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 April 2013**

## *Our Vision*

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

This is the report of an investigation into the death of a prisoner at HMP Full Sutton, who died on 26 April 2013. The cause of the man's death was congestive cardiac failure and bowel ischaemia with underlying ischaemic and hypertensive heart disease. He was 58 years old. I offer my condolences to those who knew the man.

An investigator carried out the investigation and a Clinical Reviewer conducted a review of the man's clinical care in prison. HMP Full Sutton cooperated fully with the investigation.

The man had been in prison for 22 years. He had been diagnosed with a heart condition and other chronic ailments before his imprisonment. Healthcare staff at Full Sutton put in place a heart disease management plan, which was regularly reviewed by a multi-disciplinary team in consultation with the man. An end of life care plan was used when his condition was judged to be terminal.

Although the man often refused to take his medication or comply with medical advice and frequently declined treatment, staff remained encouraging towards him throughout and offered appropriate treatment. We consider the healthcare he received at Full Sutton was at least as good as he could have expected had he been in the community. However, I am concerned that restraints used for hospital escorts were not always justified by fully considered risk assessments. Nevertheless, I am satisfied that, overall, the man received good quality care from both discipline and healthcare staff while at Full Sutton.

**Nigel Newcomen CBE**
**Prisons and Probation Ombudsman** **March 2014**

**CONTENTS**

## SUMMARY

1. The man had suffered chest pains for many years before his remand into custody on 23 June 1990. He also had a number of other chronic medical conditions.

2. During his imprisonment, the man was diagnosed with ischaemic heart disease and hypertension. Healthcare staff at Full Sutton started a coronary heart disease management plan which they regularly reviewed and updated. However, the man repeatedly failed to cooperate with taking his prescribed medication and frequently refused to attend appointments in both the prison's healthcare department and hospital. When he did attend, he would often leave before he was seen or discharge himself from hospital if admitted as an inpatient.

3. The man's heart condition deteriorated over time and, on 18 March, one of the prison doctors advised him that his future care would be palliative. Staff began palliative care two days later and put in place an end of life care plan. On 21 April 2013, following repeated refusal, he agreed to be admitted to the inpatient unit at the prison. The man's condition continued to deteriorate and, on 24 April, he was sent to hospital by emergency ambulance for the insertion of a catheter. A short time later, against the advice of hospital and prison staff, the man demanded that the catheter be removed. He discharged himself the next day.

4. The man died at 2.02pm on 26 April and his next of kin, a serving prisoner was informed later that day. Full Sutton arranged the man's funeral and paid the funeral expenses.

5. Owing to his poor compliance with medication and treatment plans and his refusal to remain as an inpatient in the healthcare wing or hospital, the man was not an easy patient to treat. (For these reasons, staff were unable to establish a prognosis that would support a credible application for early release on compassionate grounds.) Nevertheless, the investigation found that the man received good care at Full Sutton. The clinical reviewer notes that staff gave a lot of time and effort to try and help him receive the right care in the right place at the right time and considers his care was equivalent to, and in some instances better than, that which he could have expected in the community.

6. Although the man had poor mobility and was assessed as a low risk of escape, restraints were used for hospital stays after he was diagnosed as terminally ill and were sometimes retained during treatment. We consider that risk assessments need to take into account a prisoner's individual circumstances, particularly their health and mobility and we make a recommendation on this issue.

## THE INVESTIGATION PROCESS

7. Notices were issued announcing the investigation to staff and prisoners at Full Sutton, asking anyone with relevant information to contact the investigator. No one came forward.

8. The investigator visited Full Sutton on 30 April 2013. He met the manager of the wing where the man lived and spoke to staff and prisoners. He also received copies of the man's prison records, including his medical record. On 28 June, the investigator returned to the prison with the clinical reviewer and interviewed three members of staff. He wrote to another member of staff to obtain additional information. The investigator gave preliminary feedback on the investigation to the Governor.

9. Surrey Primary Care Trust (now NHS Surrey) asked a Clinical Reviewer to review the man's clinical care at the prison. She was given all relevant documents to assist her review and a copy of her report has been annexed.

10. The investigation report has been sent to the Coroner to assist his enquiries into the man's death.

11. One of the Ombudsman's family liaison officers contacted the man's next of kin to explain the investigation process. He raised an issue which did not come under the remit of the investigation. Therefore it was addressed in separate correspondence.

