

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at hospital in
November 2012 while in the custody of HMP Full
Sutton**

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 a report of an investigation into the death of a man. He died in November 2012 at hospital of acute pneumonia, diabetes and coronary artery atheroma. He was 58 years old. I offer my condolences to his family.

A clinical reviewer carried out a clinical review of the man's clinical care in custody.

The man suffered from diabetes, which caused a number of health complications, including severely infected and ulcerated feet. He had a history of not taking his medication and refusing treatment both in prison and hospital. He frequently refused to attend appointments or wait to be seen by a doctor when did attend the prison's healthcare centre.

Despite the difficulties that the man posed as a patient, healthcare staff at Full Sutton made considerable and very professional efforts to treat him as effectively as they could. Accordingly, the clinical reviewer concludes that his medical care was at least equivalent to that he could have expected to receive in the community. However, the use of restraints when he was in hospital was not always justified by risk assessments which took full account of his medical condition and his family should have been contacted sooner to alert them to his failing health. I also repeat a recommendation I have previously made to Full Sutton about the need to contribute reasonable funeral costs in line with Prison Service instructions.

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

September 2013

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SUMMARY

1. The man was convicted and sentenced to life imprisonment in December 2007 and was sent to HMP Full Sutton. He had been diabetic for over 20 years and had associated health issues. Throughout his time at Full Sutton, he received frequent treatment and was given advice on managing his diabetes and lifestyle, in particular his diet and smoking.
2. The man did not always take the medication he was prescribed for diabetes and high blood pressure. He frequently refused to attend prison healthcare and hospital appointments and often refused to wait to see a doctor if he thought he had been kept waiting too long.
3. On 11 April 2012 the man had a stroke. He was admitted to hospital but refused to stay there for tests and discharged himself in the early hours of 13 April, against medical advice. When he got back to prison, he signed a disclaimer to say he did not want to stay in the prison's healthcare centre, but wanted to return to the wing. On 14 April, he had another stroke and was readmitted to hospital. Again, he discharged himself from hospital against advice on 15 April.
4. In May, the man began to have problems with an infected heel as a result of his poorly controlled diabetes. Healthcare staff cleaned and dressed his heel when they could, but he sometimes did not attend appointments. As his heel did not improve, he was referred to hospital on 29 October 2012 for a surgical procedure. After the surgery on 30 October, he did not recover well from the anaesthetic. On 1 November, he was moved to the hospital's Intensive Care Unit and, on 3 November, to the High Dependency Unit. He gradually improved and returned to a ward on 6 November. However, he refused antibiotic medication and would not keep his oxygen mask on. As a result, his condition deteriorated and he returned to the Intensive Care Unit on 10 November. He died a few days later with his family at his bedside.
5. The clinical reviewer concludes that the man's care was equivalent to the care he could have expected to receive in the community. Staff tried to encourage him to engage with his treatment and change his lifestyle to improve his health, but he refused. We are concerned that he was restrained in hospital, despite his serious medical condition which made his risk of escape very low. His family was not informed when they should have been when he was seriously ill. We do not consider that the prison paid all reasonable funeral expenses, a matter we have commented on in previous investigations into deaths at Full Sutton.

THE INVESTIGATION PROCESS

6. On 13 November 2012, notices were issued announcing the investigation to staff and prisoners at Full Sutton, inviting anyone who had relevant information to contact the investigator. No responses were received.
7. Another investigator visited Full Sutton on 19 November, collected the man's prison and medical records, met the Governor, Deputy Governor, a member of the Independent Monitoring Board (IMB) and the investigation liaison officer.
8. A clinical reviewer reviewed the man's clinical care in custody on behalf of the local PCT. The investigator interviewed staff on 9 January with the clinical reviewer.
9. HM Coroner for the County of York has been sent a copy of this report.
10. One of the Ombudsman's family liaison officers telephoned the man's brother to explain the investigation. His brother asked if he should have been admitted to hospital sooner, and if his eyesight was appropriately monitored and treated.

HMP FULL SUTTON

11. Full Sutton is a high security prison near York which holds up to 608 category A and B prisoners serving a minimum of four years. Healthcare services are commissioned through the local PCT. There are registered general and mental health nurses, as well as nurse prescriber (a nurse who is qualified to prescribe medication) and daily GP cover. There is an inpatient unit with six beds and 24 hour nursing cover.

