

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Stephen Hughes, a prisoner at HMP Full Sutton, on 20 December 2019**

**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

**OGL**

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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 Stephen Hughes died on 20 December 2019 at York Teaching Hospital from acute renal failure and sepsis, while a prisoner at HMP Full Sutton. He was 58 years old. I offer my condolences to Mr Hughes's family and friends.

Mr Hughes had a number of long-term health conditions including diabetes, heart disease, peripheral vascular disease, stroke and high blood pressure. Mr Hughes chose not to take insulin for his diabetes on many occasions as a form of protest, despite being aware of the potentially life-threatening consequences of doing so.

The clinical reviewer found that the standard of healthcare that Mr Hughes received at Full Sutton was at least equivalent to that which he could have expected to receive in the community. However, although I am satisfied that Mr Hughes had capacity to refuse treatment, my investigation found disclaimers to show this were used inconsistently and the status of an advanced care plan from 2018 was uncertain.

I am also concerned that the use of restraints when Mr Hughes went to hospital was not justified given his poor health and very limited mobility.

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

**Sue McAllister CB**  
**Prisons and Probation Ombudsman**

**November 2020**

# Contents

Summary .....	1
The Investigation Process.....	3
Background Information.....	4
Key Events.....	5
Findings .....	10

# Summary

## Events

1. Mr Stephen Hughes was sentenced to imprisonment for life for murder in March 2003. He transferred to HMP Full Sutton in November 2005. Mr Hughes was a category A prisoner (meaning he was assessed as presenting a high risk to the public if he escaped) from 2003 until the day before he died.
2. Mr Hughes had a history of very poor health, including diabetes, heart disease, peripheral vascular disease, stroke, high blood pressure and Hepatitis C. Healthcare staff drew up care plans to manage and review Mr Hughes's conditions.
3. Mr Hughes chose not to take insulin for his diabetes and other medications on many occasions as a form of protest. He needed periodic hospital treatment as a result. He was made aware of the potentially life-threatening consequences of refusal and acknowledged that he knew his actions were harmful to his health.
4. Mr Hughes became seriously ill at the end of November 2019 after once again refusing to take insulin. He was cared for in the prison inpatient unit and transferred to hospital on 9 December 2019 when the GP became concerned that he had developed sepsis. Three officers escorted him. Mr Hughes was handcuffed to one of them using an escort chain.
5. Mr Hughes's condition deteriorated in hospital and he was put in medical restraints after becoming confused and trying to remove intravenous lines. The escort chain was removed at this point. Mr Hughes died on 20 December from acute renal failure and sepsis.

## Findings

6. We agree with the clinical reviewer that the standard of healthcare received by Mr Hughes at Full Sutton was at least equivalent to that which he could have expected in the community. His many clinical needs were appropriately assessed and monitored.
7. We are satisfied that Mr Hughes had capacity to refuse treatment and that he was made aware of the potentially life-threatening consequences of this refusal. However, we found that the use of disclaimers to evidence this was inconsistent and the prison were unable to confirm the status of an advanced care plan completed by Mr Hughes in 2018.
8. We found no evidence that the use of restraints on Mr Hughes's final stay in hospital were adequately justified given his very poor health and lack of mobility.

## Recommendations

- The Head of Healthcare should develop a refusal of care pathway to support practitioners caring for patients who refuse treatment. This should include guidance on using disclaimers to evidence reasons for refusal, awareness of consequences and discussion of alternative treatments. Advance care plans for prisoners with life-threatening conditions should be subject to regular review.

- 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 the prisoner and are based on the actual risk the prisoner presents at the time.

## The Investigation Process

9. 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 her.
10. The investigator obtained copies of relevant extracts from Mr Hughes's prison and medical records.
11. NHS England commissioned an independent clinical reviewer to review Mr Hughes's clinical care at the prison. Due to restrictions in place during the Covid-19 pandemic, the investigator and clinical reviewer obtained written answers to questions about Mr Hughes's healthcare and confirmed details by telephone if necessary. Further information was obtained electronically.
12. We informed HM Coroner for the East Riding of Yorkshire and Kingston-upon-Hull of the investigation. The Coroner gave us a copy of the post-mortem and toxicology reports. We have sent the coroner a copy of this report.
13. Our then family liaison officer wrote to Mr Hughes's next of kin, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. We did not receive a reply. Our current family liaison officer contacted Mr Hughes's next of kin at initial report stage and we have sent them a copy of this report.