## HMP FULL SUTTON

12. HMP Full Sutton, in York, is a maximum security prison holding approximately 600 category A and B adult male prisoners serving a minimum of four years. Healthcare services are commissioned by NHS England, Wakefield Area Team. In addition, the healthcare department uses Telemedicine, a service supplied by Airedale NHS Trust. Telemedicine provides remote video consultations between patients and healthcare professionals, reducing the need for admission to hospital. There are registered general and mental health nurses, as well as a nurse prescriber (a nurse who is qualified to prescribe medication) and daily GP cover. In addition to an inpatient unit with six beds and 24 hour nursing cover, there is a palliative care suite.

## HM Inspectorate of Prisons

13. The inspectorate conducted a full announced inspection of Full Sutton in December 2012. Inspectors found that the healthcare nursing team was well qualified with a good skill mix. There was a palliative care policy, a dedicated palliative care room in the healthcare unit and good links with local Macmillan cancer patient support services.

14. The Inspectorate concluded that Full Sutton had the foundations of a generally safe environment and prisoners were treated as decently as the necessary constraints allowed.

## Independent Monitoring Board (IMB)

15. Each prison in England and Wales has an Independent Monitoring Board made up of unpaid volunteers from the local community who monitor standards to help ensure prisoners are treated fairly and decently. In its most recent annual report, for the period January to December 2012, the IMB reported that terminally ill prisoners were appreciative of the treatment they had received.

## Previous deaths at HMP Full Sutton

16. The man's death was the fourth from natural causes since 2012. We have previously made recommendations to Full Sutton about risk assessments and restraints and there are similar concerns in this report.

## ISSUES

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

17. The man was convicted of sexual offences and remanded into custody on 23 June 1990. He was subsequently sentenced to life imprisonment, with a tariff of six years (the minimum amount of time the man would spend in prison). He arrived at HMP Full Sutton in 2005.

18. The man had suffered chest pains since his early twenties. He had also been diagnosed with several other chronic medical conditions for which he received treatment. In 1999, there was a suggestion of ischaemic heart disease and in 2003, hypertension (raised blood pressure). There is no record of when the diagnosis of ischaemic heart disease was confirmed but on 8 October 2007 one of Full Sutton's GPs, noted the diagnosis. Throughout the following years, healthcare staff monitored and treated the man's medical conditions, using a formal coronary heart disease management plan. They also advised him to stop smoking but he refused to do so. The man frequently attended the healthcare centre but often failed to take his medication or attend follow up appointments.

19. The man's chest pain continued. He had a number of severe episodes, including difficulty breathing but when wing officers called medical staff, he refused to be taken or admitted to the healthcare unit. There are frequent entries in his medical record indicating his refusal to attend for tests or treatment and failing to take his medication.

20. On 3 December 2012 the GP noted that the man had some swelling in his leg. Subsequent blood tests and an electrocardiogram (ECG) showed some abnormality. The GP discussed the results with a cardiologist at Airedale Hospital, West Yorkshire, via the Telemedicine facility and they decided that the man should be admitted to hospital. The GP then contacted a cardiologist at York Hospital, who admitted the man the same day for further tests. However, two days later he discharged himself against the advice of nurses and the prison staff escorting him.

21. On 15 December, another of the GPs at Full Sutton, noted that the man's condition had deteriorated further. He was increasingly short of breath and his legs, genitalia and abdomen were swollen due to fluid retention. The GP considered that the man was in established cardiac failure. He contacted a registrar at York Hospital and arranged to admit the man the same day. Hospital staff diagnosed a chest infection and, to help relieve his fluid retention, they inserted a catheter. The next day, the man once again discharged himself from hospital against medical advice. On his return to Full Sutton, he demanded that the catheter be removed.

22. At a consultation on 14 January 2013, the man told the GP that he was no longer taking the medication for his cardiac condition. The GP advised the man against this and referred him for a cardiology appointment at York Hospital.

