

**Investigation into the circumstances surrounding the
death of a man at HMP Full Sutton in September 2010**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

June 2011

This is the report of the investigation into the circumstances surrounding the death of a man, who died in September 2010. He was in the custody of HMP Full Sutton when he died. He was 60 years of age.

The loss of any family member is acutely painful, but especially so whilst they are in custody. I offer my sincere condolences to the man's family and friends.

He arrived at Full Sutton on 15 April 2009, following his transfer from HMP Frankland. His general health deteriorated in late October. After going to hospital for tests, he was diagnosed with pancreatic cancer in November. Following several operations, he was told in May 2010 that this rare form of cancer was inoperable and therefore incurable. In June he was admitted to the healthcare centre at Full Sutton where he was given palliative care.

On 3 September, he moved to a specially prepared palliative care suite where his condition deteriorated rapidly. He was given controlled drugs for pain management until 17 September, when a nurse saw him take a deep breath and he died 'peacefully and comfortably'. The post mortem confirmed that the primary cause of death was carcinoma of the pancreas with lung metastases (pancreatic cancer).

The investigation was conducted by one of my investigators. In addition, I commissioned a clinical review of the man's healthcare. I would like to thank the clinical reviewer who was appointed by the local Primary Care Trust to undertake the review. I would also like to thank the Governor of Full Sutton and his liaison officer for their assistance.

As the man died from natural causes, the findings of the clinical review play a vital part in my report. The review shows that he received care whilst he was in custody which was equitable to what he could have expected to receive in the community.

I make no recommendations as a result of this investigation and am pleased to learn that he benefited from improved arrangements to deliver palliative care.

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.

Jane Webb
Acting Prisons and Probation Ombudsman

June 2011

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SUMMARY

1. The man was imprisoned for murder in 2004 and was initially held at HMP Liverpool. He had a history of hypertension, depression and alcohol dependence, along with a tendency to self harm. He was prescribed medication to treat these conditions and was regularly seen by mental health professionals. He was described as being a difficult prisoner to manage.
2. When he was transferred to HMP Frankland in March 2007, he settled into the wing and worked in the kitchen. In October 2008, he complained of severe left-sided lower abdominal pain. He was referred to a urologist for urine tests (urinalysis) and, in February and March 2009, had further investigations and scans for haematuria (blood in urine) and oxalate crystals (kidney stones).
3. On 24 February 2009, he seriously assaulted a prison officer and as a result was taken to the segregation unit, where he remained until he was transferred to HMP Full Sutton on 15 April. Noting his medical history, the healthcare team regularly observed his condition. Further urinalysis tests proved negative.
4. The man's general health began to deteriorate in October when he was diagnosed with jaundice. After taking advice, the doctors initially treated him for gallstones and a possible infection. When he became more jaundiced, the doctor referred him to a consultant gastroenterologist.
5. Following several scans in November, he was diagnosed with cancer of the bile duct. Following operations it was discovered that the cancer had spread, which prevented any curative treatment. He was informed and a course of chemotherapy was tried. This did not have any effect and, in August 2010, he was told that it was likely that he had only weeks to live.
6. In September, his condition had deteriorated to the point where he was put on the palliative care pathway within the healthcare centre at Full Sutton. He died in September.
7. I do not make any recommendations as a result of this investigation. I am pleased to note, that the clinical reviewer has highlighted that the man was well cared for and received a good standard of treatment.

THE INVESTIGATION PROCESS

8. My office was notified of the man's death on 17 September 2010. Notices announcing the investigation were supplied by my office and displayed by the prison to staff and prisoners, who were invited to contribute any relevant information. No prisoners or staff made contact.
9. All the relevant prison records relating to him were studied by my investigator. They included the main prison record, medical records and statements made by staff. One of my family liaison officers contacted the man's daughter. She wanted our investigation to consider whether her father had any difficulty accessing the doctor when he originally began having pains sometime during 2009. I hope that my report addresses this issue.
10. A clinical review of his healthcare was commissioned from the local Primary Care Trust. They appointed a clinical reviewer to conduct the review, which is attached to this report as an annex.
11. Her Majesty's Coroner was contacted by my investigator to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, a copy of this report will be sent to the Coroner to assist his enquiries into the man's death.
12. My investigator visited HMP Full Sutton on 11 November, to familiarise himself with the general environment where the man had lived. He visited the wing and cell where the man spent the majority of his time, the segregation unit where he had spent some time in 2009, and the healthcare centre, where he visited the palliative care suite in which he died. The investigator talked to several members of staff, including the liaison officer, but did not conduct any formal interviews.
13. The draft version of this report was issued in February 2011. I have received confirmation from both the man's family and NOMS that they have no comments on that report.
14. An inquest touching on the man's death was held on 14 March 2011 by HM Coroner for the County of York, which my investigator attended. The jury returned a verdict that he had died as a result of natural causes.

