

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dennis Nilsen a prisoner at HMP Full Sutton on 12 May 2018

A report by the Prisons and Probation Ombudsman

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions I oversee can improve their work in the future.

Mr Dennis Nilsen died on 12 May 2018 of a pulmonary embolism, caused by a ruptured abdominal aortic aneurysm (AAA), while a prisoner at HMP Full Sutton. Mr Nilsen was 72 years old. I offer my condolences to his friends.

Mr Nilsen rarely engaged with healthcare staff during his 16 years at Full Sutton. He declined several routine health screenings during his time there, including a screening for AAA. I am satisfied that the clinical care Mr Nilsen received at Full Sutton up to and including the morning of 10 May 2018 was equivalent to that he could have expected to have received in the community.

However, I am concerned that when Mr Nilsen's health deteriorated during the afternoon of 10 May, healthcare staff did not review him when asked to do so by prison officers. As a result, he lay in his own faeces getting steadily more unwell for around two and a half hours.

I am also concerned that when a prison GP finally saw Mr Nilsen and decided he needed to be taken to hospital urgently, there was an unacceptable delay of around 40 minutes before an emergency ambulance was called, and that Mr Nilsen was left without any healthcare staff present for 10 minutes or more before the ambulance arrived.

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

Sue McAllister CB
Prisons and Probation Ombudsman

May 2019

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Summary

Events

1. On 4 November 1983, Mr Dennis Nilsen was sentenced to life imprisonment for multiple murders. He spent time at several prisons and was transferred to HMP Full Sutton in 2001.
2. Mr Nilsen rarely engaged with healthcare staff during his time at Full Sutton. He consistently declined vaccinations, health checks and health screenings, including one, in 2016, to detect the early stages of an abdominal aortic aneurysm (AAA, a swelling caused by a weakness in the wall of the aorta, the main blood vessel running from the heart).
3. During the morning of 10 May, two nurses saw Mr Nilsen separately after officers raised concerns about him because he was complaining of stomach pain. Both nurses recorded that his observations were unremarkable. A GP reviewed him and had no significant concerns. She suspected a urine infection or a kidney stone and asked Mr Nilsen to provide a urine sample for testing. She recorded in his medical notes that he should be reviewed if he did not improve.
4. At about 2.15pm, two officers found Mr Nilsen slumped on the toilet in his cell. Although he was conscious, he was disorientated and barely responsive. An officer telephoned the healthcare unit and was told a nurse would visit Mr Nilsen. When nobody attended, the officer rang back. Although he was asked to bring Mr Nilsen to the healthcare unit, he did not think he was fit to be moved. The officers lifted Mr Nilsen into bed. His condition deteriorated and he was incontinent of faeces.
5. At about 3.30pm, the wing supervising officer contacted healthcare and asked someone to see Mr Nilsen. He was told a doctor had already seen Mr Nilsen. He contacted the duty manager, who went to the healthcare unit and was told the same thing.
6. At about 4.45pm, the duty manager contacted healthcare staff again and asked that somebody see Mr Nilsen as wing staff were very concerned about him.
7. At approximately 4.50pm, Mr Nilsen was seen by the GP who suspected a possible ruptured AAA, a life-threatening condition. She asked an officer to call an ambulance and returned to the healthcare unit to complete her notes and then went home. An ambulance was called at 5.20pm and at 5.35pm, an emergency ambulance was requested. The ambulance crew reached Mr Nilsen at 6.13pm.
8. The ambulance left the prison at 6.52pm and took Mr Nilsen to hospital. He had emergency surgery to repair his ruptured AAA. Mr Nilsen survived the surgery, but the bleeding could not be stemmed and he died at 9.20am on 12 May.

Findings

Clinical care

9. We agree with the clinical reviewer that the healthcare Mr Nilsen received at Full Sutton before 10 May 2018 was equivalent to that which he could have expected

to receive in the community. He was appropriately offered routine health screenings, but chose to decline them.

