

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

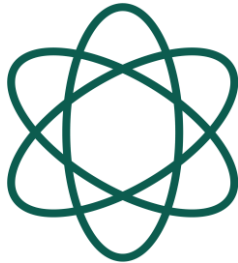
# **Independent investigation into the death of Mr Peter Battensby, a prisoner at HMP Full Sutton, on 16 April 2020**

**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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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 Peter Battensby was found hanged in his cell at HMP Full Sutton on 16 April 2020. He was 64 years old. I offer my condolences to Mr Battensby's family and friends.

Mr Battensby had served about a year of a 21-year sentence for sexual offences. He had not been in prison before. He had no substance misuse or mental health issues and no life-limiting physical health conditions. Mr Battensby planned to marry his partner but their plans were put on hold due to COVID-19 restrictions.

Two weeks before his death, Mr Battensby asked for a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order to be placed on his medical file. A prison GP approved the DNACPR but no one discussed this with Mr Battensby or assessed his risk.

We found that Mr Battensby gave little indication that he planned to take his life and that staff could not have foreseen his actions. However, we found some failings in the assessment of risk and record keeping in relation to his DNACPR request.

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**

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# Summary

## Events

1. On 20 May 2019, Mr Peter Battensby was sentenced to 21 years imprisonment for sexual offences. He was sent to HMP Leeds. He was moved to HMP Full Sutton on 16 October.
2. Mr Battensby had not been in prison before but staff had no concerns about his risk of suicide or self-harm. Mr Battensby had no substance misuse or mental health issues. He received appropriate care and medication for diabetes.
3. Mr Battensby and his partner were making plans to marry but, on 18 March 2020, the prison chaplain told Mr Battensby that he would have to put his wedding plans on hold due to COVID-19 restrictions.
4. On 2 April, Mr Battensby wrote a note to healthcare staff asking for a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order to be placed on his medical record. A prison GP approved the order but he did not discuss it with Mr Battensby.
5. On 16 April, staff found Mr Battensby sitting on a chair in his cell with a ligature around his neck which was tied to the window. Staff called a medical emergency code and healthcare staff attended immediately. There were obvious signs that Mr Battensby had been dead for some time and the DNACPR order was displayed on his wall, so staff did not attempt CPR. Paramedics arrived shortly afterwards and confirmed that Mr Battensby had died.

## Findings

6. We found that staff missed an opportunity to assess Mr Battensby's risk of suicide after he asked for a DNACPR order.
7. We found that there was no documented evidence of Mr Battensby's request for a DNACPR order or the decision to approve it.

## Recommendations

- The Head of Healthcare should ensure that all prisoners requesting a DNACPR order are assessed, preferably face-to-face, to establish if they are at risk of suicide, that they have mental capacity, and that no mental health issues are apparent.
- The Head of Healthcare should ensure that:
  - staff provide a full and accurate record of the DNACPR assessment in the prisoner's medical record, including details of all staff who have provided input and the rationale behind the decision; and
  - all correspondence received from the prisoner, or from anywhere else, relating to the DNACPR order is immediately scanned and retained on the prisoner's medical record.

## The Investigation Process

8. 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. Two prisoners wrote to her.
9. The investigator obtained copies of relevant extracts from Mr Battensby's prison and medical records.
10. NHS England commissioned a clinical reviewer to review Mr Battensby's clinical care at the prison. The investigator interviewed four members of staff by telephone in May and June 2020. The interviews were conducted by telephone due to the COVID-19 pandemic.
11. We informed HM Coroner for Hull and the East Riding of Yorkshire 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.
12. One of the PPO's family liaison officers wrote to Mr Battensby's partner to explain the investigation and to ask if there were any matters she wanted the investigation to consider. Mr Battensby's partner did not raise any issues.
13. We shared our initial report with Mr Battensby's family. They did not identify any factual inaccuracies.
14. We shared our initial report with the Prison Service. They did not identify any factual inaccuracies. The action plan has been annexed to this report.

## Background Information

### HMP Full Sutton

15. 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 24 hours a day. An inpatient healthcare unit, with six beds, provides full nursing care for patients, including a palliative care suite Buckley Hall is a category C training prison for male prisoners, on the edge of the Pennines, near Rochdale, Lancashire. The prison has four residential blocks and an operational capacity of 459. Spectrum Healthcare provide healthcare services with Greater Manchester Mental Health (GMNH) NHS Foundation providing mental health services. Drug and alcohol services are provided by Change Grow Live (CGL).