HMP FULL SUTTON

15. Full Sutton opened in 1987 as a purpose-built maximum security prison and holds category A and B male offenders. The accommodation consists of single cells. The prison will not accept prisoners who have been sentenced to less than four years, or who have less than 12 months left to serve. It has an operational capacity of 608.
16. The inpatient healthcare unit is staffed by qualified nurses, healthcare assistants and discipline officers and has six beds, with an additional two safer cells and a crisis suite. Healthcare services are commissioned through the local Primary Care Trust (PCT). The nursing staff have a variety of skills, including mental health, and there is a nurse prescriber (a nurse who is qualified to prescribe medication). Two doctors provide daily medical cover.

HM Inspectorate of Prisons

17. The then Her Majesty's Chief Inspector of Prisons made a full announced inspection of Full Sutton between 19 and 23 November 2007. In her report, the Chief Inspector said,

“Nursing staff had a wide range of clinical skills, knowledge and competences which were well utilised.

“The system for arranging outside hospital appointments was well organised, and there were few cancellations because of staff shortages or security issues.”

Independent Monitoring Board

18. Each prison is monitored by an Independent Monitoring Board (IMB), members of which are drawn from the local community. They have full access to prisoners and every part of the establishment. In its latest annual report, for the year ending 30 November 2009, Full Sutton's IMB said,

“In most cases, that level [of healthcare] is above that which they [the prisoners] might reasonably expect in the outside community.

“Full Sutton's prisoners have come to expect a particularly gold-plated standard of healthcare.

“The Board has seen an improvement in the working relationship between the Primary Care Trust and Full Sutton's healthcare staff. This is largely due to the persistence and dedication of Full Sutton's healthcare staff.”

Previous deaths at Full Sutton

19. Since my office began investigating all deaths in prison custody in 2004, there have been eight other deaths at Full Sutton. Five of these deaths were the result of natural causes. In one of these cases, I made recommendations regarding the improvement of palliative care at Full Sutton. I am pleased to note that the clinical reviewer in this case has noted that the man's palliative care was handled well, and that healthcare staff had sought expert palliative advice.

KEY EVENTS

20. The man served his first prison sentence in 1972. During an appearance at Crown Court in 1998, court papers stated he had harmed himself in the past. He was diagnosed with hypertension (high blood pressure) in 1990. Prior to his arrest in 2004 he had served 12 previous custodial sentences.
21. On 23 October 2004, he was arrested for the murder of his partner. After this incident and prior to his arrest, he attempted suicide by slashing his neck with a razor blade. The laceration to the left side of his neck was treated by having the wound glued. He also tried to suffocate himself with a plastic bag whilst he was in police custody.
22. Two days later, the man appeared at a magistrates' court where he was remanded in custody to HMP Liverpool. During his first night in custody interview, he stated that he was intent on killing himself and would commit suicide if he received a life sentence. He was then seen by a healthcare worker for his first reception health screen. The recent deep cut across his throat was noted. He said that he suffered from depression and had an alcohol addiction, consuming eight or nine litres of cider each day. He was receiving atenolol (for hypertension) and lofepramine (an antidepressant).
23. To help identify and care for prisoners at risk of suicide or self-harm, the prison service uses a care-planning system called ACCT (Assessment, Care in Custody, and Treatment). The ACCT procedures were opened on reception for him. (In his prison records, it is noted that "F2052 ACCT opened". F2052 refers to the previous system of monitoring someone at risk of potential self harm.) He was monitored every 15 minutes. He agreed to be admitted to the healthcare centre for an assessment of his mental health.
24. On admission to the healthcare centre, the man was seen by a registered mental nurse (RMN). He told the nurse he was currently suicidal with intensive thoughts of suicide. The nurse noted that he had a history of depression, anxiety and alcohol dependence. He was given librium (for detoxification of alcohol), and a sleeping tablet.
25. He settled into the healthcare centre and slept well over the following two nights. On 28 October, he told the RMN that he was now detoxified and did not need any more librium. He began to improve in mood over the following days, communicating and associating with other prisoners.
26. On 4 November, the RMN started a collaborative care plan. After speaking with the man, the RMN noted that he was suffering from a reactive depression due to his recent offence and remained at high risk of self harm. He told the RMN that he had suffered depression on and off for 15 years, he had a long history of self harm and had multiple,