10. If Mr Nilsen had accepted the screen for AAA that he was offered in 2016, it is likely that his aneurysm would have been detected in its early stages and that he would have been monitored and treated, if necessary, before it ruptured.
11. We also agree with the clinical reviewer that the healthcare Mr Nilsen received on the morning of 10 May was good and equivalent to that he could have expected to receive in the community.
12. However, we are concerned that on the afternoon of 10 May, healthcare staff did not see Mr Nilsen for around two and a half hours when prison officers expressed concerns about his health. Communication between a nurse, the Clinical Matron, and a Supervising Officer (SO), the wing manager, was poor and we consider that both showed poor judgement.
13. We cannot say whether the delay affected the outcome for Mr Nilsen, but if he had been seen and diagnosed earlier, he could have been taken to hospital earlier.

Emergency response

14. We are concerned that an emergency response was not triggered as soon as the GP realised that Mr Nilsen's condition was very serious, and that there was a delay of about 40 minutes before an emergency ambulance was requested.
15. We cannot say whether the delay in calling an emergency ambulance affected the outcome for Mr Nilsen, but if an emergency response had been triggered earlier, he could have been taken to hospital earlier.
16. We are also concerned that although the prison GP suspected that Mr Nilsen had a life-threatening medical condition, he was left without any healthcare staff present for 10 minutes or more after she left the cell and went home.

Support for staff

17. We are concerned that some of the staff who were closely involved in the events of 10 May were not offered support after Mr Nilsen's death.

Recommendations

- The Governor and Head of Healthcare should ensure that prison and healthcare staff communicate clearly about concerns over a prisoner's health.
- The Head of Healthcare should ensure that healthcare staff review prisoners, on the wing if necessary, if prison staff raise serious concerns about their health.
- The Governor should arrange for a senior manager to discuss the findings of this report with a SO.
- The Head of Healthcare should discuss the findings of this report with a Clinical Matron and a prison GP.

- The Governor should ensure that all staff are aware of their responsibilities when dealing with emergency situations and the calling of emergency medical codes.
- The Head of Healthcare should ensure that all healthcare staff are aware of their responsibilities when dealing with emergency situations and the calling of emergency medical codes.
- The Head of Healthcare should ensure that seriously ill prisoners are not left without medical assistance.
- The Governor and Head of Healthcare should ensure that support is offered to all staff who were closely involved in the events leading to the death of a prisoner.

The Investigation Process

18. The investigator issued notices to staff and prisoners at HMP Full Sutton informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
19. The investigator visited Full Sutton on 18 May 2018, and again on 14 and 15 June. He obtained copies of relevant extracts from Mr Nilsen's prison and medical records.
20. NHS England commissioned a clinical reviewer to review Mr Nilsen's clinical care at the prison.
21. The investigator interviewed seven members of staff at Full Sutton during his visits in May and June. He also interviewed a further three members of healthcare staff along with the clinical reviewer.
22. We informed HM Coroner for East Riding and Kingston upon Hull of the investigation. He gave us the results of the post-mortem examination, and we have sent him a copy of this report.
23. The investigator contacted Mr Nilsen's friend, his designated next of kin, to explain the investigation and to ask whether he had any matters he wanted the investigation to consider. He raised no particular concerns but asked to be kept informed.
24. Mr Nilsen's friend received a copy of the initial report. He did not raise any further issues, or comment on the factual accuracy of the report.
25. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Full Sutton

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

HM Inspectorate of Prisons

27. The most recent inspection of HMP Full Sutton was an unannounced inspection conducted in January 2016. The inspectors found that healthcare provision was reasonable overall, with good access to an appropriate range of services. Chronic disease management was reasonable but social care arrangements were underdeveloped. The inpatient unit provided a calm and decent service. Palliative care was available in the inpatient unit and had been used appropriately over the previous 12 months.

Independent Monitoring Board

28. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to December 2017, the IMB was satisfied that healthcare at Full Sutton was available equally to all prisoners. Visits to external hospitals were carried out discreetly, with dignity and respect.

Previous deaths at HMP Full Sutton

29. Mr Nilsen was the sixth prisoner to die at Full Sutton since the start of 2016 and the fifth to die from natural causes. We have previously made recommendations about shortcomings in the emergency response.