HM Inspectorate of Prisons (HMIP)

12. HMIP conducted an unannounced full follow up inspection of Full Sutton in October 2010. The Inspectorate found that the healthcare nursing team was well qualified with a good skill mix. Although prisoners were dissatisfied with access to and care provided by prison doctors, the Inspectorate concluded that GP provision was excellent.

Independent Monitoring Board

13. Each prison has an Independent Monitoring Board (IMB) 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. The IMB annual report for 2010-11 praised the prison's high standard of healthcare through a period of considerable physical reorganisation.

Previous deaths at Full Sutton

14. The man's is the ninth prisoner to die at Full Sutton since February 2011. Six of the previous eight deaths were due to apparent natural causes, all of which found that the clinical care at Full Sutton was at least equivalent to community health provision. As in this case, two other recent investigations found that Full Sutton did not contribute appropriately to the cost of the funeral.

KEY EVENTS

15. The man was first remanded into custody for a serious offence on 12 January 2006, following an appearance at Court. In December 2007 he was sentenced to life imprisonment, with a minimum term of 20 years. He transferred to Full Sutton prison in December 2007 as a category A prisoner (those who would be highly dangerous to the public or national security if they escaped).
16. At his initial health screen, it was noted that the man had had Type 2 diabetes for 30 years. The doctor continued a prescription for metformin (to manage diabetes). He was given dietary advice and information about a smoking cessation group, but he said he wanted to continue smoking. He was referred for blood tests, which came back as abnormal, but he refused further investigation of these results.
17. In January 2008, the man assured healthcare staff that he was taking his diabetic medication as prescribed (failure to take it could have been a possible explanation for the abnormal blood test results). He said he had never had a “proper check-up” for his diabetes in the community, and agreed to be seen by a diabetic nurse and a diabetic consultant. He said that his vision was blurred and his legs felt cold. The prison doctor suggested changing his medication to improve his symptoms, but he was reluctant and agreed to think about it.
18. In June 2008, a diabetes consultant diagnosed the man with retinopathy (damage to the eye associated with diabetes) and referred him to an optician. The consultant took his blood pressure, which was high, so he prescribed lisinopril (blood pressure medication). By August, he had stopped taking lisinopril because he did not like the side effects. Over the next two months, he was seen weekly to monitor his blood pressure and diabetes. In October, he was prescribed losartan for his blood pressure, but said it made him feel dizzy and stopped taking that as well.
19. The man had regular healthcare appointments throughout 2009, but he often did not attend. He refused to have a diabetic retinopathy screening (eye test), but had diabetic reviews and blood tests. He was again offered help to stop smoking, but said he did not want to stop, despite several chest infections. At the end of the year, he was given new spectacles.
20. In May 2010, the man had a retinal screening, the results of which were abnormal and needed more investigation. On 4 June, he had an appointment at the eye clinic at hospital, but this was cancelled for unspecified security reasons and re-booked for 25 June. That appointment was cancelled by the hospital and he then refused to attend the rescheduled appointment, but did not give a reason. In October 2010, he asked to be referred back to the eye clinic as he was seeing black dots.
21. The man was still waiting for an appointment at the eye clinic in March 2011, so the prison doctor chased the appointment. The doctor noted he had high

blood pressure (but had not taken medication for this since 2009) and had poorly controlled diabetes and retinopathy. The doctor prescribed amlodipine which controlled his blood pressure to within normal limits over the next few weeks.