23. On 18 January 2013, a Nurse from the mental health in- reach team (MHIRT) spoke to the man, about his refusal to attend appointments or be admitted to healthcare for observation and treatment, as well as discharging himself from hospital. The man replied that he would not attend any of his hospital appointments. He was fully aware of their importance but he was "not bothered". The Nurse followed up that consultation on 31 January, when she again encouraged the man to engage with secondary care providers and to consider admission to healthcare. The man repeated that he understood the possible implications of his actions but "he was not afraid to die". After that discussion, he agreed to attend future appointments but still failed to do so. Despite his apparent lack of interest, healthcare staff continued to make every effort to encourage the man to attend appointments.

24. The man agreed to be admitted to healthcare for general observations on 22 January. He said he would take all his prescribed medication, including those for his cardiac condition and staff gave him nicotine lozenges as a substitute for cigarettes. On 28 January, he told one of the healthcare staff that he planned to start the smoking cessation course the following week, but he discharged himself from the healthcare unit later that evening, giving the restrictions on smoking as his reason.

25. On 18 March, a GP at Full Sutton, noted that the man looked 'frail and bloated in his wheelchair', was breathless and his voice was weak. He also recorded that the man had swelling in his legs and scrotum and that the swelling was leaking. The man told Dr Billingsley that he was concerned that he had throat cancer, like his father. They discussed a referral to hospital for tests but the man said he did not want to know. The GP concluded that the man had heart failure and possible cancer. The next day, the man declined his medication and further investigations.

26. The clinical reviewer concludes that, following the man's worsening symptoms, both wing and healthcare staff encouraged him to cooperate with efforts to determine his diagnosis and comply with treatment. In view of his existing psychological conditions, mental health evaluations were conducted but found no mental incapacity in relation to making informed choices. We agree with the clinical reviewer's judgement that in spite of the man's non-compliance, his diagnosis was both prompt and appropriate.

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

27. The man had longstanding medical conditions, which doctors at Full Sutton regularly reviewed. He saw the GP on several occasions, when they would have frank conversations about his health, the impact of his smoking and non-compliance with treatments offered to him. When they met on 18 March 2013, the GLP informed the man that form that time forward his care was then to be palliative rather than curative. He also advised him what to expect as his illness progressed.

28. We are satisfied that despite the man's reluctance to engage with medical care, he was kept fully informed about his condition and given information on the treatment options and progression of his illness in a considerate and timely manner.

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

29. Numerous entries in the man's medical records refer to his refusal to engage with both prison healthcare and secondary care providers, as well as non-compliance with his medication. He often attended appointments at hospital, following referrals by GPs at Full Sutton, only to discharge himself before being seen. He signed appropriate disclaimers. Latterly, his refusal seemed to be partly influenced by his belief that he had cancer and he did not wish to undergo tests to establish whether this was the case.

30. After he was told that his treatment would be palliative in March 2013, he continued to refuse admission to the healthcare unit and discharged himself from hospital two days after an emergency admission on 11 April. When he returned to the prison, he declined the offer of admission to the healthcare unit.

31. All actions relating the man's care were documented and it is clear that staff were thorough in their care. In particular, his non-compliance with medical advice was repeatedly considered and alternative options offered. The clinical reviewer judges that the man's assessed healthcare needs were met and we agree.

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

32. For a number of years, doctors had prescribed medication for the man's heart-related and other medical conditions. These included painkillers for moderate to severe pain. The clinical reviewer reviewed his prescription records and it is well-documented that, as the man's condition worsened, his medication was reviewed and amended regularly.

33. The man's next of kin told our family liaison officer that he was concerned about the arrangements for storing medication. The investigation found that owing to the man's refusal to cooperate with taking his medication as prescribed, as well as suspected abuse of painkillers, healthcare staff arranged for him to be given his medication daily.

34. At 10.44am on 26 April 2013, in view of the man's continued deterioration and inability to swallow, the decision was taken to administer his medication by syringe driver (a small, lightweight, battery-powered pump which administers pain relief under the skin). Unfortunately, although this decision was timely, the man became so agitated that the syringe driver could not be used.

35. We are satisfied that the man's pain relief was well-managed. Healthcare staff were responsive to his needs and gave him pain relief as required, despite his failure to cooperate with taking it as prescribed.

**Liaison with the man's family**

36. The man had no contact with his family while in prison. Prison records show that his nominated next of kin was a fellow prisoner who had previously been his carer at Full Sutton but had since moved to HMP Frankland.

37. A Principal Officer introduced himself as the man's family liaison officer on 22 March 2013. An Officer took over the role of family liaison officer a few days before the man's death. They discussed his family and he told the officer that he would like his sister to visit him but he had lost contact with her. The Officer contacted several agencies in an attempt to trace the man's sister, without success.

