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 in January 2015, 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 man. The man died from pneumonia due to lung disease on 12 January 2015, at HMP Full Sutton. He was 65 years old. I offer my condolences to the man's family and friends

An investigator carried out the investigation. A clinical reviewer reviewed the clinical care the man received at Full Sutton. The prison cooperated fully with the investigation.

The man was sentenced to life imprisonment in 1993 and had been at Full Sutton since 1999. He had several longstanding medical conditions, including chronic obstructive pulmonary disease and hepatitis C. Healthcare staff reviewed the man frequently, but he often refused to take his medication or allow them to monitor his conditions. In May 2014, a doctor noted that the man was wheezing more than normal, but he refused any further investigation and the doctor considered his condition was stable at the time. However, the man's health steadily declined.

On 9 January, the man was suffering from pneumonia but refused to be admitted to hospital. Eventually, he agreed to be looked after in the prison's healthcare centre. On 11 January, a prison doctor considered that the man had less than 48 hours left to live. The man died in the prison's healthcare centre on the morning of 12 January.

I agree with the clinical reviewer that, although the man often refused to cooperate with medical advice and treatment, healthcare staff at Full Sutton provided a very good standard of care, which was equivalent to that he could have expected to receive in the community. At the end of his life, the man received a high standard of nursing care which covered his physical, emotional and spiritual needs

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **August 2015**

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SUMMARY

1. On 1 February 1993, the man was sentenced to life imprisonment for murder. He had been at Full Sutton since 1999. In 2006, the man, who was a heavy smoker, was diagnosed with chronic obstructive pulmonary disease (COPD) a severe lung condition and hepatitis C, a virus that can damage the liver. Doctors prescribed medication for COPD and implemented appropriate care plans. The man would not engage with doctors for active treatment of his hepatitis C, but regular blood tests showed his liver function remained within satisfactory limits and he had no major symptoms.

2. The man often did not attend healthcare appointments. He did not always take his medication as prescribed or cooperate with clinical observations to help monitor his condition. Healthcare staff encouraged him to engage with treatment but were satisfied that the man had the capacity to take decisions about his treatment and care.

3. The man had tests, which indicated that he had severe and worsening COPD. He continued to smoke but refused help to give up. In May 2014, a doctor noted that the man was wheezing more than normal. The man refused any further investigation, and his condition appeared stable at the time. His condition gradually deteriorated, but he still often continued to refuse medication.

4. On 9 January 2015, a senior nurse diagnosed the man with pneumonia. He refused to go to hospital but, later that evening, he agreed to be admitted to the healthcare centre. Prison staff tried to contact the man's family in Ireland but were unable to get through. On 11 January, a prison doctor considered that the man had no more than 48 hours to live and began an end of life care plan to keep him comfortable and pain free.

5. On the morning of 12 January, a nurse noted the man's breathing indicated he was reaching the end of life and he stopped breathing shortly afterwards. Nurses tried to resuscitate him but this was unsuccessful. The nurse recorded that the man had died just before 9.00am.

6. The man's sister had noticed missed calls and tried to phone the prison on 11 and 12 January but the switchboard had been unable to connect her to anyone who knew the situation. The man had been in contact with the Irish Commission for Prisoners Overseas and, after he died, a chaplain tried to arrange for a priest from the commission to inform his family, but he was unavailable that morning. Eventually, the prison's family liaison officer telephoned and informed his sister that the man had died. The priest visited his family that afternoon.

7. We agree with the clinical reviewer that despite the man's reluctance to engage with healthcare, he received a high standard of care at Full Sutton. Unfortunately, communication with the man's family did not go smoothly, but we consider that the prison made reasonable, if unsuccessful, attempts to contact them.

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. Two prisoners contacted the investigator in response.

9. The man also used the another name and was sentenced and known by this name in prison. In this report, we refer to him by his birth name.

10. NHS England commissioned a clinical reviewer to review the man's clinical care in prison.

11. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record.

12. We informed HM Coroner for East Riding and Kingston upon Hull District of the investigation, who provided the post-mortem report. We have sent the coroner a copy of this investigation report.

13. One of the Ombudsman's family liaison officers contacted the man's family by letter and telephone. The man's sister asked when the man had been diagnosed with hepatitis C and whether he had received appropriate treatment in prison. His sister was concerned about how she had been informed of her brother's death as she had telephoned the prison on Sunday 11 January and on the morning of Monday 12 January, to try to get information.

14. The man's family received a copy of the draft report. They remained unhappy about some of the care that the man received, but did not raise any factual inaccuracies.

HMP FULL SUTTON

15. HMP Full Sutton is a high security prison near York, which hold up to 600 men. Healthcare services are commissioned through the Yorkshire and Humber Area Team of NHS England and at the time of the man's death were provided by the prison. There are registered general and mental health nurses, as well as 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

16. The last inspection of Full Sutton was in December 2012. The Inspectorate noted that clinical governance arrangements were satisfactory and the range and quality of healthcare services were good, although prisoners were generally dissatisfied with these services. Inspectors described the inpatient healthcare unit as satisfactory and patients were positive about the quality of care they received

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 recently published annual report for the year to October 2013, the IMB noted that the healthcare unit offered a first class level of care. The IMB noted that the care of the elderly and chronically ill continued to increase in volume and costs, but staff delivered this with compassion and professionalism.