22. On 18 March, the man was seen in the eye clinic at hospital, and it was noted that he had signs of “proliferate diabetic retinopathy in need of urgent treatment”. He was supposed to have the treatment to his left eye on 30 March, but the appointment was cancelled three times by the prison (which was not noted in his medical record) and his consultant was concerned as he urgently needed the treatment. He refused to attend his next appointment on 23 April as he had not had breakfast. He was warned of the risks of not attending and the appointment was rescheduled.
23. The man eventually attended the eye clinic in June and had laser treatment to his left eye. He refused to attend the follow-up appointment and signed a disclaimer. He returned to the clinic for more laser treatment at the end of June. In August, the prison doctor gave him a patch for his left eye. He refused further laser treatment as he said it had reduced his short range vision, and then refused to attend a follow-up appointment as he said he did not feel well. He attended the rescheduled appointment, but again refused any treatment. In October, he went to hospital, where it was noted that the vision in his right eye had deteriorated and he was given a steroid injection in the eye.
24. The man suffered from broken skin on his right foot, which he said was from wearing shoes with no socks on. The wound was regularly cleaned and dressed by healthcare assistants throughout 2011.
25. In November, the man missed an annual diabetes review in the prison’s healthcare centre as he said he was unhappy about waiting to be seen, especially as he had fasted from the night before. Another appointment was booked, which he attended, but staff were unable to take a blood sample because he had not fasted

2012

26. On 4 January the man gave up his job in a prison work shop because of multiple health problems and failing eyesight. At a routine diabetes review on 10 February, the prison doctor recorded that he had stopped taking the medication for his diabetes because of side effects. He continued to smoke and eat food that he was advised not to, although he had been taking his other medication. He had a swollen leg, but said that he did not want to take diuretic tablets for this.
27. The man had an appointment at the eye clinic on 14 February, but this was cancelled. The reason for this was not recorded. He attended an appointment four days later and was prescribed drops for both eyes.

28. On 11 April, the prison doctor saw him because officers thought he might have had a stroke. He had a weakness on the left side of his face, slurred speech and appeared confused. He had raised blood pressure and the results of an Electrocardiogram (ECG) were abnormal. He was admitted to the prison healthcare centre where he seemed to improve. He regained his speech and was able to recognise people but was confused about the time and where he was. The prison doctor arranged for him to be admitted to hospital for assessment the next day.
29. The man was taken to hospital on 12 April but, before any tests could be carried out, he refused treatment and insisted on returning to prison. In the early hours of 13 April, he returned to prison and a nurse tried to assess him. The nurse described him as volatile and could not persuade him to see a doctor or be admitted to the healthcare centre that night. He signed a disclaimer and went back to the wing. The nurse asked officers to check him hourly and report any concerns to healthcare staff immediately. The nurse also made an appointment for him to see a doctor the next morning.
30. The next morning, the man told a doctor that there had been delays in arranging a computerised tomography (CT) scan and carotid artery doppler scan at the hospital. He said he had fallen over when going to the toilet and accidentally exposed himself, which had made him embarrassed so he wanted to leave the hospital. He had hurt his back and knee, which caused him pain when he moved around. The doctor recorded that he had recovered from the stroke and advised him to take painkillers. The doctor also said that he needed to control his blood pressure, weight and cholesterol better. The doctor said that he would arrange for him to have the tests he missed, but recorded that it was likely he would refuse surgery.
31. On 14 April, wing staff contacted the healthcare centre as they were concerned about the man. He appeared disorientated, was not making sense when he spoke and had difficulty understanding simple commands, such as raising his arms. He was persuaded to visit the healthcare centre as officers suspected he had had another stroke. He fell asleep as soon as he got into a bed in the healthcare centre. A doctor saw him a short time afterwards. He agreed that he had had a stroke, and he was to be admitted to the hospital stroke ward that day.
32. That evening healthcare staff telephoned the hospital for an update. They were told that the man was on the acute stroke ward and that his CT scan had not shown a bleed. They said he was being a difficult patient, using colourful language, and was not co-operating with nurses. The next morning, 15 April, he was diagnosed with a stroke and a chest infection.
33. On 19 April, against medical advice the man discharged himself from hospital and returned to the prison healthcare centre. He agreed to stay for one night, but wanted to return to the wing the next day. A doctor reviewed him the next morning. They discussed what had happened, but he said he would not change his lifestyle or adjust his diet. He returned to the wing that day.

