PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Full Sutton in March 2014

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 in March 2014, while a prisoner at HMP Full Sutton. He was 54 years old and died from brain cancer. I offer my condolences to the man's family and friends.

An investigator was appointed. A clinical reviewer reviewed the clinical care the man received at Full Sutton.

On 7 May 2013, the man had symptoms which caused the prison GP to be concerned that he had a bleed on the brain. He was admitted to York District Hospital for an MRI scan and further tests shortly afterwards. He was diagnosed with a brain tumour and had surgery, but not all of the tumour could be removed. The man was discharged from hospital to Full Sutton on 20 May.

The man's tumour was aggressive and his condition incurable. He had radiotherapy and chemotherapy and further surgery in February 2014. Unfortunately, his treatments were unsuccessful and his condition deteriorated quickly. He died on 31 March.

The clinical reviewer concludes that the man's care at Full Sutton was at least as good as that he could have expected in the community and his palliative care was excellent. Interventions were timely, healthcare staff were attentive to his changing condition and considerable efforts were made to maintain his comfort and minimise his symptoms.

While I am satisfied that the man was well looked after at Full Sutton and that efforts were also made to help him re-establish contact with his family, I am not fully satisfied that risk assessments for the use of restraints or for compassionate release, appropriately took into account the man's actual condition at the time.

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 **October 2014**

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SUMMARY

1. The man was sentenced to life imprisonment for murder in November 2008 and moved to HMP Full Sutton. He had no longstanding medical conditions and appeared in good health.

2. On 7 May 2013, a nurse was concerned that the man had some left sided weakness and he reported a headache and an inability to tolerate light. A doctor reviewed him and was concerned he might have a bleed on the brain. He sent him to hospital for a brain scan. The result showed that the man had a brain tumour and he was admitted to hospital.

3. On 16 May, the man had surgery four days later to attempt to remove the tumour. He was discharged to Full Sutton on 20 May.

4. On 23 May, the man was told that the tumour was one which grows and spreads very quickly. Hospital and prison healthcare staff supported him and gave him information about his condition and treatment options.

5. The man had radiotherapy and chemotherapy over the next 12 months and further surgery in February 2014. However, his tumour was very aggressive and the treatment was unsuccessful.

6. On 27 February, the man moved to the prison healthcare unit, as his condition had deteriorated significantly and it was no longer safe for him to live on his wing. On 24 March, he moved to the prison's palliative care suite. He died on 31 March.

7. The clinical reviewer concludes that the man's care at the prison was excellent and at least equivalent to that in the community. His symptoms were promptly investigated and he received appropriate support. Interactions with healthcare staff were well documented and there was very good communication between prison healthcare staff and external services. Interventions were timely and healthcare staff were attentive to his changing needs. Considerable effort was made to maintain his comfort and minimise his symptoms.

8. The man had not been in touch with his family for some time, but the prison helped him re-establish contact. His mother and sister visited him shortly before he died. Sadly, they were unable to afford to visit him again to be with him again for the final hours of life.

9. We are concerned that the man's health condition was not fully considered in the risk assessment process for the use of restraints when attending hospital. He was restrained without any healthcare input about his condition or the impact this had on his risk of escape, contrary to guidance about the lawful use of restraints. His medical condition was also not fully taken into account in the compassionate release process. We make two recommendations.

THE INVESTIGATION PROCESS

10. The investigator issued notices to staff and prisoners at HMP Full Sutton informing them of the investigation and inviting anyone with relevant information to contact her. Two prisoners responded.

11. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. She interviewed three members of staff and a prisoner at Full Sutton on 2 June 2014 and carried out a further interview by video link on 16 June. The investigator gave the Governor initial written feedback about the preliminary findings of the investigation.

12. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.

13. We informed HM Coroner for East Riding and Kingston upon Hull of the investigation, who provided the results of the post-mortem examination. We have sent the Coroner a copy of this investigation report.

14. One of the Ombudsman's family liaison officers contacted the man's mother and sister to explain the investigation. His family did not have any specific concerns for the investigation to consider.

15. The man's family received a copy of the draft report and indicated that they were satisfied with the findings.

16. The report was issued for consultation with the Prison Service. There were no factual inaccuracies and the action plan has been added to the end of the report.

