Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mariusz Krezolek a prisoner at HMP Full Sutton on 27 January 2016

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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*

© Crown copyright 2015

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

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 Mariusz Krezolek died of a heart attack in his cell at HMP Full Sutton on 27 January 2016. He was 36 years old. I offer my condolences to Mr Krezolek's family and friends.

Mr Krezolek's death was sudden and unexpected but I am concerned that staff did not use an emergency medical code when Mr Krezolek first reported chest pain and difficulty breathing in the early hours of 27 January. This meant that it was over twenty minutes before a nurse saw him and no one called an ambulance. While the nurse's assessment was that Mr Krezolek did not need emergency hospital treatment, it is important that staff follow the emergency response procedures in national Prison Service instructions. Mr Krezolek died sometime during the night, after the nurse's assessment, and we cannot know whether an earlier assessment by paramedics would have altered the outcome.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **August 2016**

Contents

Summary

1. In March 2012, Mr Mariusz Krezolek was remanded to prison charged with murder. He was sentenced to life imprisonment in August 2013 and had been at HMP Full Sutton since 5 August 2013.

2. Mr Krezolek had been treated for a fistula (an abnormal connection between the intestinal tract or stomach and the skin) in prison and inflammatory bowel disease but refused to go to hospital for treatment, as he said he was afraid he would be recognised. (His offence had attracted a high degree of media interest.) Mr Krezolek had no other significant health problems.

3. Around 3.00am on 27 January 2016, Mr Krezolek rang his cell bell and complained of chest pains. Staff did not call a medical emergency but asked a prison nurse to attend, who did not arrive until over 20 minutes later. The nurse assessed Mr Krezolek and recommended he had an electrocardiogram (ECG) test in the prison's healthcare centre. Mr Krezolek refused to go but accepted some painkillers. The nurse did not consider that Mr Krezolek needed to go to hospital as an emergency.

4. At 8.25am, an officer found Mr Krezolek unresponsive in his bed. The officer radioed a code blue medical emergency and an ambulance was called. Mr Krezolek was cold and there were signs of rigor mortis but the officer and nurses tried to resuscitate him. At 8.54am, a prison GP arrived and recorded that Mr Krezolek had died. A post-mortem examination found that Mr Krezolek had died of a heart attack.

Findings

5. We are concerned that staff did not follow the procedures in Prison Service Instruction (PSI) 3/2013 for medical emergencies when Mr Krezolek first reported chest pain and difficulty breathing in the early hours of 27 January. Staff should have used a medical emergency code and called an ambulance. We cannot say that this would have prevented Mr Krezolek's death, as it is possible that the nurse who examined him would have cancelled the ambulance when she assessed that he did not need immediate treatment. However, as Mr Krezolek had refused to go to the healthcare centre for an ECG, a paramedic should have assessed him. When staff found Mr Krezolek unresponsive later that morning, they tried to resuscitate him, although the presence of rigor mortis should have indicated this was futile.

Recommendations

- The Governor should ensure that, in line with PSI 3/2013, staff use the appropriate emergency code whenever there are serious concerns about the health of a prisoner; that the control room calls an ambulance immediately; and nurses are able to reach prisoners quickly, including at night.
- The Governor and Head of Healthcare should give clear guidance to staff about the circumstances in which resuscitation is inappropriate, in line with established professional guidelines and Spectrum Healthcare's resuscitation policy.

The Investigation Process

6. 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.

7. The investigator visited Full Sutton on 1 February 2016. He obtained copies of relevant extracts from Mr Krezolek's prison and medical records.

8. NHS England commissioned a clinical reviewer to review Mr Krezolek's clinical care at the prison.

9. The investigator and clinical reviewer interviewed ten members of staff at Full Sutton on 2 March and 3 March. The investigator interviewed three other members of staff by video-link on 27 April.

10. We informed HM Coroner for East Riding and Kingston upon Hull of the investigation. We have sent the coroner a copy of this report.

11. One of the Ombudsman's family liaison officers contacted Mr Krezolek's friend, whom he had named as his next of kin, and his family, to explain the investigation. They had no specific matters they wanted the investigation to consider.

Background Information

HMP Full Sutton

12. HMP Full Sutton is a high security prison near York. It holds up to 600 men. Spectrum Community Health provides healthcare services with registered general and mental health nurses, and a nurse qualified to prescribe medication. There is daily GP cover. There is a healthcare inpatient unit with six beds and 24-hour nursing cover.

