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 St James's University Hospital, Leeds, while a prisoner at 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 the investigation report into the death of a prisoner at HMP Full Sutton, the man died in hospital after suffering a cardiac arrest and a haemorrhage after surgery. He was 66 years old. I offer my condolences to the man's family and friends.

An investigator carried out this investigation. A doctor reviewed the man's clinical care in prison.

The man was diagnosed with oesophageal cancer in June 2011. In October, he had his oesophagus removed and a feeding tube inserted into his stomach. In April 2012, the man underwent oesophageal reconstruction. Shortly afterwards, his intestines started to leak and, in June, he had an urgent operation to repair this. The man found his artificial feeding arrangements difficult despite help from hospital and prison healthcare staff. On 17 July, he had further surgery to repair his intestines but did not recover and died in the early hours of 18 July.

The clinical reviewer considers that the man's care was equivalent to the care he could have expected to receive in the community, although he believes he should have been referred to hospital more urgently, once cancer was suspected. Prison healthcare staff supported the man well with the complexity of his feeding arrangements but more assistance from community services might have helped him manage these better. Finally, I am concerned that security risk assessments did not always adequately take into account the man's health and how this impacted on his risk. The assessment was not reviewed during his final stay in hospital, resulting in restraints being used until minutes before he died.

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

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SUMMARY

1. In September 2008, the man was sentenced to 20 years imprisonment. He initially went to HMP Forest Bank and on 29 May 2009 transferred to HMP Full Sutton.

2. The man saw a doctor in January 2011, as he felt that food was getting stuck in his throat. A chest X-ray and blood tests proved normal, but he was referred to hospital in May because he was still having difficulty eating and had lost weight. In June, biopsies confirmed the man had oesophageal carcinoma (cancer of the gullet). In August, he had chemotherapy which improved his condition. On 12 October, he had surgery to remove his oesophagus and insert a feeding tube. The man returned to the prison healthcare centre on 14 November, but went back to hospital briefly two days later to have the feeding tube unblocked.

3. In March 2012, a scan showed no evidence of cancer, so the man had oesophageal reconstruction in April. In May, he developed significant leaks in his intestines and, in June, had an operation to repair this. A stoma bag to collect waste products from the body was also fitted. He was discharged in July.

4. In August, the prison doctor wrote to the consultant because he was concerned that the prison might not be able to deliver the specialist nursing care that the man needed. There is no record of any response.

5. In January 2013, healthcare staff discovered that the man was not feeding himself properly. He was referred to a doctor and the mental health team who encouraged him to follow his instructions. The man had difficulty managing the feeding and stoma bags which healthcare staff tried to help him overcome.

6. On 15 May, the man told his consultant that he was finding it difficult to live with the artificial feeding arrangements and his stoma bag. The consultant agreed he might benefit from more surgery and he was admitted to hospital on 1 July in preparation for intestinal surgery on 17 July. After the operation, the man haemorrhaged and hospital staff resuscitated him. He was rushed back to the operation theatre, but had a cardiac arrest on the way which proved fatal. He was pronounced dead at 3.10am on 18 July.

7. Overall, we agree with the clinical reviewer that the man's care was equivalent to that he could have expected in the community, although note his opinion that the original diagnosis could have been quicker. The man found it difficult to manage his complex condition. Although he was well supported by prison healthcare staff, more could have been done to engage community services to help. We are concerned that the man's serious medical condition was not adequately taken into account when assessing his security risk when he was taken to hospital and not reviewed during his final hospital stay.

THE INVESTIGATION PROCESS

8. The investigator issued notices informing staff and prisoners at HMP Full Sutton of the investigation and asking anyone with relevant information to contact him. One prisoner was interviewed as a result.

9. The investigator visited the prison on 24 July. He met the liaison officer, the Governor and other prison managers including the Head of Healthcare. The investigator obtained copies of the man' relevant prison medical and prison records and visited his cell in the healthcare centre,

10. NHS England appointed a doctor to review the clinical care that the man received at the prison.

11. HM Coroner for West Yorkshire was informed of the investigation and provided a copy of the post-mortem report. The Coroner has been sent this report.