Abdominal aortic aneurysm (AAA)

30. The aorta is the main blood vessel leaving the heart. An abdominal aortic aneurysm (AAA) is a swelling of the aorta due to a weakness in the aorta wall. The cause of this weakness is unclear, but smoking and high blood pressure are thought to increase the risk, and the condition most commonly occurs in men over 65 years old. Due to the risk posed by an AAA, all men are invited to a simple screening test when they turn 65.
31. An AAA has no noticeable symptoms normally, although larger AAAs may display some signs. An AAA does not necessarily pose a serious threat to health but the larger the swelling, the greater the risk of it rupturing. If an AAA is detected during screening, it will be monitored and surgery may be considered if it becomes dangerously large.
32. A ruptured aneurysm can cause massive internal bleeding and is usually fatal. Approximately 80% of sufferers die before they reach hospital or following surgery. The most common symptom of a ruptured AAA is sudden and severe pain in the abdomen.

Key Events

33. On 4 November 1983, Mr Dennis Nilsen was convicted of a series of murders and sentenced to life imprisonment with a minimum term of 25 years. The Lord Chief Justice subsequently increased his sentence to a whole life tariff.
34. Mr Nilsen spent time at several prisons before being transferred to HMP Full Sutton on 27 November 2001. He was classified as a Category A prisoner, the highest security classification, for his entire time in prison.

Medical history at Full Sutton

35. Mr Nilsen rarely engaged with healthcare staff at Full Sutton. In 2009, a prison GP reviewed him following complaints of cramps in his calves. He diagnosed night cramps and recorded that he did not have a blood clot. The GP noted that Mr Nilsen was a smoker and offered him advice to quit, which he declined.
36. In 2011, Mr Nilsen submitted a formal complaint against healthcare after he was called up for a flu vaccination. He stated that he had better things to do than attending the healthcare unit for something he did not want.
37. In February 2012, staff moved Mr Nilsen to the healthcare unit prior to an eye operation. It is standard practice to relocate Category A prisoners ahead of planned hospital visits to prevent information about their movements leaking, but Mr Nilsen was very unhappy about being moved and rejected the explanation given. He refused to go to the hospital for the operation and signed a disclaimer to this effect. He submitted a formal complaint following this incident. His eye operation was never rescheduled.
38. Over the next few years, Mr Nilsen rarely engaged with healthcare staff or the services they offered. In autumn 2012, he declined the offer of a flu vaccination and consistently declined this each autumn when it was offered. In May 2014, he declined a NHS health screening on three separate occasions. He declined several more that were offered over the next few years. In May 2017, his medical records note that he had declined bowel cancer screening.
39. On 20 December 2016, Mr Nilsen declined an abdominal aortic aneurysm (AAA) screen, saying he did not want to engage with healthcare.
40. On 12 December 2017, a prison GP saw Mr Nilsen after he complained of a skin rash. The prison GP diagnosed a skin infection and prescribed Mr Nilsen with antibiotics. On 3 January 2018, a prison GP reviewed him after his rash became worse. She prescribed a different antibiotic and some anti-bacterial cream. Mr Nilsen's skin complaint did not improve over the next few months so GPs kept him under review. On 11 April, a prison GP noted that Mr Nilsen attended for a skin biopsy but that his skin was fragile and easily fell apart. On 16 April, a prison GP noted that the biopsy results were normal and that no further action was required.

Events of 10 May 2018

The morning

41. At 7.20am on 10 May, a mental health nurse saw Mr Nilsen in his cell at the request of wing officers. She recorded in Mr Nilsen's medical notes that Mr Nilsen was lying on his bed but got up to speak to her at the observation panel. Mr Nilsen told her that he had a very painful abdomen so she asked staff to unlock his cell so she could take his observations. She recorded that he was sweating slightly but all his physical observations were within the normal range. Mr Nilsen said that he did not feel nauseous or dizzy. She noted that Mr Nilsen's NEWS score was 0. (The National Early Warning Score, NEWS, is a predictive tool used to gauge the medical condition of a patient – 0 equates to no risk.) She advised him to drink fluids and booked him into the nurses' clinic for later that day.
42. The Clinical Matron said that Mr Nilsen was brought to the clinic in a wheelchair, and that she was "quite surprised" to see him there because Mr Nilsen never engaged with healthcare.
43. At about 9.30am, a nurse reviewed Mr Nilsen in the nurses' clinic. She recorded in his medical notes that he complained of a constant sharp pain in his abdomen round to his back that had started about 3.00am, but he could not be specific about where his pain was. He was able to walk around and transfer himself to the treatment bed. His observations were normal and she assessed his NEWS score as 0. However, because Mr Nilsen so seldom engaged with healthcare, she referred him to the GP.
44. A prison GP reviewed Mr Nilsen immediately afterwards. She noted that his abdomen was tender but that "his observations were absolutely fine". She suspected a urine infection or a kidney stone, and planned for his urine to be tested when he was able to give a sample. She said that she was not particularly worried by Mr Nilsen's presentation. She prescribed paracetamol and noted in his electronic medical records that he should be reviewed if he had not improved.

