Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Douglas Fone, a prisoner at HMP Full Sutton, on 17 March 2015

A report by the Prisons and Probation Ombudsman
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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 Douglas Fone died on 17 March 2015, after taking an overdose of medication for high blood pressure, at HMP Full Sutton. He was 74 years old. I offer my condolences to Mr Fone's family and friends.

Mr Fone had been due to be released from prison on 17 March. Staff and prisoners who had spoken to him the night before, said that he had appeared in a good mood and they had no reason to be concerned about him. Mr Fone's actions were unexpected and I am satisfied that staff at the prison could not have predicted or prevented his death. Although it does not appear that this would have altered the outcome for Mr Fone, the investigation identified a need for improvements in emergency procedures at Full Sutton.

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 **November 2015**

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Summary

Events

1. On In 2005, Mr Douglas Fone was sentenced to 15 years imprisonment for sexual offences. He was due to be released on 17 March 2015 to live in probation approved premises.

2. Mr Fone had several long-standing health problems, including high blood pressure. He was not regarded as at risk of suicide and self-harm and, in line with arrangements in the community, he kept stocks of medication in his cell to administer as required.

3. On 16 March, a number of staff and prisoners spoke to Mr Fone to wish him luck and say goodbye before his release the next day. They said Mr Fone seemed happy and did not give them any indication that he was worried about being released.

4. At 8.17am on 17 March, an officer found Mr Fone unresponsive when he unlocked his cell. He appeared semi-conscious and the officer radioed an emergency. A nurse arrived and, at 8.30am, asked for an ambulance. The nurse gave Mr Fone oxygen, which seemed to help a little, and took him to the prison's healthcare centre on a stretcher. They planned to check his heart using an electrocardiograph (ECG), but the ECG on their floor was not working and they could not get to the working machine, as it was on the floor above. The prison have since informed the investigator that the ECG machine was working but it did not have any paper in as it had not been replenished. They also said that the upstairs ECG is portable and could have been moved downstairs to Mr Fone. Officers checked Mr Fone's medication and noticed a large amount of atenolol tablets (used to treat high blood pressure) was missing.

5. At 8.42am, paramedics arrived and treated Mr Fone. At 9.38am, they took Mr Fone to hospital. At 10.53am, he was pronounced dead. A post-mortem examination found that Mr Fone died from an overdose of atenolol.

Findings

6. Mr Fone gave no indication of his intention to kill himself and we do not consider that staff at Full Sutton could have predicted or prevented his death. Although it does not appear that it would have affected the outcome for Mr Fone, there were some deficiencies in the emergency response. The control room did not call an ambulance immediately an emergency code was called as should have happened; and staff need to ensure that all emergency equipment and ECG machines are functional.

Recommendations

- The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Full Sutton has a medical emergency response code protocol based on the PSI that ensures that:
    - Healthcare staff attend the emergency as quickly as possible;
    - control room staff call an ambulance as soon as an medical emergency code is broadcast;
    - Staff do not move a prisoner after an emergency code has been called unless there are compelling reasons to do so;
    - All emergency equipment works and is tested regularly.

The Investigation Process

7. The investigator issued notices informing staff and prisoners at HMP Full Sutton of the investigation and asking anyone who had relevant information to contact her. No one responded.

8. On 24 March 2015, the investigator visited Full Sutton, and obtained Mr Fone's prison and clinical records. She spoke to officers and prisoners on B Wing, where Mr Fone had lived and had known him.

9. A clinical reviewer reviewed Mr Fone's clinical care and treatment at the prison on behalf of NHS England. The clinical reviewer and the investigator jointly interviewed seven members of staff at Full Sutton.

10. The investigator informed HM Coroner for East Riding of Yorkshire of the investigation and we have sent the coroner a copy of this report.

11. One of the Ombudsman's family liaison officers wrote to Mr Fone's daughter to explain the investigation process and ask if she had any relevant matters she wanted the investigation to take into account. We received no response.

12. Mr Fone's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Full Sutton

13. HMP Full Sutton is a high security prison near York holding around 600 men. NHS East Riding of Yorkshire provides health services at the prison. There is a full-time GP and an inpatient unit for up to eight prisoners.