12. One of the Ombudsman's family liaison officers spoke to the man's nominated next of kin, his offender manager, to explain the purpose of the investigation. The man's offender manager had no specific issues for the investigation to consider. West Yorkshire police advised that The man's family did not want to be involved with the investigation.

13. The man's family were informed the draft report was available, but did not wish to receive a copy or make any comment.

HMP FULL SUTTON

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

HM Inspectorate of Prisons

15. At their most recent inspection of Full Sutton in December 2012, HM Inspectorate of Prisons found that clinical governance arrangements were satisfactory and the range and quality of healthcare services were good, although prisoners were generally dissatisfied with these services. The inpatient healthcare unit was described as satisfactory and the Inspectorate found that inpatients were complimentary about the quality of care received. There was a palliative care policy, a dedicated palliative care room in the healthcare unit and good links with local Macmillan cancer patient support services.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who monitor all aspects of prison life to ensure that prisoners are treated fairly and decently. In their latest published annual report for 2011-12, the IMB reported that terminally ill prisoners had been appreciative of the treatment they had received.

Previous deaths at Full Sutton

17. The man was the sixth prisoner to die at Full Sutton since 2012. Five of the previous deaths were as a result of natural causes. We have previously made recommendations to Full Sutton about risk assessments and the use of restraints for hospital escorts which we repeat in this report.

KEY EVENTS

18. Before his imprisonment, the man had suffered from osteoarthritis and sciatica for which he took co-codamol (a painkiller). He used a walking stick to aid his mobility. In 2007, he had had a duodenal ulcer removed and was found to be allergic to anti-inflammatory medication.

19. On 25 September 2008, the man was sentenced by a Crown Court to 20 years imprisonment for serious sexual offences and was initially sent to HMP Forest Bank. On 29 May 2009, he was transferred to the vulnerable prisoner wing of HMP Full Sutton.

2011

20. The man told a prison doctor, on 12 January 2011 that over the previous four weeks, he had felt that food had been getting stuck when he swallowed. A chest X-ray and blood test proved normal. He was reviewed three times over the next few months and, on 26 April, a nurse made an appointment for him to see a doctor the next week because he was still in pain and had lost weight.

21. On 28 April, the man could not eat and told the doctor that something was stuck in his oesophagus (gullet), so he was admitted to the healthcare centre for observation and further assessment. The next day he told the doctor he had difficulty swallowing solids and he had lost 10kgs in six months. The man was told there was probably a blockage in his oesophagus which needed urgent investigation.

22. On 3 May, the man was referred for a gastroscopy, which was carried out on 24 May and showed a malignant stricture (a narrowing which was likely to become progressively worse). On 14 June, an urgent scan at York District Hospital confirmed that the man had oesophageal cancer. A more detailed CT scan showed a suspicious lymph node next to his oesophagus. He had two cycles of chemotherapy on 2 and 22 August. The man began to find it easier to swallow and gained some weight. He was subsequently referred for surgery.

23. On 12 October, the man had his oesophagus removed and a feeding tube inserted. He then developed complications which required more surgery and a prolonged stay in hospital. On 3 November, the consultant surgeon agreed that prison nurses should observe the man's care to familiarise themselves before he returned to the prison. The man was discharged from hospital back to the prison health care centre on 14 November. The man's feeding tube became blocked several times. Prison healthcare staff could not unblock it, so the man went back to hospital for a day on 16 November to have the blockage removed.

24. The man was admitted to hospital again on 19 December to have his feeding tube replaced.

2012

25. A CT scan on 12 March showed no evidence of cancer and the man wanted to have oesophageal reconstructive surgery. His weight had increased, so he was admitted to St James's University Hospital, Leeds on 23 April for intestinal surgery, but there were complications. On 9 May, he developed a significant intestinal leak and he remained in hospital.

