

**Investigation into the circumstances surrounding the
death of a prisoner at
HMP Full Sutton, at York District Hospital
in December 2008**

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

December 2009

This is the report of an investigation into the death of a man who was a prisoner at HMP Full Sutton, who died unexpectedly in December 2008 after a short illness. He was 51 years old. I offer my condolences to his family and many friends for their sudden loss.

The investigation was undertaken by one of my investigators. A clinical review of the healthcare provided to the man was also commissioned by East Riding of Yorkshire Primary Care Trust (PCT), and I am grateful for the review. I would also like to express my thanks to the Governor of Full Sutton, and his staff for their co-operation. The assistance of the residential governor who acted as liaison officer was invaluable to my investigator.

The man who died was nearing the end of a seven year sentence when he developed back pain for which he received analgesics. However, the pain worsened until he was spending most of his time in bed. When he became very unwell on 19 December 2008, he was transferred first to the prison's healthcare centre and, six hours later, to the local hospital. He lost consciousness the following evening and died 12 hours later. The post mortem found that he had been suffering from multiple myelomas (cancers that develop from cells in the bone marrow).

I make four recommendations touching on clinical matters, and commend one example of good practice.

Stephen Shaw CBE
Prisons and Probation Ombudsman

December 2009

CONTENTS

Summary	4
The investigation process	5
The Inquest	5
HMP Full Sutton	6
Key findings	7
Issues	14
Recommendations	19

SUMMARY

The man who died was born on in November 1957 and died on 21 December 2008 at York District Hospital. He was 51 years old and suffering from multiple myelomas (cancer of the bone marrow).

He was sentenced to seven years imprisonment on in November 2004 and, after two weeks at HMP Leeds, transferred to HMP Full Sutton. Over the next four years he made full use of his time, attending offending behaviour courses, education classes and studying for GCSEs. He was a Listener (a prisoner trained by the Samaritans to provide confidential emotional support to fellow prisoners in distress), and represented his wing on the prison's consultative committee. He was a cleaner and spent a lot of time in the gymnasium.

On 12 November 2008, the man went to the prison's healthcare centre as his back was painful. Over the next three weeks he had several appointments with nurses and one with the doctor. He was given paracetamol, was prescribed an anti-inflammatory gel, and then given anti-inflammatory tablets. The man did not take the anti-inflammatory medication regularly, telling other prisoners that it was not working.

At a gym class on 2 December, the man suddenly stopped the exercise he was doing, telling the others that his back was very painful. He returned to his unit where, over the next two days, he spent most of his time in his cell. He did not go to the gym or education again and could not continue working as a cleaner. A nurse visited the man in his cell and advised him to try to keep active and complete the course of medication.

By the morning of 19 December, the man was unable to get out of bed and had been incontinent. He was transferred to the healthcare centre where he was made comfortable. Blood tests revealed a very high calcium level, indicating to the doctor that the man had a serious health problem. The healthcare and discipline staff worked quickly to have him transferred to York District Hospital that evening.

The following day, the man underwent a series of tests but his condition quickly worsened. The hospital staff asked the prison for his next of kin details. The address of his parents was in his records but there was no telephone number. The duty manager made the decision to wait until the morning and, although a number was found, there was no reply when officers rang. Sadly, at 10.05am on Sunday 21 December, before the prison was able to get in touch with his family, the man died.

Prison managers contacted the family afterwards and offered their assistance. A memorial service was held in the prison on 29 December which some of the man's family attended along with staff and prisoners.

I make four recommendations on clinical matters. I also draw attention to an example of good practice.

THE INVESTIGATION PROCESS

1. The man died on 21 December 2008. My investigator opened the investigation by letter. She received copies of all the man's prison records.
2. HMP Full Sutton issued notices to staff and prisoners informing them of the investigation and inviting anyone who had relevant information to contact the investigator. In response to the notices, several prisoners contacted the investigator and she arranged to interview them when she visited the prison. She conducted interviews on three occasions between March and May 2009, accompanied on the first visit by a colleague.
3. A clinical review of the healthcare provided to the man was commissioned by East Riding of Yorkshire Primary Care Trust. I am grateful for the review which is attached as an annex to this report.
4. One of my Family Liaison Officers spoke to the man's family to ask if they had any concerns that they wanted to be addressed in the investigation. She and the investigator subsequently visited the family. They raised a number of issues relating to the man's health during the last three weeks of his life, how they were told he was in hospital, and the time of his death. I hope that my report goes some way to answering their questions.

