Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Orme, a prisoner at HMP Full Sutton, on 12 June 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr John Orme, a prisoner at HMP Full Sutton, died of internal bleeding and cirrhosis of the liver in hospital, on 12 June 2015. He was 52 years old. I offer my condolences to Mr Orme's family and friends.

There was a slight delay in sending Mr Orme to hospital in the early hours of 12 June, while a nurse clarified with GPs, the implications of an advance directive Mr Orme had signed about his future care. Better communication about the conditions of the directive might have avoided this. However, I am satisfied that, although Mr Orme did not always cooperate with treatment plans, overall, he received a good standard of care at Full Sutton.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in the investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **December 2015**

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Summary

Events

1. In March 2010, Mr John Orme was sentenced to 15 years imprisonment and taken to HMP Full Sutton. He had cirrhosis of the liver and hepatitis C, which was probably the result of previous excessive alcohol consumption and substance misuse (he had been an intravenous drug user).

2. Mr Orme often declined to attend healthcare appointments in the prison and at hospital. He often refused treatment and did not always take his prescribed medication.

3. In April 2010, a prison GP referred Mr Orme to an infectious disease specialist, but he refused to have a liver biopsy. Initially, he did not cooperate with treatment plans. In March 2011, he began a course of injected antiviral medication to try to slow down the rate of liver damage. The treatment was unsuccessful and ended three months later.

4. The specialist continued to review Mr Orme's condition, with six-monthly blood tests and yearly ultrasound scans. In August 2012, an endoscopy examination of his oesophagus showed 'barely noticeable' varices (enlarged veins that can rupture and are common in people with liver disease). Mr Orme's liver function continued to deteriorate, but he often declined to see his consultant and continued to take his medication irregularly.

5. In November 2014, Mr Orme submitted to the healthcare team, an advance directive for the refusal of treatment (sometimes known as a living will). It set out how he wanted his body should be treated before and after dying, consistent with his Buddhist beliefs. This included an order that he should not be resuscitated if he was unable to breathe or his heart stopped working. Mr Orme discussed this with a prison GP and eventually signed an agreed version in May 2015.

6. At 11.00pm on 11 June 2015, Mr Orme told a nurse he had vomited blood. After examining him, the nurse telephoned the out of hours GP, who advised her to monitor him and call again if his condition deteriorated. At about midnight, Mr Orme vomited more blood and the nurse called the GP again. The nurse's understanding of the doctor's advice was that she should keep Mr Orme comfortable and not to call an emergency ambulance, because of the advance directive. The doctor believed she had agreed to discuss this with a doctor who had been treating Mr Orme.

7. The nurse telephoned a prison GP, who knew Mr Orme and was familiar with the details of the advance directive. The GP advised her to send Mr Orme to hospital immediately.

8. Prison staff called an emergency ambulance and after further discussion with the prison GP, they took Mr Orme to York District Hospital at 1.30am.

9. In the afternoon of 12 June, a prison family liaison officer informed Mr Orme's wife that he was seriously ill in hospital. The prison arranged transport to take her to the hospital the next day but, sadly, Mr Orme died that evening.

Findings

10. The clinical reviewer was satisfied that, overall, the care Mr Orme received at Full Sutton was of a high standard and equal to that he could have expected in the community. However, she was concerned that on the night of 11/12 June, the out-of-hours doctor did not give sufficient active support and that the complexity of the advance directive led to some confusion and delay until the nurse was able to clarify this with a prison GP. The prison did not inform Mr Orme's wife of his admission to hospital until the afternoon of 12 June. As he was seriously ill, we consider they should have informed early that day.

Recommendations

- The Head of Healthcare should ensure that whenever there is serious concern about a prisoner's condition at night, admission to hospital should be considered, discussed and documented. When there are grave concerns about a prisoner's immediate health, an ambulance should be called without the need for GP advice or assessment.

- The Governor and the Head of Healthcare should ensure that advance directives are clear and that prisoners' decisions about life saving treatment in an emergency are effectively communicated to all relevant staff.

- 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 so that they are able to visit them in hospital without unnecessary delay.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Full Sutton informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

12. The investigator visited Full Sutton on 17 June 2015. He obtained copies of relevant extracts from Mr Orme's prison and medical records.

13. The investigator interviewed a member of staff on the telephone on 8 July and obtained a statement from a nurse.

14. NHS England commissioned a clinical reviewer to review Mr Orme's clinical care at the prison. The clinical reviewer has made a number of recommendations in her review, which the Head of Healthcare will need to address.