26. On 12 June, because of the seriousness of his condition, the prison appointed a family liaison officer. The family liaison officer contacted Victim Support, who liaised with the man's family, who confirmed that they did not want further contact.

27. The man had another operation on 19 June to repair his stitches. He was treated for a fungal infection for 14 days, but was discharged on 23 July and returned to the prison's healthcare centre.

28. A prison nurse had visited the hospital on 21 July to plan for his discharge. She noted his clinical requirements, dietary needs and what needed to be in place before his return. The man had a stoma bag which he could empty himself, but his feeding regime was managed by nurses. He was prescribed tramadol (used to treat moderate to moderately severe pain) and oramorph (for severe pain). The hospital's discharge plan included a protocol for unblocking his feeding tube and relevant hospital contact details, which was filed in his medical notes.

29. On 1 August, the prison doctor wrote to the consultant in charge of the man's case, because he was concerned that his needs could not be met in prison. The doctor was worried about the man's ongoing surgical wound and thought he needed specialist nursing care, which they would struggle to deliver in prison. There is no record of any response.

30. A tissue viability nurse assessed the man on 20 September, because his skin had become raw after several leaks from the stoma bag. She gave him wipes and lotion to improve his skin condition. This was the first of several appointments when the man was taught to manage his own stoma bag.

31. On 24 November, the man was described as frail and depressed. He wanted to move back to his cell on the wing. Healthcare staff encouraged him to look after himself more and exercise so that he would eventually be fit enough to return to his wing. They suggested that he should join an older prisoners' group and visit his old wing. By 23 December he was self-caring, changing his own stoma bag and up and about.

2013

32. The man was admitted to St James's University Hospital on 6 January 2013. A CT scan showed that the cancer had still not returned. His feeding tube was moved and the hospital explained to the man and prison nurses how to manage his feeding tube via a new feeding bag, as well as manage his stoma bag. The man was told that he needed to weigh at least 60kgs before he could have another operation. (He weighed 52kgs at that time – just over eight stone.)

33. On 20 January, healthcare staff noticed that the man was not following the hospital's instructions about feeding. He said he felt depressed but had no thoughts of self-harm or suicide. He was referred to a doctor and mental health team. The mental health team reviewed him on 22 January and he said that he was frustrated about his treatment regime. It was agreed that the man should receive intermittent support from the mental health team when he needed it.

34. On 23 January, the man weighed 50.8kgs, and he still was not managing his feeding regime well. Healthcare staff reminded him of the importance of following the hospital's instructions, but the man did not feed himself properly or manage his stoma bag effectively. Over the next week, he became more positive, because he wanted to have reconstructive surgery. He engaged with his physiotherapy and tried to follow his feeding regime and manage his stoma bag as he had been instructed.

35. At a MDT meeting on 1 February, it was agreed that the man should be discharged from the healthcare centre to a vulnerable prisoner wing, C wing. He was moved on 4 February and another prisoner was appointed as his wing carer. He weighed 49kgs on 11 February.

36. The man continued to find it difficult to manage his feeding regime and his stoma bag. At times, he ran out of the bags, resulting in him going to the healthcare centre with secretions running down his body. Healthcare staff reminded him about how to use the bags properly and advised him about hygiene.

37. The man refused to go to consultant appointments at St James's University Hospital on 12 March and 3 April, because he said he did not feel well enough. The mental health nurse reviewed him again on 22 March, and concluded that he had no mental illness, but found it difficult to come to terms with and cope with his condition.

38. On 22 April the man weighed 48.3kgs. On 14 May an upper gastrointestinal surgeon reviewed the man at the hospital. The man told the surgeon that he was having problems with his stoma bags leaking and the smell of the fluid. He said that he was given two bags every 24 hours (this is normal practice), but said this meant that he had to put up with soiled clothing. The man said he found that he found managing the bag connected to his feeding tube

difficult to bear. The surgeon agreed that the man could benefit from more surgery and planned to admit him on 1 July.