THE INQUEST

5. HM Coroner for Kinston Upon Hull, held the Inquest into the man's death. The jury's verdict was:

“Following deterioration in his health whilst at HMP Full Sutton, [the man] was transferred to York District Hospital, where at 10.05 on 21 December 2008, he died due to complications of multiple myeloma. Insufficient monitoring, record keeping and communication between healthcare and prison staff resulted in missed opportunities to manage [the man's] condition appropriately, ultimately contributing to his death.”

HMP FULL SUTTON

6. HMP Full Sutton is a purpose-built, high security prison for category A male prisoners in a rural location ten miles from York. It opened in 1987 and was later extended when two further wings were built. The accommodation is all single cells. Slightly over half the prisoners are serving life sentences and all are serving a minimum of four years imprisonment.
7. The Independent Monitoring Board's most recent report is for the year ending 30 November 2008. The report describes the period as "a dynamic and excellent year". Most of their concerns, although having some relevance to the man's life in Full Sutton, had no direct bearing on his living conditions and care.
8. The most recent inspection by HM Chief Inspector of Prisons, Dame Anne Owers, was an announced inspection in November 2007. In her report, Dame Anne said:

"Almost all prisoners were purposefully occupied, with good education provision, at various levels, and the opportunity to gain vocational qualifications. For most prisoners, the immediate objective was ... to ensure ... something positive to do, some progress to record and some milestones to achieve."

The wide range of activities and responsibilities the man was involved in illustrates Dame Anne's point very well.

9. Dame Anne was less positive about staff/prisoner relationships, saying:

"Though we saw some examples of positive staff engagement, most staff were distant, and most prisoners distrustful of them."

The man's relationships with staff were at the positive end of the scale, which may be related to his character and the positive influence he had on his unit.

10. I have investigated two previous deaths at Full Sutton. The circumstances surrounding those deaths have no issues in common with this investigation.

KEY FINDINGS

11. The man was convicted of a violent offence on 26 November 2004 and sentenced to seven years imprisonment. After a little over two weeks at HMP Leeds, he transferred to HMP Full Sutton where he served the remainder of his sentence. His appeal against conviction was dismissed in October 2005.
12. It was not the first time the man had been in prison and he settled well into the routine. Over the next three years, he held a number of jobs, including working in the kitchen and the PICTA workshop (an IT course). He participated in his annual sentencing planning meetings, the most recent being 25 June 2008, and completed a number of offending behaviour courses. (Sentence planning is intended to ensure that the best decisions are taken in regard to a prisoner's needs and issues of risk. It aims for continuity in decision-making, so that decisions are taken having gathered as much information as possible. Effective sentence planning should enable a prisoner to use their time constructively and to avoid further offending on release.) The man also attended regular sessions in the gym and took education classes.
13. By 2008, the man was one of the cleaners on E wing and had gained certificates for several specialised cleaning methods. All the prisoners and staff who spoke to my investigator described him as a popular and friendly man. A manager told my investigator, he "was a force for good" in the unit. He represented his wing on Full Sutton's prisoner consultative committee and was a Listener, having been trained by the Samaritans to offer help and support to other prisoners. He worked as a wing cleaner, and officers described him singing reggae songs as he went about his tasks. He was studying for GCSEs and frequently attended the gym. Above all, everyone spoke of his sense of humour and how much it boosted the morale of the unit. He joked with everyone.
14. From May to October 2008, healthcare staff gave the man two days supply of paracetamol tablets (16) approximately every two weeks. The tablets were first prescribed for toothache but, although each subsequent occasion is recorded in the medical notes, no reason was given. It is therefore not possible to say why the man took the medication on each occasion, although one of his friends told my investigator that the man had complained of back pain for about a year. During this period, he began wearing a very broad belt, rather like the support belt that weightlifters wear. However, my investigator could not find out where the belt came from.
15. Also during these months, the man was treated for eye problems, after an optician referred him to the doctor with suspected glaucoma. He attended eye clinics at the York District Hospital on 10 July and 15 September. However, there is no correspondence in the medical record about the results of the eye examination, just a note on 4 November that his repaired glasses had been returned to him.
16. On 12 November 2008, the man asked for an appointment with a nurse as his back was painful. He told the nurse that his left side had been painful "on and off" for the past two weeks. The nurse arranged an appointment for the doctor

