Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Martin Stafford a prisoner at HMP Full Sutton on 12 November 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*

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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 Martin Stafford died of pneumonia and liver disease, while a prisoner at HMP Full Sutton, on 12 November 2015. He was 47 years old. I offer my condolences to Mr Stafford's family and friends.

Mr Stafford had several chronic health problems, including advanced liver disease Prison healthcare staff monitored his medical conditions closely, liaised well with hospital staff and gave sensitive and compassionate care. I am satisfied Mr Stafford received appropriate clinical care at Full Sutton, equivalent to that he could have expected in the community. However, even allowing for Mr Stafford's high security category, I am concerned that security decisions did not always fully take into account Mr Stafford's serious ill-health, including a decision not to open his cell at night when a nurse was concerned about him and the use of restraints in hospital until very shortly before his death.

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 **September 2016**

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Summary

Events

1. On 31 July 2012, Mr Martin Stafford was sentenced to life imprisonment for murder. He had been at HMP Full Sutton since 7 November 2012.

2. Mr Stafford had a history of drug and alcohol abuse, and associated health complications, including hepatitis C and advanced liver disease. His symptoms included a build up of fluid in his abdomen (ascites); he was often taken to hospital for this to be drained. Prison healthcare staff monitored Mr Stafford closely and liaised with a consultant hepatologist for advice on his medication and managing his symptoms. In August 2013, prison healthcare staff began a short life span care plan and reviewed it periodically.

3. Mr Stafford's condition deteriorated over time and he was admitted to the prison's healthcare centre as in inpatient in June 2015. He was unable to walk without help and used a wheelchair. He also needed help with his personal care.

4. On 8 November, Mr Stafford developed a respiratory infection and was admitted to hospital. A prison manager decided he should be restrained by an escort chain. Over the next few days, his condition continued to decline. Early in the morning of 12 November, a prison manager agreed that officers should remove the escort chain. Mr Stafford died later that day.

Findings

5. We are satisfied that Mr Stafford's clinical care at Full Sutton was equivalent to that he could have expected to receive in the community. Healthcare staff thoroughly assessed and treated the symptoms of his liver disease and liaised effectively with hospital staff. There was good continuity and consistency of care.

6. However, we are concerned that in August 2015, the night manager refused to open Mr Stafford's cell to allow a nurse to check Mr Stafford had not been injured after he had fallen and to remove hazards from his cell.

7. The risk assessments for Mr Stafford's hospital admissions did not have sufficient information about his condition and how it affected his level of risk. We are not satisfied that the level of restraints used was adequately justified.

Recommendations

- The Governor should ensure that healthcare staff are able to examine prisoners at night when they have concerns about their wellbeing and safety, unless there are exceptional documented security reasons why a cell should not be opened.

- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Investigation Process

8. 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 her. No one responded.

9. The investigator obtained copies of relevant extracts from Mr Stafford's prison and medical records.

10. NHS England commissioned a clinical reviewer to review Mr Stafford's clinical care at the prison. In her clinical review, she has made some recommendations not included in this report, which the Head of Healthcare will need to address.

11. 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.

12. One of the Ombudsman's family liaison officers contacted Mr Stafford's next of kin to explain the investigation. He did not have any questions or concerns for the investigation to consider and said he believed Mr Stafford had received a good standard of care.

13. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

14. Mr Stafford's next of kin received a copy of the initial report and indicated that he was satisfied with the findings.

Background Information

HMP Full Sutton

15. HMP Full Sutton is a high security prison near York, which holds up to 600 men. Spectrum Community Health provides a range of integrated healthcare services. There are healthcare staff on duty twenty-four hours a day. An inpatient healthcare unit, with six beds, provides full nursing care for patients, including a palliative care suite. Spectrum contracts the East Riding of Yorkshire Council for social care arrangements.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Full Sutton was in January 2016. Inspectors found that healthcare provision was reasonable, with good access to an appropriate range of services. The inpatient unit provided a calm and decent service. Chronic disease management was reasonable, but social care arrangements were underdeveloped. A patient forum, made up of wing-based prisoner representatives, was proactive in identifying service improvement.

Independent Monitoring Board

17. 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 to January 2016, the IMB noted that there had been a high turnover of healthcare staff and significant staff shortages, with a reduction in suitably skilled staff. This had resulted in the closure of the in-house renal unit.

Previous deaths at HMP Full Sutton

18. There have been eight deaths from natural causes at Full Sutton since the beginning of 2015. Three of the other deaths are still under investigation. We have previously made recommendations about inadequate risk assessments for the use of restraints.