34. The man developed a heel ulcer (as a result of poorly controlled diabetes) which became infected, and had problems with it throughout May, June and July. It was cleaned and dressed daily by healthcare staff and a doctor prescribed antibiotics. Sometimes he would not attend his appointments.
35. An appointment was made for the man to see an optician on 24 July due to his on-going eyesight problems, but he refused to attend.
36. On 3 August, a doctor saw the man as he wanted to take a photograph of his heel and refer him to a dermatologist. He refused all dietary advice and information about diabetes control. His heel had deteriorated, was sloughy, smelt offensive and had a reddened area approximately two centimetres deep. The dressing was changed daily, except when he missed a couple of appointments. On 16 August, a nurse (who usually dealt with his dressing) noted that his heel looked worse. She urged him to attend his appointments every day, but he said he did not like waiting in a holding cell, which prisoners waiting to see healthcare staff had to do.
37. A photograph of the man's heel was eventually taken on 23 August and sent to a diabetic podiatrist at the hospital for assessment. He was referred for vascular surgery, as he needed a heel debridement (removal of dead, damaged or infected tissue). The doctor arranged for admission to hospital on 24 August, but he could not go for operational reasons. He went to hospital on 29 August, but, against medical advice refused to have the procedure and returned to prison later that day. He continued to have his heel cleaned and dressed daily by healthcare staff.
38. A consultant at the diabetic clinic at hospital saw the man on 22 October. In a letter to a prison doctor, the consultant said that his diabetic control was acceptable, but noted that his foot ulcer had not healed and said he had advised him to stop smoking.
39. On 25 October, a nurse noticed that the man's heel looked much worse. As a result, a doctor arranged an emergency referral to hospital. It was agreed with a vascular surgeon at the hospital that he would be admitted for surgery on 29 October.

Admission to hospital

40. When the man was taken to hospital on 29 October, he went in a category A vehicle, accompanied by three officers and a senior officer. On the 'Escort Security Information Sheet', the prison noted that he was at risk of attempting to escape from custody and that he was violent. An escort risk assessment considered him to be a medium security risk to the public and of escape. The medical section of the form, which considers the prisoner's physical condition and health, noted that there were no medical reasons why restraints could not be used but did not address how his medical condition affected his risk. He was double cuffed to a prison officer and only the Director of High Security could give authorisation for restraints to be removed. When he arrived at the hospital, officers removed the double cuffs and used an escort chain instead

(a six foot chain with a hand cuff at each end, one attached to the prisoner and the other to an officer).

41. The next day, 30 October, the man had the debridement procedure. The escort chain was removed as soon as he was anaesthetised. It was planned that officers would use the chain again once he was out of theatre and before he became fully conscious.
42. A consultant vascular surgeon at the hospital recorded that the surgery involved a radical debridement of the man's heel to remove all dead and infected tissue. A report from the hospital noted that hospital staff had difficulty waking him from the anaesthetic and that he had developed an irregular heart beat for which he required amiodarone (tablets used for heart rhythm disorder). They had debrided his heel to the bone and it was likely he would require below the knee amputation. On 1 November the hospital reported that his condition had deteriorated and he was admitted to the Intensive Care Unit (ICU).
43. On 2 November, the surgeon said he would not operate while the man had such a bad chest infection and he remained in the ICU. At about 10.00pm, officers put the escort chain back on him, with the hospital's consent. He was moved to the High Dependency Unit on 3 November. By 5 November, his chest infection had developed into pneumonia and he was given intravenous antibiotics and oxygen. He was still restrained by an escort chain. On 6 November, his condition improved slightly. He was moved to a ward and was said to have been arguing with hospital staff.
44. On 10 November, the man refused to take antibiotics because they made him feel unwell. He was hypoxic (a condition in which the body (or brain) is deprived of adequate oxygen supply) but refused to keep his oxygen mask on. His condition deteriorated significantly. He was described as medically paralysed, unable to function and his breathing was managed via a ventilator. The last rites were administered. The escort record noted that he was unconscious and not expected to survive much longer. Prison staff carried out a further risk assessment and, at 9.30pm, permission was given to remove all restraints. It was noted that the escort chain should not be used again without permission of a duty governor. On 11 November, he returned to the ICU. He had had a cardiac arrest during the night. Arrangements were then made for his family to be told.
45. The man's family visited him and the prison appointed a family liaison officer (FLO) to liaise with the family because of the seriousness of his condition. The next day a consultant at the hospital said they were going to turn off the life support machine, which was done at 3.20pm and he died just over an hour later.
46. The FLO spoke to the man's next of kin and explained what happened when a prisoner died in custody. The funeral was held on 27 November. Initially it was going to cost £2,534, and the prison offered to contribute £1,500 towards

this. However, the family found another funeral director and the cost was reduced to £1,807. The prison still offered £1,500.

