Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Kimberley a prisoner at HMP Full Sutton on 19 May 2016

A report by the Prisons and Probation Ombudsman
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Our Vision

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

Our Values

We are:

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

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

The 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 Michael Kimberley died on 19 May 2016 of pneumonia at York Hospital. He was 54 years old. I offer my condolences to Mr Kimberley's family and friends.

I am satisfied that Mr Kimberley's care at Full Sutton was at least equivalent to that he could have expected in the community. Although there were communication difficulties caused by his confused mental state, healthcare staff managed Mr Kimberley's medical conditions well and when his vital signs became abnormal, a doctor promptly sent him to hospital.

However, I am concerned that healthcare staff did not reassess Mr Kimberley's risks in keeping his medication in his cell, despite a clear deterioration of his cognitive function. I am also concerned that in spite of Mr Kimberley's poor physical condition and limited mobility, officers restrained him with double handcuffs and that the prison did not inform his family promptly that he had been admitted to hospital.

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

Richard Pickering
Deputy Prisons and Probation Ombudsman **December 2016**

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Summary

Events

1. On 11 March 2013, Mr Michael Kimberley was sentenced to ten years imprisonment for sexual offences. He had been at HMP Full Sutton since 11 July.

2. Mr Kimberley had a number of medical conditions, including hypertension (high blood pressure), hypercholesterolemia (high levels of cholesterol in the blood), angina, diabetes and a fatty liver. Healthcare staff created care plans to manage his chronic conditions and prescribed a range of medication.

3. From May 2015, Mr Kimberley became increasingly confused and this affected his mobility and eating. In November, healthcare staff admitted him to the inpatient unit. They created a care plan to assist him with his daily living and reviewed him several times a day. On the day that he moved, staff found a stockpile of medication in his previous cell.

4. On 12 May 2016, nurses noted that Mr Kimberley's pulse was too high, his temperature too low and he was particularly weak. A doctor sent Mr Kimberley to hospital, where he was diagnosed with severe sepsis. While in hospital, he was initially restrained with double handcuffs, later reduced to an escort chain.

5. Mr Kimberley's condition continued to deteriorate and he died at 10.05am on 19 May.

Findings

6. We agree with the clinical reviewer that the care Mr Kimberley received at Full Sutton was at least equivalent to that he could have expected in the community. Healthcare staff monitored Mr Kimberley closely in the prison's inpatient unit and when his vital signs became abnormal, a doctor promptly sent him to hospital.

7. However, the investigation found that staff did not effectively assess Mr Kimberley's suitability to keep his medication in his cell after his cognitive function became significantly impaired.

8. We are concerned that officers restrained Mr Kimberley with double handcuffs, in spite of his restricted mobility, low risk of escape and a doctor's opinion that he was incapable of escaping unaided.

9. The prison did not immediately contact Mr Kimberley's family when he was seriously ill in hospital.

Recommendations

- The Head of Healthcare should ensure that risk assessments for in-possession medication take account of a prisoner's history and are reviewed if the prisoner presents with reduced cognitive function.
- The Governor 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 Governor should ensure, in line with Prison Rule 22 and PSI 64/2011, that the next of kin of seriously ill prisoners are informed as soon as possible so that they are able to visit them in hospital without unnecessary delay.

The Investigation Process

10. 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.

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

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

13. We informed HM Coroner for East Riding and Kingston Upon Hull of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.

14. One of the Ombudsman's family liaison officers contacted Mr Kimberley's daughter, to explain the investigation. She did not have any concerns for the investigation to consider.

15. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly.

16. Mr Kimberley's family received a copy of the initial report. They did not make any comments.

Background Information

HMP Full Sutton

17. HMP Full Sutton is a high security prison near York, which holds up to 626 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

18. 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

19. 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 hour basis for terminally ill prisoners during the reporting year.

Previous deaths at HMP Full Sutton

20. Mr Kimberley was the eighth person to die of natural causes at Full Sutton since January 2015. We have made previous recommendations about the inappropriate use of restraints and the need for prompt family liaison when a prisoner is sent to hospital.

Key Events

21. On 11 March 2013, Mr Michael Kimberley was sentenced to ten years imprisonment for sexual offences. When he went into prison, Mr Kimberley had several existing medical problems, including hypertension (high blood pressure), hypercholesterolemia (high levels of cholesterol in the blood) and angina. He had suffered two heart attacks in January 2013 and surgeons had inserted stents to improve his blood flow. Mr Kimberley also suffered from depression and chronic alcoholism.