17. The prison doctor examined the man on 20 November and carried out tests. He diagnosed muscle strain and prescribed Ibugel, a gel containing ibuprofen, for the relief of pain and inflammation. The test results showed nothing abnormal. Five days later, the man received another 16 paracetamol.

18. Around this time, the man and one of his friends were cleaning the wing when they began “messaging about”. The friend could not recall what day it was but he thought it was around 25 November. He told my investigator that the man:

“... has come at me play fighting and I am saying to him, ‘Listen, you are a big lad, you know, but I will put you on your back. You don’t want to be messaging about all the time.’

“I said, ‘I have had enough of your talk’ ... and I just threw him down. Picked him up and threw him down the floor and it was on the camera. So he got up and he has gone, ‘Did everyone see it? You have hurt my pride now, you have hurt my pride now!’”

19. The man went back to the healthcare centre on 1 December. A nurse practitioner assessed him and noted that he could move well, even touching his toes. The nurse diagnosed “Acute low back pain” and prescribed Voltarol tablets (which contain diclofenac sodium, an anti-inflammatory medication). The nurse told the man to move about and return if the pain continued or worsened.

20. The following day, the man and several others attended their weekly weight loss class as usual. They had been taking this exercise programme for a few months in an attempt to lose weight. (This was in addition to the man’s regular gym sessions and basketball course.) Another of the participants told my investigators that, as the men were doing the exercises, the man said that his back was painful. At first, he thought the man was fooling about as he often did, but when he looked at his face he could see that something was wrong. The man then spoke to the physical education instructor, who told him to go back to the wing, which he did.

21. The man did not go to any more gym sessions, being marked as “injured” and “sick” on the attendance sheets. His education classes were on Wednesday afternoons and all day on Thursdays. On 3 December, he was marked as “Work” on the education attendance record and, the following day, “Present” for the morning Art class but “Work” for the afternoon session. Thereafter, he was marked as “Sick”. As far as my investigator could discover, after 4 December the man did not leave the wing until he was taken to the healthcare centre on 19 December.

22. Also on 4 December, the man returned to the healthcare centre for an appointment with the nurse practitioner for back pain. The nurse wrote in the

23. The next day, the man remained in bed. From this point onwards, it appears that he spent all his time in his cell, often in his bed. His friends and other prisoners helped him by fetching his meals and tidying the cell. One friend told my investigator that he noticed that the man was eating very little but drinking a lot. He also noted that his lips were very dry and cracked.
24. On 10 December, wing staff telephoned healthcare staff and asked them to visit the man. A nurse went to his cell and examined him. He could bend to each side and backwards but not forwards. The nurse noted "some muscle spasm palpable to left side". As the man had not been taking the diclofenac, she advised him to do so. If there was no improvement when he finished the course of medication, she told him to contact healthcare staff again. She also recommended that he should "gently mobilise". According to the prisoners who spoke to my investigator, the man told them that the nurse said that he was exaggerating his condition and he should move around.
25. The following day, a pharmacy technician delivered another 56 paracetamol to the man. The man asked her for pads which she thought were for a TENS machine (used to control pain). There is no information about who provided the machine, or whether pads were supplied. On the technician's return to the healthcare centre, she told staff that she thought the man "looked poorly". However, no follow-up action was taken.
26. A probation officer visited the man on the wing four days later to discuss the report for the Parole Board he had written. He told my investigator that the man appeared to be "very full of flu" and he had difficulty walking from his cell on the ground floor to the upper level. He "struggled to think about things" and could not remember what he had wanted to say to the probation officer. The man had said that he would prefer to discuss the report when he felt better and would ask to speak to the probation officer at that point. A number of prisoners recalled seeing the man struggle to walk back to his cell from the first floor, which might have been on this occasion. They said that he moved very slowly and then sat on the bottom stair to recover.
27. On 18 December, the pharmacy technician returned to E wing to deliver more paracetamol. An officer signed for the tablets and said that he would take them to the man, who was in his cell.