HM Inspectorate of Prisons

13. The most recent inspection of Full Sutton was in January 2016. Inspectors reported that health care provision was reasonable overall, with good access to an appropriate range of services. Clinical governance arrangements were satisfactory. Inspectors noted responses to medical emergencies, both within the prison and by external agencies, were good.

Independent Monitoring Board

14. 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 recent annual report for the year ending 2015, the IMB noted that a competitive tendering exercise for health services had caused staff anxiety and a high turnover of healthcare staff. This had resulted in significant staff shortages during the year.

Previous deaths at Full Sutton

15. Mr Krezolek was the sixth prisoner to die of natural causes at Full Sutton since 2015. Our investigations into the other deaths found that the men received a good standard of care at the prison.

Key Events

16. Mr Marius Krezolek was Polish and came to the United Kingdom in 2005. In March 2012, he was remanded to prison charged with the murder of his young stepson. On 2 August 2013, he was sentenced to life imprisonment with a minimum term to serve of 30 years before he could be considered for release. His partner also received a life sentence. The court case attracted a lot of media attention.

17. Mr Krezolek had no identified cardiac problems. In 2001, in Poland, he had suffered from peritonitis and a large section of his intestine was removed. He developed adhesions (when sections of the bowel fuse together) and a fistula (an abnormal connection that develops between the intestinal tract or stomach and the skin). He had received treatment for these conditions.

18. On 15 August 2013, Mr Krezolek was transferred to HMP Full Sutton, where he lived in a unit for vulnerable prisoners. On 8 and 9 June 2014, Mr Krezolek said that he had had stomach pains for the previous three days. Healthcare staff offered to monitor Mr Krezolek in the prison's inpatient unit but he refused to be admitted. He took paracetamol for the pain and said that he would only have treatment if the pain became intolerable.

19. Mr Krezolek's stomach pain became worse. Doctors found he had developed another fistula but he refused to go to hospital for a surgical examination. A prison GP sought advice from a gastroenterologist specialist at hospital, who subsequently diagnosed Mr Krezolek with inflammatory bowel disease, based on tests taken in the prison. He continued to refuse to be referred to hospital for treatment or to be admitted to the prison's inpatient unit. He told healthcare staff that he was afraid he would be recognised if he went to hospital.

20. Healthcare staff tried to make Mr Krezolek comfortable by managing his symptoms and dressing the fistula. A GP prescribed tramadol for pain relief but subsequently changed this to nefopam and gabapentin, as Mr Krezolek complained that tramadol affected his mood.

21. In July 2015, Mr Krezolek's partner hanged herself in prison. Staff began to manage Mr Krezolek under Prison Service suicide and self-harm prevention procedures, but he would not engage with the mental health team. He said his main concern was managing his stomach and fistula problems. However, in September he told a consultant psychiatrist that he had tried to hang himself twice in the previous fortnight. Officers found a noose in his cell and he was moved to the inpatient unit and prescribed an antidepressant.

22. At the end of September, Mr Krezolek went back to his wing. Staff noted Mr Krezolek's mood was good. He attending work and interacted with others. In December, Mr Krezolek stopped taking antidepressants.

27 January 2016

23. At 3.07am on 27 January, Officer A responded to Mr Krezolek ringing his cell bell. Mr Krezolek was sitting behind the cell door. CCTV shows that he spoke to Mr Krezolek for around three minutes through the door. He said that Mr

Krezolek looked unwell. He said he was coughing and was struggling to breathe. Mr Krezolek told him he had chest pain and wanted to see a nurse. He told Mr Krezolek to go back to bed and he would contact a nurse.

24. Officer A went back to the staff office and told Officer B, who phoned a nurse. She said she would check Mr Krezolek's healthcare record. At 3.14am, Officer B went to Mr Krezolek's cell and found him squatting on the floor, holding his right hand to the upper part of his chest. He phoned the nurse, who said she would need to examine Mr Krezolek. As he had chest pains, she might need to take him to the healthcare centre for an electrocardiogram (ECG).

25. Officer B contacted the night manager. As a high security prison, the night security arrangements required a minimum of four officers including a dog handler to be present to unlock a cell, except in an emergency. The manager arranged for staff to meet him at Mr Krezolek's cell and for an officer to collect the nurse, as healthcare staff do not have keys at night.