Key Events

19. On 9 December 2011, Mr Martin Stafford completed a seven-year prison sentence for rape in Ireland. Shortly after his release, he was arrested and extradited to the UK to stand trial for murder. On 31 July 2012, he received a life sentence, with a minimum term to serve of 32 years.

20. Mr Stafford had been at HMP Full Sutton since 7 November 2012. He had a history of drug and alcohol abuse. He had been diagnosed with several chronic mental and physical health conditions, including hepatitis C (a blood borne virus that affects the liver), advanced liver disease, portal hypertension (raised pressure in the blood vessels linked to the liver) and significant abdominal ascites (build up of fluid in the abdomen due to poor circulation). He was under the care of a consultant hepatologist at hospital, who advised him to delay treatment for hepatitis C as new treatment and drugs were imminent. Prison GPs and nurses managed his symptoms, including frequent blood tests to monitor his liver function.

21. At the end of 2012, Mr Stafford's condition began to deteriorate. In August 2013, prison healthcare staff produced a short life span care plan, which they reviewed periodically and referred him to a Macmillan nurse.

22. On 23 June 2014, Mr Stafford reported severe stomach pain to a prison GP, who prescribed codeine (an opiate painkiller). The GP found that Mr Stafford had gained ten kilograms (kg) in weight due to a build up of abdominal fluid, despite taking spironolactone (a diuretic to reduce water retention). Mr Stafford's fluid retention worsened and, on 26 June, the GP sent him to hospital to have it drained. Mr Stafford remained in hospital until 5 July.

23. Between June and October, Mr Stafford went to hospital a further five times for fluid to be drained. The hospital discharge letter after his last admission said that he was not suitable for a liver transplant, but, if they treated his fluid retention, there was a 50% chance that he would live for up to five years. The hospital inserted a central line (to administer liquid medication) to help better manage Mr Stafford's condition and prison nurses received training to manage it.

24. Between September and November 2014, Mr Stafford successfully completed treatment for hepatitis C and his condition remained relatively stable until April 2015. However, he then experienced an increasing build up of fluid and breathlessness. His mobility decreased and he began to use a wheelchair, as he could walk only for short distances. A prisoner carer helped him by collecting his meals and cleaning his cell.

25. On 1 May, a prison GP told Mr Stafford that his condition was deteriorating. After consulting a gastroenterologist at the hospital, she produced a detailed clinical management plan. She increased his diuretic medication and requested weekly blood tests.

26. On 7 May, Mr Stafford was taken to hospital for fluid to be drained. A prison manager decided that three officers should escort him and use double handcuffs and an escort chain when he was receiving treatment or using the toilet. (Double handcuffing is when the prisoner's wrists are handcuffed in front of him and one

wrist is attached to a prison officer by an additional set of handcuffs. 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.) Mr Stafford returned to Full Sutton on 11 May. A nurse noted he still had obvious fluid retention in his stomach and legs.

27. Mr Stafford became increasingly frail. On 22 May, a prison GP advised that he should be admitted to the prison's inpatient unit, but he refused. She informed the Head of Healthcare and wing officers of his deteriorating condition and asked his carer to give him extra help. On 26 May, she reviewed Mr Stafford, who was unable to stand up from his wheelchair and was mildly confused. She telephoned his consultant hepatologist at the hospital, who advised her to prescribe antibiotics until his next hospital appointment and said he would try to attend the next multidisciplinary meeting at the prison, in two weeks.

28. On 1 June, a hepatologist from the hospital reviewed Mr Stafford in the prison. He diagnosed possible bacterial peritonitis (an infection of ascitic fluid) and changed the antibiotics. He advised prison GPs and nurses to monitor Mr Stafford closely for deterioration.

29. On 4 June, Mr Stafford asked to move to the inpatient unit, as he was feeling weaker, and he was admitted later that afternoon. Two days later, he was moved to a cell with a hospital bed.

30. On 8 June, a prison GP discussed Mr Stafford's management, the underlying reasons for his deterioration and the possibility of a liver transplant with his consultant. Mr Stafford was not suitable for a transplant.

31. At a review on 19 June, the prison GP found that Mr Stafford was more coherent and less confused but referred him to hospital for an urgent MRI scan to assess whether he had cerebral disease. On 17 July, she noted that Mr Stafford shuffled his feet and leaned to the right when walking, and that he had fallen several times. She asked that he should stay in the inpatient unit indefinitely. Mr Stafford was a category A prisoner (the highest security category) and she discussed with the Head of Healthcare the possibility of downgrading his security status so he could transfer to a unit better able to manage frail or elderly prisoners. The Head of Healthcare thought this unlikely, as a previous application, in November 2014, had been unsuccessful.

