

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Stephen Dunne, a prisoner at HMP Full Sutton, on 18 January 2020

**A report by the Prisons and Probation Ombudsman**

## 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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## Summary

1. 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.
2. 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.
3. Mr Stephen Dunne died in hospital of lung cancer on 18 January 2020. He also had heart disease, which did not cause but contributed to his death. He was 64 years old. I offer my condolences to those who knew him.
4. The clinical reviewer concluded that the clinical care that Mr Dunne received at HMP Full Sutton was of a good standard and was at least equivalent to that which he could have expected to receive in the community.
5. We identified one non-clinical issue of concern about the use of restraints when Mr Dunne travelled to hospital.

## Recommendations

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

## The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Dunne's clinical care at Full Sutton.
7. The PPO has investigated non-clinical issues, including Mr Dunne's location, the security arrangements for his hospital escorts and whether compassionate release was considered. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
8. Mr Dunne had not identified a next of kin, and so our family liaison officer was unable to contact anyone about our investigation.

### Previous deaths at HMP Full Sutton

9. Mr Dunne was the tenth prisoner to die at Full Sutton since January 2018. Of those deaths, seven were from natural causes, one was a homicide and two were self-inflicted. We have recently made a recommendation about restraints in an investigation into the death of another prisoner at Full Sutton and are waiting for the prison's response.

## Key Events

10. In 1982, Mr Stephen Dunne was sentenced to life in prison for sexual offences. He was transferred to HMP Full Sutton in 2011.
11. On 2 January 2020, he complained that he had had back and knee pain and constipation for the last two weeks. Healthcare staff noted he had lost weight and took blood tests.
12. On 6 January, Mr Dunne's pain increased, and healthcare staff recorded his observations and weight. A prison GP reviewed Mr Dunne and identified that he had lost 10kg over a 10-month period. The GP suspected cancer and referred Mr Dunne to hospital.
13. On 9 January, Mr Dunne's pain increased again. A prison GP reviewed him and suggested sending him to hospital straightaway. Mr Dunne declined and opted to stay in prison until his appointment.
14. On 11 January, Mr Dunne was diagnosed with lung cancer, with a secondary large abdominal mass. That day, he was reviewed on the wing and at his request, was sent to hospital by ambulance. Two officers escorted him and on his way he was restrained with an escort chain which remained in place until 13 January.
15. On 14 January, Mr Dunne said that he wanted to receive care at Full Sutton.
16. Mr Dunne died in hospital on 18 January.

### Post-mortem report

17. The post-mortem concluded that that Mr Dunne died from disseminated lung cancer. He also had ischaemic heart disease which did not cause but contributed to his death.

### Clinical findings

18. The independent clinical reviewer concluded that the care that Mr Dunne received was of a good standard and was at least equivalent to that which would have been received in the wider community.

### Non-clinical findings

#### Restraints, security and escorts

19. 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 considers a prisoner's health and mobility.
20. 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 they have 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 reviewed as circumstances change. The judgement found that using handcuffs or other restraints on terminally or seriously ill prisoners was inhumane, unless justified by security considerations.

21. On 11 January, when Mr Dunne went to hospital, prison staff completed a risk assessment. A prison governor authorised that an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer) was appropriate to restrain Mr Dunne while he travelled to hospital (and that if his condition improved, he should be double cuffed for his return journey to prison). A nurse noted that there were no medical objections to the use of restraints and that Mr Dunne's medical condition did not restrict his ability to escape unaided. She also said that Mr Dunne had poor gait, with a slow shuffle, and that restraints would need to be removed for treatment and investigations when in hospital.
22. On 13 January, Full Sutton reviewed the restraints decision and removed Mr Dunne's restraints.
23. Mr Dunne was a Category B prisoner. He was considered to pose a low risk of escape and a medium risk to the public. He was 64 years old, he had poor mobility, he had complained of back and knee pain in the two weeks before he went to hospital, he had cachexia (a complex syndrome associated with an underlying illness causing ongoing muscle loss) and had lost 10kg of weight in the 10 months before he went to hospital. We are concerned that no one objected to using restraints on Mr Dunne, despite his poor health and mobility issues which the healthcare assessment acknowledged.
24. We recognise that the Full Sutton reviewed the restraints decision two days later, after Mr Dunne was told that his cancer was terminal and arranged for restraints to be removed. However, we are not satisfied that the initial decision to restrain Mr Dunne was justified, particularly as he was accompanied by two prison officers. We have seen no evidence that Full Sutton took into account Mr Dunne's age, that he was unwell, he had mobility issues, he posed a low risk of escape and medium risk to the public, when they restrained him. We make the following recommendation:

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

**Caroline Mills**  
**Assistant Ombudsman**

**March 2021**

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