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

HMP FULL SUTTON

18. HMP Full Sutton is a high security prison near York. It holds up to 600 Category A and B male prisoners. 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 who is qualified to prescribe medication, and daily GP cover. There is an inpatient healthcare unit with six beds and 24 hour nursing cover.

HM Inspectorate of Prisons

19. The last inspection of Full Sutton was in December 2012. The Inspectorate noted that clinical governance arrangements were satisfactory and the range and quality of healthcare services were 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

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its most recently published report for the year to October 2013, the IMB noted that the healthcare unit offered a first class level of care. The IMB reported that care of the elderly and chronically ill continued to increase in volume and costs, but was delivered with compassion and professionalism.

Previous deaths at HMP Full Sutton

21. The man was the fifth prisoner to die of natural causes in the last year at Full Sutton. We have raised the issue of the need for appropriate risk assessment for the use of restraints before.

ISSUES

The diagnosis of the man's terminal illness and informing him of his condition

22. The man had been in prison since 2007 and was generally in good health with no longstanding medical conditions, until a sudden onset of symptoms and the diagnosis of brain cancer in May 2013.

23. On 7 May 2013 at 3.52pm, a nurse went to see the man at the request of wing staff. An officer said he had exhibited "bizarre behaviour". (We were told that he had been staring into space and dropping things.) The officer explained that the man could not move his left arm and staff were concerned he had had a stroke. The nurse spoke to the man and noted he could walk and talk normally, and move all of his limbs. The man said that the issue with his arm was an injury from the gym. The nurse told wing staff to contact the healthcare unit again if there were any other problems.

24. At 6.18pm that evening, the nurse was called back to the wing as the man's condition had changed. He was leaning to the left, had slight weakness to his left grip and was dragging his left leg. He was squinting and found it difficult to tolerate the light. The man said he had had a headache behind his eyes for a few hours. The nurse asked the prison GP to see him urgently.

25. The GP saw the man at about 7.45pm, when he said his headache had gone and he felt fine. However, the doctor noted he still had left sided weakness and was concerned that the man had a bleed on his brain. He requested an emergency ambulance at 7.50pm which arrived at 8.07pm.

26. The man was taken to York District Hospital at 8.47pm and admitted. The results of a CT scan the next day showed a five centimetre mass in his frontal lobe (the part of the brain behind the forehead). Hospital consultants explained this to the man and he remained in hospital while his treatment options were considered.

27. On 12 May, the man transferred to Hull Royal Infirmary. A consultant neurosurgeon told him that it was likely that he had a high grade brain tumour (which is aggressive and fast growing) and prescribed dexomethasone (a steroid). On 16 May, the man had surgery to try and remove the tumour and he moved to the high dependency unit of the hospital. Four days later he returned to Full Sutton.

28. On 23 May a neurosurgeon at Hull Royal Infirmary, told a prison GP that they had been unable to remove the entire tumour because of a significant risk of paralysis. The test results showed that the man had a high grade tumour and needed chemotherapy and radiotherapy. The GP spoke to the man that day and he said he was aware of his diagnosis. They discussed the effects of chemotherapy and radiotherapy.

29. On 29 May, an oncology consultant saw the man at Castle Hill Hospital, Hull, and indicated that the tumour was a grade four. (Tumours are graded one to

four, four being malignant and the most serious.) The consultant told the man his condition was terminal and he had a life expectancy of about a year.

30. The man's symptoms were sudden and were promptly investigated. He was appropriately informed of his diagnosis by hospital staff. Prison healthcare staff discussed his condition with him to ensure he fully understood it and supported him. We agree with the clinical reviewer that the prompt investigation and treatment of the man's symptoms were commendable. Communication between prison healthcare staff and the hospital were excellent and well documented.

The man's medical treatment

31. The man's blood sugars were regularly monitored because of possible side effects from his steroid medication. A care plan was implemented on 7 June. On 17 June, the man started a 30 day course of radiotherapy, which he completed on 26 July.

32. Two nurses and a Macmillan Clinical Nurse Specialist met the man on 19 July. He said he was happy with his treatment and had not experienced any side effects, except he felt more tired than usual. The man said that the information he had been given was clear and helpful, and he was eating and drinking well. He had not experienced any visual disturbances or headaches. On 24 July, a further care plan was implemented, to ensure the man understood his diagnosis and prognosis and received appropriate support. His observations (such as blood pressure and temperature) were taken every two weeks and remained within normal limits. He said he felt well.