## **Background Information**

### **HMP Full Sutton**

14. HMP Full Sutton is a high security prison near York, that holds up to 626 adult men. Spectrum Community Health CIC provides a range of integrated health services. Healthcare staff are on duty for 24 hours a day. An inpatient healthcare unit, with six beds, provides full nursing care for patients, including a palliative care suite.

### **HM Inspectorate of Prisons**

15. HM Inspectorate of Prisons most recently inspected Full Sutton in February/March 2020. Inspectors found the overall quality of clinical records was variable. The management and monitoring of long-term conditions undertaken by the lead nurse and lead GP were effective. An effective multi-disciplinary approach was taken to overseeing and monitoring patients with pain management concerns.

### **Independent Monitoring Board**

16. 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 latest annual report, for the year to December 2019, the IMB said staff shortages had occasionally compromised the full provision of healthcare services, although waiting times to see a GP were comparable to those in the community.

### **Previous deaths at HMP Full Sutton**

17. Mr Hughes was the seventh prisoner to die at Full Sutton since May 2018. Five of the previous deaths were by natural causes and one was a homicide. There have been two deaths since Mr Hughes's – one natural causes and one self-inflicted. We found no significant similarities between Mr Hughes's death and the other deaths.

### **Diabetes, foot ulcers and wound healing**

18. Diabetes is a lifelong condition that causes a person's blood sugar level to become too high. A diabetic patient's wounds heal slowly, can worsen rapidly and require close monitoring. Foot ulcers are the most common wounds in diabetic patients.

### **In-possession medication**

19. Ideally, prisoners should be responsible for managing their own medication and have the autonomy they would have in the community. There are a number of benefits to this approach, but prisons also have a duty of care to ensure security and the safety of prisoners. Allowing prisoners to keep stocks of medication in their possession can lead to bullying and intimidation or trading in medication and other misuse. The risks and benefits therefore need to be carefully assessed.

## Key Events

20. Mr Stephen Hughes was sentenced to imprisonment for life for murder in March 2003. It was not his first time in prison. He transferred to HMP Full Sutton in November 2005. Mr Hughes was a category A prisoner (meaning he was assessed as presenting a high risk to the public if he escaped) from 2003 until the day before he died.
21. Mr Hughes had a significant history of poor health including:
  - hepatitis C since 1996;
  - insulin dependent diabetes since 2004;
  - ischaemic heart disease (narrowing of the arteries in the heart) since 2008;
  - hypertension (high blood pressure) since 2009; and
  - peripheral vascular disease (a blood circulation disorder causing blood vessels outside of the brain and heart to narrow or block) since 2014.

He had a heart attack in 2008, three coronary artery bi-pass grafts in 2009 and a stroke in 2010.

22. Mr Hughes was not diagnosed with any mental illness. In 2008, he attended a support group run by the mental health in-reach team and a few appointments with a mental health nurse. He suffered from low mood and self-harmed throughout his sentence. During these periods he was managed under Prison Service suicide and self-harm monitoring procedures and referred to the mental health team. Mr Hughes also referred himself to the mental health team, but apart from attending the resulting assessments, he declined to work with them.
23. Mr Hughes refused to take insulin for significant periods of time in protest at staff behaviour or changes to his treatment. He also tried to bargain his compliance in return for higher doses of gabapentin, pregabalin (both anti-convulsants used to treat neuropathic pain from diabetes) and opiate pain relief. (All these drugs are highly tradeable in prison.)
24. In October 2014, Mr Hughes took an overdose of insulin because he said he was angry with staff on his wing. He required hospital treatment but denied that he had tried to end his life. Mr Hughes protested against a subsequent decision that he take his insulin under supervision by refusing to take any insulin at all. He signed a disclaimer confirming that he had received advice about the life-threatening consequences of refusing it. He resumed taking insulin in July 2015.
25. The prison GP said that Mr Hughes openly acknowledged that by refusing insulin, he was “cutting off his nose to spite his face”. He said Mr Hughes repeated a cycle of refusing insulin, becoming very unwell, often to the point of needing to go to hospital, and then accepting insulin and recovering.
26. By 2019, Mr Hughes was unable to walk unaided and used crutches for short distances and a wheelchair for longer distances. His social care needs were

reviewed regularly and, apart from short periods in the inpatient unit when he was very unwell, Mr Hughes lived on a standard wing.