22. Healthcare staff diagnosed Mr Kimberley with a fatty liver and type II diabetes mellitus, in May 2014 and March 2015, respectively. They monitored and reviewed these conditions, in line with care plans and prescribed a range of medication.

23. From May 2015, at HMP High Down, Mr Kimberley became increasingly confused. Healthcare staff referred him for a series of tests, including a CT scan, an electrocardiogram, an MRI scan and an electroencephalogram to establish whether this had been caused by a physical injury or organic brain disease. His confusion caused problems with eating and impaired his mobility.

24. On 11 July, Mr Kimberley returned to HMP Full Sutton (he had been there between March 2014 and April 2015). During the reception process, he signed a form to allow him to keep his medication in his cell and a pharmacy technician dispensed it two days later.

25. On 24 September, a hospital elderly care consultant asked for a review of Mr Kimberley's use of his medicines. A pharmacist reviewed all his medications, explained their use and when to take them. He then informed the consultant that an unexplained drop in Mr Kimberley's blood pressure might be due to him taking extra tablets. There is no evidence that a further review took place before Mr Kimberley was admitted to the inpatient unit.

26. Mr Kimberley was admitted to the inpatient unit on 29 November, after a nurse found that he could not answer simple questions. On the same day, a nurse went to Mr Kimberley's previous cell to retrieve his medication and found a number of different unused medications. As a result, healthcare staff decided that Mr Kimberley could not look after his own medication. After reviewing him the next day, a prison GP considered that his confusion might be due to dementia but noted that Mr Kimberley had appeared normal before his admission to the inpatient unit.

27. On 5 December, a nurse created an inpatient care plan to assist with Mr Kimberley's daily living, including his intake of food and drink, pain levels and vital signs. As a result, healthcare staff reviewed him several times a day. Investigation of his confusion continued during 2016 and healthcare staff noted the difficulties caused by the absence of a diagnosis.

28. Due to construction work in Full Sutton's inpatient unit, Mr Kimberley transferred to Wakefield's inpatient unit temporarily between 9 March and 2 May.

29. On 6 May, a nurse noted that Mr Kimberley was at an increased risk of falling so she created a care plan to reduce this risk. As part of this care plan, healthcare staff were to record any falls, assess his gait and mobility and consider whether he needed any walking aids. On 10 May, she noted that he had an unsteady gait and that staff needed to supervise him when he moved about.

30. On 12 May, a prison GP wrote to the psychiatric team at Newton Lodge, Wakefield, about his concern that Mr Kimberley might have pre-senile dementia and to request advice from a psychiatrist with experience of dementia.

31. At 10.37am the same day, a nurse took Mr Kimberley's vital signs. She noted that his pulse was high at 97 beats per minute (bpm) (the normal range is 51bpm to 90bpm) and his temperature low at 35.9°C (the normal range is 36.1°C to 38.0°C). At lunchtime, another nurse reviewed Mr Kimberley at the request of healthcare officers. They were concerned as he was very weak and needed a lot of help and direction to swallow a small amount of fluid. At 1.30pm, a prison GP examined Mr Kimberley and noted that he was pale, cold and clammy. He sent Mr Kimberley to the acute medical unit at hospital.

32. A senior prison manager authorised two officers to escort Mr Kimberley, using double handcuffs to restrain him, though officers could use an escort chain to allow treatment.

33. While Mr Kimberley was in hospital, doctors diagnosed severe sepsis. Healthcare staff frequently contacted the hospital for updates on his condition. On 14 May, hospital staff inserted a cannula into Mr Kimberley's left arm, so a prison manager authorised officers to remove the double handcuffs.

34. On 15 May, the hospital moved Mr Kimberley to the intensive care unit. They placed him on a ventilator and treated him with intravenous antibiotics. The senior prisoner manager then authorised officers to remove Mr Kimberley's restraints, though the escort chain was reapplied between 8.45pm on 16 May and 5.50am on 17 May.

35. Mr Kimberley's condition continued to deteriorate and he died at 10.05am on 19 May.

Contact with Mr Kimberley's family

36. On 17 May, a hospital doctor informed the escort officers that the prison should contact Mr Kimberley's next of kin. Initial attempts to contact his daughter were unsuccessful. The prison then appointed an officer as the family liaison officer. He contacted Mr Kimberley's brother to inform him of Mr Kimberley's condition and to offer support.

