment. On the recommendation of the security assessment, the Governor directed a three officer escort because of his poor health and limited mobility. He remained restrained during the hospital visit, apart from during the CT scan.

71. A further escort was scheduled for 10 May for the man to have blood tests at hospital. A doctor completed the medical assessment and gave no medical objections to the use of restraints but said that they should be removed for treatment. He provided a summary of the man's health, stating that he was "very ill, likely terminal. His mobility is highly limited and I deem that restraints are unlikely to be necessary". The security risk assessment was as before.

72. The Head of Security instructed that no restraints would be used during the escort and that the man would be accompanied by three officers. He noted that he was at the end of his life and wheelchair-bound. He eventually refused to attend hospital that day as he no longer wanted to have blood tests.

73. Prison Service guidance is that restraints are not normally necessary for an escort when a prisoner's mobility is severely limited. When the man went to hospital on 18 April, his health and mobility were poor. Although he did not have a confirmed diagnosis at the time of the escort, medical staff had suspected he had a serious illness for some months. A physiotherapy assessment the day before the escort said that he was struggling to walk unaided and using a wheelchair to mobilise in the healthcare unit where he lived. While the security assessment also stated that he was in poor health and struggling with mobility, but nevertheless full restraints were directed.

74. We are pleased to see that the risk assessment for the man's planned appointment on 10 May (which in the event he did not attend) contained a more detailed medical summary. Such detail would have been helpful in the earlier risk assessment for 18 April and might have resulted in a different decision regarding restraints. However, the security section of the assessment on 18 April still referred to his poor health and mobility and this

should have been taken into account in the decision to restrain him. In an interview with the investigator, the Head of Security said that the man's health issues were well-known to staff.

75. In light of the man's poor health and lack of mobility, we do not consider the risk he presented warranted the use of double handcuffs or an escort chain during an escort for a medical procedure. His risk level to staff was judged as low and, although his risk to the public was recorded as medium, there were no current reports to indicate he posed a specific threat. We believe that the three officer escort would have been sufficient to protect hospital staff and the public.

76. We have made previous recommendations to Full Sutton about the use of restraints and consider there is a need for all those involved in making decisions to ensure that a prisoner's health and mobility are fully taken into account in risk assessments for hospital escorts and that staff follow the guidance in the High Court judgment. We make the following recommendation:

The Governor and Head of Healthcare should ensure that a prisoner's health and mobility are fully taken into account when deciding the staffing levels of escorts and whether restraints are needed.

RECOMMENDATION

The Governor and Head of Healthcare should ensure that a prisoner’s health and mobility are fully taken into account when deciding the staffing levels of escorts and whether restraints are needed.

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 and Head of Healthcare should ensure that a prisoner's health and mobility are fully taken into account when deciding the staffing levels of escorts and whether restraints are needed.	Accepted	The assessment of a prisoner's suitability for medical appointments by a Doctor or Healthcare Manager is managed through a standard set of prescriptive questions. These form the risk assessment which is now in place for all prisoners at Full Sutton. This process includes an assessment of the individual needs of the prisoner in relation to their state of health and mobility. The outcome of that evaluation then forms part of the escort risk assessment to determine restraint arrangements and staffing levels. Management checks include an assessment of a prisoner's well-being and that restraint arrangements are proportionate to the risk posed of escape and to the public.	Completed	