33. On 4 September, at a hospital appointment, the consultant noted the man had tolerated the treatment well and his white blood cell count had increased. (It had been low after his radiotherapy treatment.) His chemotherapy medication was increased for four weeks

34. The two nurses and Macmillan nurse saw the man on 1 October. He said he felt well and they asked questions about his treatment. The next day, 2 October, the consultant saw the man before his second four week high dose of chemotherapy. His white platelet count had fallen, so the treatment was delayed until 14 October.

35. The man began his third round of chemotherapy on 13 November and a fourth round on 18 December. On 30 December, the man collapsed in his cell. He said he was very tired and wanted to sleep. A nurse took him to the healthcare unit in a wheelchair. His blood pressure and pulse were high and he was sensitive to bright light. The GP reviewed the man and noted he was booked to have an MRI scan. The doctor thought the man had suffered a seizure and advised waiting for the MRI scan and results before taking any action, unless he became worse. His blood pressure and pulse had reduced and he stayed in the healthcare unit overnight.

36. On 29 January, the man attended an appointment with the consultant who noted that the man had completed four cycles of chemotherapy, which had caused some headaches and nausea. The results of a recent MRI scan showed that the cancer had progressed. The consultant increased the man's steroid dose. He explained that further surgery would be the best option, but if surgery was not appropriate, he could have chemotherapy. On 5 February, the consultant told the man that they would proceed with further surgery.

37. The man had the operation on 12 February and spent a week recovering in hospital. He was discharged to the healthcare unit at Full Sutton on 19 February and stayed there for observation over the weekend. He was prescribed paracetamol, oxycodone and tramadol (opiate based pain relief).

38. The GP saw the man on 24 February. They discussed an end of life care pathway. The man said he was not distressed and he still had the same prognosis as before the recent surgery. He said that he did not wish to be resuscitated in the event of cardiac or respiratory arrest and signed an order confirming this decision. The man said that his pain relief was fine. He returned to the wing that day.

39. On 26 February, the nurse saw the man in his cell. He said he was in pain and it looked as though he had not taken his medications properly and had eaten very little. A doctor saw the man the next morning. He said that he felt off balance on his left side. He had some slight confusion and his blood pressure was low, but his pulse was high so the doctor admitted him to the healthcare unit for observation. On 28 February, the doctor reviewed the man. There were no other concerns or symptoms and he had been given a dosette box to help him take his medications properly.

40. On 3 March, the GP noted that the man's pain relief was inadequate and prescribed morphine. His appetite was poor. By 5 March, the man's condition had deteriorated. He was unable to dress himself and went to a hospital appointment in a wheelchair. The consultant told him he needed another MRI scan before any further treatment options could be considered and it was likely he would have additional chemotherapy.

41. On 6 March, a custodial manager, nurse, a member of the chaplaincy team, an officer, Mental Health Nurse and the man attended a case conference in the healthcare unit. They noted that the man had deteriorated over the previous two weeks. The meeting planned his future care and noted the need to review his pain relief medication regularly. On 7 March, the GP changed the man's pain relief from morphine to oramorph (liquid morphine).

42. A multi-disciplinary team meeting on 11 March, noted that the man's condition had deteriorated and he was more confused. His steroid dose was increased and he was prescribed amitriptyline to help manage the nerve pain around the scar site. The man remained confused and needed constant prompting to complete daily tasks, such as taking medication and eating. Diet and fluid charts were implemented to monitor his intake.

43. On 21 March, the GP prescribed palliative care medication and a syringe driver (a small portable pump that can give a continuous dose of medication intravenously) was made available, in case it was needed. The doctor contacted the man's consultant who decided that further chemotherapy was inappropriate. His prognosis was less than a month.

44. The man's condition continued to deteriorate, he was vague and his reaction times slower. He needed extra help with dressing and personal hygiene. He moved to the palliative care suite at Full Sutton on 24 March. He was unable to stand safely without the assistance of two staff. His steroid medication was reduced as it was not working and his blood sugars were becoming high. He slept most of the time and had a pressure relieving mattress.