2.15pm to 4.30pm (approximately)

45. Officers A and B were in the wing office on Mr Nilsen's wing that afternoon. At about 2.15pm, two prisoners told them that Mr Nilsen appeared to have fallen asleep on the toilet in his cell, and the officers went to his cell to check on him.
46. Officer A said that they found Mr Nilsen sitting on his toilet, naked, with "his head slumped on his right arm... I tried unsuccessfully to get a response from Mr Nilsen, verbally at first and then by pinching his right elbow". He added that Mr Nilsen was clearly breathing and had no visible injuries, but did not respond to verbal prompts apart from "some flickering of his eyes". In an incident report written the following morning, the officer said that he "did not call it as a Code Red or a Code Blue, as I did not think it met the criteria made out in Governor's Order 05, 2018, which had only been released, I think, three weeks earlier." (A code blue call is an emergency radio code which indicates someone is unconscious or having problems breathing. It triggers the immediate attendance of healthcare staff and the control room to call for an ambulance.)

47. Officer B noted in Mr Nilsen's prison record that, when he and Officer A went to the cell, they found Mr Nilsen on his toilet "weak and in a disoriented state". He told the investigator that Mr Nilsen gave verbal responses, but was disorientated, so he left Officer A with him and went to the office to telephone for healthcare assistance. He said that Mr Nilsen could lift his head and respond and there was nothing to indicate a code blue was necessary.
48. Officer A said that when Officer B went to ring healthcare, he stayed with Mr Nilsen, talking to him. He said Mr Nilsen started to show some verbal responses in that he "seemed to reply" to questions about whether he was in pain, but he was "far from coherent".
49. Officer B recorded in Mr Nilsen's notes that he had spoken to someone in healthcare who said they would send a nurse to the cell when someone was free.
50. He recorded that after approximately 30 minutes an unidentified person in healthcare told him that Mr Nilsen had been seen earlier and he just needed to give a urine sample and get some rest. Officer A said in his incident report that after Officer B spoke to healthcare the first time, he asked him to go back and speak to them again "as Mr Nilsen was obviously in a bad way".
51. There was still no indication that healthcare would be coming to see Mr Nilsen so, with the help of a prisoner, the officers lifted Mr Nilsen onto his bed with great difficulty, as he was a dead weight and was also very clammy and difficult to get hold of. They placed him in the recovery position and covered him with a sheet.
52. Officer B said that when healthcare did not come, he called a Supervising Officer (SO) and told him how they had found Mr Nilsen and asked him if he thought he should call a code blue. He said the SO said no, but that that he should ring healthcare again.
53. Officer B said that he called healthcare about every 15 minutes and that different people answered but he could not recall who. Officer A said that Officer B rang healthcare "on several occasions". Officer B noted in Mr Nilsen's record that someone from healthcare later rang and asked to see Mr Nilsen in the healthcare unit but that he explained to them that this would not be possible as Mr Nilsen "was essentially a dead weight".
54. Both officers said that they kept checking on Mr Nilsen. Officer B said that Mr Nilsen seemed to deteriorate and was incontinent of faeces. Officer A said that after a while Mr Nilsen turned onto his back and was snoring loudly.
55. Officer B said he told the SO that healthcare staff had not attended. He thought that the SO intended to call a code blue "to force healthcare to come and see Mr Nilsen".
56. Both officers told the investigator that they felt very unsupported during the afternoon. They were on their own with a high-profile prisoner whose health was deteriorating, they could not leave the landing and they could not get healthcare to see him. Officer A said he thought the SO should have been more proactive and come to see Mr Nilsen's condition for himself. He said the SO did not come to the landing at all during the afternoon. He said that when he left the wing at

about 4.45pm, he spoke to the SO and said that he thought Mr Nilsen needed medical attention.