The deterioration in the man's health and his transfer to hospital on 19 December

28. At approximately 9.30am the following morning, an officer went into the man's cell to carry out the daily cell fabric checks. (This is a check of the physical

29. A healthcare assistant (HCA) went to the man's cell. When she saw how ill he was, she telephoned the healthcare centre and asked for the duty prison doctor, a part-time doctor, to examine the man. He completed his rounds in the segregation unit and arrived at the man's cell at 1.35pm. He saw the man lying in a bed which was soaked in urine. There was a bucket containing a little urine at the side. The man made a joke of it, saying that he had been lazy and not got up to go to the toilet. When the doctor asked him to sit on the side of the bed, the man could not move his legs. He was in pain and very dehydrated.
30. The doctor decided to admit the man to the healthcare centre and a nurse and a male HCA brought the evacuation "evac" chair to the cell. (This chair is similar to a stretcher, except that the patient's back is raised to a 45-degree angle. It is designed to transport patients up or down stairs.) Between E wing and the healthcare centre there are two internal flights of stairs to negotiate. The nurses wrapped blankets around the man and strapped him into the chair. Prison managers agreed that, to avoid moving him up and down the stairs, staff could, exceptionally, move him through the grounds. While the doctor was in the cell, he saw that the man had not taken the diclofenac tablets.
31. Once in the healthcare centre, the nurses washed the man and gave him an intra-muscular injection of diclofenac to reduce his pain. When the doctor went to examine the man later that afternoon, he found him lying on his side eating toast and drinking tea. The doctor diagnosed lower back pain and suspected that the man was also suffering from a urinary tract infection. The staff took blood samples and sent them by taxi to York District Hospital to be tested. When the results arrived back that evening, they showed a very high reading for calcium, indicating a serious problem. The doctor told my investigator that the reading was the highest he had ever seen. He spoke to a doctor at the hospital to arrange to admit the man as soon as possible. By this time the prison doctor was at home, so he emailed a letter for the hospital staff to the nurse on duty in the healthcare centre. She printed it out, attached the blood test results, and gave it to the paramedics when they arrived.
32. The prison staff asked for an ambulance, which arrived at 8.17pm. The two paramedics went to the cell and asked the man about his pain. He was conscious and able to describe its location and severity. One of the paramedics wrote in his report, "[The man] ... was conscious and in a stable condition, as demonstrated by his calm and jovial attitude." The staff then moved his bed into the corridor to make it easier to move him onto a spinal board, which is used to immobilise and transport patients with suspected spinal injuries. The movement

33. At the hospital, the paramedics took the man into the Suture Room in the Accident and Emergency (A&E) Department. They gave a verbal hand-over to the hospital staff and passed over the patient information from the prison healthcare staff. One of the paramedics noted that, as they left, the man was joking with the hospital and prison staff. The prison staff remained with him and telephoned the nurse in healthcare with regular updates. The man remained in the A&E Department for some time, under investigation, but shortly before 5.00am (on Saturday 20 December) he was admitted to a ward.
34. The prison officer who was in charge of the escort, asked for permission to remove the handcuffs as he felt they were interfering with the man's care. Managers agreed but the man remained cuffed to an officer by an escort chain. (This is a long chain with a handcuff at both ends. For prisoners in hospital, it is used while they are in bed or being examined, if there is deemed to be a risk of escape.) When he was taken for an x-ray and MRI scan, the chain was removed. The officer said in his statement to police that the man moved in and out of consciousness during the day and needed to wear an oxygen mask.
35. At about 9.00pm, the man's condition deteriorated and he collapsed. After staff stabilised him, he was moved to the Intensive Care Unit where he was sedated and put on a ventilator. He was diagnosed with pneumonia and his kidneys were failing. The escort officers gained permission to remove the escort chain and it was not replaced. The hospital staff asked the escort for details of the man's next of kin. The orderly officer at the prison found the address of the man's mother but there were no telephone numbers available. The duty governor decided to wait until the morning when the day staff would be able to provide the telephone numbers on the man's approved list. The next morning, the day staff found numbers for his mother, sister and former partner. When the duty governor rang the numbers, there was no reply from any of them.
36. At 9.10am, the man suffered a cardiac arrest but staff managed to stabilise him. The escort decided that two of the team should move outside the room to allow hospital staff more room around the bed. The consultant asked the officer in charge of the escort for details of the man's next-of-kin and he passed the request to staff at the prison. At that point, they asked the police to contact the man's mother, who did not live locally, to tell her that he was seriously ill. However, the police did not manage to speak to her immediately.
37. One of the hospital doctors told the escort staff at about 9.50am that the man would not survive the day. Just ten minutes later, a doctor told the escort staff that he was very close to death. At 10.05 am, another doctor pronounced the man's death. The prison contacted the police again and asked them to tell the man's mother that he had died. Later that morning, the duty governor made contact with the family.