39. An escort risk assessment was completed on 17 June, in advance of the man's admission to hospital. A prison GP, recorded that the man's medical condition did not restrict his ability to escape unaided, he had no medical objections to the use of restraints and there was no need to remove them for treatment or consultation. This was the same formulation used in all previous risk assessments. The prison security assessment was that the man was a medium risk to the public because of his index offence, but a low risk of escape, a low risk to prison and hospital staff, a low risk of hostage taking and a low risk of having outside assistance. Despite the low risk of escape, the assessment concluded that the man should be double cuffed (double cuffing is when the prisoner's hands are cuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs). It was recorded that an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer) could be used to facilitate an intravenous drip, when he used the toilet, washed, showered, ate meals and for treatment.

40. On 19 June, the man weighed 46.8kgs (7 stone 5lbs) and the MDT agreed that he should be admitted to the healthcare centre for two weeks to monitor his nutritional intake. He was admitted the same day. He was helped to manage his feeding and stoma bag himself and returned to his wing on 24 June. He told his personal officer he felt more comfortable there.

July 2013

41. The man went to St James' University Hospital on 1 July to prepare him for surgery. He was escorted by two prison officers and restrained by double cuffs. Shortly after arrival, his handcuffs were removed and officers used an escort chain. He was attached to an intravenous drip for feeding. Officers on bedwatch often recorded that there were no concerns about the man and that he was polite to all staff.

42. The man had his operation on 17 July. The escort chain was removed just before the operation, and replaced less than an hour after he was out of theatre. Nurses monitored the man regularly and took his blood pressure every half an hour.

43. At 8.00pm, an officer noted that the man was in good spirits. Throughout the evening the man was attended to by hospital staff. At 11.45pm, the man told the prison officers he had stomach pain and pressed his button to call a nurse. Nurses advised him how to control the morphine which was being intravenously administered. At 1.35am, a nurse told the escort officers that the man might need to go into theatre because he might be bleeding internally. His condition deteriorated significantly, but it was not until the man became unresponsive at 3.05am, that his restraints were removed so that he could be resuscitated.

44. The man was resuscitated, but had a cardiac arrest before he got to theatre. The man was pronounced dead by a hospital doctor at 3.10am.

45. The duty governor held a debrief at the hospital with the two officers who were with the man and offered them the services of the staff care and welfare teams. The man had a prisoner carer on the wing and a prison chaplain told him in person that the man had died.

46. The man had nominated his offender manager (probation officer) as his next of kin. He was notified of his death by the hospital. The prison arranged and paid for the man's funeral.

Post-mortem report

47. The post-mortem report showed that the man died from:

1. shock and haemorrhage due to jejunal resection and repair of fistula;
2. adenocarcinoma of the oesophagus (resected) and coronary atheroma.

ISSUES

48. The clinical reviewer considers that the man's care was complex, but the prison managed his needs well, with the exception of the following areas of concern.

The man's diagnosis

49. Although the man had complained of discomfort since January 2011, it was not until 28 April 2011, that a doctor suggested that he should be referred urgently for investigation. It then took another five days before the referral was made and the subsequent gastroscopy did not take place until 24 May. It was eventually confirmed that he had cancer on 14 June.

50. We agree with the clinical reviewer that action could have been taken sooner to refer the man for investigation of his symptoms. Once the doctor identified on 28 April that he might have had a malignant blockage in his throat, he should have been referred immediately under NHS guidelines. These require any cases of suspected cancer to be seen by a specialist within two weeks of an urgent referral. We make the following recommendation:

The Head of Healthcare should ensure that prisoners with suspected cancer are referred as two week urgent referrals in line with NHS guidelines.