15. We informed HM Coroner for East Riding and Kingston upon Hull of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

16. One of the Ombudsman's family liaison officers contacted Mr Orme's wife to explain the investigation. She had no specific concerns, but wanted to know about her husband's treatment in prison.

17. Mr Orme's wife received a copy of the initial report and indicated that she was happy with the findings.

18. The initial report was shared with the Prison Service. There were no factual inaccuracies and the action plan has been appended to this end report.

Background Information

HM Prison Full Sutton

19. HMP Full Sutton is a high security prison near York, which holds up to 626 men. Healthcare services are commissioned through the Yorkshire and Humber Area Team of NHS England and, since 1 June 2015, are provided by Spectrum Community Health. (They were previously provided by the prison.) There is daily GP cover and registered general and mental health nurses, as well as a nurse who is qualified to prescribe medication. From 7.30pm, there is a single nurse on duty and GP cover is provided by a community out-of-hours service. There is an inpatient healthcare unit with six standard and two safer custody beds, and a palliative care suite.

HM Inspectorate of Prisons

20. The most recent inspection of HMP 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. Inspectors described the inpatient healthcare unit as satisfactory and patients were positive about the quality of care they received.

Independent Monitoring Board

21. 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 annual report for the year to October 2014, the IMB noted that the healthcare unit continued to provide a comprehensive service in all areas of primary care.

22. Uncertainty about the change to a new healthcare provider meant that some healthcare staff had left the prison, leaving several posts in primary care, dialysis, mental health and pharmacy unfilled.

Previous deaths at HMP Full Sutton

23. Mr Orme was the seventh prisoner to die of natural causes at Full Sutton since the start of 2013. There were no significant similarities with the circumstances of the previous cases.

Key Events

24. On 4 March 2010, Mr John Orme was sentenced to 15 years imprisonment for attempted rape and false imprisonment. He moved from HMP Preston to HMP Full Sutton a week later, on 11 March.

25. On 12 March, a prison GP noted that Mr Orme had several medical conditions, including hepatitis C, a history of depression, as well as previous alcohol and intravenous drug misuse. He told the GP that in 2009, he had been treated for a pulmonary embolism (a blockage in the artery that transports blood to the lungs) and an MRI scan had indicated advanced cirrhosis of the liver. He said that he had recently been referred to a gastroenterology specialist due to abdominal pain.

26. The GP recorded that Mr Orme looked pale and unkempt, and his abdomen was swollen due to ascites (the build-up of fluid in the abdomen). He diagnosed alcoholic cirrhosis and arranged a CT scan of Mr Orme's abdomen and chest, and blood tests for hepatitis and HIV.

27. Mr Orme said he had used herbal medication before he went to prison, which he had bought on the internet. The prison would not allow him to continue this, as it was unregistered and unlicensed. Mr Orme initially refused to give a sample of blood, or to engage with prison medical staff until they agreed to his request. However, on 1 April, he had a CT scan, which confirmed cirrhosis. He eventually agreed to blood tests in June, but continued to refuse treatment over the following months and his liver function deteriorated. Doctors prescribed gabapentin (an anticonvulsant sometimes used to treat nerve pain).

28. On 31 January 2011, a visiting consultant in infectious diseases suggested to Mr Orme that weekly injections of the antiviral drugs, peginterferon and ribavirin, might slow down the rate of liver damage. In line with national guidelines, if there was no improvement within three months, the treatment would stop. Mr Orme agreed to the treatment, which began on 24 March and included a hepatitis C care plan with weekly blood tests, but his condition did not improve. On 3 June, after a multidisciplinary team meeting and advice from two hospital consultants, a prison GP stopped the treatment. On 26 July, the consultant in infectious diseases explained to Mr Orme that the chances of a successful cure were negligible but there were significant risks associated with continued treatment.

29. On 30 January 2012, the consultant in infectious diseases reviewed Mr Orme and noted he was generally well and that he should continue to have cirrhosis screening, including an annual ultrasound scan, a gastroscopy (to examine the inside of his stomach) and six-monthly blood tests. He agreed to review him again later in the year.

30. Mr Orme asked for a second opinion on treatment for his liver condition and on 23 April, he saw a consultant gastroenterologist at York District Hospital, who explained that new hepatitis C treatments had been licensed and had a success rate of around 30-40 percent. He asked Mr Orme to consider participating in a trial of the new treatment. On 4 July, Mr Orme told the consultant in infectious diseases he was not interested in having further conventional treatment. The consultant explained he could not receive the alternative therapies that Mr Orme

had taken before he went into prison, but he should continue to have regular liver screens.