57. The SO told the investigator that he first became aware that Mr Nilsen was unwell during the handover from the night shift on the morning of 10 March. He said he knew Mr Nilsen went to the healthcare unit in the morning and was sent back to the wing to rest. In the afternoon an officer told him that they had found Mr Nilsen slumped on the toilet and that they were getting some response from him but he was not very coherent, and that he had rung healthcare.
58. The SO said that Officer B rang him again later and told him healthcare had not come to see Mr Nilsen. He thought he rang healthcare himself at that point – he could not remember who he spoke to – and said Mr Nilsen was much worse and they needed to come to see him. He then rang the duty manager, the custodial manager (CM), at about 3.15pm, and told him that landing staff were very concerned about Mr Nilsen. He asked whether he should call a code blue but the CM said he would speak to healthcare himself.
59. The SO said he had not personally seen Mr Nilsen but he thought he had spoken to Officer B in the office on the landing at some point, and recalled other prisoners complaining about the smell as Mr Nilsen had been incontinent of faeces.
60. The CM told the investigator that the SO contacted him to say that he had “grave concerns” about Mr Nilsen’s condition and that staff had had to lift him off the toilet and put him on his bed. The CM said that he then went to see a nurse, who told him that a GP had seen Mr Nilsen earlier in the day and had had no concerns, and that she was satisfied that wing staff were “probably, if anything, over-exaggerating his condition”. The CM said he had accepted this and returned to his duties.
61. Healthcare staff give a slightly different account of these events.
62. At 3.30pm, a healthcare support worker noted in Mr Nilsen’s medical record that an officer from B wing had rung about Mr Nilsen and that a nurse had returned the call and advised the officer to bring Mr Nilsen to the healthcare unit if required.
63. At 4.00pm, a nurse recorded that she had taken a telephone call from the SO who wanted to know why no one from healthcare had been to see Mr Nilsen as he had requested half an hour earlier. He told her that he was close to calling a code blue emergency. She said that she tried to ask him questions about whether Mr Nilsen was conscious and responsive, but he put the phone down. She did not know if he did this intentionally or because he was busy. She immediately informed another nurse, who then called the SO.
64. The nurse did not record her conversation with the SO. She told the investigator that the SO said Mr Nilsen needed to be seen and threatened to call a code blue. She said she told the SO that she had already received a call, possibly two, from an officer on Mr Nilsen’s landing asking for someone to see Mr Nilsen, and that she had told the officer that they already knew Mr Nilsen was unwell and that he had been seen by a nurse and a GP and needed to rest and drink plenty of fluids. She told the SO that the landing officer had been happy with that and the SO

said he had not been aware of that. She said she also told the SO that he could not threaten to call a code blue, he either called one or he didn't and if he called one, they would respond.

65. She said a CM then came to the healthcare unit and said Mr Nilsen was unwell. She said she told him that Mr Nilsen had been seen by a nurse and a GP, that his NEWS score was 0 so they did not think it was anything serious and suspected he had a urine infection. She told him that they needed to get his urine sample back so they could test it and see if he had a urine infection. She said the CM was happy with this. She said she did not think any more about it and went home at the end of her shift.
66. The nurse said that healthcare staff receive a lot of calls throughout the day about prisoners, and that prison staff had said nothing to indicate how poorly Mr Nilsen was. She accepted that healthcare staff should have reviewed him, as a prison GP had advised, but said that because prison staff had not brought him to the healthcare unit, it was assumed that he must be feeling better. She said that if prison staff had said that Mr Nilsen was too ill to be moved, healthcare staff would have gone to see him on the wing.

