

**Investigation into the death of a man whilst in the custody  
of HMP Full Sutton, in February 2009**

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

**August 2009**

This is the report of an investigation into the death of the man who died in February 2009 at hospital, whilst in the custody of HMP Full Sutton. He had been taken to hospital in February. The man had been diagnosed with cancer.

A post mortem was held at the request of Her Majesty's Coroner for East Riding and Kingston upon Hull. It found that the man died of natural causes resulting from his cancer.

The man had asked that his family should not be informed of his illness or death. Nevertheless, staff at HMP Full Sutton made enquiries to identify any next of kin. Up to the time of my circulating this report, no one has been traced. I extend my condolences to anyone touched by the man's passing.

This investigation was undertaken by one of my investigators. In addition, a review of the man's healthcare was commissioned from the East Riding of Yorkshire Primary Care Trust. The Head of Quality Standards and Governance for East Riding of Yorkshire NHS, carried out that review, and I am grateful to her. I would also like to thank the Governor of Full Sutton, and his staff for their help and assistance. I am particularly indebted to the liaison officer.

I endorse the four recommendations taken from the clinical review. These address improved links to palliative care, training for healthcare staff in end of life care, assessments for care planning, and the signing of entries in medical notes.

In this final report, I have made three amendments taken from the response by the Prison Service in relation to chaplaincy care, the McMillan team, and aids to make the man more comfortable. In response to the recommendations, the Head of Healthcare has accepted the first recommendation and it has been suggested that recommendations two and three be the joint responsibility of the Head of Healthcare and the Primary Care Trust (PCT). I have amended those recommendations to reflect that comment. Recommendation four is still pending a response from the PCT.

The 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.

**Stephen Shaw CBE**  
**Prisons and Probation Ombudsman**

**August 2009**

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## SUMMARY

The man was sentenced to life imprisonment in April 1973 by the Glasgow High and Jury Court. He was released on a life licence and moved to North East England. The man was twice recalled to custody; the second time was following a conviction for indecent assault. The man was held in several high security prisons until his last transfer into Full Sutton in 2001. The man was category A prisoner.

On reception into Full Sutton it was recorded in his medical notes that the man had high blood pressure, asthma, chronic obstructive pulmonary disease and arthritis. He was a heavy smoker. He was seen on a regular basis in the healthcare unit to review his health and go to specialist medical clinics.

In July 2008, the man was admitted to the healthcare unit with a possible chest infection. An electrocardiograph (ECG) to measure his heart rate was carried out, and antibiotics were prescribed. He returned to his wing the following day at his own request. He was regularly monitored on the wing by healthcare staff and had consultations with the doctor.

The man saw the doctor in September after complaining of chest pain. After being examined, he was prescribed pain relief and it was noted that it was possibly the effects of his chronic obstructive pulmonary disease. The doctor referred the man for an x-ray on 14 October, and he was admitted to the healthcare unit to treat dry skin. The following day, he again returned to the wing at his own request. In October, he went to an out patient appointment with an orthopaedic consultant about his chest pain. An x-ray showed nothing of note in November.

The doctor spoke to a consultant physician in November regarding the man's continued chest pain. A referral was made a computerised tomography (CT) scan (which shows images of the whole body). In December, the CT scan showed the man had bone metastasis (cancer). He was admitted to the healthcare unit in December and prescribed pain relief medication.

In January 2009, the man declined further medical investigations. He was now being prescribed Oromorph, an opiate medication, and was being nursed for a terminal illness.

Two weeks later, the man was admitted to hospital as his condition had deteriorated and he needed constant oxygen. He was escorted by two officers and restraints were put in place. Two days later, the restraints were removed as he was nearing the end of his life. He died in February.

The man was nursed in the healthcare unit until three days before his death. The clinical review has highlighted some issues regarding palliative and end of life care, in addition to the need to improve entries in medical notes. I judge that the man received good personal and emotional support from prison healthcare staff.