38. Prison managers held a hot debrief for staff involved in taking the man to the hospital and watching him. (This is a meeting to discuss any lessons learned as the result of a serious event.) They reviewed their actions and highlighted the absence of telephone numbers as an issue to be resolved. Since the man's death, the procedure for sending a prisoner to hospital has been revised to include asking for details of next of kin to be contacted in an emergency. The checklist has been updated to include a section where staff write the address and telephone number on the form. I commend this action on Full Sutton's behalf and draw it to the attention of the NOMS Safer Custody and Policy Group as a practice that might be adopted across the estate.
39. The prisoners at Full Sutton held a collection in memory of the man who died and raised the sum of £495.50. Managers arranged a memorial service on 29 December which his family attended. After the service, many of the man's friends spoke to the family and offered their condolences and many others sent cards saying how positively the man had influenced their lives. Several staff later attended the funeral and the Governor wrote to the man's parents to offer his condolences. The family were appreciative of the sensitivity and care shown by the Governor in his letter. They were particularly impressed with the thoughtful and personal comments made about the man.

ISSUES

High security prison

40. The man's family have questioned why he was still in a high security prison when he died, when he had less than a year left to serve. At a sentence planning board meeting on 25 June 2008, the man's targets for the period ahead had been discussed. The summary in his records shows that one goal was to take steps to work towards "a local discharge i.e Armley (HMP Leeds)" but [the man] was "not too keen on this". He later told his personal officer that he wanted to remain at Full Sutton so that he could finish his education courses, and it was agreed that he could do so.

Health

General

41. Throughout his time in prison, the man attended regular appointments with the dentist, optician and chiropodist. He also received treatment for several minor ailments such as headaches and colds.

Back pain

42. After the man's death, a number of prisoners told his family that, in their opinion, he had not received adequate care. My investigator interviewed six of the prisoners who expressed concerns about him.

43. Several of the prisoners said that the man had suffered from back pain for about a year, but there is no evidence in the records or from interview to support their belief. The first time back pain is noted in his medical record is at his appointment on 12 November 2008. Even after that day, he continued to attend the gym several times a week. Whilst two of his friends said that he "messed about" rather than used the equipment, others said that he took part in the sessions, including a basketball course. Likewise, he continued to carry out his cleaning duties, which were physically demanding, until after the gym class on 2 December. If the man did suffer from back pain before November 2008, it would seem it was not sufficiently severe for him to have sought medical attention, or to stop his gym sessions or work.

44. However, from 2 December onwards, it appears that the man's pain increased markedly. After 4 December, he spent most of the day in his cell and was often in bed. His friends noticed a change in him as he became quieter and of shorter temper. Various members of staff also noticed how ill he looked, including the pharmacy technician, probation officer and both healthcare and discipline staff.

45. When discussing the treatment that healthcare staff gave the man, the clinical reviewer concludes:

"The fact that the back pain commenced following gym exercise led both the man and healthcare to assume that the back pain was related

to an injury sustained from exercising in the gym which resulted in a treatment plan that focussed on treating pain associated with a back injury. This was not an unreasonable assumption to make as there were no other symptoms that would have indicated an alternative reason for the back pain.”