healed deep scars over the forearm, chest and abdomen. Overall, he had over 300 stitches over his body.

27. A psychiatrist saw the man on 5 November. He told the psychiatrist that he had taken two overdoses in two days, one week before the incident, both whilst under the influence of alcohol. (The second overdose was considered serious enough for him to be admitted to an intensive care unit for 24 hours but he discharged himself from the medical ward against advice.) They discussed his offence and he accepted responsibility for the death of his partner. They talked over his medical history and medication, his personal, family and forensic histories.
28. In a summary of his mental state, the doctor noted that the man had depressive symptoms but there were no psychiatric symptoms evident. The doctor concluded that he was a high suicide risk, should remain on one to one observations and prescribed zispin (an antidepressant).
29. He was regularly reviewed and his condition slowly improved. He was compliant with his medication and by the end of November was settled in mood and manner, eating well, interacting with others and gave no indication that he would harm himself. On 12 December, he was transferred to the main wing where he was regularly reviewed by a doctor. On 17 December, he was prescribed chlorpromazine (an antipsychotic), and three weeks later the doctor noted an improvement.
30. On 4 March 2005, the man was convicted of murder at Crown Court. He was sentenced to life imprisonment with a recommendation that he should serve a minimum of 20 years. On his return to Liverpool, he became anxious and stressed. An ACCT was opened due to his past history of talking about taking his own life and he was admitted to the healthcare centre.
31. As he settled into the prison routine, it was noted that there were no anxieties expressed or observed. He was interacting well and no further thoughts of self harm were expressed. The ACCT was closed on 13 April and he was transferred back to the wing, where he shared a cell.
32. At the end of May, he began to be abusive, aggressive and confrontational towards staff. He did not want to share a cell, wanted to move to another prison and said he had no intention of doing any courses to address his offending behaviour. On 19 June, he was seen by a doctor and granted single cell occupancy, and his attitude improved.
33. The man continued to be regularly assessed by the prison community mental health team and had his antidepressant medication changed on 21 July to amitriptyline, as he had displayed symptoms of low mood. He continued to improve, settling into the prison regime. He worked in

the leather workshop and began receiving visits from his brother, sister and niece.

34. In April 2006, he reiterated his intention not to participate in any coursework at Liverpool and said that he wanted a transfer to another prison. However, in October 2006, when he was told there were spaces at HMP Frankland, he said that he did not want to move yet.
35. In December, the man again began verbally abusing members of staff. When this was discussed with him, he said it was the result of his high blood pressure and he was unable to control himself in these situations.
36. He became extremely irate and angry on 23 January 2007, shouting unintelligible threats to staff. He could not be reasoned with and was taken into his cell while still making threats. He was moved to another wing on 7 February. On 20 February, he was abusive towards another prisoner and threatened to break his nose.
37. During a scheduled cell sharing risk review on 11 March, it was noted that he was continually having loud, aggressive and violent outbursts. The risk of him harming a cell mate was assessed as high.
38. On 27 March, the man was transferred to HMP Frankland, where all the accommodation is in single cells. During his initial reception, it was noted that he had stopped taking antidepressant medication two weeks previously. A doctor prescribed medication for hypertension and acid reflux (a condition in which acid leaks from the stomach into the oesophagus).
39. He settled into the wing and worked in the kitchen. He continued to have a poor attitude towards staff which often ended with formal warnings. His hypertension was reviewed regularly and he had a mental health review on 31 July. Mirtazapine (an antidepressant) was prescribed on 31 August.
40. In March 2008, he was referred by the doctor to an urologist following ongoing problems with splitting and bleeding of his foreskin. Initially seen at hospital he had a minor operation on 29 July at another hospital.
41. On 7 October, the man complained to a doctor of having left-sided lower abdominal pain for over two hours. On 12 November, a urine test confirmed oxylate salts (from which kidney stones can develop), and the presence of red blood cells. He said that he did not see any blood passing in his urine. The doctor liaised with the urology department at the first hospital requesting further investigation of the pain and haematuria (presence of red blood cells in urine).