## **THE INVESTIGATION PROCESS**

1. In February 2009, my investigator visited Full Sutton to open the investigation into the man's death. My investigator was met by the Liaison Officer and reviewed the man's prison files and medical records. My investigator requested copies of those documents to be sent to her.
2. The Ombudsman's notice of investigation and terms of reference had been sent in advance of my investigator's visit. Members of the Independent Monitoring Board and the Prison Officers' Association did not ask to see my investigator. Staff and prisoners did not respond to the notices of investigation.
3. On my investigator's visit, she visited the healthcare unit and saw the cell the man lived in prior to his admission to hospital. Evidence for the report has been taken from documents and records held in the man's prison files. It was determined that no staff needed to be interviewed.
4. A clinical review of the man's medical care was commissioned with East Riding of Yorkshire PCT, and it was carried out by the clinical reviewer. The review looked at his medical history, his diagnosis of cancer, treatments, and palliative care. The reviewer interviewed some members of healthcare staff.

## HMP FULL SUTTON

5. Full Sutton is a high security prison holding some of the most difficult and dangerous offenders in the country. It was opened in 1987 and is a modern, purpose built maximum-security jail for male category A and B prisoners.
6. The four original residential units are of a square design: A wing holds main wing prisoners; B, C and D Wings hold vulnerable prisoners. E and F wings, which were added later, are of improved design and both hold main wing prisoners. Half of F wing houses the segregation unit. G wing is used for induction and holds some vulnerable prisoners.
7. Healthcare services are commissioned through East Riding of Yorkshire Primary Care Trust (PCT). Full Sutton has an inpatient healthcare unit that is staffed by qualified nurses, healthcare assistants and discipline officers. The nursing staff have a range of skills including mental health and there is a nurse prescriber. Medical cover is provided by two doctors on a daily sessional basis. An electronic records system has been introduced for patients' notes.
8. Nurse led clinics for ongoing conditions and vaccinations are held regularly, and a dentist, physiotherapist and optician hold sessions in the unit. A walk in centre for prisoners is available daily along with a practice nurse clinic for appointments.
9. Her Majesty's Chief Inspector of Prisons' most recent inspection of Full Sutton was in 2007. An extract from that report, commenting on healthcare services says:

“There was evidence of individual patient care on the wings, with a multidisciplinary approach involving the prisoner, discipline staff and nurses and a joint care plan. This allowed a sick man to remain on the wing at his request with at least twice daily support from health services staff.”

10. The Independent Monitoring Board noted in their Annual Report of 2007:

“The healthcare centre manager has worked hard to introduce a community care healthcare care system into Full Sutton which aims to reflect the healthcare that individuals receive in the community. Clearly, the restrictions that are inevitably imposed by operating in a high security prison dictate that the new system needed some adaptation through a process of medical risk assessments. The system aims to push the initial healthcare treatment down to wing level as well as introducing two nursing teams; one being responsible for the vulnerable prisoners whilst the other cares for the main wing prisoners. An important consequence of adopting the new healthcare system is that an individual has the opportunity to take more responsibility for his own health and he knows that the first point of contact is a nurse from his wing team.”

11. There have been three previous deaths at Full Sutton since my office started investigating all deaths in prison custody in 2004. Two of the deaths were self-inflicted and the other, which was due to natural causes, did not have any similarities to that of the man's.