Previous deaths at HMP Full Sutton

18. The man was the sixth prisoner to die of natural causes at Full Sutton since the start of 2013. There were no significant similarities with the circumstances of the previous cases.

KEY EVENTS

19. On 21 December 1993, the man, was sentenced under the name of Adam Hughes to life imprisonment with a minimum period to serve of 16 years before he could be considered for release. He had been at HMP Full Sutton since May 1999.

20. The man's healthcare records show that doctors diagnosed and treated him for depression in 1994. In 2006, he was diagnosed with chronic obstructive pulmonary disease (COPD), the name used for a collection of lung diseases including chronic bronchitis and emphysema. People with COPD have difficulty breathing, primarily due to the narrowing of their airways. He was also diagnosed with hepatitis C, a virus that can damage the liver. The clinical reviewer noted that it was not clear when the man had contracted hepatitis C, but it could have been the result of an infected blood transfusion many years previously, before blood was screened.

21. The man was a heavy smoker and doctors considered this was the main cause of his COPD. Healthcare staff frequently offered him help to stop smoking, but he always declined. Healthcare staff monitored the man's COPD regularly, but the man often refused to attend healthcare appointments.

22. The man would not engage with doctors about his hepatitis C, so received no active treatment, such as anti-viral drugs. However, he had regular blood tests, which showed his liver function remained within satisfactory limits and there were no signs of any symptoms to suggest his condition was deteriorating.

23. The man had a number of chest X-rays and spirometry tests to measure the progress of his lung disease, which indicated that he had severe and worsening symptoms. Doctors prescribed medication to ease the symptoms, but he did not always take it.

24. Throughout 2012 and most of 2013, healthcare staff saw the man frequently but he continued sometimes to refuse to take medication and still did not want any help to give up smoking. He also continued to miss many healthcare appointments. Healthcare staff often spoke to the man about the importance of taking his prescribed medication, but this had little effect. Doctors and a mental health nurse assessed him as having the mental capacity to make decisions about his health and treatment.

25. On 8 September 2013, a prison GP, examined the man and noted that he had continued to lose weight due to his COPD. The doctor restarted some of his medication and inhalers to help relieve his symptoms. In November and December, the man did not attend chest X-ray appointments, arranged to help monitor the progress of his COPD.

26. Healthcare staff saw the man whenever he asked or would agree to see them. On 27 May 2014, the GP noted he had a worsening wheezy chest, he was speaking in short sentences and there were crackles (crepitations) across his chest. The GP recorded that there was little they could do, as his condition was stable at that point, and the man did not want further investigation.

27. For the remainder of 2014, healthcare staff saw the man a number of times for unrelated health complaints. His weight loss persisted and doctors prescribed a food supplement. As previously, he sometimes refused his medication and did not attend all healthcare appointments.

28. At 9.30am on 9 January 2015, an officer asked for urgent medical help. A nurse went to the man's cell and noted he was breathless. He told the nurse that he had been experiencing flu-like symptoms for five days. The nurse arranged for him to go to the healthcare centre where he had an electrocardiogram (ECG) test, which showed that his heart rhythm was normal but the rate was fast.

29. A nurse prescriber examined the man and diagnosed right-sided pneumonia, for which he prescribed an antibiotic. The man refused to go to hospital or to be admitted to the healthcare centre as an inpatient for treatment and monitoring. (The man had a fear of going to hospital because of a previous traumatic experience many years earlier.) The nurse explained the risks of rapid deterioration and that he might die if nothing was done, but the man said he understood. The nurse noted that he had no reason to question the man's mental capacity and his ability to make his own decisions about his care. The nurse booked a chest X-ray and took blood samples.

30. At 2.00pm that day, the nurse reviewed the man, who said he was feeling better than he had that morning. Nurses checked the man three more three times during the afternoon. At 5.15pm, officers called for medical help as the man was having difficulty breathing. A nurse attended and suggested the man should move to the healthcare centre for monitoring, but again he would not go. Healthcare staff considered providing the man with oxygen in his cell to help alleviate his breathing difficulties, but he continued to smoke, so this would be dangerous.

31. Later that evening, the man became acutely unwell and asked to be admitted to the healthcare centre inpatient unit. He agreed he would go to hospital if there were further complications. In the inpatient unit, nurses assessed his risk of falls, pressure sores and nutritional status. They began a fluid balance chart and referred him to the Macmillan service. (The man's condition deteriorated very quickly and a Macmillan nurse was unable to see him before he died.)