42. He started work as a cleaner in the gym, which he enjoyed. He declined to attend a mental health appointment and was therefore discharged from the team's caseload. On 30 November, he asked about being moved to a prison further south. He maintained a routine, kept a low profile and caused no concern to staff.
43. On 19 February 2009, the man returned to hospital. A consultant urologist carried out further tests and arranged for a CT (computerised tomography) urogram (this type of scan can help diagnose a variety of conditions).
44. When prison officers were trying to restrain another prisoner on 24 February, the man assaulted an officer by hitting him with a chair and punching him in the face. Following a violent struggle, he was restrained and taken to a cell in the segregation unit.
45. He went to hospital for a CT scan on 31 March, and had further investigations for haematuria and oxalate crystals (kidney stones). He remained in the segregation unit until he was transferred to Full Sutton on 15 April.
46. During his reception at Full Sutton, the man was seen by healthcare who noted his history of hypertension and depression. As he still had concerns about his kidneys and had occasional pain, and had recently been to outside hospital, he was referred to a doctor.
47. The following day, he was seen by the chief medical officer. The recent CT urogram and investigation of haematuria and oxalate crystals were noted, as was his history of depression, alcohol misuse and that his mood fluctuated and he became aggressive at times.
48. On examination the doctor found that he was not depressive and had no suicidal thoughts. The doctor diagnosed him with depressive disorder and hypertension and said he should continue medication for hypertension, depression and dyspepsia (indigestion).
49. The next day, the man complained of loin pain and was seen by a prison doctor. As his urinary microscopy, culture and sensitivities reports were normal, showing no signs of blood or stones, the doctor took no further action.
50. On 8 May, he was told that the police wished to interview him about the assault on the prison officer at Frankland. (He was later charged with grievous bodily harm on a prison officer, and committed to stand trial at Crown Court. The trial had not taken place by the time that he died.) Two days later, on 10 May, he smashed up his cell, urinated on the floor and cut a 20 centimetre wound into his left arm with a razor blade, stating that he was tired and fed up. The wound was cleaned, steri-stripped and dressed. An ACCT was opened. He was taken to the healthcare centre where he became increasingly aggressive, threw a

television onto the floor in his cell and removed the steristrips and dressing from his wound. He had to be restrained and relocated in a safer custody cell (safer cells are designed to make the act of suicide or self-harm as difficult as possible. This is achieved chiefly by reducing ligature points). His arm was redressed. His daughter was due to visit.

51. During a mental health review the following day, the man said that he had been upset by a dream relating to his offence. It was decided that he required regular mental health team support and, as he appeared sufficiently recovered to return to the wing, he was fit for adjudication and segregation location if required. An ACCT review was carried out and it was decided to observe him every hour. The ACCT was closed after one week. His daughter visited him on 30 May.
52. An ACCT was opened again on 18 June, after an adjudication decided that he would lose access to his television for 14 days. He said he would go on hunger strike and refused to take the medication prescribed for his depression. He also refused to speak to anyone. He started eating and taking his medication again two days later, after speaking to his daughter on the telephone.
53. The ACCT was closed on 30 June, the man had his television back and he was engaging with staff and peers. He attended work, went to education twice a week, regularly attended the gym and ran on the yard. He fully complied with the wing regime and had regular contact with his family.
54. Another ACCT was opened on 12 October, when he threatened to self harm as he had a sore mouth from toothache and wanted to see a doctor for pain relief. When he saw the chief medical officer three days later, he told him that he had not taken his antidepressants for three weeks and that he became angry easily. On examination the doctor noted that he was not depressed or suicidal and had no psychoses. The doctor's diagnosis was mood disorder and back ache. The urinalysis showed no abnormality and the ACCT was closed.
55. A week later, he complained of seeing blood in his urine and of having flu symptoms for the previous two days. Urinalysis again showed no abnormality, but the chief medical officer decided to write to a consultant urologist at hospital, asking for expert opinion.
56. On 3 November, the man was admitted to another hospital with obstructive jaundice (an interruption to the drainage of bile, which is produced by the liver to aid digestion). He saw a consultant gastroenterologist for a CT scan. The doctor performed two tests. The first was an endoscopic retrograde cholangiopancreatography (ERCP), a technique that combines the use of endoscopy (looking inside the body with an endoscope, a flexible tube with a camera). The second test was a fluoroscopy (an imaging technique used to obtain real-time moving images of the internal structures of a patient through the use of