HM Inspectorate of Prisons

14. The most recent inspection of Full Sutton was in December 2012. Inspectors noted that very few prisoners were released from the prison but there were comprehensive pre-release arrangements to cover matters such as accommodation and public protection. Prisoners being released had a routine discharge appointment with the GP. The range and the quality of health services were good with a satisfactory mental health service. Relationships between staff and prisoners were mostly positive but personal officer work needed development. Attendance at safer custody meetings was inconsistent, and analysis of data to assess patterns and trends of self-harming behaviour was underdeveloped.

Independent Monitoring Board

15. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recent published annual report for 2013, the IMB commented that the prison was staffed by professional and dedicated people and had adapted well to budget cuts. The IMB noted that over 100 prisoners were over the age of 55 and special groups were run for older prisoners. The IMB considered that the quality of delivery of health services was very good. The IMB reported that it had become more difficult to transfer prisoners to local prison before release, which would allow some better preparation with local agencies near to the prisoner's release address.

Previous deaths at HMP Full Sutton

16. Since the beginning of 2013, there had been seven deaths at Full Sutton before Mr Fone's. Six were from natural causes and one was self-inflicted. There were no significant similarities with the circumstances of the other deaths. There have subsequently been two further deaths at the prison, both apparently from natural causes.

Key Events

17. On 24 June 2005, Mr Douglas Fone was sentenced to 15 years imprisonment for sexual offences. He had been at Full Sutton since February 2007 and was due to be released on 17 March 2015.

18. When Mr Fone was first sentenced, he had admitted his offences but began to deny guilt after he arrived at Full Sutton. This meant he was not able to participate in the Sex Offender Treatment Programme, which requires offenders to accept responsibility for their actions. He refused to participate in sentence planning and accepted that this was likely to mean he would not get early release.

19. Mr Fone suffered from high blood pressure, heart problems, arthritis, back pain, asthma and anxiety. In 2011, a consultant cardiologist had advised that he should have an echocardiogram (a heart scan) every two years, but Mr Fone declined to have one while he was in prison. He was prescribed the following medication:

    - Adalat, atenolol, doxazosin and simvastatin for high blood pressure
    - Aspirin to thin his blood
    - Diazepam for anxiety
    - Fluticasane for asthma
    - Ibuprofen for arthritis pain
    - Salbutamol to help with breathing

20. Prison healthcare staff reviewed Mr Fone's medication each month. He had never taken an overdose or been assessed as at risk of suicide or self-harm and was allowed to keep his medication in his cell. He lived in a single cell on B Wing, the vulnerable prisoner wing. He did not have visitors and was estranged from his family because of his offences. According to his friends on the wing, this did not seem to affect him adversely. He attended groups run for older prisoners.

21. In December 2014, four months before his release date, the prison's resettlement officer saw Mr Fone to plan his release. Mr Fone had agreed to live in approved premises (a probation hostel) in Cheshire when he was released. The resettlement officer said that prisoners at Full Sutton usually transfer to a local prison before their release to help prepare, but Mr Fone had wanted to be released directly from Full Sutton. The resettlement officer said that Mr Fone had seemed content with the release arrangements and he had had no concerns about him.

22. One of Mr Fone's friends told the investigator that he thought that Mr Fone did not want to leave prison. He said that Mr Fone had not said anything specific but he knew that Mr Fone had chosen not to apply for parole. However, another prisoner told the investigator that Mr Fone had said that he was looking forward to getting his own home, and moving back to Wales, where he came from.

23. On 6 March, Mr Fone received a month's supply of his medication, including 28 atenolol tablets. On 16 March, the day before his release, Mr Fone attended an

appointment with a prison GP. The GP recorded that Mr Fone had no immediate issues and he reminded him to register with a doctor when he got to the approved premises. He noted that Mr Fone suffered from anxiety, high blood pressure and aortic stenosis (heart valve problems).

24. That evening, Mr Fone was with a group of prisoners in a cell when his friend went to see him to say goodbye. His friend and another prisoner said that Mr Fone was laughing and joking with the other prisoners and seemed fine. The resettlement officer also went to see Mr Fone and said the same.

25. An officer, who worked on B Wing, said that, on the evening of 16 March, he had asked Mr Fone about the first thing he would do after he was released. Mr Fone told him he was going to go shopping for clothes.