4.30pm to 5.20pm (approximately)

67. The SO said that after Officers A and B had locked up at about 4.45pm, they told him that Mr Nilsen had still not been seen by healthcare and that they were very concerned about him.
68. The CM said that the SO called him again at about 4.45pm and told him that Mr Nilsen had become progressively worse and he was "very, very concerned" about him. The CM said he expressed his concerns to a nurse. She told him that she was a mental health nurse but that the doctor was still there so she would bring her down to see Mr Nilsen.
69. The nurse said that another nurse and the general nurses had gone home at about 4.30pm and that she then provided cover. There was no handover. After they had gone, she got a call from the CM to say that he was worried about Mr Nilsen. She said she was worried because staff were so concerned and that she therefore asked a prison GP if she could see Mr Nilsen before she left for the day.
70. A prison GP said she saw Mr Nilsen in his cell at approximately 4.50pm, accompanied by a healthcare support worker. She said it was clear something acute had happened since she had seen him in the morning and that she suspected a possible ruptured AAA. She noted in his medical record that Mr Nilsen had become confused during the day, was still complaining of pain and had been incontinent of faeces, which he was covered in. He was "very confused, pale and shaking" and had a raised respiratory rate and pulse. She recorded: "Acute abdomen? Perforation? AAA needs admission to A&E to assess via 999."

The emergency response

71. The GP told the investigator that she requested a 'blue light' (emergency) ambulance some time between 5.00pm and 5.20pm and then returned to the healthcare unit where she completed her notes. She said that she had only

worked three shifts at the prison and that she was unsure of the procedure for calling an emergency ambulance. She said that nobody from healthcare remained with Mr Nilsen but she assumed the ambulance would be there imminently. She said that she left the prison at approximately 5.45pm, assuming the ambulance was on its way.

72. The CM told the investigator that the GP had asked him to call an ambulance but did not specify that it was a code blue situation. He said that he checked whether a 'blue light' ambulance was required, but she said not, just a normal one. The CM telephoned the control room himself to arrange for an ambulance. He said that approximately 20 minutes later it was escalated to a code blue emergency by healthcare and he passed this information to the control room.
73. A nurse said that the GP returned to the healthcare unit after seeing Mr Nilsen and told her that she needed to call an ambulance as she wanted him taken to hospital. She said she asked the GP if it was a code blue situation, but the GP was new and did not know the procedures and said that he needed to go out "quite urgently", so the nurse said she rang the wing and told them it was a code blue.
74. The control room log records that an ambulance was requested at 5.20pm and then upgraded to a 'blue light' at 5.35pm, and that a code blue was called at 5.52pm. The ambulance log records that they were called at 5.34pm.
75. The nurse said she rang another nurse at about 5.45pm to tell her that Mr Nilsen needed to go to hospital. The second nurse told her to go to the wing in case Mr Nilsen deteriorated and needed CPR or basic life support. She said she collected the emergency bag and the defibrillator and went to the wing with a healthcare support worker. She also took the paperwork with her to handover to the ambulance crew. She said that she did not know exactly what time she went to the cell but that she had spent "quite a lot of time" organising the ambulance and getting the paperwork ready so the doctor could sign the escort risk assessment form.
76. The nurse recorded in Mr Nilsen's notes that when she got to the cell "Mr Nilsen was laid on his bed, there was faeces on his bed and clothing. He was conscious and verbally responding, but appeared very weak". She told the investigator that the doctor left to go home because she had childcare issues and that she was left on her own with Mr Nilsen with just a healthcare support worker and prison staff while they waited for the ambulance. She said she found this very stressful because she was a mental health nurse, not a general nurse, and that she was surprised that the doctor had left. She checked Mr Nilsen's pulse and tried to take his blood pressure but it was fluctuating too much.
77. The control room log records that the ambulance arrived at 6.03pm and that the crew arrived on B Wing at 6.12pm.
78. The CM said that he had not realised how ill Mr Nilsen was until the paramedics arrived and seemed "very, very concerned". They said that Mr Nilsen had to be transported by stretcher because he needed to remain lying down and could not sit up in a wheelchair. This meant the ambulance had to be moved closer to the

wing. He tried to get a member of staff to escort the ambulance but they did not know the grounds, so he went to the gate and escorted the ambulance himself.