32. On 10 January, a prison GP discussed with the man whether he wanted to be resuscitated if he stopped breathing. The doctor told us that the man fully understood that his condition was terminal and that, in his condition, resuscitation was unlikely to be successful. However, the man said he wanted staff to try. The GP noted that as the man's condition was so poor, he

would need to be given oxygen and heart massage therapy as any further intervention would be futile and cause the man unnecessary indignity. The GP recorded that there would be no purpose in calling an emergency ambulance, unless resuscitation was successful. That day, the medical records indicate that he had asked to see the Imam and a priest in view of his 'dual faith'.

33. At 11.35am on 11 January, the GP examined the man and noted his condition had deteriorated since the day before. He considered that the man had less than 48 hours to live. The man did not want to move to the palliative care room in the inpatient unit. The GP considered the man still had mental capacity and understood that his condition was terminal.

34. The GP prescribed medication, in case it was needed, to ensure the man's comfort and to relieve anxiety as he reached the end of his life. Healthcare staff implemented an end of life care plan to keep the man as comfortable as possible and to help ensure he had a dignified death.

35. Between 8.15am and 8.30am on 12 January, the nurse assessed the man and noted that his breathing had altered and he appeared to be nearing the end of his life. The nurse went to prepare some medication for him and when she got back, she found the man unresponsive. She called for help and another nurse joined her. The nurse started to attempt resuscitation, and gave oxygen in line with the man's wishes and the doctor's instructions.

36. The man did not respond and the nurse checked the man and found he had no vital signs. She decided that further intervention would be futile. At 8.59am, she recorded that the man had died.

Liaison with the man's Family

37. The man had converted to Islam and on 10 January 2015, when he became increasingly unwell, one of the prison chaplains, the Imam, tried to help him telephone his family in Belfast, who were aware he was unwell. However, they were unable to get through. The man agreed that the custodial manager in the healthcare centre, should continue try on his behalf. The custodial manager tried again on Sunday 11 January, but was still unable to get through. No one from the prison was able to speak to the man's family before his death to let them know he was critically ill.

38. On 12 January 2015, the prison appointed an officer as the family liaison officer. After the man's death, the Imam tried to contact a priest from the Commission for Irish Prisoners Overseas, to ask him to inform the man's family that he had died. However, the priest was not available at the time, so he left a message for him.

39. At 11.19am, the family liaison officer rang the telephone number they had for the man's mother and his sister replied. The family liaison officer informed her of the man's death and offered his condolences and assistance. The

priest from the Irish Prisoners Overseas Commission visited his family that afternoon to offer support.

40. The prison held a memorial service for the man on 21 January. The family liaison officer helped arrange the repatriation of the man's body to Northern Ireland for his funeral and the prison contributed towards the cost in line with national policy.

Support for staff and prisoners

41. A Governor's notice informed staff and prisoners of the man's death and offered support to anyone affected. On 12 January, a prison manager debriefed the nurses who were with the man when he died and offered them support. Staff reviewed all prisoners identified as at risk of suicide and self-harm, in case they had been adversely affected by the man's death.

Post-mortem

42. A post-mortem examination found that the man had died of acute bronchopneumonia caused by pulmonary emphysema.

ISSUES

Clinical care

43. The clinical reviewer concluded that the man's standard of healthcare at Full Sutton was equivalent to that he could have expected to receive in the community. She noted that healthcare staff regularly reviewed the man, despite the difficulties caused by his frequent non-compliance with treatment. They made good efforts to ensure that he had the expected level of chronic disease monitoring, which the man often declined. They also encouraged the man to take his prescribed medication, but he frequently refused. Because the man had a fear of hospitals, healthcare staff arranged for consultants to see him in prison when possible.

44. The clinical reviewer was satisfied that the healthcare staff managed his COPD appropriately, and that the treatment provided was in line with the internationally recognised Gold Standard for managing COPD.

45. The clinical reviewer considered that the man received a high standard of nursing care at the end of his life, which covered his physical, emotional and spiritual needs. He remained comfortable and communicated either verbally or through signs when he had insufficient breath to speak. He did not report any pain. Nurses treated him with compassion and enabled him to die peacefully and with dignity.

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Liaison with the man's family

46. From 10 January, when it became apparent that the man was seriously ill, the prison Imam and a custodial manager tried to help he man contact his family in Ireland but were unable to get through. His sister noted missed calls from the prison on Sunday 11 January, but when she tried to call back, she said switchboard staff were not helpful and did not know who to put her through to. She rang again on 12 January and left a message on a prison chaplaincy phone. Shortly after, she received the call informing her that her brother had died. The miscommunication must have been distressing for the man's family and indicates a need to ensure that switchboard staff know to direct such calls to the duty manager. However, we consider that the prison made reasonable, if unsuccessful, attempts to inform the man's family that he was seriously ill.

47. Usually we would expect a member of prison staff to inform a prisoner's family in person when they die, but because of the distance, this was not feasible. The prison tried to contact a priest from a voluntary organisation for Irish prisoners to inform them in person, but unfortunately could not contact him that morning. It would have been preferable to have then asked the Northern Ireland police to inform his family, but this would have caused a further delay. The prison decided to phone his family directly as they wanted them to hear the news as quickly as possible. While not ideal, in the circumstances, we do not consider that this was unreasonable.