## KEY FINDINGS

12. The man was born in Scotland. He was divorced with two children. In April he was sentenced to life imprisonment at Glasgow High and Jury Court for murder and robbery. In October 1993, he was released from prison on a life licence and moved to the North East of England.
13. In January 1986, the man was charged with three offences and remanded to a bail hostel in Durham. In February, he was recalled to custody by the Scottish Home and Health Department and detained in HMP Durham. In March, the man was sentenced to six months imprisonment for indecent assault. He was transferred from Durham to Barlinnie prison in Scotland.
14. In October, in Perth prison, the man was the subject of a severe assault during a riot. He later gave evidence at trial, and for fear of reprisals asked for a move to England so that he could be released in England rather than Scotland. He was transferred from Perth to HMP Leyhill in December 1989.
15. The man was released to a hostel, located in the grounds of HMP Wakefield, in August 1990. The hostel provided accommodation for life sentenced prisoners who were progressing towards their release on licence into the community. He was employed whilst living at the hostel. During this time he spent some weekend leave in Middlesbrough.
16. In March 1993, the man confessed to a senior officer at the hostel that he had sexually assaulted a child. He was immediately taken back into HMP Wakefield and placed in the segregation unit for his own protection. In September, he appeared at Leeds Crown Court. He was sentenced to 15 months imprisonment, and his licence was revoked. He remained at Wakefield until later transferring to HMP Durham.
17. The man was received into Full Sutton in 2001, and a first reception health screen document was completed. It was noted that he had high blood pressure, heart disease, chronic obstructive pulmonary disease, asthma and some arthritis to his right knee. A prescription chart was opened and the man was prescribed medication for his medical conditions, including an inhaler for his asthma.
18. From 2001 until early 2008, the man was seen regularly by healthcare staff for repeat prescriptions, and attended specialist clinics for his heart disease and asthma. He also saw the optician and the dentist.
19. On 2008, the man was seen in the healthcare unit after complaining of diarrhoea. He was advised to take plenty of fluid and rest. Two months later, he experienced sore skin and pain in his back. He was seen in July by a nurse who referred him to see the doctor. Four days later, the doctor prescribed ointment for his skin and a bath oil to help the irritation. Pain relief (Co-codamol) was also prescribed for his back pain.

20. The man had an appointment with a nurse in July as he was short of breath and still experiencing back pain. The nurse wrote that the man was taking pain relief medication and noted she would check on him later. Two days later, he was seen in his cell by a nurse. He had chest pain, with the pain radiating down his left arm, and was short of breath. His blood pressure was 145/85 (normal range of blood pressure is 130/80) and his pulse rate was 77 beats per minute (normal rate is between 60-100). The man was transferred to the healthcare unit for observation. His blood pressure had risen to 149/91 and his pulse rate was down to 66. An ECG was carried out. He remained on the healthcare unit so he could be reviewed by the doctor. Blood tests were taken.
21. A doctor examined the man four hours later. He was feeling better, and was no longer short of breath or in pain. A chest infection was diagnosed and anti-biotic medication prescribed. He was discharged from the healthcare unit and returned to his cell. The next day, the man saw the doctor and the blood tests were repeated. The doctor suggested that he stayed in the healthcare unit for observations, but the man preferred to return to his cell and assured the doctor that he would tell wing staff if he felt unwell.
22. In July, a nurse visited the man in his cell. She wrote that, although she had been told he was unwell, on her arrival he was smoking and laughing. He told the nurse that he felt better than earlier in the day. He was advised to continue with the anti-biotics and pain relief. In August, his medical notes showed that an x-ray result had been received. Nothing of note was seen in the results.
23. The following day, wing staff asked healthcare staff to visit the man in his cell. On arrival, a nurse noted that he was carrying out his wing cleaning duties. She asked him to sit down and tell her what was wrong with him. The man said that he had pain in his kidney area. The nurse advised him to have some time off his duties and to rest in his cell. Although he was not happy about this, he accepted her advice. The man was also advised to contact healthcare if he had any further health problems.
24. The man next saw a nurse in August as he had unexplained bruising to his right leg. The nurse noted that he had good circulation to his leg and there were no signs of a deep vein thrombosis.
25. In September, the doctor examined the man who said that he had chest pain three days previously. On examination, the doctor wrote that there was poor airflow to the lungs and tenderness over the rib area. The man could not recall any physical reason for the tenderness. The doctor also noted his concern about the man's chest pain and that he was not well. He had not lost weight and he told the doctor the pain was not too bad. The doctor changed his medication and requested a review of the man in a few weeks.
26. A week later, the man was seen by a nurse and he told her that he had pain in the left side of his chest. The nurse made an appointment for him to see the doctor the following morning. The doctor examined him in October; he was