31. On 26 July, the consultant in infectious diseases contacted one of the prison GPs as a recent scan of Mr Orme's liver had identified a lesion (an area of damaged or abnormal tissue) that possibly indicated hepatocellular carcinoma (liver cancer). He recommended an MRI scan and further tests, which were conducted over the following months. On 3 October, the consultant confirmed the lesion was a harmless benign tumour.

32. On 3 December, the consultant in infectious diseases reviewed Mr Orme, who said he had general abdominal pain, often with diarrhoea, but an examination of his abdomen revealed no concerns. He recorded that Mr Orme's cirrhosis was stable, with only minimal varices. Mr Orme repeated that he did not want conventional treatment and the consultant said he would continue to see him occasionally.

33. At his annual review on 2 December 2013, the consultant in infectious diseases noted that Mr Orme's cirrhosis remained stable but he required up-to-date blood tests and a further ultrasound scan. He agreed to see him again in six months to discuss new drugs. The scan, in 14 January 2014, showed evidence of cirrhosis and an enlarged liver (as expected for someone with his condition).

34. Healthcare staff saw Mr Orme frequently over the next six months for a number of other, unrelated medical problems. He missed a number of appointments as he said he felt under threat from other prisoners and did not feel safe going from his wing to the healthcare centre. (In November 2013, another prisoner had stabbed and seriously wounded Mr Orme. He subsequently gave evidence in court.) Prison officers agreed to accompany Mr Orme to the healthcare centre and remain with him during his examination but this did not always satisfy him and he refused to move to a different cell where officers could have given him greater support. Prison intelligence information suggested that his problems might be due to involvement in trading medication. On 4 August, he refused to attend the healthcare centre for a planned appointment with the consultant in infectious diseases. Blood tests and scans showed further deterioration in his liver function.

35. On 17 November, Mr Orme completed an advance directive for the refusal of treatment, which explained the medical treatment he wanted if, for any reason in the future, he lacked the mental capacity to make decisions about his medical care. This included several requests about the treatment of his body during the dying process and after his death, in keeping with his Buddhist beliefs. He acknowledged that some of these arrangements could not be accommodated as a prisoner.

36. The advance directive was a complex document which also covered Mr Orme's wishes about resuscitation. He asked to die naturally with no attempt at resuscitation and no use of life support machines. It included the statement, "I do not wish to have cardiopulmonary resuscitation if I am likely to be in the dying process and if such action is likely to be medically futile". Mr Orme made it clear that while he remained conscious and had capacity, his verbal instructions should override anything in the document. On 20 November, a prison GP

discussed the document with him. He confirmed that although Mr Orme had a number of chronic conditions, he did not have a terminal illness.

37. On 23 April 2015, a prison GP agreed to update Mr Orme's advance directive and, on 14 May, Mr Orme read and signed the new version. He told the GP that he would be willing to see the consultant in infectious diseases again and staff placed him on the list for his next visit, scheduled for 1 June.

38. On 29 May, Mr Orme reported worsening constipation, bloating and abdominal pain. Nurses kept him under observation and a prison GP saw him on 1 June. He prescribed movicol (a laxative), and booked Mr Orme for an ultrasound scan of his liver and repeat blood tests. The consultant in infectious diseases was unable to see Mr Orme during his visit that day, but he reviewed his notes and blood test results and started arrangements for further treatment.

39. At 2.49pm on 3 June, Mr Orme told a nurse he still had a pain in his abdomen, but had stopped taking movicol, as the side effects might include bloating. She offered to admit him to the healthcare unit as an inpatient, for observation, but he declined. At 5.42pm, a nurse telephoned the on-call GP who advised a rectal examination. The results were normal and the nurse advised Mr Orme to take the movicol as prescribed and drink more fluids.

40. A prison GP reviewed Mr Orme on 5 June. She found he had gained weight, was still constipated and had a swollen abdomen that was consistent with ascites. He also had some breathing difficulties. She prescribed lactulose (a laxative), spironolactone (to treat fluid retention) and nefopam hydrochloride (a non-opioid painkiller). She booked further blood tests and a chest and abdominal X- ray.

