

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Geoffrey Swann a prisoner at HMP Full Sutton on 1 April 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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 Geoffrey Swann died on 1 April 2016 from bilateral pneumonia, as a result of complications arising from a stroke, diabetes and chronic kidney disease, while a prisoner at HMP Full Sutton. He was 59 years old. I offer my condolences to those who knew him.

Mr Swann suffered with an under active thyroid and type one diabetes, which caused chronic kidney disease and renal failure. In March 2016, Mr Swann was admitted to hospital following deterioration in his condition. Medical investigations indicated that he might have had a stroke, additional to his deteriorating diabetes, kidney disease and renal failure. Mr Swann's health rapidly declined in hospital. I am satisfied that Mr Swann received a very good standard of care at Full Sutton, at least equivalent to that he could have expected to receive in the community.

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

October 2016

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Summary

Events

1. On 22 January 2007, Mr Geoffrey Swann was sentenced to 20 years in prison for sexual offences. His medical history included hyperthyroidism (an under active thyroid) and type one diabetes, which resulted in chronic kidney disease and renal failure (that required dialysis treatment up to three times a week), he also had poor eyesight.
2. Mr Swann attended outpatient appointments for his chronic ill health and had several emergency hospital admissions. On 3 August 2012, he transferred to HMP Full Sutton, as their healthcare unit was able to facilitate on-site dialysis.
3. Over the next three years, Mr Swann's health gradually declined. Despite advice from healthcare staff, he did not keep to his diabetic diet and there were times when he refused to attend his dialysis sessions.
4. In December 2015, a doctor spoke to Mr Swann about his quality of life and palliative care plans. Mr Swann told the doctor he was not interested in making decisions about his health, any care plans, or his prognosis.
5. On 22 March 2016, prison staff found Mr Swann unwell in his cell. Nurses responded and found that he was drifting in and out of consciousness. They could not take his medical observations, due to his agitation, and they asked for an emergency ambulance. Paramedics took Mr Swann to hospital, where he was admitted to intensive care.
6. Medical investigations indicated that Mr Swann might have had a stroke. On 26 March, hospital staff withdrew treatment and Mr Swann was placed on an end of life care plan. At 12.50pm on 1 April, Mr Swann stopped breathing and a hospital doctor confirmed his death.

Findings

7. We agree with the clinical reviewer that Mr Swann's care in prison was very good and at least equivalent to that he could have expected to receive in the community. At the end of his life, Mr Swann received a high standard of nursing care that covered his physical, emotional and spiritual needs. We make no recommendations.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Full Sutton, informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.
9. The investigator obtained copies of relevant extracts from Mr Swann's prison and medical records.
10. NHS England commissioned a clinical reviewer to review Mr Swann's clinical care in prison.
11. We informed HM Coroner for Hull of the investigation, who gave us the results of the post-mortem examination. We have sent the coroner a copy of this investigation report.
12. Mr Swann had no recorded next of kin and did not want anyone to be told of his illness or death.
13. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Full Sutton

14. HMP Full Sutton is a high security prison near York, which holds up to 600 men. Spectrum Community Health CIC provides a range of integrated health services. Healthcare staff are on duty for 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

15. The most recent inspection of Full Sutton was an unannounced inspection in January 2016. The inspectors found that healthcare provision was reasonable overall, with good access to an appropriate range of services. Chronic disease management was reasonable but social care arrangements were underdeveloped. The inpatient unit provided a calm and decent service.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure prisoners are treated fairly and decently. In its most recently published annual report for the year to January 2015, the IMB commented that the care and treatment of terminally ill prisoners at Full Sutton was exemplary. They found that the prison had resolved problems with the provision of medical and social care on a twenty-four hours basis for terminally ill prisoners during the reporting year.