She further says:

“The PCT Associate Medical Director has advised that it is standard general practice to advise analgesia for first six weeks of back pain.”

46. The prison doctor prescribed paracetamol and then diclofenac sodium, both of which are analgesics (pain killers). The nurse who visited the man on 10 December noted that he had not been taking the diclofenac sodium and encouraged him to do so. She also advised him to contact healthcare staff if, having finished the medication, he was still in pain.
47. Discipline staff were also aware that the man was suffering a lot of back pain. Again, they thought it was because of a gym injury. Discipline staff may not have been aware that he was being treated by healthcare staff, or what the treatment consisted of. However, the realisation that other prisoners were collecting the man’s meals for him should have triggered a request for healthcare staff to assess his needs. The clinical reviewer notes that poor communication between wing and healthcare staff resulted in healthcare being unaware of how poorly the man was. If they had been told that the man stayed in bed, this should have triggered an immediate review. They regularly attended to assess other prisoners on the wing but were not asked to see him. On 10 December, staff did call healthcare staff to examine the man but they did not do so again before 19 December.

The Governor and Head of Healthcare should draw up a protocol to identify the triggers that should lead wing staff to request a member of healthcare to visit a prisoner on the wing.

48. The man’s family asked whether his frequent requests would have alerted staff to an underlying health problem. My investigator asked the clinical reviewer to address the issue. She spoke to healthcare staff at Full Sutton and examined national documents, then added an additional section to the clinical review. The revised review is at Annex 2.
49. The clinical reviewer concludes that the man’s:
- “...requests were not made on a weekly basis and were therefore not frequent enough to alert the pharmacist to place him on the doctors list for a clinical review.
- The Prison service permits 64 tablets a month (one pack of 16 tablets per week) to be issued without any form of medical input in a similar way that the general public can obtain Paracetamol from a local shop. This is in line with ‘A Pharmacy Service for Prisoners section 8.27 (June 2003) which is a document jointly produced by the Department of Health and HM Prison Service.”

50. The clinical reviewer makes two further recommendations relating to the actions of healthcare staff with which I agree. I have slightly recast them.

The Head of Healthcare should assess the training needs of the nurse who assessed the man on 4 December in relation to documenting decisions on assessments.

The Head of Healthcare should take steps to raise the awareness of healthcare professionals of their responsibility to alert colleagues of the clinical condition of prisoners who are possibly reluctant to engage with healthcare, to ensure appropriate action is taken.

Events on 19 December

51. When the officer saw how ill the man was, she went to the senior officer and said that he needed to be examined by a member of the healthcare staff. The senior officer told her that healthcare staff had already been notified and were coming to visit the man. However, healthcare staff have no record of a request for the man until 12.50pm. This lack of communication between wing and healthcare staff meant that the man spent a very uncomfortable morning which could have been avoided. The wing staff did not record the requests they made, so there is no evidence that the call was made or to whom.

The Governor should ensure that requests for healthcare staff to attend the wing are recorded in the wing observation book, including the time of the request.

Delay in notifying the man's family that he was in hospital

52. The man's family greatly regretted that prison managers contacted them too late for them to visit him before he died. They told my staff that they would have done whatever was necessary to reach the hospital in time. My investigator asked the duty governor on the day about the timing of the contact with the family. He said that the swiftness with which the man became seriously ill took everyone at Full Sutton by surprise. When the man went to hospital, both officers and governors thought that it was for tests for possible kidney problems. They assumed that he would have the necessary treatment and, after a few days, return to the prison in better health. They therefore followed the normal procedures for sending a prisoner to hospital.

53. The duty governor said that, as a high security prison, Full Sutton has to balance the care of prisoners with the security of the public. The policy is to prevent a prisoner in hospital having contact with his family for the first ten days to prevent the possibility of escapes being arranged. Therefore, it was only when hospital staff asked the escort officers for the next of kin details that prison staff began to try to obtain the information. By that time, the night staff were on duty and they had no access to the telephone records. On the man's arrival at the prison he had given his mother's address but no telephone numbers.