41. Mr Orme continued to deteriorate and was admitted to the prison's inpatient unit on 6 June. Healthcare staff took regular recordings of his temperature, pulse, blood pressure and respiratory rate, which they used to calculate a 'NEWS' (National Early Warning Score). This allowed them to assess the severity of his illness and deterioration to ensure timely interventions. In a telephone consultation the next day, a prison GP suggested an enema to relieve Mr Orme's constipation.

42. On 8 June, a prison GP reviewed and emailed the results of Mr Orme's blood tests to the consultant in infectious diseases. She suggested that antiviral treatment should start as soon as possible. A further prison GP saw Mr Orme that afternoon and confirmed ascites, but recorded that an ascetic tap (to drain fluid) would not be required because he did not have breathing problems. He prescribed senna, a third laxative, which had been successful previously.

43. On 10 June 2015, at 9.13am, Mr Orme's observations indicated a 'NEWS' score of five, which meant that a senior nurse or a GP should have been alerted to his condition. It is not clear if this happened or what action was taken. On 11 June, a prison GP arranged for Mr Orme's admission, the next day, to the Liver Unit at Hull Royal Infirmary, where the consultant in infectious diseases planned to assess him for further treatment. Staff took blood tests in preparation.

44. At 11.25am on 11 June, a nurse noted that Mr Orme's breathlessness had increased and he looked grey. He would not let her examine him, as he was in

such pain. As Mr Orme had already taken a dose of nefopam, she could only give him paracetamol. At 2.23pm, a prison GP examined Mr Orme and noted that he had a 'splinted diaphragm' (a displacement of air at the base of both lungs due to pressure from the ascites). As Mr Orme was due to go into hospital the next day, the GP prescribed medication for temporary relief - a single dose of furosemide (a drug which removes fluid from the body, with different action on the kidneys to spironolactone) and morphine sulphate liquid (a liquid opioid-based painkiller which also removes fluid) to relieve Mr Orme's increasing pain.

Events during the night of 11 and 12 June

45. At 10.59pm on 11 June, Mr Orme rang his cell bell and told a nurse that he had vomited blood. The nurse did not consider it an emergency, and asked for the night manager to attend to open the cell so she could examine Mr Orme. While the nurse waited for him to arrive, she spoke to Mr Orme, who said that his pain was not too bad. She described him as being calm and not in any distress.

46. The night manager and a senior officer arrived a few minutes later. At 11.05pm, the nurse went in to his cell and noted fresh blood in the sink and around Mr Orme's mouth. There was no record of his blood pressure, but his pulse was fast at 137 beats per minute (though this was not significantly higher than earlier observations).

47. The nurse telephoned the out-of-hours GP and outlined Mr Orme's medical condition and symptoms. The GP advised her to monitor Mr Orme for any further deterioration or increased pain and to offer further pain relief if required. The nurse was aware that Mr Orme had an advance directive about his treatment and told the GP that this was a complex document and its instructions were difficult to follow. She was not sure if Mr Orme was for palliative care.

48. The nurse went back to Mr Orme's cell at about 11.30pm and said she would make an appointment for him to see the prison GP in the morning. Mr Orme declined further pain relief.

49. At around midnight on 12 June, Mr Orme rang his cell bell again and told the nurse that he had vomited more blood. He showed her a plastic beaker containing approximately 200mls of dark red liquid. Mr Orme remained calm and was not in pain or short of breath.

50. The nurse contacted the out-of-hours' GP again. She later recorded in the medical notes (at 12.49am) that the GP had advised that if Mr Orme was for palliative care and had an advance directive an emergency ambulance should not be called. In a statement for the investigation, she said that the GP had advised that she should keep him comfortable and give him oramorph (an opioid painkiller). She said that he advised her to speak to Mr Orme about resuscitation and that any verbal instructions would override the advance directive. She did not consider this appropriate. She said she decided to ask a prison GP for a second opinion as she found Mr Orme's advance directive complex.

51. The out-of-hours' GP told the clinical reviewer that there was confusion about Mr Orme's advance directive. He said that he had agreed with the nurse that

telephoning one of the prison GPs, who knew Mr Orme, for a second opinion, was the best course of action and that the matter was taken out of his hands.

52. At about 12.15am, the nurse telephoned a prison GP for a second opinion. He was not on call, but had helped to draft the advance directive. His wife, also a GP, took the call as she had recently reviewed Mr Orme. She had a good knowledge of his medical conditions and advised the nurse to send him to hospital by emergency ambulance.