27. Three days later, the man was admitted to the healthcare unit as he was in some discomfort with chest pain. An x-ray was ordered and the doctor also asked for his blood pressure, pulse and temperature to be checked frequently. In October, he was examined by the doctor who noted that he seemed to be in less pain, but was tender in his rib area. There was no shortness of breath and he was comfortable, however the doctor requested an x-ray to check whether he had fractured a rib. He further wrote that the man's dry skin condition was still present and advised him to stay in healthcare for some intensive treatment.
28. The following day, the man asked if he could return to his wing cell as he was feeling much better. The nurse and the man discussed his smoking habit, although he said he was not keen to give up. It was agreed that he would go to healthcare everyday for skin care and a daily bath in special oils.
29. In October, a nurse was asked to see the man in his cell. The nurse saw that he was sitting in a chair and appeared to be in some discomfort with pain in the right side of his chest. His observations were noted as high blood pressure of 206/96, and a regular pulse rate of 70 beats per minute. He had not taken any pain relief since the previous day. He was transferred to the healthcare unit and a chest x-ray was booked for the following day. Four hours later, he told the nurse that he had hurt himself the previous day whilst getting out of the bath and he was given Co-codamol. Later that evening, he was advised to get into bed; he managed this without assistance from the nurses.
30. The next day, He was examined by the doctor who again noted the chest pain and tenderness in the rib cage area. He was not short of breath and a recent x-ray did not show any changes. The doctor thought this was not a simple case of low back pain, although there was no history of a physical injury. If there were no immediate improvements then further levels of investigations would be needed. The doctor repeated prescriptions for pain relief, and asked for him to have his weight checked and a blood test taken. He concluded that the man should be admitted to healthcare for a few days.
31. In October, the man went to an outpatient's appointment with an orthopaedic consultant. He remained an inpatient and the next day felt better and his skin condition was improving. His notes showed that he had received two flu vaccinations in error. The doctor and charge nurse were informed of this mistake. The nurse told him about the mistake, which he laughed about. The man was told he would be monitored very carefully over the next few days. In November, he was discharged from healthcare and returned to his wing. The doctor asked that nurses keep him under regular review whilst on the wing.

32. The next day, a nurse visited the man in his cell and found him holding his chest and complaining of pain. He had not taken his pain relief that morning. The nurse advised him to take his medication and contact healthcare staff if the pain increased. The nurse visited him again later that day and noted that he was looking well, although he still had some discomfort.
33. In November, the man was seen by a nurse and told her that the pain had returned since he stopped taking the Co-codamol. The nurse noted that the man looked untidy and was finding mobility difficult. She wrote that she would speak to the doctor about him.
34. Two days later, healthcare staff saw the man in his cell following a call from wing staff. He was lying on his bed, his blood pressure was high at 168/95 and his pulse rate was 82 beats per minute. He told the nurse he had again not taken his pain relief. The nurse encouraged him to have his medication and take it regularly. Later, the nurse checked with wing staff on his condition and was told that he was now sitting up and feeling better. The wing staff agreed to continue to monitor him.
35. In November, the doctor spoke to a consultant physician at hospital about the man's current medical condition and the pain at the base of his lung. X-rays and blood results did not support the diagnosis of a cancerous tumour. The consultant suggested that the man be treated symptomatically, and to repeat medical investigations in a few weeks time. The doctor wrote in the man's medical notes that he would discuss his treatment with healthcare staff. The doctor made a referral for him to have CT scan.
36. Later, a nurse saw the man in his cell. He was lying on his bed complaining of abdominal discomfort and his pain relief was not helping. The nurse noted that his cell was unclean and he looked dishevelled. He was taken to the healthcare unit for a bath and healthcare staff asked wing staff if his cell could be thoroughly cleaned. The man was admitted to the healthcare unit for observation.
37. The following day, the man asked to go back to his wing cell. He said that he felt better and his pain was under control. On 24 November, a multi-disciplinary case meeting was held to discuss his risks, plans for his support, and maintenance of his independent activities. It was agreed that both wing and healthcare staff would work together to assist him to remain independent. He would continue to go to healthcare for a bath twice a week and his cell would be cleaned by a prisoner trained in specialist cleaning routines.
38. Two days later, the man was visited by a nurse who assessed his general physical condition and personal hygiene. On 4 December, he attended an outpatient appointment for a CT scan.
39. The following day, a consultant physician from hospital telephoned the prison doctor. The man's CT scan showed spinal metastasis (spread of cancer cells in his spine). The primary source of the cancer was unknown. The doctor discussed any further tests with the consultant, prior to him being referred to