### HM Inspectorate of Prisons

16. 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 multidisciplinary approach was taken to overseeing and monitoring patients with pain management concerns.

### 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 latest annual report, for the year to 31 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

18. Mr Battensby was the ninth prisoner to die at Full Sutton since April 2018. Seven of the previous deaths were by natural causes and one was a homicide. We found no significant similarities between Mr Battensby's death and the other deaths. However, a previous investigation found poor record keeping about a prisoner's advance care plan and DNACPR.

### Advance Directives/Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

19. A person can make an advance directive preventing clinical staff from resuscitating them if they stop breathing or their heart stops beating. This is known as a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR). All adults are presumed to have sufficient mental 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 directive to refuse particular medical treatments for a time in the

future when they might be unable to make such a decision, including requesting DNACPR orders.

# Key Events

## Background

20. On 15 May 2019, Mr Peter Battensby was remanded into custody at HMP Leeds for sexual offences. It was his first time in prison. Reception staff found no evidence that he was at risk of suicide or self-harm. Mr Battensby had no mental health or substance misuse issues, but he engaged with healthcare services for treatment of type 2 diabetes and a skin abscess.
21. On 20 May, Mr Battensby was sentenced to 21 years imprisonment. He remained at Leeds, where records show that he settled in well. He engaged with his key worker on a regular basis and started work. Staff described him as polite and helpful and he received many positive behaviour entries in his prison record.
22. On 16 October, Mr Battensby was moved to HMP Full Sutton. Reception staff had no concerns about his risk of suicide or self-harm.
23. On 24 October, Mr Battensby met with his allocated key worker. He told his key worker that he had settled in well and he had applied for work.
24. On 14 November, Mr Battensby was assigned a new key worker. The officer told the investigator that Mr Battensby engaged well in regular key worker sessions. He said that he helped Mr Battensby with some issues relating to his education and employment at the prison. Mr Battensby was also making plans to marry his partner and asked him for help and advice on matters relating to his wedding.
25. On 18 March 2020, the prison chaplain met with Mr Battensby to discuss his wedding. The chaplain told the investigator that Mr Battensby and his partner wanted to get married as soon as possible. However, due to COVID-19 restrictions and associated changes to the prison regime, the registrars were unable to complete the necessary processes. He told Mr Battensby that his wedding would therefore have to be postponed until after 30 June at the earliest. The chaplain said that Mr Battensby was saddened by the news but he thought he took it well. He said he had no concerns about Mr Battensby after he spoke to him but he did not see him again after that day.
26. On 20 March, Mr Battensby gave an officer a copy of a letter from his solicitor, stating that he had given his partner Power of Attorney over his legal matters. The officer told the investigator he did not find this concerning as Mr Battensby told him it would help his partner to sort out the wedding formalities more quickly.
27. On 2 April, a healthcare administrator entered a note in Mr Battensby's medical record indicating that a DNACPR form had been received. Later that afternoon, a prison GP, made an entry stating, 'In the event of cardiopulmonary arrest – not for resuscitation.' No further documentation or written account was found in Mr Battensby's medical record.
28. A nurse told the clinical reviewer that she had seen a handwritten note from Mr Battensby requesting a DNACPR order and stating that, due to concerns about COVID-19, he did not want to attend healthcare for a consultation. She said that she discussed Mr Battensby's request with the prison GP. They agreed to the order being put in place, without discussing it with Mr Battensby, on the basis that he was

known to healthcare and was not considered to be at risk of suicide or self-harm. Mr Battensby's handwritten note was subsequently lost and therefore was not in his medical record.

29. The GP told the investigator that it was not unusual for prisoners to request Advance Directives and DNACPR orders. He said healthcare staff would usually discuss any such request with the prisoner. The GP said that, due to the COVID-19 situation, he had seen a higher number of DNACPR requests than usual. He said that Mr Battensby had made it clear that he did not want to come to healthcare to discuss his request and the lockdown regime meant that it was not possible for him to see Mr Battensby on the wing. The GP said that, as part of the assessment, he and a nurse would have shared the information with wing staff and made enquiries with the mental health team. He described Mr Battensby's note as 'quite detailed' and said that it 'explained everything nicely'. He was surprised that the note had gone missing.