53. Around five minutes later, the night manager and senior officer returned to the healthcare unit while the nurse was still speaking to the doctor. The night manager also spoke to the prison GP who had recently reviewed Mr Orme who explained that, although Mr Orme had an advance directive, they should make every effort to save his life, including resuscitation and insisted that he be taken to hospital without an out-of-hours GP assessing him first. At 12.24am, the night manager radioed the control room to call an emergency ambulance. The nurse returned to Mr Orme's cell and told him they had called an ambulance. She described him as calm and rational, though he told her he knew he was dying. (In her entry in the medical record at 12.49am she noted that Mr Orme had just asked to go to hospital.)

54. The first ambulance crew arrived at 12.38am, followed by a second at 12.46am. Ambulance staff examined Mr Orme and, on the advice of the prison GP who had recently reviewed him, planned to take him to Hull Royal Infirmary, where he was due to be treated later that day. Mr Orme's condition then deteriorated rapidly and became life-threatening, so the paramedics telephoned the GP, who agreed that he should go to the nearest hospital, York District Hospital, to be stabilised and then transfer to Hull. She telephoned both hospitals to update them on the situation, including information on Mr Orme's Buddhist beliefs and how he should be cared for if he died.

55. After consulting the nurse and the GP about the use of restraints, the night manager authorised three prison officers to escort Mr Orme and restrain him with an escort chain. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.) The ambulance left Full Sutton at 1.30am. At 7.05am, one of the escort officers removed the chain at the request of nurse at the hospital. It was not reapplied. At 9.50am, a senior manager reduced the escort staff from three officers to two.

56. Mr Orme was in the intensive care unit and members of the prison healthcare team contacted the hospital several times during the day to check his condition. At 6.10pm, Mr Orme's Buddhist minister visited him and was present, at 7.29pm, when a doctor confirmed that Mr Orme had died.

Contact with Mr Orme's family

57. On 12 June, at about 1.00pm, the prison appointed a family liaison officer. The family liaison officer telephoned Mr Orme's wife, who he had given as his next of kin, to tell her that Mr Orme was seriously ill in hospital. She explained that if Mr Orme died, the prison would ordinarily inform her in person. Mr Orme's wife said that as the prison was some distance from her home, they could telephone her if this happened.

58. Mr Orme's wife asked to visit Mr Orme and the family liaison officer arranged for a driver to collect her the next day and take her to the hospital. She arranged for the Buddhist minister to visit him that day.

59. Immediately after Mr Orme's death, control room staff at Full Sutton contacted the family liaison officer at home and informed her of the death. She telephoned Mr Orme's wife straight away, to let her know that he had died. She offered her condolences and explained how the prison could help and support her.

60. On 17 June, the family liaison officer and the prison chaplain visited Mr Orme's wife at her home. They accompanied her to the funeral directors to discuss arrangements and arranged a visit to the prison on 24 June.

61. Mr Orme's funeral was held on 1 July 2015. In line with national policy, the prison contributed to the costs.

Support for prisoners and staff

62. The night manager, the GP and the Head of Healthcare offered support to the nurse.

63. A senior manager held a debrief for the staff present at the hospital when Mr Orme died, to ensure they had the opportunity to discuss any issues arising and to offer his support and that of the care team. The night manager and the SO had gone off duty before the debrief but received appropriate support later.

64. The prison posted notices informing prisoners of Mr Orme's death, and offering support. Staff reviewed prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Orme's death.

Post-mortem report

65. A post-mortem report concluded that Mr Orme died from bleeding oesophageal varices due to liver cirrhosis.

Findings

Clinical Care

66. The clinical reviewer considered that the healthcare team at Full Sutton acted professionally and with patience and compassion in caring for Mr Orme, who was a demanding and often non-compliant patient. Tests, investigations, referrals and treatments were appropriate and generally timely. She noted some inconsistencies in recording observations and NEWS scores in Mr Orme's medical record. However, overall, the clinical reviewer was satisfied that Mr Orme received a good standard of care at Full Sutton, which was equivalent to that he would have expected to receive in the community.

67. The clinical reviewer had some concerns about the response when Mr Orme became unwell on the night of 11 and 12 June and considered that the out-of-hours GP could have managed the situation more proactively. She considered that a patient with known liver failure and oesophageal varices who had coughed up blood should have been sent to hospital immediately. Although there was only a slight delay in arranging this, it was unnecessary.