## 2018

27. In April 2018, Mr Hughes developed an ulcer on his foot. He had regular appointments with the podiatrist and received wound care from nurses. His ulcer healed in May, but he needed antibiotics to combat cellulitis (an infection of the deeper layers of skin) that developed on the site.
28. In June 2018, Mr Hughes refused insulin because it was removed from his possession after he self-harmed and threatened to kill himself. In August he developed another foot ulcer and recommenced antibiotics. Mr Hughes continued to refuse insulin and became increasingly poorly.
29. On 3 October 2018, he completed an advance care plan (ACP – a voluntary agreement about future care between an individual and their care providers). Mr Hughes said he wanted to receive pain management and to be taken to hospital but did not want to be resuscitated in the event of cardiac or respiratory failure. He did not want life-prolonging treatment in the event of coma. A prison GP completed a Do Not Attempt Resuscitation (DNACPR) order the same day. His record indicated he changed his mind about this a couple of days later, but the record does not make clear whether the DNACPR was removed.
30. On 9 November, Mr Hughes was admitted to the prison's inpatient unit after being found conscious in his cell with a shoelace around his neck. He continued to refuse insulin but accepted other medication. On 19 November, his medical record showed he had signed a disclaimer confirming that he had received advice about the life-threatening consequences of refusing insulin. The clinical reviewer asked the prison for a copy of this disclaimer, but they were unable to provide it. Mr Hughes resumed insulin on 21 November.

## 2019

31. On 9 January 2019, a noted Mr Hughes had stopped taking insulin in protest at being refused a higher dose of pregabalin. The nurse completed a mental capacity assessment which confirmed Mr Hughes had capacity to refuse his medication. The nurse told the investigator that Mr Hughes was aware of the dangers of not taking his insulin.
32. On 25 February, Mr Hughes resumed insulin but became very unwell and required admission to hospital. He was diagnosed with oesophagitis (inflammation of the oesophagus lining) and discharged on 27 February.
33. On 4 March, the prison pharmacist noted that the ulcer on Mr Hughes's foot was inflamed and there were signs of cellulitis. He prescribed antibiotics and booked Mr Hughes for a review with the podiatrist. The podiatrist saw Mr Hughes for weekly check-ups and he received regular wound care from nurses.
34. On 10 March, Mr Hughes's medical record indicated he had signed a disclaimer confirming that he had received advice about the life-threatening consequences of refusing his medication, although the record also indicated he was compliant at the

time. The clinical reviewer asked for a copy of this disclaimer, but the prison was unable to provide it.

35. On 14 March, a prison GP examined Mr Hughes's foot after he reported worsening cellulitis. She noted that he had been prescribed antibiotics, but said she was not certain he had complied with the dose. She confirmed that the infection had worsened and prescribed clarithromycin (another antibiotic commonly used to treat bacterial infections that cause ulcers). On 2 April, the podiatrist noted that there was no longer any obvious sign of infection. Mr Hughes remained compliant with taking insulin under supervision from March to November 2019.
36. In September 2019, the podiatrist noted that Mr Hughes had developed an ulcer on his left foot. Despite wound care, further examination on 29 October revealed the ulcer had become infected. Mr Hughes was prescribed antibiotics. On 5 November, the podiatrist noted the infection had improved and Mr Hughes continued with antibiotics.
37. On 23 November, Mr Hughes was discovered attempting to divert his medication by concealing it in his wheelchair. On 25 November, a prison GP noted that Mr Hughes had stopped taking insulin. The next day, Mr Hughes told the senior pharmacy technician that he would not take his insulin until his "pain relief was sorted out". She advised Mr Hughes against this however he refused to take any of his medication in response.
38. A prison GP reviewed Mr Hughes on 2 December. Mr Hughes complained of vomiting and agreed to take cyclizine to treat his nausea. The prison GP offered to admit Mr Hughes to the inpatient unit because he appeared very unwell. Mr Hughes said he was "not ready as yet" to do this. Mr Hughes was monitored every 4-6 hours and assessed using the National Early Warning Score 2 (NEWS2) tool to categorise the severity of his illness and help early identification of deterioration.
39. On 3 December, nurses noted Mr Hughes was pale and weak. He refused a follow-up appointment with the podiatrist to check the infection in his foot but agreed to restart his other medication. The next day, on 4 December, Mr Hughes agreed to move to the inpatient unit.
40. On 5 December, Mr Hughes fell in his cell when he tried to get out of bed to use his cell bell. He remained conscious and his baseline observations were within the normal range. A nurse completed a falls risk assessment. Another nurse made an appointment for Mr Hughes with the GP and provided him with a call bell, so he did not have to get up to call for help.
41. Mr Hughes was monitored daily using the NEWS2 tool on 5, 6, 7 and 8 December. The results were between zero and two, indicating a low clinical risk of deteriorating. He was lethargic and nauseous but alert and responsive to staff.