40. In December, the man was now located the healthcare unit. His mobility was poor and he used a wheelchair. The doctor and nurse told him about the results of the CT scan and the diagnosis of cancer cells in his spine. He became very distressed at the news and was supported by healthcare staff. The doctor told him that the priority was to get his pain under control and that he would speak to an oncologist. The man told the healthcare staff that he did not want his family told of his diagnosis.
41. Later, the doctor examined him and noted that he had a slight headache and pain in his chest. The doctor asked staff to monitor his emotional well being following the news of his diagnosis earlier in the day. The doctor also spoke to a consultant urologist (a specialist in kidney and urine illness) and a consultant in haematology (specialist in blood disorders) at the hospital. As the primary source of the cancer had not been identified, the doctor had a discussion with the specialists to see what investigations would best be followed.
42. The next day, the man saw a member of the mental health in reach team. They discussed his diagnosis and his feelings about the news. He said he would accept help when any problems arose and would be happy to see his friends from the wing. He settled into the healthcare unit and was seen by the doctor in December. The doctor noted that he would be more comfortable sitting in a chair than in bed. His pain relief was reviewed and Tramadol (an opiate based medication was prescribed). The following day, a recliner chair was given to him to aid his comfort.
43. The man remained in the healthcare unit during December. He was monitored daily and prescribed pain relief that worked to good effect. In January 2009, a nurse recorded in the man's medical notes that he was in severe pain, weeping, distressed, and that his pain relief medication was having little effect. The nurse telephoned the doctor who prescribed Oromorph (a morphine based medication). Later, he was noted to be settled in his chair and far more comfortable. He was not keen to have too much Oromorph as he felt it was a sign of his deteriorating condition. He became weepy when the nurse reassured him about the control of his symptoms and the emotional support that was available to him.
44. The man saw the doctor the following day. The doctor noted that he was settled, although the Oromorph had caused some disorientation. An oncologist had spoken to the doctor and agreed to see him in his clinic on 5 January. Later, the doctor gave him his Oromorph and the man said he would rather feel disorientated than be in pain. The doctor recorded that the nurses would look in on him later.

45. In January, the man was seen by an oncologist at hospital. On his return to Full Sutton it was recorded that he had fractured his shoulder, which was possibly due to the metastasis in his bones. His arm was in a sling and he had received a session of radiotherapy (a treatment for cancer). The consultant oncologist suggested further radiotherapy plus x-rays. He was tearful. The following day, the doctor visited him and recorded that he was comfortable with good pain control.
46. The man was seen by an occupational therapist in January to assess him for aids that might help his mobility and daily living. The therapist recommended a self-propelling wheelchair so the man could be mobile, and contact with MacMillan Nurses (who specialise in the care of terminally ill people) for a recliner chair. The doctor visited him and saw that he was coping and content with the care being provided for him.
47. Later, a nurse spent some time with the man, and explained the likely progression of his illness and the poor prognosis. He told the nurse that he was not interested in applying for compassionate release. Although he became distressed, he told the nurse that he wanted to die in prison as it had been his home for the last 18 years. He again told the nurse he did not want his family informed and felt that they would not welcome contact. The nurse assured him and told him he could talk to staff at any time to discuss any fears or concerns.
48. In January, the man had an x-ray of his pelvis and shoulder. His pain relief was working well and he only asked for Oromorph when he felt he needed it. Two days later, the doctor noted that an oncologist had telephoned the healthcare unit and said they were waiting for the results of the latest x-rays before making any further plans for his medical care.
49. The doctor saw him in January. He told the doctor that the extra pain relief was working well. He was happy with the care and attention he was receiving from healthcare staff and enjoying visits from friends and wing staff. He again told the doctor that he did not wish any family involvement. Following discussion with outside consultants, it was agreed that he would be admitted to hospital for an examination of his bowel and stomach (colonoscopy and endoscopy).
50. In January, a nurse spoke to him about his forthcoming hospital appointment for the colonoscopy. He was concerned about the procedure and unsure whether he wanted to go through with it. The nurse explained what the procedure would entail. He said he would think about it and said he did not want to have Oromorph at bedtime as it made him sleepy the next morning.
51. The following day, he told the nurse that he did not want to have the colonoscopy and signed a disclaimer to that effect. The nurse notified the hospital and the security department. The doctor also recorded that the man did not want any further investigations and that he understood the poor prognosis. He did say he would have a biopsy of his shoulder. The doctor noted he would discuss this with hospital colleagues.