a fluoroscope, which uses x rays to obtain the images) to diagnose and treat certain problems of the biliary or pancreatic ductal systems.

57. Two days later, a sub centimetre tight stricture (an abnormal narrowing) was identified in the bile duct with gross dilatation (widening of the duct). During an operation, brushings were obtained for cytology (a study of the cells) and a nine centimetre plastic stent (artificial tube) was inserted to assist the bile drainage. The consultant gastroenterologist commented 'This looks like a cholangiocarcinoma' (bile duct cancer).
58. The man was discharged back to Full Sutton the following day. Following a meeting of the pancreatic multi-disciplinary team meeting, he went to hospital on 20 November, where he saw a doctor. The doctor told him that he might have cancer and would have to go to Leeds for more examinations. He also said that his condition might still be operable at this stage.
59. Another ERCP was carried out at hospital on 25 November. This identified a distal bile duct stricture consistent with cholangiocarcinoma. A consultant pancreatic surgeon informed him of the likely diagnosis and that he may require chemotherapy treatment.
60. The ACCT procedures were opened again on 28 November, due to his emotional state. He said that he did not feel safe and might harm himself. He was placed on hourly observations, and his daughter visited him again.
61. On 1 December, he was taken to the healthcare centre for observations, after he complained of abdominal pain and generally feeling unwell. He was taken to hospital the following day for a CT scan of his abdomen and pelvis and was readmitted two days later when it was discovered that the stent in his bile duct was blocked.
62. The ACCT support was closed on 7 December. The following day, the man was diagnosed with destructive jaundice caused by the stent blockage. He had another ERCP and the stent was changed. He was discharged back to the prison's healthcare centre the next day. A positron emission tomography (PET) scan (to see how the organs and tissues are functioning) was performed on 18 December at hospital.
63. Another ACCT was opened for him on 15 January 2010, when he became extremely vocal and aggressive. This was closed on 20 January.
64. He was admitted to hospital on 24 January for a potential Whipples procedure (a major operation to treat cancerous tumours on the head of the pancreas, bile duct or intestine). Surgeons were unable to proceed when the pre-operation CT scan showed that two aortic caval lymph nodes (lesions) were hard and positive, representing metastasis

(the spread of a disease). (Lymph nodes are vital parts of the immune system.) A large mass tumour was also found in the head of his pancreas, which extended up the bile duct. A palliative double bypass of the bile duct and pancreas was performed by the surgeons.

65. The man was discharged from the hospital on 8 February, and returned to his wing where he was seen regularly by healthcare staff and doctors. He was fitted with three wound bags in order to release fluid from the operation wounds and these were regularly checked, cleaned and emptied.
66. The wounds healed by 22 March, and, on 24 March, he asked if he could go into the gym to use the treadmill. There were regular medication reviews and at a full multi disciplinary team meeting on 30 March, it was decided that his main issue was pain management. He had pain during the early hours of the morning which he described as cramp like, sometimes intense and disturbing his sleep. It was decided to increase tramadol (to treat moderate to severe pain) as necessary, in 100mg increments up to 600mg, then switch to morphine (to relieve severe or agonising pain) as needed.
67. He complained of shortness of breath on 3 April. He attended hospital on 7 April, and the radiology department at another hospital on 12 April. The chief medical officer referred him to a psychiatrist as he was concerned about his ongoing anxiety state.
68. A consultant psychiatrist saw him on 30 April. The man told him that he was aware of his diagnosis and prognosis but was worried about whether he had months or a year to live. The psychiatrist determined that he may have a depressive disorder and prescribed an antidepressant.
69. On 14 May, he went to hospital and saw a doctor. He was informed that his cancer was inoperable and therefore incurable and he was referred for a Macmillan review. (Macmillan Cancer Support provides specialist health care, information and financial support to people affected by cancer.) The doctor discussed treatment and advised oral chemotherapy.
70. During this period, managers at Full Sutton considered whether it would be appropriate to move the man to a prison closer to his daughter. This did not happen after a sentence planning meeting on 4 June recommended that he should not be transferred.
71. On 11 June, he was admitted into the healthcare unit on a permanent basis and a palliative care pathway (to maintain and support the activities of daily living) was put in place. He saw the doctor again on 15 June, who told him that without treatment his life expectancy was between three to six months but that treatment might add a few months. He agreed to be treated. Following another visit to hospital a