37. That evening, Mr Kimberley's daughter contacted the hospital for information on Mr Kimberley's condition. The following day, a senior prison manager authorised her to visit Mr Kimberley in the hospital.

38. After Mr Kimberley had died, the family liaison officer met Mr Kimberley's family at the hospital. He offered his condolences and supported them until Mr Kimberley's funeral.

39. Mr Kimberley's funeral was held on 8 June and the prison contributed to the costs, in line with national instructions.

Support for prisoners and staff

40. After Mr Kimberley's death, a prison manager debriefed the staff involved in the bedwatch to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

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

Cause of death

42. The coroner confirmed that the cause of death was bilateral pneumonia. Mr Kimberley also had ischaemic heart disease and cirrhosis of the liver.

Findings

Clinical care

43. We agree with the clinical reviewer that Mr Kimberley's cognitive confusion, and the inability to diagnose the cause, placed increased pressure on healthcare staff in managing his medical conditions. However, they responded with a high level of compassion and they supported his needs with numerous care plans.

44. Before his death, there was no evidence that Mr Kimberley was suffering from pneumonia. Healthcare staff regularly took his clinical observations and, until 12 May, his breathing rate, temperature and pulse remained normal. When these vital signs became abnormal, a prison GP promptly sent Mr Kimberley to hospital.

45. We agree with the clinical reviewer that the care that Full Sutton provided to Mr Kimberley was at least equivalent to that he could have expected in the community, though she identified a problem with keeping his medication in his cell.

46. Although Mr Kimberley showed signs of confusion from May 2015 and his ability to perform day-to-day tasks deteriorated, he continued to receive his medication in-possession. In November, it became clear that he had been hoarding his medication. We agree with the clinical reviewer that healthcare staff at Full Sutton should have reviewed the appropriateness of Mr Kimberley keeping his medication in his cell when it became clear that his cognitive function had diminished. We make the following recommendation:

    The Head of Healthcare should ensure that risk assessments for in-possession medication take account of a prisoner's history and are reviewed if the prisoner presents with reduced cognitive function.

Restraints, security and escorts

47. 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.

48. When Mr Kimberley went to hospital on 12 May 2016, a prison GP confirmed in the risk assessment document that he did not have any medical objections to the use of restraints, though his condition meant that he could not escape unaided. In the same assessment, a senior officer stated that Mr Kimberley presented a medium risk to the public and a low risk to hospital staff and of escape. He authorised officers to restrain Mr Kimberley with double handcuffs, with permission to use an escort chain for treatment. (Double cuffing is when the

prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs, while 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.)

49. On 14 May, a prison manager authorised a reduction in the level of restraints to accommodate intravenous treatment and officers completely removed them on 17 May.

50. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances. Double handcuffs are usually used for healthy prisoners yet Mr Kimberley was clearly acutely unwell. He had problems with his mobility and medical opinion was that he could not escape unaided. In spite of this, the senior officer authorised officers to use double handcuffs and an escort chain. We do not consider that prison managers appropriately considered how Mr Kimberley's physical condition had affected his risk of escape, or to the public, in line with the High Court judgment. We make the following recommendation:

The Governor 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.

Family liaison

51. Prison Rule 22 requires that when a prisoner becomes seriously ill, the Governor should "at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed". In addition, Prison Service Instruction (PSI) 64/2011, about safer custody, states that where prisoners suffer a rapid deterioration in their physical health, prisons must have in place procedures for supporting the prisoner and engaging with their next of kin.

52. Mr Kimberley was taken to hospital on 12 May. Doctors diagnosed severe sepsis, a life-threatening condition and placed him on a ventilator in the intensive care unit on 15 May. However, the prison did not appoint a family liaison officer or attempt to contact Mr Kimberley's family until 17 May. While Mr Kimberley's family were able to visit him in hospital before he died, delays in informing a family when a prisoner is seriously ill can mean that they miss the opportunity to see the prisoner before they die. We make the following recommendation:

The Governor should ensure, in line with Prison Rule 22 and PSI 64/2011, that the next of kin of seriously ill prisoners are informed as soon as possible so that they are able to visit them in hospital without unnecessary delay.

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