32. On 29 July, a nurse found Mr Stafford confused. She took his basic observations, which were all within the normal range. A prison GP reviewed him later that day and discussed his symptoms with a doctor at the hospital. The hospital doctor advised twice-daily phosphate enemas to reduce the build-up of toxins caused by liver failure. Nurses started a food and fluid monitoring chart. The next day, staff noticed that Mr Stafford had difficulty following instructions and was incontinent of urine. The GP sent him to hospital, where he was diagnosed with dehydration. Officers used double handcuffs to restrain him.

33. Mr Stafford returned to Full Sutton on 1 July. He was alert and orientated but, over the next few weeks, he continued to fluctuate between confused and lucid. GPs thought his confusion was due to toxicity from liver disease. By mid-August, he needed help with all his personal care and could not walk without help.

34. On the morning of 13 August, Mr Stafford appeared confused and was unable to understand instructions. Staff gave him an enema, which helped his symptoms. At 5.15pm, a prison GP noted that Mr Stafford was in an "acute confusional state" and listed him for a further review the next day.

35. At 10.40pm, a nurse looked through Mr Stafford's door hatch and was concerned as there was food all over his cell floor; he had plugged the sink with a towel and left the tap running. She was concerned about his safety as there were electrical items on the floor.

36. The nurse asked the night manager to open the cell so she could safeguard him, due to his confusion and the risk of him falling. The night manager refused to allow this as he considered there was insufficient risk, weighed against Mr Stafford's category A security status. At 2.30am, the nurse checked him again and saw him slip and fall. She immediately asked for the cell to be opened, so that she could check Mr Stafford and make the cell safe, but the night manager again refused, as it was not an emergency. Mr Stafford remained confused throughout the night.

37. On 19 September, a prison GP reviewed Mr Stafford, who was very confused, unable to stand and looked mildly jaundiced. He sent Mr Stafford to hospital. Escort staff used single handcuffs and an escort chain. Doctors found that his deterioration was due to a build up of toxins, but Mr Stafford refused to allow hospital staff to perform an enema or insert drainage tubes. Hospital doctors assessed that he had the mental capacity to make decisions about his medical care and discharged him to Full Sutton on 24 September.

38. For the next few weeks, Mr Stafford was reluctant to take his full dose of diuretic and refused some medication. Nurses encouraged him to take his medication and noted that his mental capacity fluctuated.

39. On 14 October, Mr Stafford went to hospital for fluid drainage. Escort staff initially used handcuffs and an escort chain. The next day, the deputy governor decided they should be removed, as they were restrictive and impeded his treatment. Mr Stafford returned to Full Sutton on 16 October.

40. Mr Stafford's fluid retention worsened. Prison GPs reviewed him frequently and revised his medications. On 20 October, a GP examined Mr Stafford. She noted that she had not met Mr Stafford before, but would be surprised if he survived for 12 months.

41. At about 1.00am on 3 November, a nurse examined Mr Stafford after he shouted from his bed that he was short of breath. He asked to see the out of hours GP, but she decided it was not an emergency and he went back to sleep. At 8.32am, a nurse gave Mr Stafford his medication and took his observations. His weight had increased (due to the fluid build up), he was short of breath and his legs and feet were swollen. She asked the GP to review him as soon as possible and monitored his observations in the meantime.

42. That afternoon, a prison GP reviewed Mr Stafford and sent him to hospital, where hospital doctors drained the excess fluid. Escort officers used double handcuffs and an escort chain during some of his treatment. On 4 November, the deputy

governor decided the escort chain should be removed temporarily for treatment. It was then reapplied. Mr Stafford returned to Full Sutton's inpatient unit on 6 November.

43. Mr Stafford's breathlessness continued. On the morning of 8 November, a prison GP prescribed antibiotics and nebulisers for a possible chest infection. After reviewing him that evening, a nurse and another GP sent him to hospital. Escort officers used an escort chain.

44. Hospital doctors diagnosed a respiratory infection and fluid on Mr Stafford's lungs and admitted him as an inpatient. He did not recover and, after a fall in the hospital on 11 November, hid condition deteriorated rapidly. At 5.20am on 12 November a prison manager decided officers should remove the escort chain. Mr Stafford died at 5.47pm that evening.