Allegations after the man had died

47. After the man had died, nurses at the hospital made a number of complaints about the prison escort officers as part of safeguarding concerns they had about a vulnerable patient. Nurses were concerned that officers had not re-applied his oxygen mask when he had discarded it. The aim of the safeguarding adults procedure is to both prevent abuse and provide protection to vulnerable adults and to promote their well-being. Anyone who has contact with vulnerable adults and hears allegations or has concerns about potential abuse and neglect has a duty to pass them on appropriately. These concerns are then taken forward by senior staff. The hospital held a safeguarding conference, with representatives from the prison and the local council, to discuss the allegations surrounding the treatment of the man by some prison staff, while he was in hospital.
48. These matters were referred to the police, who obtained statements from hospital staff. Although the police concluded that they would take no further action, the prison commissioned an investigation, conducted by a senior governor from another prison. The investigation has concluded and no safeguarding issues were identified or substantiated.

ISSUES

Clinical care

49. The clinical reviewer concludes that the man had regular diabetes checks, but noted he frequently refused to accept treatment or advice from healthcare staff. Diabetes can only be managed successfully if the person complies with treatment and changes his lifestyle, dietary and exercise habits. It was clear that he viewed his diet and smoking, as among the few enjoyable aspects of his existence in prison and had no intention of changing.
50. The man experienced a number of physical health issues during the three years before his death and were all caused, or exacerbated, by his poorly controlled diabetes. The occurrence of abscesses, the deterioration of his eyesight and problems with his feet are all common indicators for diabetes. The risks of stroke and heart disease and the frequency of medical amputations are considerably higher in people with diabetes. He was regularly reminded of these facts by clinicians, yet he chose not to follow the advice he was given about this.
51. The clinical reviewer finds that the man's healthcare while at Full Sutton was equivalent to, and in some ways in excess of, what would be expected in the community and that healthcare staff at Full Sutton discharged their duties professionally.

Cancelled hospital appointments

52. Although the man refused to attend hospital on a number of occasions, the appointments were also frequently cancelled by the prison or Prison Service Headquarters. On one such occasion, eye treatment was cancelled twice, despite the consultant's recommendation that the treatment was urgent. His first heel surgery was cancelled in August 2012. There is no record of the reason for these cancellations, beyond citing generic security or operational reasons. When prisoners' hospital appointments are cancelled, particularly for essential treatment, there should be fully documented reasons given and we make the following recommendation:

The Governor should ensure that hospital appointments are cancelled only as a last resort and that staff clearly record the reasons for cancellations.

Restraints

53. The man was a Category A prisoner, regarded as a medium risk of escape and danger to the public. In accordance with Prison Service Instruction (PSI) 03/2010 'Category A prisoners', in operation at the time, permission was sought from Prison Service Headquarters when restraints were to be applied and removed.

54. 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 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 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 also to be regarded as inhumane unless justified by other relevant considerations.
55. PSI 3/2010 sets out the requirements for risk assessing Category A prisoners. It confirms Full Sutton's local instruction that the Director of High Security must endorse the removal of restraints in all circumstances. The recently revised PSI 9/2013 requires that escort risk assessments must be regularly reviewed to ensure that any changes in the individual's clinical condition are taken into account. The level of restraint used on prisoners must at all times be proportionate to the perceived security risks.
56. Full Sutton kept comprehensive escort and risk assessment records which demonstrated that they assessed the man's risk and contacted the category A team whenever there was a change in his condition or location in the hospital. However, it is not apparent that medical opinion about his risk was sought. The category A team told the investigator that they rely on the prison's risk assessment and arrange authorisation for the removal of restraints once the prison advises that the prisoner's risk has reduced.
57. The escort chain was removed on 30 October when the man went under general anaesthetic. Officers put the chain back on him on 2 November, while he was still in the Intensive Care Unit. Three days later he was diagnosed with pneumonia and given intravenous treatment and oxygen all this was noted in the escort records, but he was still considered a risk of escape and to the public. The change of location/change of medical circumstances of the assessment included details of change of location in the hospital on 5 November but there was no record of a change in his medical circumstances and how this affected his risk. The escort chain remained in place until 10 November.
58. While the man's assessments were reviewed during his time in hospital it is apparent that his clinical condition was not given sufficient weight. Restraints were not removed until he was paralysed and very near death.