45. By 28 March, the man was bedbound and a catheter was inserted. The GP advised that the syringe driver should be used. By the evening, the man was barely rousable. On 31 March, the GP examined the man and thought he had developed bronchopneumonia. As he was in the final stages of his terminal illness, the GP considered there was no benefit in treating the infection. That afternoon, the man's breathing was recorded as rapid and shallow. Nurses monitored him frequently. During the evening, the man stopped breathing. The GP examined him and pronounced him dead at 6.20pm.

46. We agree with the clinical reviewer that the palliative care the man received at Full Sutton was excellent. Interventions were timely and healthcare staff were very attentive to his changing condition. There were regular multi-disciplinary meetings that involved the man, appropriate care pathways were implemented and considerable effort was made to maintain his comfort and minimise his symptoms.

The man's location

47. After the man's diagnosis, he was offered a move from his wing to the healthcare unit but he refused. Subsequently, the man had brief periods of admission to the healthcare unit, but chose to remain on his wing. When his condition deteriorated significantly he moved to the healthcare unit on 27 February 2014. As he became more ill, he moved to the prison's palliative care suite on 24 March.

48. We consider the man's location throughout his illness was appropriate. He moved in accordance with his changing needs.

Restraints, security and escorts

49. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as 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 and mobility. 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 medical opinion about the prisoner's ability to escape must be considered as part of the assessment process. It also deemed that restraining by handcuffs of a prisoner receiving chemotherapy (and by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.

50. The man attended many hospital appointments, including an emergency escort. The risk assessments completed for all the escorts note he was considered a medium risk to the public and low risk to hospital staff, of hostage taking, of escape and of outside assistance. There was minimal input into the risk assessments from healthcare staff, with no evidence of how his condition would impact on his risk of escape, as required by the 2007 High Court judgement. His behaviour was noted as positive and there were no concerns. Despite his apparent low risk of escape, during escorts the man was restrained with double cuffs. (Double cuffing is when the prisoner's hands are cuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs.) During his radiotherapy treatment, the handcuffs were removed from the officer, who stood outside the door, but the man remained restrained throughout the treatment with an escort chain. When his treatment finished, he was immediately re-cuffed to the officer. The only time restraints were removed was for surgery and for an MRI scan. Handcuffs were reapplied immediately after.

51. The man's condition deteriorated significantly in March 2014 and he was taken to hospital in a wheelchair. He was unable to dress himself and was confused. Despite the significant change in his condition his risk assessment remained the same and he was double cuffed.

52. The Prison Service has a responsibility to protect the public, but security must be balanced with humanity and measures must be proportionate to a prisoner's individual circumstances. We accept that the man was convicted of very serious offences, but we consider that the man's condition was not always appropriately considered during the risk assessment process. Although a category A prisoner, the man was considered a low risk of escape at the time of the risk assessments and the high level of restraint was unjustified, particularly as he became increasingly ill and immobile. We are concerned that there was insufficient healthcare input into the risk assessment, in relation to how his health condition impacted on his risk of escape. It is also concerning that he remained restrained during radiotherapy treatment, despite the 2007 High Court judgement. Ultimately it is the Governor's responsibility to ensure that the process is managed properly, but the Head of Healthcare also needs to ensure that healthcare staff understand their responsibilities and have appropriate input into the risk assessment process. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time

Liaison with the man's family

53. Prison staff often asked the man if he wanted to inform his family of his condition, but he refused as he had had no contact with them for many years and said he did not want to burden them with his illness. A prison family liaison officer was appointed and spoke to the man frequently about this in case he changed his mind.

54. On 10 March, during a meeting with a Macmillan nurse, the man said he now wanted to contact his family. The family liaison officer discussed this with him and telephoned the man's mother and sister on 14 March and asked if they wanted to visit the man. They explained they could not afford the train fare. The prison manager said the prison could not pay for the man's mother and sister to travel to York, but would pick them up from York train station. The man's sister and mother visited him in the healthcare unit on 21 March. After the visit, they were given an assisted visits form so they could claim reimbursement for the train fare.

55. The family liaison officer kept them up to date with changes in the man's condition and telephoned the man's sister at 10.12am on 31 March and explained he had deteriorated overnight. He offered them the opportunity to visit the man and said he would see if the prison could assist with travel arrangements. He spoke to the manager, who said that the prison would not pay for their train fare, but would pick them up from the station. The man's mother and sister did not have the money to pay for a ticket at short notice so asked to be informed by telephone if the man died. (We understand that advance payments are possible from the assisted prisons visits unit, but they require ten days notice.) The man died that evening. The family liaison officer telephoned his sister at 6.35pm and broke the news.