26. A night patrol officer checked Mr Fone's cell between 7.05am and 7.10am on 17 March, as part of a routine morning check to establish that all prisoners were present in their cells. After Mr Fone's death, the night patrol officer wrote an email to a prison manager. In it he said that, when he checked, Mr Fone was underneath his bedding with his head and shoulders exposed. He said he saw Mr Fone yawn but did not see him open his eyes. He did not have any concerns about him and carried on checking the rest of the prisoners.

27. On the morning of 17 March, an officer, Officer A, was collecting used razors on the wing. At 8.15am, he went to Mr Fone's cell. Officer A told the investigator that he looked through the observation hatch into Mr Fone's cell and saw that he was still in bed. He shouted to Mr Fone but did not get a response. He then opened the cell door and went in with another officer, Officer B, who was also on the landing. He called to Mr Fone again and shook him. A third officer, Officer C, who was nearby, went to the cell in case they needed help.

28. Officer A said that Mr Fone looked like he was waking from a deep sleep but then he realised that he was in a semi-conscious state and mumbling incoherently. Officer A immediately radioed a code blue emergency at 8.17am. (A code blue is used to indicate a medical emergency in situations such as when a prisoner has breathing problems or is unconscious. It should alert control room staff to call an ambulance immediately and healthcare staff and others to attend with emergency equipment.)

29. The officers kept talking to Mr Fone to try to keep him awake, and put him in the recovery position on the bed. Officer C found a large bag of medication in his cell, which she gave to the nurses when they arrived.

30. After a couple of minutes, a custodial manager arrived at Mr Fone's cell, followed by two nurses, Nurse A and Nurse B, who brought emergency bags. The nurses later noted in Mr Fone's clinical record that they had arrived at 8.25am.

31. Nurse A told the investigator that, when she arrived at the cell, she realised that they need an ambulance, so she asked control room staff to call one. The nurses checked Mr Fone, who was hot and clammy, pale and barely conscious. His pulse rate was high at 144 beats per minute. They were unable to get a clear blood pressure reading but managed to get a systolic reading of 60, which was very low. Mr Fone's left pupil did not react to light and the nurses had difficulty

checking his right pupil because of his position. They attached a defibrillator but this did not advise a shock. The nurses gave Mr Fone oxygen, and he became a little more responsive. He was able to squeeze Nurse A's hand with his right hand but not his left.

32. The nurses decided to take Mr Fone to the healthcare centre on a stretcher, where they had more equipment available and more room to treat him. They took Mr Fone along a long corridor, which had only one door to open instead of nine, if they had used the usual route through the prison.

33. The nurses had intended to check Mr Fone's heart function using an electrocardiograph machine (ECG). However, they were unable to get Mr Fone to the ECG on the upstairs floor of the healthcare centre and the only other one, on their level, was broken. Nurse A told the investigator it had been broken for some months.

34. A doctor arrived and took over Mr Fone's care. He recorded that Mr Fone was breathing spontaneously with the oxygen mask on and he had an intermittent pulse of around 100 beats per minute.

35. Healthcare staff checked Mr Fone's medication and noticed that a large amount of atenolol was missing. The doctor suggested that Mr Fone might have taken an overdose of atenolol but thought his symptoms could also be indicative of a stroke.

36. The control room log shows that they called an ambulance at 8.31am. Paramedics arrived at 8.42am and, after further treatment, took Mr Fone to hospital at 9.38am. He was not restrained. As Mr Fone was due to be released that day, prison staff planned to discharge him from hospital. However, at 10.53am, hospital staff pronounced his death.

Contact with Mr Fone's family

37. An officer, the prison's family liaison officer, noted that Mr Fone had not named anyone as a next of kin to be contacted in an emergency. He knew that some of Mr Fone's family were victims of his offences and had not been in contact with him since 2011, so he contacted Mr Fone's offender manager (probation officer). It was agreed that contact would be more appropriate through the victims' liaison unit, who notified one of Mr Fone's daughters, who then informed other family members. Another daughter later telephoned the prison to say that she would act as the official next of kin.