## **Transfer to hospital on 9 December**

42. On 9 December, at 12.23pm, a prison GP noted Mr Hughes was "generally unwell". Mr Hughes agreed to have a blood test and the results confirmed he still had an infection. The prison GP noted an area of redness on Mr Hughes's left foot. Despite his NEWS2 score remaining low, the prison GP decided Mr Hughes should be transferred to York District General Hospital for urgent assessment.

43. There are two versions of the first page of the risk assessment for the hospital escort dated 9 December in Mr Hughes's record. The first was completed by the prison GP by hand. He confirmed that there were medical objections to the use of restraints and that restraints should be removed for hospital treatment and consultations. He indicated that Mr Hughes's medical condition did not restrict his ability to escape unaided. He gave "possible sepsis" (a potentially life-threatening condition caused by an infection) as the reason for escort to hospital and classed the appointment as essential.
44. The second version of page one of the risk assessment is typed. This indicated that there were no medical objections to the use of restraints, that they should not be removed for hospital treatment and consultation, but that Mr Hughes's mobility was impaired because of a previous heart by-pass and stroke. This form also indicated verbal authority to transfer Mr Hughes to hospital had been gained from the Category A Section at HMPPS Headquarters. It was not signed.
45. A Supervising Officer (SO) completed the remainder of the risk assessment. The criminal history section said Mr Hughes had a history of concealing weapons and that "if given the opportunity would attempt to escape injuring anyone who got in the way". (In 1992 Mr Hughes escaped from hospital escort and in 1996 he wounded a court custody officer, both on previous sentences.) The SO concluded that Mr Hughes presented a medium risk of escaping.
46. A Custodial Manager (CM) completed the analysis of the SO's assessment. He noted that Mr Hughes had ongoing medical issues that "added to his frailty". He set the level of escort as a SO and two officers. He added that "due to limited mobility and failing health Mr Hughes to be escorted using an escort chain only".
47. Mr Hughes was taken to York District Hospital at 4.18pm. He was admitted to the intensive care unit, put on intra-venous antibiotics and fluids and catheterised. Subsequent tests confirmed Mr Hughes had developed sepsis from the wound on his foot.
48. On 12 December, a SO applied for approval to remove Mr Hughes's escort chain. He said Mr Hughes remained in intensive care and was "very poorly". He was in and out of consciousness and very confused. He had been placed in medical restraints to stop him pulling out his intravenous lines and catheter. The hospital had also placed him under a temporary section order under the Mental Health Act because of his poor mental condition and risk of harm to himself. The operational manager gave permission for the escort chain to be removed the same day. His decision was approved by the Directorate of High Security prisons the next day. Restraints were not reapplied to Mr Hughes before he died.
49. On 13 December, Mr Hughes became unconscious and unresponsive. On 16 December, the hospital rang Mr Hughes's next of kin because they were extremely concerned about his condition. On 18 December, Mr Hughes's security category was downgraded to category B. Mr Hughes died during the night of 19/20 December.

## **Contact with Mr Hughes's family**

50. The prison contacted Mr Hughes's next of kin on the day he was taken to hospital. Mr Hughes's next of kin were able to visit him there and treatment was withdrawn

from Mr Hughes with their consent. The prison contributed to the cost of the funeral in line with national guidance.

### **Support for prisoners and staff**

51. The prison posted notices informing other prisoners of Mr Hughes's death, and to offer support.

### **Post-mortem report**

52. The post-mortem report concluded Mr Hughes died from acute renal failure and sepsis, caused by left lower limb ischaemia (restriction in the blood supply), which in turn was caused by peripheral vascular disease and diabetes. Underlying cardiac failure and ischaemic heart disease contributed to but did not cause the death.