56. The man's funeral was held on 15 April and the prison contributed towards the cost in line with national guidance.

57. We are satisfied that the man's wishes about contacting his family were respected and that the prison helped him re-establish contact with them when he wanted to do so. The family liaison officer kept in contact with the man's family once they had been informed. It is unfortunate that the man's family were not able to visit him at the very end of his life, but we accept that the prison would not have had the authority to make any payment. We understand that it is possible to get payments in advance from the assisted prisons visits unit, but that these take some days to arrange.

Compassionate release

58. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. Among the criteria for compassionate release is 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 his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of the National Offender Management Service (NOMS).

59. The man was asked several times whether he wished to apply for compassionate release and each time he said he did not. However, on 12 March, the man told the GP that he would like to apply for compassionate release. That day, his offender manager completed the offender manager section of the compassionate release application form. She noted that his offending history would raise concerns about breach of trust and absconding. If he was to be released under any circumstances, including ill health, his risk to the public would be high. The man's offender supervisor noted he had not completed offending behaviour work. He considered that there was insufficient evidence of a reduction in the risk factors associated with his offending. They concluded that the man should not be released on compassionate grounds as he had the ability to reoffend and remained a high risk to others. It does not appear that the man's very serious state of health at the time was taken into consideration in reaching these assessments.

60. The GP completed the medical section of the application on 21 March. The man's consultant was contacted for his opinion. He noted that the man had an aggressive form of brain cancer and surgery, chemotherapy and radiotherapy had been unsuccessful. No further active treatment was attempted and his life expectancy was weeks, with a strong possibility of less than a month. He noted the form of brain cancer the man had was particularly distressing in its last stages and prompt early release should be considered. The symptoms, included seizures, pain and sensitivity to loud noises, and he would be unable to complete independent living tasks such as washing or dressing. The consultant considered it would be difficult to control some of the issues, such as loud noise, in a prison environment. The GP considered the man's terminal care would be more easily facilitated in a hospice, despite the facilities available in the healthcare unit. The GP said that his condition was very poor and did not consider him a risk to the public.

61. The Acting Governor completed the final section. She did not contact the local hospice to see whether release there would be a possibility, as she considered the man's security category and offending history would be a problem. She noted that, due to the man's medical condition, there was a suggestion that his capability of reoffending had reduced. However, given the lack of offending behaviour work and the existing level of risk, any benefit he

would gain from compassionate release would be outweighed by his risk to the public. She therefore did not support the application for release, but submitted it to the PPCS on 27 March. The man died before a decision had been made.

62. In the light of the medical advice, it is difficult to understand how the man could still be considered a risk to the public when he was seriously ill, unable to care for himself and with a life expectancy of weeks. The possibility of release to a hospice appears to have been discounted without investigation. As with assessment for the use of restraints, the risk assessment for compassionate release, by their nature, should be based on the actual risk the prisoner poses at the time, taking into account their terminal condition. Both doctors considered that the man's physical condition meant he was no longer a risk to the public. There might well have been a number of reasons why the man was not suitable for compassionate release, but we do not consider that the risk assessments properly reflected his physical condition at the time. We make the following recommendation:

The Governor should ensure that staff assessing risk for the purposes of compassionate release make a distinction between the risks posed by the prisoner when fit and those posed by the same prisoner when suffering from a terminal condition.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time

2. The Governor should ensure that staff assessing risk for the purposes of compassionate release make a distinction between the risks posed by the prisoner when fit and those posed by the same prisoner when suffering from a terminal condition.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1.	The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time	Accepted	All risk assessments will be carried out in line with the Graham judgement. Subsequent management checks will also review the condition of the prisoner to establish if there has been any deterioration in health; this will be reflected in the documentation.	30 September 2014 Security	
2.	The Governor should ensure that staff assessing risk for the purposes of compassionate release make a distinction between the risks posed by the prisoner when fit and those posed by the same prisoner when suffering from a terminal condition.	Accepted	In line with the palliative care policy and end of life pathway, the multi-disciplinary case conference will discuss the risk posed by the prisoner when fit and the impact of their terminal condition on risk.	Completed Multi-disciplinary case conference	