The Governor should ensure that risk assessments for prisoners in hospital fully take into account individual circumstances, including their

health, and are based on the actual risk the prisoner presents at the time.

Family Liaison

59. The man responded unexpectedly badly to surgery on 30 October and was admitted to the Intensive Care Unit. On the 9 November he received a visit from his family and on 10 November his condition deteriorated significantly and he was administered the last rites.

60. PSI 64/2011 Safer Custody requires:

“Where prisoners have a terminal illness or suffer an unpredicted and/or rapid deterioration in their physical health, prisons must have in place procedures for supporting the prisoner, engaging with their next of kin or nominated person and providing support for staff.”

61. As well as the procedures in PSI 64/2011 – Prison Rule 22(1) states:

‘Notification of illness or death

’22 – (1) If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner’s spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed.’

We consider that when the man was first admitted to the hospital’s intensive care unit on 1 November, he should have been regarded as seriously ill and his family contacted at that stage. They should certainly have been informed on 10 November when he was so ill he was given the last rites yet they were not telephoned until 11 November. We make the following recommendation:

The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible.

Funeral expenses

62. PSI 64/2011 provides the following instruction with regard to funeral costs:

“Prisons must offer to pay a contribution towards reasonable funeral expenses of up to £3000.”

63. The PSI provides examples of which costs and services might be considered as reasonable for the prison to pay. The funeral cost a total of £1,807, and Full Sutton contributed £1,500. With the exception of the organist’s fee of £90, all the other costs are described as reasonable in the PSI. We asked the prison to explain the basis for the decision to pay £1,500 which they have not provided. In a previous case they paid the same amount which they said was based on an average of other funeral costs paid, which we considered

inappropriate. Although it was reported that the family were grateful for the money they received for the funeral, we do not consider that the prison paid all reasonable funeral expenses.

64. We have raised the issue of funeral expenses in other investigations at Full Sutton in July and September 2012, and make a similar recommendation here.

The Governor should ensure that an appropriate contribution of up to £3,000 is made towards a family's reasonable funeral expenses.

RECOMMENDATIONS

1. The Governor should ensure that hospital appointments are cancelled only as a last resort, and that staff clearly record the reasons for cancellations.

Accepted – Hospital escorts are only cancelled as a last resort and there are a number of cases whereby despite knowledge of the prisoner these appointments are risk assessed and undertaken. PSI 9/2013 notes that in such cases a Dynamic Risk assessment is carried out. Although this has been the case the only recording is in the security diary which does not include the reasoning. The security diary will be updated to include reasons for any cancellation.

2. The Governor should ensure that risk assessments for prisoners in hospital fully take into account individual circumstances, including their health, and are based on the actual risk the prisoner presents at the time.

Accepted – PSI 9/2013 NSF A Function Annex B outlines 7 questions regarding the suitability for medical appointments by doctor or healthcare manager. These prescriptive questions form the risk assessment which is now in place for category A prisoners at Full Sutton. The ‘gist’ of these will be transposed to the management check to ensure that the manager visiting the patient seeks clarification that the cuffing arrangements are proportionate to the risk posed of escape and to the public.

3. The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible.

Accepted – PSI 9/2013 and PSI 64/2011 notes ‘Liaison between the prison and the category A prisoner’s family should not normally occur, however where contact is considered it must be balanced against the security risk that this would create.’ The term seriously ill is subjective and the deterioration of the man’s condition was rapid. Previous behaviour including abusive and threatening behaviour to the prison and nursing staff had resulted in him return to prison. Full Sutton will continue to comply with the PSI and balance the risks such contact would make. A decisions log will be included to ensure that the reasons are outlined and documented including intelligence reviews and police contact.

4. The Governor should ensure that an appropriate contribution of up to £3,000 is made towards a family’s reasonable funeral expenses.

Full Sutton responded that each case will be managed on its own merit in line with PS policy.