The management of the man's condition

51. When the man was discharged from hospital back to the prison health care centre on 14 November 2011, his feeding tube became blocked on several occasions and healthcare staff found it difficult to unblock it. The man went back to St James' University Hospital on 16 November to have it unblocked. The next time the man was discharged from hospital, in July 2012, a nurse went to the hospital in advance of his discharge to ensure that all measures were in place ready for his return to the prison. His discharge plan included a protocol to unblock his feeding tube.

52. The man found it difficult to manage his stoma bags, despite instruction from a tissue viability nurse and prison healthcare staff. The man wanted to change his bag frequently, rather than just empty it and reuse it as he had been instructed. Despite the support he received from prison healthcare staff, there were distressing occasions when the man could not manage leaks from his stoma bags.

53. The clinical reviewer considers that the man might have benefited from more support from the tissue viability nurse, or community stoma care services and we note that the prison doctor wrote to the man's consultant because he was concerned about the limited facilities and expertise at HMP Full Sutton to meet the man's specialist needs. Although it is clear that healthcare staff at Full Sutton worked hard to meet the man's needs, we agree with the clinical reviewer that more use of specialist community services to support the man's

care would have been helpful. We therefore make the following recommendation:

The Head of Healthcare should ensure that the help of specialist community nursing services is sought when prisoners would benefit from expertise not available in the prison.

Use of restraints

54. The Prison Service has a duty to protect the public when escorting prisoners outside prison such as to hospitals, 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.

55. The man had a number of visits to the hospital and was considered a low risk for the most part, although he was a medium risk to the public. The medical section was completed for each escort risk assessment, but the wording never changed as his health deteriorated and he became frailer. The levels of his assessed risk never changed and he was always regarded as a low risk of escape. Nevertheless, double cuffs were always judged to be necessary for escorts, which is the standard arrangement for a fit category A or B prisoner in good health.

56. Security measures must be proportionate to a prisoner's individual circumstances and these must be fully considered, taken into account and balanced against the security risks. We are concerned that, despite the man's poor physical health and frailty, he continued to be restrained until minutes before he died. The risk assessment completed four weeks earlier was never revised.

57. We have made previous recommendations to Full Sutton about the use of restraints and consider there is a need for all those involved in making decisions to ensure that a prisoner's health and mobility are given sufficient weight in risk assessments for hospital escorts and that staff follow the guidance in the High Court judgment, including the need to review assessments as circumstances change. We make the following recommendation:

The Governor and the Head of Healthcare should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances, based on the actual risk the prisoner presents at the time and kept under review.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that prisoners with suspected cancer are referred as two week urgent referrals in line with NHS guidelines.

2. The Head of Healthcare should ensure that the help of specialist community nursing services is sought when prisoners would benefit from expertise not available in the prison.

3. The Governor and the Head of Healthcare should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances, based on the actual risk the prisoner presents at the time and kept under review.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that prisoners with suspected cancer are referred as two week urgent referrals in line with NHS guidelines.	Accepted	All suspected cancer referrals are now completed in line with the two week referral pathway into secondary care.	Completed Head of Healthcare	
2	The Head of Healthcare should ensure that the help of specialist community nursing services is sought when prisoners would benefit from expertise not available in the prison.	Accepted	The Health & Justice Commissioning Manager of NHS England and the Head of Health from HMP Full Sutton will work together to agree what specialist community nursing provision needs to be secured on a clinically required basis for individual patients. Following this the Commissioning Manager will contract with York Teaching Hospitals NHS Foundation Trust to commission that specialist provision. Specialist community nursing services are sought when prisoners would benefit from expertise not available in the prison.	Ongoing NHS England/ Head of Healthcare	
3	The Governor and the Head of Healthcare should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances, based on the actual risk the prisoner presents at the time and kept under review.	Accepted	The daily management check has been altered to ensure that the person carrying out the review pays particular attention to the risk assessment and the restraints that are applied. The level of restraints will be proportionate to risk which will include the health and mobility of the individual.	Completed The Head of Security	