26. At 3.28am, the nurse and night manager went into Mr Krezolek's cell. The nurse recorded in his medical record that, at the time, Mr Krezolek was squatting beside his bed and leaning forward. He felt warm and his face was flushed. Mr Krezolek complained of chest pains and alternating feelings of being chilled and having a high temperature. He said the pain was different from his stomach pain. She noted that Mr Krezolek did not have pain radiating to his arms, neck or jaw. Mr Krezolek said he was breathless when lying flat but felt better, when he was squatting.

27. The nurse checked Mr Krezolek's temperature, blood pressure and breathing. She told the investigator that Mr Krezolek had a slight temperature, that his blood pressure was quite high (but this was usual for him) and that his pulse was a little fast. She said that when she entered the clinical observations to get a National Early Warning Score (a clinical decision tool developed by the Royal College of Physicians) Mr Krezolek's result was 'one'. She recommended that a nurse should repeat clinical observations in four to six hours, in line with the national guidelines.

28. The nurse wanted to take Mr Krezolek to the healthcare centre for an ECG to rule out heart problems but Mr Krezolek refused to go and said he would see the doctor the next morning. The night manager offered to take him in a wheelchair, but he still refused and repeatedly asked for gabapentin to relieve the pain. As he had already taken his prescribed gabapentin, the nurse gave him paracetamol and asked the officers to check him regularly. She left Mr Krezolek's cell at 3.43am. She said that at that stage Mr Krezolek did not need to be taken to hospital and she did not consider that she needed to see him again that night, as she had asked the officers to keep an eye on him.

29. Officer B checked Mr Krezolek at around 5.00am and at 7.00am. Both times, the cell light was off. Mr Krezolek was in bed under a duvet and appeared comfortable and asleep.

30. At approximately 8.10am, two officers began unlocking cells. At 8.26am, Officer C unlocked Mr Krezolek's cell and greeted him. When Mr Krezolek did not respond he went into the cell and tried to rouse him. He noticed his face

appeared discoloured. When he did not respond, he called to Officer D for help. The officers checked him but could not find a pulse and, at 8.27am, Officer D radioed an emergency medical code blue (which indicates situations such as when a prisoner is unconscious or not breathing). The control room called an ambulance immediately.

31. Both officers said that Mr Krezolek felt cold and, when they rolled him onto his back, his arms were stiff and bent at the elbows, which indicated rigor mortis. His skin was mottled and discoloured because his blood had pooled. Although they believed that Mr Krezolek was dead, they began to try to resuscitate him.

32. At 8.30am, more staff arrived at Mr Krezolek's cell. A healthcare assistant brought a medical emergency bag. Both officers then left the cell.

33. A nurse sad Mr Krezolek's arms were cold and he had rigor mortis in his arms and legs, but his torso was still warm. He had no pulse and there was no evidence of breathing. She attached a defibrillator, which found no shockable heart rhythm.

34. An officer helped the nurses place Mr Krezolek on the floor and they continued cardiopulmonary resuscitation. The nurse observed that Mr Krezolek's whole body appeared rigid. His neck was stiff and his tongue was swollen. His face was purple and they were unable to move his head back to allow a clear airway path. She said they continued cardiopulmonary resuscitation because Mr Krezolek's torso was warm and she believed they were obliged to do this. An officer tried to give Mr Krezolek oxygen but his airway was blocked and no air entered his lungs.

35. Staff continued cardiopulmonary resuscitation for around 25 minutes and checked Mr Krezolek's pulse after every two rounds of chest compressions. They did not use the defibrillator again. When a prison GP arrived at the prison that morning, an ambulance had still not arrived and staff directed her to the emergency. She arrived at Mr Krezolek's cell at 8.50am and assessed him. She said he was unresponsive, had abdominal swelling, his pupils were fixed and dilated and rigor mortis was present. At 8.54am, she recorded that Mr Krezolek had died.

Contact with Mr Krezolek's family

36. Mr Krezolek had named a friend as his next of kin but he had had no contact with his for some years. The prison and police were unable to trace him until the morning of 28 January. The prison's family liaison officer informed him of his death by telephone. Mr Krezolek's friend asked the prison to arrange Mr Krezolek's funeral.