Previous deaths at HMP Full Sutton

17. Mr Swann was the seventh person to die of natural causes at Full Sutton since January 2015. There has been one other natural cause death since Mr Swann died. There were no significant similarities with the circumstances of the previous cases. We have consistently found that prisoners received a good standard of healthcare at Full Sutton

Key Events

18. On 22 January 2007, Mr Geoffrey Swann was sentenced to 20 years in prison for sexual offences and was sent to HMP Hull. On 28 October 2009 he moved to HMP Wakefield.
19. Mr Swann's medical history included hyperthyroidism, type one diabetes, which resulted in chronic kidney disease and renal failure (that required dialysis treatment up to three times a week) and poor eyesight. While he was able to care for himself, he had assistance from buddy carers to fetch his meals (a prisoner trained to support older prisoners and those in need of assistance).
20. On 3 August 2012, Mr Swann was transferred from HMP Wakefield to HMP Full Sutton, as they were able to facilitate on-site dialysis.
21. On 7 August, a consultant physician and nephrologist documented that Mr Swann needed dialysis three times a week, which could take place at Full Sutton and Mr Swann would have outpatient reviews at the renal unit at hospital every three to four months.
22. In February 2013, the consultant reviewed the prospect of Mr Swann's placement on a kidney transplant list. However, Mr Swann was high risk due to his underlying medical conditions and poor health so this was not pursued at the time.
23. On 27 August, a nurse created a 'short life span' care plan for Mr Swann. The care plan ensured Mr Swann was aware of his illness and prognosis, that there was appropriate monitoring of his condition and that he received assistance with his daily living activities as required.
24. On 16 December, Mr Swann went to hospital by emergency ambulance, as he had chest pains. A doctor confirmed that the chest pain was caused by fluid overload (a side effect of kidney disease). The doctor agreed with Full Sutton that Mr Swann should increase his dialysis to four times a week.
25. Mr Swann's condition continued to deteriorate with spells of poor health and emergency admissions to hospital. Despite frequent advice from healthcare staff, Mr Swann did not keep to his diabetic diet.
26. On 3 September 2014, Mr Swann went to hospital with a swollen right arm, suspected to be a DVT (deep vein thrombosis) and abdominal pain. Medical investigations showed a slow heart rate due to elevated potassium levels which were treated in hospital. On 25 September, Mr Swann returned to Full Sutton. Three days later, Mr Swann told a mental health nurse that his recent stay in hospital had frightened him so he had decided to make a conscious effort to change his diet and look after both his mental and physical health.
27. On 3 November 2015, Mr Swann attended hospital for an ultrasound scan. The scan showed evidence of an abnormal build-up of fluids in the abdominal cavity and around the left lung. The consultant wrote to Full Sutton and confirmed that Mr Swann was in end stage renal failure. He said that, although Mr Swann had dialysis four times a week dialysis, his fluid balance was still not controlled,

through his diet and ongoing poor health. Again, records showed that Mr Swann did not keep to his diabetic diet and he often declined to attend dialysis sessions. Clinicians were satisfied that he had the mental capacity to make decisions about his care.

28. On 17 December, a prison GP noted that Mr Swann's condition was declining and that his prognosis was poor. Mr Swann was due to see the consultant at an outpatient appointment the next day, but he refused to attend.
29. On 18 December, Mr Swann saw a prison GP and they discussed palliative care plans. He wrote that Mr Swann did not want to know about advanced care planning or be part of any decisions about his poor prognosis. Mr Swann told him that he had no preferred place to die. He wrote that Mr Swann had been consistent with his wishes and attitude.
30. On 9 January 2016, Mr Swann moved to the inpatient's unit for an extended, potentially permanent basis. A nurse noted that he was concerned about being isolated. She arranged for Mr Swann to continue to attend the chapel and the over 60's group. She also arranged for his reading mentor to visit him and for him to maintain contact with the education department.
31. Healthcare staff continued to review Mr Swann daily. On 15 January 2016, a prison GP spoke to Mr Swann and they discussed his quality of life. Mr Swann said he preferred to be in his cell on the wing rather than an inpatient in the healthcare unit. Mr Swann also said that if he had not been in prison over the past few years his lack of self-control would have meant he would more than likely have died before now.
32. On 18 January, a nurse spoke to Mr Swann following his refusal to attend for dialysis. He told the nurse his legs were too painful and he was unhappy being an inpatient. The nurse explained to Mr Swann that, as an inpatient, staff were able to monitor his blood sugars and help with his care. However, Mr Swann was insistent he wanted to return to his wing cell.
33. Later that day, a prison GP met Mr Swann and they discussed his wishes about resuscitation. Mr Swann said he did not want staff to attempt resuscitation if his heart or breathing stopped and he completed a form to that effect. He noted that this was Mr Swann's decision and made while he had full capacity and insight.
34. Later, a care plan was prepared for Mr Swann to remain in the prison's inpatient unit. However, if his condition stabilised he wanted to return to his cell. The plan noted that Mr Swann would have the option to move to the palliative care suite when he no longer wanted to have dialysis.
35. On 19 January, Mr Swann agreed to attend hospital for a MRI scan. Mr Swann told a nurse that he had no next of kin and did not want anybody contacted in the event of his death.
36. On 21 January, Mr Swann attended a case conference with healthcare staff and prison staff to talk about future management of his health. The meeting noted that Mr Swann now wanted staff to attempt resuscitation. It also decided that the chaplaincy would support Mr Swann and the prison would submit an application for a compassionate release.