week later, when the chemotherapy regime was explained, he started to take palliative capecitabine (a chemotherapeutic tablet) on a two week on, one week off regime.

72. The man's condition deteriorated rapidly on 21 July. The chief medical officer noted that he looked frail, unwell and jaundiced. The doctor liaised with the hospital doctor who agreed to admit him immediately into hospital for further care. At the hospital a scan showed that his cancer had spread and his tumour had enlarged. On 23 July, he returned to Full Sutton to resume his palliative care regime. Following a discussion between the chief medical officer and an oncologist at the hospital, the oncologist advised that the man's condition was likely to deteriorate. He had weeks rather than months left to live and the hospital had not arranged to see him again. He was also told that he could not tolerate the chemotherapy and he agreed that it should be discontinued.
73. The man told the chief medical officer on 28 July that he felt better without the chemotherapy and was happy with his current pain control medication. He was not depressed and maintained social contact with his daughter and spent time visiting his old wing for association.
74. The following day, he discussed his current situation and the progression of his disease with the multiple disciplinary team, which included the chief medical officer, a Macmillan nurse, three other nurses and a chaplain. End of life issues and symptom management were discussed. It was agreed that, when he was unable to take his oral medication, key palliative care drugs would be administered by injection.
75. By 2 September, his health was rapidly getting worse. He did not know what time or day it was. The following day he moved to a specially prepared palliative care suite within the healthcare centre. An integrated care pathway for the dying patient (ICPDP) replaced the previous assessment, care plan and evaluations. (This plan of care provides pain relief for symptoms and other treatments are stopped. The patient's emotional and physical needs are fully supported in the days leading up to death.) The multidisciplinary team meeting agreed that he was dying and handwritten progress notes were kept. The cell was left unlocked to allow 24 hour access for staff to administer medication and give other assistance.
76. Staff had previously considered whether an application for early compassionate release would be appropriate. However, because of his conviction and volatile behaviour, it was decided that he should stay in prison. On 3 September, the possibility of release was discussed with him, but he said that he wished to continue his current care and was happy in the palliative care suite.

77. Over the next few days, the man became rapidly disorientated and unsteady on his feet but ate and drank small amounts. He had a visit from his daughter and two nieces on 7 September. The chaplains saw him every day and shared in his spiritual and emotional preparation for dying.
78. Diamorphine was administered via a syringe driver (to continuously administer painkillers and other drugs) from 8 September. He was by now only able to take sips of fluid and remained in bed. The prison doctor discussed the end of life pathway with him. It was agreed that if his heart stopped he would not be resuscitated. He asked that his daughter be informed of his impending death by telephone. Observations were maintained throughout the night.
79. The Macmillan nurse saw the man and his daughter on 10 September. His condition had deteriorated further and he complained of abdominal pain, headache and feeling forgetful. The nurse recommenced the syringe driver with diamorphine increased to 40mg and midazolam (for relieving fear) at 10mg.
80. By 15 September, he was unable to take liquids and very rarely opened his eyes or communicated. His diamorphine had been increased to 100mg and midazolam to 20mg. The chaplain visited regularly, had performed Holy Communion and updated his daughter on his condition. Officers and nurses sat with him whenever they could.
81. At 7.20pm on 16 September, Nurse A began her duty at the healthcare centre. She checked the man regularly and delivered his general nursing care. She noted that he was near the end of his life, having had a laboured day, and that his breathing was very slow, weak and erratic. At 6.30am the following morning she noted that his breathing had become more laboured.
82. Nurse B took over the care of the man from another nurse at 7.10am on 17 September. Realising that he was probably very close to death, she sat with him. At 7.30am she saw that his breathing had become shallower and then "he took a deep breath and died peacefully and comfortably".
83. The nurse informed other healthcare centre staff. The doctor was called and the chaplain attended and gave the man the Last Rites. The prison doctor arrived and pronounced him dead at 8.40am.
84. The man's daughter was informed of his death by the family liaison officer. She had been told of the deterioration in his condition and had discussed various arrangements before her father died.
85. Shortly after his death, the prison activated its death in custody contingency plan. His next of kin, Humberside Police, the Governor, the Independent Monitoring Board, and the Ombudsman were