37. The police liaised with the Polish embassy, who located Mr Krezolek's sister in Poland. In February, Mr Krezolek's body was repatriated to his family in Poland. The prison contributed to the costs of the repatriation, in line with Prison Service policy.

Support for prisoners and staff

38. The duty governor debriefed the staff involved in the emergency response to offer support and ensure they had the opportunity to discuss any issues arising. The staff care team also offered support.

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

Post-mortem report

40. A post-mortem examination found that Mr Krezolek had died from an acute myocardial Infarction (heart attack). Toxicology tests showed therapeutic levels of gabapentin and paracetamol but no evidence of any illicit substances.

Findings

Clinical care

41. The clinical reviewer concluded that Mr Krezolek's general standard of healthcare at Full Sutton was equivalent to that he could have expected to receive in the community. He noted that healthcare staff regularly reviewed, monitored and treated Mr Krezolek for his stomach problem and inflammatory bowel disease, despite his refusal to go to hospital. This condition was not related to the cause of his death. Mr Krezolek had no obvious symptoms of coronary heart disease before his death, which was sudden and unexpected.

Emergency code

42. Prison Service Instruction (PSI) 3/2013 (which covers medical emergency response codes) refers to an NHS Ambulance guide for use in the community, which states that an ambulance should be called in circumstances including when there are signs of chest pain, difficulty in breathing or unconsciousness. The PSI says that this must also be the case for prisoners and, in these circumstances, staff should radio a medical emergency and the control room should call an ambulance immediately. Chest pain is the first symptom indicated in the annex of the PSI for a code blue to be used.

43. PSI 3/2013, also notes that it should not be a requirement for a member of healthcare staff or a manager to attend before an emergency code is called. It says it is better to act with caution and request an ambulance that can be cancelled if it is later assessed as not required

44. When Mr Krezolek complained of chest pain and difficulty breathing in the early hours of 27 January 2016, Officer A did not radio an emergency code blue, as should have happened, but telephoned a nurse, who did not arrive for over twenty minutes. Using an emergency medical code blue should have alerted the control room to call an ambulance immediately and the nurse to attend Mr Krezolek's cell urgently.

45. We cannot say that the outcome for Mr Krezolek would have been different had Officer A called an emergency code. The nurse considered Mr Krezolek's presenting symptoms and clinical history, and appropriately used the National Early Warning Score. However, we consider he should have been assessed by paramedics, particularly as the nurse considered he needed an ECG, (but he had refused to go to the healthcare centre). We recognise that if paramedics had not arrived by the time the nurse assessed him, it is possible that she could have stood the ambulance down, as she did not consider that he needed to go to hospital for immediate treatment. Nevertheless, an ambulance should have been called initially.

46. While the failure to use an emergency medical code might not have made a difference to the outcome for Mr Krezolek, in other emergencies, particularly involving rapid onset chest pain, any delay could be critical. It is important that prison staff follow the emergency procedures set out in the national instruction. We make the following recommendation:

The Governor should ensure that, in line with PSI 3/2013, staff use the appropriate emergency code whenever there are serious concerns about the health of a prisoner; that nurses are able to reach prisoners quickly; and that the control room calls an ambulance immediately.

Resuscitation

47. Staff responded quickly to the emergency code blue, called at 8.27am on 27 January. The nurses told the investigator that they believed they should try to resuscitate Mr Krezolek because his torso was warm. This was despite clear signs of death: Mr Krezolek's limbs were cold; he had no pulse, there were signs of rigor mortis; and his blood had pooled in his limbs. We understand the commendable wish to attempt and continue resuscitation until death has been formally recognised but staff should understand that they are not required to carry out cardiopulmonary resuscitation in these circumstances.

48. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. Spectrum Healthcare's resuscitation policy (October 2015) is clear that staff should not attempt resuscitation if rigor mortis is present. European Resuscitation Council Guidelines 2010 say, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile …", such as the presence of rigor mortis. In October 2014, the British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued guidance about making appropriate resuscitation decisions. The guidance says that every decision should be made on the basis of a careful assessment of each individual's situation. We make the following recommendation:

The Governor and Head of Healthcare should give clear guidance to staff about the circumstances in which resuscitation is inappropriate, in line with established professional guidelines and Spectrum Healthcare's resuscitation policy.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141