37. At approximately 7.00am on 22 March, two nurses examined Mr Swann, as he was unwell. They found that Mr Swann was drifting in and out of consciousness, and was extremely agitated to the extent that they had to restrain him to prevent him from injury. They were unable to obtain any medical observations due to this distress. At 7.26am, a nurse asked for an emergency ambulance.
38. The ambulance arrived at 8.00am and the paramedics stabilised Mr Swann and took him to hospital. The hospital admitted Mr Swann and, at 2.10pm, he moved to the intensive care unit.
39. Following a brain scan on 26 March, the hospital told prison healthcare staff that there was a possibility that Mr Swann had suffered a stroke. He was unable to communicate and his prognosis was poor. The hospital confirmed that end of life care would now be provided and dialysis withdrawn.
40. At around 12.50pm on 1 April, hospital staff noted Mr Swann was not breathing and a hospital doctor confirmed his death.

Contact with Mr Swann's family

41. The prison appointed an officer as a family liaison officer for Mr Swann after he moved to Full Sutton. The officer regularly spoke with Mr Swann, who always said that he had no next of kin and did not communicate with anyone outside of the prison.
42. On 21 January 2016, during a case conference, Mr Swann reiterated that he had no next of kin and that there was no one to be told of his present poor health or death. The officer and members of the chaplaincy team continued to visit Mr Swann to offer support.
43. Mr Swann's funeral was on 20 April. The prison arranged and contributed towards this in line with national policy.

Support for prisoners and staff

44. After Mr Swann's death, a prison manager debriefed the prison escort staff who had been with Mr Swann in hospital to give them the opportunity to discuss any issues arising, and to offer support.
45. The prison posted notices informing prisoners and staff of Mr Swann'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 Swann's death. The prison also held a service of remembrance for Mr Swann in the chapel.

Post-mortem report

46. A post-mortem examination concluded that Mr Swann had died of bilateral pneumonia, as a result of complications arising from a stroke, diabetes and chronic kidney disease.

Findings

Clinical care

47. The clinical reviewer was satisfied that Mr Swann received a high standard of care in HMP Full Sutton. The healthcare staff created appropriate care plans with instructions on how to manage Mr Swann's numerous medical conditions and he was able to be involved in his care, although he did not always wish to be. Healthcare staff provided him with advice and support throughout.
48. There were discussions between healthcare staff and Mr Swann about his preferences for his end of life care, including his wishes on resuscitation. Mr Swann was involved in these decisions, and they were made known to prison, healthcare and hospital staff.
49. The standard of care Mr Swann received throughout his time at Full Sutton and around his dialysis was of a high standard. There was a very good level of communication between the prison healthcare staff and hospital staff. There was evidence that healthcare staff treated Mr Swann with care and compassion. The care he received was at least equivalent to that he could have expected to receive in the community.

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