### **Events of 15/16 April**

30. On Around 7.00pm on 15 April, an officer made sure all prisoners were locked away for the night. The officer told the investigator that he said goodnight to Mr Battensby and had no concerns about him. He said he had no reason to check on Mr Battensby again during the night.
31. At around 6.10am on 16 April, while carrying out the early morning welfare check, the officer saw Mr Battensby sitting in his chair. He said good morning but got no response. He kicked the door and shouted to Mr Battensby but still got no response. The officer told the investigator that he could not see Mr Battensby moving and he felt that something was not quite right but he did not know what. He said it was not good practice for him to go into a cell alone and he would only do so if he felt confident it was safe, so he went to the office to request assistance.
32. The officer and two prison managers went into the cell. They found Mr Battensby sitting on the chair in front of the television. He had a ligature around his neck which was tied to the window. Staff called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties that alerts healthcare staff and tells the control room to call an ambulance immediately) on the radio and healthcare staff arrived at 6.15am. Mr Battensby had signs of rigor mortis and the DNACPR order was displayed on his wall, so staff did not attempt CPR. Paramedics arrived shortly afterwards and, at 6.36am, they confirmed that Mr Battensby had died.

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

33. At 8.55am on 16 April 2020, the prison's family liaison officer telephoned Mr Battensby's partner to tell her that Mr Battensby had died. Due to COVID-19 restrictions in place at the time, the prison was unable to break the news to Mr Battensby's partner in person. The prison contributed to the cost of Mr Battensby's funeral in line with national guidance.

## **Support for prisoners and staff**

34. After Mr Battensby's death, a prison manager debriefed staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising and offering support. The staff care team also offered support.
35. The prison posted notices informing other prisoners of Mr Battensby's death and offering support. Staff reviewed all prisoners assessed as being at risk of self-harm or suicide in case they had been adversely affected by Mr Battensby's death..

## **Post-mortem report**

36. The post-mortem report concluded Mr Battensby died from hanging. Toxicology tests showed that he had no illicit drugs or alcohol in his system.

# Findings

## Assessment of risk of suicide and self-harm

37. Mr Battensby did not have a history of suicide or self-harm. He did not have any mental health issues and appeared to be coping well in prison, despite his long sentence. Although he was frustrated about his employment situation within the prison and the postponement of his wedding, we consider that these issues were not sufficient to lead staff to believe he was at risk of suicide or self-harm. We consider that there was little indication at any point during his time in custody that Mr Battensby was at risk of suicide or self-harm.
38. However, we are concerned that Mr Battensby's request for a DNACPR order was authorised without any discussion or assessment of potential risk issues. We accept that the GP account that there were many prisoners asking for DNACPR orders due to COVID-19 but, given that Mr Battensby did not have any life-limiting or chronic illnesses, we consider staff could have made more of an effort to discuss his request with him. In the event, it is likely that he requested the DNACPR as he intended to take his life. We therefore consider this was a missed opportunity to assess his risk. We make the following recommendation:

**The Head of Healthcare should ensure that all prisoners requesting a DNACPR order are assessed, preferably face-to-face, to establish if they are at risk of suicide, that they have mental capacity, and that no mental health issues are apparent.**

## Record keeping

39. Mr Battensby wrote a note setting out his request for a DNACPR order, stating that he did not wish to attend healthcare to discuss this further. The note was subsequently lost and is therefore not recorded in his medical notes.
40. A nurse and a GP discussed Mr Battensby's request and agreed to it on the basis that he had mental capacity to make that decision and he was not considered to be at risk of suicide or self-harm. The GP said that they 'would have consulted with wing staff and the mental health team' as part of their assessment. However, we found no documentary evidence of the wider consultation nor the basis of their assessment. We make the following recommendation:

**The Head of Healthcare should ensure that:**

- **staff provide a full and accurate record of the DNACPR assessment in the prisoner's medical record, including details of all staff who have provided input and the rationale behind the decision;**
- **all correspondence received from the prisoner, or from anywhere else, relating to the DNACPR order is immediately scanned and retained on the prisoner's medical record.**

## **Inquest**

At the inquest held on 5 September 2022, the coroner concluded that Mr Battensby's death was due to suicide.

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Third Floor, 10 South Colonnade  
Canary Wharf, London E14 4PU

Email: [mail@ppo.gov.uk](mailto:mail@ppo.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T | 020 7633 4100