68. Although experienced, the nurse, an agency nurse, was relatively new to Full Sutton. She had looked at Mr Orme's advance directive and was unclear about his wishes. She spoke to the out-of-hours GP about this and there appears to have been some confusion about whether Mr Orme was for palliative care. We consider that this would have been difficult for the out-of-hours GP to advise on, as he did not have a copy of the advance directive. He did not work at Full Sutton and did not know Mr Orme. The out-of-hours GP advised the nurse to speak to Mr Orme as any verbal instructions would override the advance directive. The nurse told the clinical reviewer that she did not consider this was appropriate, but appears to have been about Mr Orme's wishes about resuscitation rather than active treatment for his condition. Mr Orme subsequently said that he wanted to go hospital. In the circumstances, we consider the decision to seek advice from the prison GP who knew Mr Orme and the conditions of his advance directive seems sensible.

69. After speaking to the night manager, the GP advised the nurse to call an ambulance and this was done immediately. It seems from the GP's entry in the medical record that the night manager was initially reluctant to call an ambulance without a GP assessment in person. This should not be an expectation as it could delay essential treatment. We also note that the nurse seemed to consider she needed a GP to advise hospital referral, rather than relying on her own clinical judgement.

70. The discussions with the doctors had taken about 20 minutes, but Mr Orme was stable at the time and the nurse did not consider his condition was life-threatening. The rapid deterioration in his condition happened after paramedics had arrived and there is no evidence that this affected his subsequent treatment in hospital. Nevertheless, all such delays should be avoided. Where prisoners have made an advance directive, healthcare staff and duty managers responsible for their care, need to be clear about the implications in an emergency. In Mr Orme's case we do not consider there should have been any

confusion as the advance directive had said that while he remained conscious and had capacity, his verbal instructions should override anything in the document. There is no record of any active consideration between the nurse and the out-of-hours GP about whether admission to hospital was necessary. We make the following recommendations:

The Head of Healthcare should ensure that whenever there is serious concern about a prisoner's condition at night, admission to hospital should be considered, discussed and documented. When there are grave concerns about a prisoner's immediate health, an ambulance should be called without the need for GP advice or assessment.

The Governor and the Head of Healthcare should ensure that advance directives are clear and that prisoners' decisions about life saving treatment in an emergency are effectively communicated to all relevant staff.

Mr Orme's location

71. Mr Orme believed he was at risk from other prisoners at Full Sutton and prison intelligence reports suggested this was because he traded medication. After a serious assault in November 2013, staff moved Mr Orme to a different wing. However, after a second assault, a year later, he refused to move again.

72. Mr Orme missed several medical appointments and he told prison staff he did not feel safe going from the wing to the healthcare centre. Prison officers agreed to accompany him, remain during his examination or treatment and take him back to his cell but there were still occasions when he still refused to attend appointments. .

73. We are satisfied that Mr Orme's location was appropriate and that the prison took appropriate steps to protect him by allocating officers to escort him and support him at medical appointments.

Restraints

74. When prisoners have to travel outside of the prison to a hospital or hospice, a risk assessment is conducted to determine the nature and level of any security arrangements, including any restraints.

75. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity and maintain their dignity. The level of restraints used should be necessary in the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes account of factors such as the prisoner's health and mobility.

76. When Mr Orme went to hospital on 12 June, he was conscious and mobile although in pain. The night manager authorised the use of an escort chain after seeking the nurse's views. We are satisfied the risk assessment for the escort

was appropriate, as it took account of the risks he presented as well as his condition at the time.

77. We are pleased to note that when a hospital nurse asked escort officers to remove the escort chain later that morning, they did so immediately and did not use them again.

Family liaison

78. Prison Rule 22 requires that when a prisoner becomes seriously ill, the Governor should "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".

79. When Mr Orme was taken to hospital in the early hours of 12 June, it was evident that his condition had become life-threatening. We consider that, in line with the Prison Rule, the prison should have considered informing his next of kin straight away or at least in the morning. However, the prison waited for further updates about his condition and it was not until a family liaison officer was appointed on the afternoon of 12 June that anyone informed his wife of his admission to hospital and that he was seriously ill. Commendably, the prison arranged transport to take Mr Orme's wife to hospital the next day, but he died that evening before she was able to visit. We accept that the prison had good intentions and wanted to see whether Mr Orme's condition stabilised before informing his wife. However, any delay in informing families when a prisoner is seriously ill can mean that they miss the opportunity to see them before they die. 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 so that they are able to visit them in hospital without unnecessary delay.