38. At 7.19pm, the family liaison officer telephoned Mr Fone's daughter to offer support. He explained what had happened and what would happen next. He continued to liaise with Mr Fone's family and arranged the funeral, which was led by the prison chaplain. The prison paid for the funeral in line with national Prison Service instructions.

Support for prisoners and staff

39. Managers debriefed the staff involved in the emergency response, before they left the prison at the end of their shifts. The staff told the investigator that managers and the prison's care team had offered them a good level of support.

Staff checked prisoners assessed as at risk of suicide and self-harm, in case they had been affected by the news of Mr Fone's death.

Post-mortem report

40. During the post-mortem examinations, toxicology tests found a significantly higher concentration of atenolol in Mr Fone's blood than would be expected for therapeutic use. The concentration found was consistent with an overdose, which would have caused symptoms such as hypotension (low blood pressure) and heart failure. There was a large amount of tablets in Mr Fone's stomach and the pathologist gave the cause of death as atenolol poisoning

Findings

Clinical care

41. Mr Fone suffered from heart disease, high blood pressure, asthma, back pain and anxiety. Healthcare staff regularly reviewed his chronic conditions, and prescribed appropriate medications, which he was allowed to keep in his possession. Mr Fone refused to take part in any talking therapies and was prescribed a low dose of diazepam to use when necessary to help his anxiety.

42. On 16 March, the day before he was due to be released, a prison GP saw Mr Fone and noted in the clinical record that Mr Fone had no significant mental health issues and that he had reminded him to register with a doctor and arrange an echocardiogram on his release, as he had not had one for several years.

43. The clinical reviewer found that, overall, healthcare staff provided Mr Fone with care that was equivalent to that which he could have expected to receive in the community. He did not identify any reason why staff should have considered that Mr Fone was at risk of suicide or self-harm.

Emergency response

44. Prison Service Instruction 03/2013 requires that governors must have a medical emergency response code protocol, which ensures that an ambulance is called automatically in a life-threatening medical emergency. The protocol should give guidance on efficiently communicating the nature of a medical emergency, ensure that staff take the correct equipment to the incident and that there are no delays in calling an ambulance.

45. In response to the PSI, Full Sutton issued a Governor's Order (GO) about responding to emergencies on 28 March 2013. The order states that when a member of staff believes an emergency code should be used and they have access to an outside line they can request an ambulance. If they are not near a phone, they can instruct the control room to call one. A healthcare professional reviews whether the ambulance is necessary when it arrives and confirms or stands down the vehicle as appropriate.

46. Officer A radioed a code blue emergency when he found Mr Fone semi-conscious in his cell. Control room staff did not call an ambulance immediately as the national instructions require and none of the staff present asked for an ambulance. It was another six minutes, after nurses arrived at the cell, before anyone called an ambulance. Nurse A told the investigator that custom and practice at Full Sutton was for healthcare staff to respond to an emergency code first, assess the patient and, if necessary, ask control staff to call an emergency ambulance.

47. These arrangements are not consistent with PSI 03/2013. It should not be necessary for a member of staff to request an ambulance separately. The PSI states that when a medical emergency is called, the control room should call an ambulance immediately. There should be no requirement to wait for a member of healthcare staff or a manager at the scene to confirm that an ambulance is needed.

48. In this case, nurses did not arrive at the cell for eight minutes, and there was a further six minute delay while they assessed Mr Fone to see whether they considered whether an ambulance was needed. It is likely that an ambulance would have been at the prison in that time had one been called immediately, as should have happened. The instruction noted that it is better to act with caution and request an ambulance that can be cancelled if it is later assessed as not required. There is no evidence that the delay in this case affected the outcome for Mr Fone, but in other emergencies, such a significant delay could be critical.

49. Nurses decided to move Mr Fone to the healthcare unit, and they had difficulty using emergency equipment, including oxygen masks and ECG machines. The clinical reviewer considers that they should have treated Mr Fone in his cell until the paramedics arrived. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Full Sutton has a medical emergency response code protocol based on the PSI that ensures that:

- **Healthcare staff attend the emergency as quickly as possible;**
- **control room staff call an ambulance as soon as an medical emergency code is broadcast;**
- **Staff do not move a prisoner after an emergency code has been called unless there are compelling reasons to do so;**
- **All emergency equipment works and is tested regularly.**

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