54. The duty governor decided not to ask the police to visit the man's mother that night to tell her that he was seriously ill in hospital but to wait until he had a telephone number for her. He was influenced by the knowledge that some prisoners do not want their next of kin notified. He also considered the impact of the police visiting an elderly lady late at night to pass on such news. However, balanced against this should have been the possibility that the family would want to go to the hospital as soon as they could.
55. The problems caused by not having full contact details were raised at the hot debrief held after the man's death and I am both pleased and impressed to learn that the procedures have been changed. On 29 December 2008, prison managers issued an instruction that staff who escort a prisoner to hospital must have the contact details for his next of kin. When the prisoner is unconscious, the escort staff should try to obtain the contact details before they leave the prison. I am pleased that managers acted so quickly to ensure that in future such delays notifying the next of kin will not arise. I have formally recognised this as good practice.

Use of restraints

56. I note that the man's handcuffs were removed shortly after he was admitted to a hospital ward in the early hours of 20 December. An escort chain was applied in place of the handcuffs, and this was removed when his condition deteriorated further and it seemed unlikely that he would survive. It is clearly a matter of judgement as to the circumstances in which to retain restraints, but it is questionable whether the use of the escort chain was really required on such a seriously ill and debilitated man. I have commented on this issue in many recent reports, and questioned how far the over-use of physical restraints is consistent with the Prison Service's own 'decency agenda'.

Time of death

57. One of the questions that the man's family asked was for a definitive time of death, as several different times had appeared in various documents. The documents obtained by my investigator variously give 10.02am, 10.05am, 10.15am and 10.24am as the time of death.
58. The different timings arose because of the way in which they were noted and passed on by hospital and prison staff. At 10.02am, hospital staff told the escorting officers that the man had died. However, the doctor who certified his death recorded it as 10.05am which means that the actual time of death was 10.05am. When the news was given to the escorting officer, he used the time on his watch when completing the prison record. However, his watch was ten minutes faster than the doctor's watch. When the Governor wrote to the man's parents, he gave the time as 10.24am, the time recorded by the duty governor. The duty governor told my investigator that he had made a note of the conversation in which he was told of the man's death and that he wrote the time as 10.24am. In retrospect, he thought that this could have been the time of the message, rather than the death.

59. The man's sisters spoke movingly to my staff of their great regret at not being at his side when he died. The uncertainty over the actual time of his passing may well have added to their distress. I would urge the Governor to impress upon his staff the absolute necessity of obtaining the officially recorded time of death and checking the factual accuracy of any other information to be given to families before passing it on.

Conclusion

60. It is surprising that the man could have lived with such a serious and painful condition for so long, without proper diagnosis. However, the clinical reviewer concludes that, given the man's gym activities, a diagnosis of back pain arising from a back injury was reasonable. On the evidence available, I concur with this view. The man's condition deteriorated rapidly over a relatively short period. In spite of the swift intervention of the duty prison doctor when the man's condition declined further, the disease had clearly progressed too far for him to be successfully treated.

61. It is open to debate as to whether prior detection and intervention could have extended the man's life. However, nothing has emerged from my investigation to suggest that discipline or healthcare staff at Full Sutton should have been aware earlier of the seriousness of his illness

RECOMMENDATIONS

1. The Governor and Head of Healthcare should draw up a protocol to identify the factors that should trigger wing staff to request a member of healthcare to visit a prisoner on the wing. Such requests should be recorded in the wing observation book.
2. The Head of Healthcare should assess the training needs of the nurse who assessed the man on 4 December in relation to documenting decisions on assessments.
3. The Head of Healthcare should take steps to raise the awareness of healthcare professionals of their responsibility to alert colleagues of the clinical condition of prisoners who are possibly reluctant to engage with healthcare, to ensure appropriate action is taken.
4. The Governor should ensure that requests for healthcare staff to attend the wing are recorded in the wing observation book, including the time of the request.

Good Practice

I commend Full Sutton for revising its procedure for sending a prisoner to hospital to include asking for address and phone details of next of kin to be contacted in an emergency. I draw this to the attention of the NOMS Safer Custody and Policy Group as a practice that might be adopted across the estate.

ANNEXES

1. Documents considered during the investigation

Core Record
Custody File
Medical Records