38. On 26 April 2013, the family liaison officer another family liaison officer at HMP Frankland, to advise her of the man's condition and ask her to inform his nominated next of kin. She arranged for two members of the chaplaincy team to tell the man's friend that he was seriously ill and not expected to survive. The man died at 2.02pm. Later that day, his friend was informed of his death by his personal officer at Frankland.

39. The man's funeral was held on 15 May. The service was conducted by one of the chaplaincy team, A Reverend, and was attended by staff from the prison. In line with national guidance, Full Sutton met the costs of the funeral.

40. We are satisfied that good efforts were made to try to locate the man's sister when his wishes changed and that the notification to his nominated next of kin was timely and sensitively handled.

**The man's location**

41. The man persistently declined offers of admission to the healthcare unit, preferring instead to remain in his residential wing for as long as possible, where he had the support of friends and staff he knew. He also had assistance from carers (fellow prisoners who assisted him with his everyday needs) and his care plans were centred on delivering care on the wing, enabling him to remain there as long as possible. During his consultation with a GP on 18 March, when the man was informed that his condition was terminal, they once again discussed the issue of admission to the healthcare unit but the man was adamant that he wished to remain in his residential wing.

42. As his condition deteriorated, and it became clear that he required more care than could be given on his wing, staff repeatedly advised the man to move to the healthcare wing. He refused as it was a non-smoking area. To assist

him, healthcare staff offered the man nicotine replacement medication and smoking cessation advice, but he declined all offers of help to stop smoking.

43. On 21 April 2013, the man was reviewed after passing out. After a conversation with a Nurse, he agreed to move to the inpatient unit within the healthcare wing. He was given the biggest cell, closest to the nurses' office.

44. It is appropriate that terminally ill patients are involved in decisions about their location. Throughout his illness, the man's wish was to remain in his wing and this was facilitated by the staff at the prison. We are pleased to note that the man was accommodated according to his wishes and good efforts were made to meet his needs.

**Compassionate release**

45. Early 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 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).

46. An application for early release on compassionate grounds was made for the man on 27 March 2013. However, as he had failed to cooperate with secondary care providers, the GP could not be specific about the man's prognosis when completing the medical section of the application. The lack of information in relation to the man's life expectancy, coupled with his lack of commitment to reducing his risk of re-offending led to the refusal of his application.

47. On 24 April, the Officer informed the man that his application had been refused. He noted that the man was not surprised and took the news well.

48. The man's application for compassionate release was made shortly after he was told that his future treatment would be palliative only. We believe it was timely and it seems that his lack of engagement contributed to its refusal.

**Palliative care**

49. On 18 March 2013, during a frank conversation about his prognosis, the doctor told the man that his future care would be palliative as opposed to

curative. The man acknowledged that he was very unwell.

50. When a patient with a terminal illness reaches the final stages of their life, healthcare staff at Full Sutton use a care plan to ensure that everything possible is done for the patient in accordance with their wishes. On 20 March, the man's existing care plan was altered to reflect the change to palliative care. A Nurse started the Care Pathway for the Dying Patient. This was tailored to suit the man's requirements, regularly updated and reviewed as his condition deteriorated. Specialist nurses managed his palliative care and healthcare staff also produced a management plan to help wing staff support him.

51. The man agreed to move to a cell in the inpatient unit on 21 April, five days before his death. The next day, he told the GP that he intended to remain in the unit and did not want to move back to the wing. The GP asked him about resuscitation in the event of cardiac failure and the man confirmed that he did not wish to be resuscitated. The GP made a note of this in the man's prison records and gave him some time to think about it but he died before the relevant documents could be signed.

52. On 24 April, a GP recorded that the man was entering the terminal phase and should be given oral morphine as often as necessary, at the discretion of nurses. A multi-disciplinary meeting was held the next day to discuss the man's care. He was present and able to contribute to the decision-making about his care and location.

53. Entries in the man's medical record indicate that staff followed the end of life pathway and that medication was given in accordance with his care plan.

54. The clinical reviewer considers that the man's palliative care was well-coordinated and regularly updated. There is evidence in his medical records that he was involved in multi-disciplinary meetings to discuss his care. In addition, staff respected his wish to remain in his residential wing for as long as possible. We agree that the man's palliative care was carefully managed and conclude that he received a good level of person-centred care.