79. The log records that the stretcher was brought to the cell at 6.38pm and that the ambulance left the prison with Mr Nilsen at 6.52pm.
80. The ambulance crew took Mr Nilsen to hospital. He was given emergency surgery to repair a ruptured AAA and was then located in the Intensive Care Unit (ICU). He had surgery again the following morning because the repaired aneurysm was leaking, but the bleeding could not be stemmed and he remained in the ICU in a critical state. He died at 9.20am on 12 May.

Post-mortem report

81. The post-mortem concluded that Mr Nilsen died from a pulmonary embolism (a blocked artery in his lungs) and retroperitoneal haemorrhage (an accumulation of blood), caused by deep vein thrombosis and a repaired aortic aneurysm rupture.
82. Retroperitoneal haemorrhage is often caused by a ruptured aortic aneurysm, and can cause a build-up of clots in the bloodstream. In Mr Nilsen's case, a clot travelled through the bloodstream and caused a blockage in an artery in his lungs, causing his death.

Contact with Mr Nilsen's family

83. Mr Nilsen had no contact with his family. His listed next of kin was a friend. On 11 May, a prison manager telephoned Mr Nilsen's friend and informed him of Mr Nilsen's condition, and that he was in hospital. Mr Nilsen's friend visited Mr Nilsen in hospital later that day.
84. On 12 May at 10.08am, the duty governor informed Mr Nilsen's friend by telephone that Mr Nilsen had died. This means of communication had been agreed between them in advance. The Governor offered his support and made himself available for any questions over the weekend.
85. The prison appointed a prison manager and an officer as Mr Nilsen's family liaison officers (FLOs). On 14 May, one of the FLOs contacted Mr Nilsen's friend and introduced himself. They also discussed the potential media interest in the case and how this should be approached.
86. Mr Nilsen's funeral was held on 7 June. The prison contributed to the cost in line with national guidance.

Support for prisoners and staff

87. After Mr Nilsen's death, the duty governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
88. An officer said he had not been offered support. He said he was not on duty over the weekend and the first he knew that Mr Nilsen had died was when he read it in the Sun newspaper.

89. The nurse said she had not been involved in a debrief, was not offered support and had not felt supported at all, particularly by healthcare staff. She has since left Full Sutton.
90. The prison posted notices informing other prisoners of Mr Nilsen's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Nilsen's death.

Findings

Clinical care

91. We agree with the clinical reviewer that the clinical care Mr Nilsen received in Full Sutton before 10 May 2018 was equivalent to that which he could expect to have received in the community. He rarely engaged with healthcare staff and generally refused medical treatment. He consistently declined flu vaccinations and health screens and, significantly, he declined a routine screen for AAA when this was offered in 2016. If Mr Nilsen's AAA had been discovered earlier, it would have been monitored and he could have had surgery, if necessary, to prevent it rupturing. Healthcare staff would also have been aware that he had an AAA when he complained of abdominal pain on 10 May.
92. During the morning of 10 May, when Mr Nilsen first reported that he was in pain, he was seen by three separate healthcare professionals. A nurse saw him in his cell and recorded a NEWS score of 0. A nurse subsequently reviewed him in the prison clinic and also recorded a NEWS score of 0. A prison GP then saw Mr Nilsen and had no significant concerns, although she noted that he should be reviewed if he did not improve. It is difficult to diagnose an AAA in its early stages and it was not unreasonable to think that his symptoms suggested a possible urinary infection or kidney stone. We agree with the clinical reviewer that Mr Nilsen was appropriately reviewed during the morning.
93. However, we are concerned that, although officers raised their concerns about Mr Nilsen on a number of occasions from 2.15pm onwards, no one from healthcare saw him until 4.50pm. This was despite the fact that a prison GP had recorded in Mr Nilsen's medical records that morning that he should be reviewed if his condition did not improve. As a result, Mr Nilsen lay in his own faeces with his health deteriorating for around two and a half hours without being seen by healthcare staff.
94. There is no clear record of how many times prison staff contacted healthcare staff that afternoon, nor of exactly what was said on each occasion and by whom. However, everyone agrees that prison staff contacted healthcare on multiple occasions asking healthcare to see Mr Nilsen, and that this included contact from the wing SO and the duty manager as well as from the landing officer.
95. An officer recorded that at some point before 3.54pm healthcare staff asked officers to bring Mr Nilsen to the healthcare unit to be seen and that he said this was not possible because Mr Nilsen was too unwell. A nurse told the investigator that healthcare staff were never told that Mr Nilsen was too ill to come to the unit, but we consider it is unlikely that the officer would have withheld this information. The SO also said that he told a nurse that Mr Nilsen was too ill to come to the unit.
96. The officers and two nurses all say that a SO threatened to call a code blue to force healthcare staff to see Mr Nilsen. The mention of a possible code blue should have prompted a nurse to ask why prison staff were so concerned about Mr Nilsen's condition, but it appears from her evidence that it prompted a bad-tempered exchange of words with the SO instead.