Contact with Mr Stafford's next of kin

45. A Supervising Officer (SO) had acted as Mr Stafford's family liaison officer since September 2014. He had contacted the next of kin, a named representative from the Irish Council for Prisoners Overseas, and explained that Mr Stafford would write to him about his wishes. He offered support to Mr Stafford and obtained updates on his condition.

46. As the SO was not on duty on 12 November, the Safer Custody Manager informed Mr Stafford's next of kin of his death and explained the procedures.

47. The SO kept in contact with Mr Stafford's next of kin, including discussing the funeral arrangements. Mr Stafford's funeral was held on 27 November. The prison arranged and paid for his funeral, in line with national policy.

Support for prisoners and staff

48. After Mr Stafford's death, a prison manager debriefed the escort staff. He offered his support and that of the staff care team.

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

Post-mortem report

50. The report of the post-mortem examination indicated that the cause of Mr Stafford's death was pneumonia of the left lung and decompensated chronic alcoholic liver disease (where the liver is not able to perform all its functions properly, resulting in serious symptoms and complications).

Findings

Clinical care

51. Mr Stafford had several serious medical conditions, including advanced liver disease and hepatitis C. Prison healthcare staff reviewed and treated his symptoms and often sent him to hospital to drain the fluid from his abdomen and lungs.

52. The clinical reviewer considered that the overall standard of both nursing and medical care was good. It was delivered with sensitivity and tailored to Mr Stafford's needs. There was thorough consideration of his complex medical needs, and commendable liaison and joint working with the specialist hepatology team at the hospital, and between different disciplines within the prison. There was good continuity and overall consistency of care. We are satisfied that Mr Stafford had a good standard of care at Full Sutton, which overall was equivalent to that he could have expected to receive in the community.

Opening cells at night

53. During the night of 13/14 August 2015, a nurse considered that Mr Stafford was at risk. He was confused, there was a lot of food on his cell floor, and water was running on the floor where there were electrical items. Mr Stafford slipped and fell. The nurse wanted to examine him, check his condition and make the cell safe, but the night manager refused this twice. He considered the situation insufficiently serious.

54. As a high security prison, the night security arrangements require a minimum of four officers to be present to unlock a cell, except in an emergency. There should be sufficient staff available to allow this in appropriate circumstances. We are concerned that the night manager overrode the nurse's clinical judgement about a prisoner in the inpatient unit, placing Mr Stafford at greater risk of injury and delaying any treatment he might have needed. In this respect his care was not equivalent to community care. We make the following recommendation:

    The Governor should ensure that healthcare staff are able to examine prisoners at night when they have concerns about their wellbeing and safety, unless there are exceptional documented security reasons why a cell should not be opened.

Escort risk assessments

55. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. 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 takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated

that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

56. Mr Stafford was able to walk only short distances with help, and used a wheelchair. In the last few months of his life, he fell frequently and found it difficult to stand. The risk assessments for hospital admissions considered him a medium risk to the public, staff and of hostage taking, and a low risk of escape. None of the assessments included specific information about his medical or physical condition, and how this affected his level of risk. During Mr Stafford's last admission to hospital, in November 2015, he was very unwell. An escort chain was used and not removed until shortly before he died. The post-mortem report noted that there was bruising to his wrists from the handcuffs.

57. The prison mostly used the standard escort security procedures for category A prisoners in good health; three escort officers accompanied Mr Stafford, using double handcuffs and an escort chain in hospital if needed. Although this arrangement was appropriate while Mr Stafford was fully mobile, the risk assessment did not consider his deteriorating health and his assessed level of risk did not change.

58. The prison's Head of Security said that all prisoners who leave the prison go out with some form of restraint, the minimum being an escort chain. He said this was because prisoners at Full Sutton had committed violent or sexual offences and, historically, had shown they are still able to reoffend, even if nearly immobile. All restraints would be removed if the prisoner was immobile, or heavily sedated. We do not consider that this approach meets the requirements of the High Court judgment, which requires an individual assessment in each case, taking into account information from healthcare staff.

59. The Prison Service has a responsibility to protect the public, but security must be balanced with humanity and measures must be proportionate to a prisoner's individual circumstances. Mr Stafford's condition had significantly deteriorated towards the end of his life, but the risk assessments and decisions about the use of restraints did not reflect this and considered that he presented the same risk as when he was in better health. We are not satisfied that staff appropriately assessed Mr Stafford's risk. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time

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