**The use of restraints**

55. The Prison Service has a duty to protect the public when escorting prisoners to hospital and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that a medical opinion regarding the prisoner's ability to escape must be considered as part

of the assessment process. It deemed that handcuffing a prisoner receiving chemotherapy (and, by implication, other life saving treatment) was degrading and that such restraint would be likely to be regarded as inhumane unless justified by other relevant considerations.

56. The investigator examined the risk assessments and escort logs for several of the man's hospital visits. On 15 December 2012, staff completed a risk assessment before the man left the prison for a medical assessment at York Hospital. He was assessed as low risk of escape and to escort staff and medium risk to the public and hospital staff in the event of an escape. In the healthcare section of the form, staff recorded no objections to the use of restraints. He was accompanied by three prison staff, who were instructed to use double handcuffs (two pairs of handcuffs; one to cuff the prisoner's wrists together and one to cuff one of his wrists to that of an officer). While receiving treatment, using the toilet or eating a meal, the man's wrists were handcuffed together but the handcuff to the officer was replaced by 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).

57. On 11 April 2013, the man was admitted to hospital as a result of tightness in his chest and shortness of breath. His risk was assessed at the same levels as those described previously and, aside from being accompanied by two officers, the escort arrangements and restraints remained the same. Information from healthcare staff about the man's deteriorating condition was taken into account when determining the number of staff required but the level of restraint remained the same as his previous risk assessment.

58. On 25 April, the day before his death, the man was again admitted to hospital as an emergency. The level of risk was the same as the previous occasions and he was accompanied by three officers. It is clear from staff entries in the escort log that during this admission, the man remained double cuffed while in bed. Staff used an escort chain while he was eating, using the toilet or receiving treatment, including during the insertion of the catheter.

59. On all the risk assessments mentioned, the justification for the level of restraint was that the man was a rude and aggressive individual who was often non-compliant. The risk assessment document that is completed before a prisoner leaves the prison contains the following statement:

> *" … The decision that a prisoner remains double cuffed while in bed must take account of the security and control risks set against the need to maintain decency. There must not be a blanket application where all prisoners are double cuffed unless there is a reason not to, or where all prisoners are single cuffed unless there is a reason to double cuff. Risk assessments must still be carried out on an individual basis …"*

60. Prison Service guidance is that restraints are not normally necessary for an escort when the prisoner's mobility is severely limited. The man had a

serious heart condition which was known to be life limiting. As the man's condition deteriorated, he often needed a wheelchair to get about and by the time the latter two appointments took place, he was known to be terminally ill.

61. British Medical Association guidance is that there should be a presumption that prisoners are examined and treated without restraints, unless there is a high risk of escape or the prisoner represents a threat to himself, the health team, or others. We acknowledge that public protection is paramount, but security measures must be proportionate to a prisoner's individual circumstances. The man had been assessed as a low risk of escape and a medium risk should he do so. In the light of the severity of his condition and his lack of mobility, we do not consider the risk he presented warranted the use of double handcuffs or an escort chain during invasive procedures. We therefore make the following recommendation:

**The Governor should ensure that risk assessments for prisoners taken to hospital are completed fully, take into account individual circumstances, are updated regularly and are based on the actual risk the prisoner presents at that time. Unless there are exceptional circumstances restraints should not be used during invasive treatment.**

**ACTION PLAN**

| No | Recommendation | Accepted/Not Accepted | Response | Target date for completion | Progress (to be updated after 6 months) |
|---|---|---|---|---|---|
| 1 | The Governor should ensure that risk assessments for prisoners taken to hospital are completed fully, take into account individual circumstances, are updated regularly and are based on the actual risk the prisoner presents at that time.<br>Unless there are exceptional circumstances restraints should not be used during invasive treatment. | Accepted | The Governor will ensure an updated risk assessment is carried out by the Security department following any change in an individual prisoner's circumstances as advised by escort staff.<br>This will be measured against future prisoner risk assessments for routine and in particular seriously ill prisoners requiring outside hospital treatment<br>Restraints will not be routinely applied during invasive treatment and any application of restraints will be risk based. This will be reviewed daily as part of every management check. | 31 October 2013 | |