# Findings

## Clinical care

53. The clinical reviewer is satisfied that Mr Hughes's care and treatment in prison was at least equivalent to that he could have expected to receive in the community. His long-term conditions, including hypertension, coronary heart disease, peripheral artery disease and diabetes, were managed using appropriate care plans, reviewed regularly and monitored in accordance with NICE guidelines. In addition to regular blood sugar monitoring, Mr Hughes had regular appointments with the podiatrist. He received appropriate wound care and antibiotics to treat foot ulcers. He also received regular eye-screening to monitor the decline in vision associated with diabetes.
54. During the period he spent on the prison inpatient unit in December 2019, Mr Hughes's condition was monitored correctly using the NEWS2 tool. Although this did not indicate that he was deteriorating, he was transferred to hospital when the prison GP became concerned that he showed signs of possible sepsis, a diagnosis that was borne out by hospital tests.

## Mr Hughes's refusal of insulin and other medication

55. All patients must give their consent before they receive any type of medical treatment. For consent or refusal of treatment to be valid the decision must be voluntary and the patient must be appropriately informed. Information must include what the treatment involves, whether there are reasonable alternative treatments and what will happen if the treatment does not go ahead. All patients should be given continuing opportunities to review their decision.
56. The only exception is if the health professionals involved think the patient lacks the capacity to make an informed and voluntary decision. All adults are presumed to have sufficient capacity to decide on their own medical treatment unless there is sufficient evidence to suggest otherwise. Adults also have the option of making an advance decision to refuse particular medical treatments for a time in the future when they might be unable to make such a decision. Mr Hughes completed an advanced care plan in November 2018.
57. Mr Hughes's medical records showed that he was regularly informed of the dangers and risks of not taking insulin and other medication, and that he was aware of the potentially life-threatening consequences. According to his records he signed disclaimers to this effect in November 2018 and March 2019. We asked for these documents, but the prison was unable to provide them. The medical records, and healthcare staff, were also unclear about the status of the advanced care plan that Mr Hughes completed in 2018.
58. The clinical reviewer is satisfied that Mr Hughes had capacity to refuse treatment. However, consent is a continuing process and best practice requires careful documentation of the patient's decision, regular review and evidence that consequences have been explained and alternative treatment has been explored. Given Mr Hughes's very poor health and the life-threatening consequences of him refusing insulin, we consider it would have been prudent for Full Sutton to have kept

an auditable trail to evidence this. Efforts should also have been made to update Mr Hughes's advanced care plan when he became very ill at the end of November 2019. We make the following recommendation:

**The Head of Healthcare should develop a refusal of care pathway to support practitioners caring for patients who refuse treatment. This should include guidance on using disclaimers to evidence reasons for refusal, awareness of consequences and discussion of alternative treatments. Advance care plans for prisoners with life-threatening conditions should be subject to regular review.**

## **Restraints, security and escorts**

59. 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.
60. 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.
61. The records provided by the prison for Mr Hughes's final hospital admission are confusing. There are two versions of the first page – one recorded medical objections to the use of restraints and that restraints should be removed during treatment and consultation and the other recorded the opposite. Mr Hughes was escorted to hospital handcuffed to an officer by an escort chain with two other officers present. The escort chain remained in place for three days. Mr Hughes was assessed as at medium risk of escape and his motivation to escape was considered high because he had escaped from hospital escort nearly thirty years previously.
62. We are concerned that restraints were used on Mr Hughes. He was unable to walk without crutches or a wheelchair and four days earlier he had fallen while attempting to get out of bed and was unable to get up from the floor. In addition, he had an infected foot and was unable to bear weight on it. He was sufficiently unwell to be immediately admitted to intensive care, given intravenous fluids and catheterised.
63. We are particularly concerned because the assessment acknowledged that Mr Hughes was frail and unstable on his feet. It is difficult to see how Mr Hughes was capable of escaping from an escort of three officers. The assessment failed to consider the actual risk of escape, as the High Court judgment requires. Furthermore, it appeared that Mr Hughes was in and out of consciousness and had been medically restrained under hospital order because of impaired cognition, before the escort chain was removed. 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 the prisoner and are based on the actual risk the prisoner presents at the time.**

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