informed. A prison family liaison officer was appointed. The police visited the prison at 12.00pm, interviewed staff and took several statements, copies of which were given to my investigator. The police found that there were no suspicious circumstances.

86. Notices to inform prisoners and staff of the man's death were issued throughout the prison. Prisoners who knew him, and patients and staff in the healthcare centre, were spoken too individually and offered support.
87. At 11.55am on 20 September, a Home Office Consultant Pathologist carried out a post mortem examination on the body of the man. He concluded that his death was due to natural causes caused by carcinoma of the pancreas with lung metastases.
88. The prison offered to contribute towards funeral expenses and the man's funeral was held on 1 October.

ISSUES

Clinical issues

89. The man suffered long term depression following his imprisonment in 2004. He had hypertension which was observed and treated up until his death. In November 2009, he was diagnosed with cancer. This spread to other areas preventing any curative treatment. By September 2010, his condition deteriorated to the point where he was put on the palliative care pathway within the healthcare centre at Full Sutton, where he died.
90. The clinical reviewer principally looked at the management of the man's long-term depression and hypertension, the timing of his diagnosis of his cancer, and its investigation, and his palliative care.
91. The clinical reviewer comments in his review that both the man's depression and hypertension seem to have been addressed appropriately. Indeed, from reviewing his records, both discipline and healthcare staff appear to have been aware of the possibility that he might harm himself, and addressed these concerns appropriately.
92. The man also had several urological issues. The clinical reviewer believes that they were addressed appropriately, although he does note that there was a break in care around the time of his transfer between Frankland and Full Sutton.
93. The diagnosis of his cancer was, according to the clinical reviewer, delivered in an "acceptable timeframe" and was not delayed by the man's imprisonment. As the clinical reviewer points out, however, cancer of the bile duct is rare and symptoms often only appear at a late stage, meaning that curative treatment is not possible.
94. In a previous investigation at Full Sutton, I have made recommendations around the issue of palliative care. I am pleased to note the clinical reviewer's opinion that, for the man, palliative care was delivered very well, involved the use of multi-disciplinary teams and that palliative care specialists were consulted when required. In particular, I am pleased that an end of life care pathway was used and that clinical decisions were made after consultation with him. His daughter told my family liaison officer that he felt that he had been cared for very well at Full Sutton once his condition was diagnosed and I hope that the Governor will pass my remarks on to his staff.

Compassionate release

95. On several different occasions staff considered whether it would be appropriate to seek early compassionate release for the man. Although at first they decided that it would not, this decision was reviewed as appropriate, and he himself was consulted about the final

decision on 3 September. I am pleased to note that his views were taken into account.

Contact with the man's family

96. The man's daughter also commented that she had been kept well informed of the progress of her father's illness. It is always a difficult time when a family member is ill, but it is often all the more difficult when that person is in prison. It is important that family members are informed of progress, should the prisoner wish them to be, and in this case I judge that staff at Full Sutton did this very effectively.

CONCLUSIONS

97. The man had served several prison sentences before being remanded in custody in 2004. He was subsequently convicted of murder.
98. He was diagnosed with depression and hypertension and treated properly for both. He later had urological issues that were also treated appropriately, until he was diagnosed with cancer of the bile duct late in 2009. After it was agreed that curative surgery would not be possible, he was given palliative chemotherapy. This was stopped after it became clear that he was not tolerating the medication, and a palliative care plan was put in place. His pain was controlled effectively until he passed away in September 2010.
99. I agree with the clinical reviewer that the man's treatment was well managed. In particular, palliative care was delivered effectively.