52. The man continued to receive nursing care and pain relief medication. His mobility was reducing but he remained in good spirits. In January, he attended a mobile scanning unit for a magnetic resonance imaging scan (MRI). (This scan uses magnetic and radio waves to take pictures of the body tissues.) In January, it was recorded that Mr Peat fell over whilst going to the toilet during the night. He did not sustain any physical injury but was shaken by the experience.
53. The man was given an anti-sickness injection in February as his appetite was poor. He was encouraged to take more fluids and a chart was started to record and regulate his fluid intake. Both his legs were sore and dressings were applied.
54. The following day, he was examined by the doctor who recorded that he looked unwell. The primary site of his cancer was still unknown and the hospital consultants were waiting for the results of the MRI scan to see if a bone biopsy would be appropriate. In February, it was recorded that he fell off his chair and bumped his head. He told the nurse he was alright, but he was seen by the doctor who noted that he looked unwell and frail.
55. In February, the man appeared to be short of breath. He was given oxygen and the nurse contacted the doctor. Later, a doctor examined him and found he was experiencing breathing difficulties. He was given steroids, continued with the oxygen, and arrangements were made for him to be admitted to hospital. He was becoming distressed and by this time the healthcare unit was running low on oxygen. He was escorted by two officers to hospital. He arrived at hospital at 3.20pm, the double cuffs were removed and escort chain applied. (An escort chain is a 1.8 metre length of chain with one cuff attached to the prisoner and the other to an officer.)
56. The following day a nurse at the hospital contacted the healthcare staff. The nurse told the staff member that the man was now on a 'pathway to die plan'. (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.) His medical notes showed that a case conference was held at the prison's healthcare unit and at which it was agreed that, in accordance with his wishes, his next of kin would not be informed of his terminal illness or imminent death. The prison chaplain visited him hospital later in the day.
57. In February, the escort chain was removed. The man was now unable to get out of bed and was receiving pain relief via a syringe driver. At 5.30pm, he had another visit from the chaplain. He died at 4.20am the following day.
58. Following his death the prison's family liaison officer, made several enquiries to trace any relatives. Although the man had specifically instructed that his next of kin should not be informed of his illness or death, the prison made the decision to make some enquiries to find any relatives. A letter was sent to an address in the North East of England, thought to be that of the man's sister,

59. The man's friends were informed of his death by wing staff. The chaplain at Full Sutton arranged a funeral service which was attended by the family liaison officer and the Governor. A memorial service for him was held in the prison chapel in February 2009.
60. The chaplaincy at Full Sutton have asked that the report be amended to reflect the fact that they saw the man on a daily basis and shared in his spiritual and emotional preparation for dying. They also visited the hospital at 7.00am on the day he died to administer Last Rites.

## ISSUES

### Clinical Care

#### *Clinical findings*

61. The clinical reviewer, spoke to healthcare staff at Full Sutton and read the man's medical records. In her review she comments on four aspects of the man's care. She says there was some difficulty in identifying members of staff who had made entries in his medical records, and interventions and care plans were not always clearly documented. There were no measurements in place to risk assess his pain control and accidental falls, and no documentation to indicate a review of his long term medications. Lastly, the clinical reviewer comments on the lack of liaison with the community palliative care team for support and advice to healthcare staff.
62. A response to the draft report notes that several messages were left with the McMillan team in respect of the palliative care needs of the man. Unfortunately, by the time they arrived some three weeks later he had already been transferred to hospital.
63. A lack of training and education for the care and management of terminally patients was a factor in the man's care whilst in Full Sutton. An end of life care plan was not always used, with no evidence of special pressure relieving resources being made available. An assessment of his deterioration and effective pain control was not evident, but he did not always offer a good description of his symptoms. He preferred to stay on the wing rather than be in the healthcare unit and was anxious about the effects of some of his medication.
64. It was noted in a response to the draft report that he slept on an airflow mattress and was also provided with a soft recliner chair, which he found more comfortable.
65. Healthcare staff told the clinical reviewer that the absence of a diagnosis, and the man's reluctance to take some medication, would have had some effect on the levels of his pain relief during the later stages of his illness. He had told healthcare staff that he was comfortable. In the future, pain control templates will be used in the healthcare unit.
66. The clinical reviewer writes that there was evidence of good communication between healthcare staff and the man at throughout his illness. The availability of dedicated healthcare staff allowed him to stay on the wing whilst benefiting from regular health reviews.
67. The clinical reviewer comments:

"It was not evident in the records that the palliative care team was contacted for advice or that pain management assessment tools were utilised as a basis for a developing pain management plan. This could

have aided the healthcare team in the management of the man's symptoms. Although this would not have affected the outcome it may have resulted in a more effective approach to care during the terminal stages of his life. It is however acknowledged that documentation shows that he was ... reluctant to comply with advice which could have had an impact on the recognition of his symptoms."

68. I endorse the following recommendations made by the clinical reviewer:

**The Head of Healthcare should improve liaison with the palliative care team with the aim to obtain advice regarding adoption of Gold Standards Framework within the prison healthcare setting.**

**The PCT should adopt validated risk assessment tools which include assessment, care planning and outcomes with regard to tissue viability, nutrition and falls.**

69. The clinical reviewer further comments:

"It is recognised that to nurse terminally ill patients within a prison environment as a preferred place of death is at present unusual and, due to restrictions of security and access to services, can be challenging. However, as HMP Full Sutton could be identified as a preferred place of death in the future it is suggested that consideration be given to the systems which would need to be in place for this to be achieved."

She therefore makes the following recommendation which again I endorse:

**The Head of Healthcare should ensure healthcare staff are provided with training regarding end of life care with specific reference to symptom management and oncological emergencies through the palliative care team.**

70. The clinical reviewer concludes:

"I found the documentation to be fragmented and on some occasions it was very difficult to establish what nursing interventions had taken place and by whom. Although names were evident on all entries often the designation of the staff member who had undertaken the care was not"

**There should be a review of documentation to ensure that evidence of care planning and the designation of staff are clearly evident.**

## **Support for the man**

71. It was clear to my investigator that the man received support and assistance from discipline and healthcare staff throughout his illness. His friends helped him to remain on the wing by assisting with his day to day living. When he transferred to healthcare, he was visited by his friends. This support was

72. I acknowledge the prison's decision in not making contact with the man's family during his illness, as was his wish. I believe their attempts to make contact following his death were carried out with sensitivity. The opening of the man's inquest was delayed as the Coroner suggested that the prison try to find his next of kin. Despite enquiries by the Liaison Officer, no family members have yet been traced.

## **Conclusion**

73. The clinical reviewer has made recommendations in relation to the care of prisoners with terminal illnesses and access to community palliative care services. That aside, I judge that the man was well cared for by prison and healthcare staff. In the absence of family support, He received emotional and practical help which reflected by his wish to die in prison surrounded by people who had, in effect, become his surrogate family.

## RECOMMENDATIONS

### For the Head of Healthcare

1. There should be a review of documentation to ensure that evidence of care planning and the designation of staff are clearly evident.

**Accepted** – “This is a systems error on the Systm One Clinical record system, which has been reported. Until the fault is resolved staff will enter information manually.”

### For the Head of Healthcare and the Chief Executive of East Riding of Yorkshire PCT

2. The Head of Healthcare should improve liaison with the palliative care team with the aim to obtain advice regarding adoption of Gold Standards Framework within the prison healthcare setting.

Pending

3. The Head of Healthcare should ensure healthcare staff are provided with training regarding end of life care with specific reference to symptom management and oncological emergencies through the palliative care team.

Pending

### For the Quality Assurance Manager East Riding of Yorkshire PCT

4. The PCT should adopt validated risk assessment tools which include assessment, care planning and outcomes with regard to tissue viability, nutrition and falls.

This is to be responded to by the PCST - Pending