97. Given a prison GP's note that Mr Nilsen should be reviewed if he did not improve, given the number of contacts from prison staff suggesting that Mr Nilsen had deteriorated, and given that Mr Nilsen did not normally seek medical attention, we find it very difficult to understand why a nurse did not arrange for a nurse to see him. We consider it was an error of judgement that she did not do so.
98. We also agree with the clinical reviewer that it was poor practice not to have had a formal handover when the general nurses left at the end of their shift.
99. Having said that, we also have concerns about the judgements made by the SO. Given the concerns expressed by landing staff, we consider that he should have gone to see Mr Nilsen and assessed his condition for himself, especially as he knew that one of the officers had only a few months' experience as a prison officer. He could then have described Mr Nilsen's condition in detail to healthcare staff. This would have been more persuasive and professional than threatening to call a code blue to force healthcare staff to attend. We cannot say whether the SO put the phone down on a nurse but, if he did, this would also have been unhelpful and unprofessional behaviour.
100. The evidence suggests that communication between the SO and the nurse was poor that afternoon and that, as a result, the deterioration in Mr Nilsen's health may not have been effectively conveyed, questioned or understood. We cannot say whether this was an isolated incident or whether there was a poor relationship between prison staff and healthcare staff generally, but this is something the Governor and Head of Healthcare will need to consider.
101. If healthcare staff had seen Mr Nilsen earlier on the afternoon of 10 May, it is likely that an ambulance would have been called earlier and that he would have been taken to hospital earlier. We cannot say whether the outcome would have been different for Mr Nilsen.
102. We make the following recommendations:

The Governor and Head of Healthcare should ensure that prison and healthcare staff communicate clearly about concerns over a prisoner's health.

The Head of Healthcare should ensure that healthcare staff review prisoners, on the wing if necessary, if prison staff raise serious concerns about their health.

The Governor should arrange for a senior manager to discuss the findings of this report with a SO.

The Head of Healthcare should discuss the findings of this report with Clinical Matron and a prison GP.

Emergency response

103. Prison Service Instruction (PSI) 03/2013, *Medical Response Codes*, requires prisons to have a two-code medical emergency response system in place. Calling an emergency medical code should automatically trigger healthcare staff to attend and the control room to call an ambulance. The PSI says that a code blue should be used when a prisoner is displaying the following symptoms: chest

pain; difficulty in breathing; unconscious; choking; fitting or concussed; severe allergic reaction; and suspected stroke.

104. The PSI also says that when healthcare staff respond to an emergency medical code, they will confirm whether an ambulance is needed and stand it down if it is not needed.
105. Full Sutton's local policy is set out in Governor's Order 005/2018 *Emergency Response Codes in Custody – Codes Red and Blue*. This mirrors the policy in the PSI with one exception: the symptoms that trigger a code blue include "fitting or confused" (rather than "fitting or concussed").
106. When officers initially found Mr Nilsen slumped on his toilet at about 2.15pm, they did not call a code blue. Officer A said that Mr Nilsen initially gave no response when he spoke to him or when he pinched him on his elbow. He said that Mr Nilsen later started to respond a little but was not very coherent. Officer B said that Mr Nilsen did respond but was disorientated. The officers said that they discussed whether to call a code blue but felt that it was not appropriate as Mr Nilsen was breathing and conscious. Officer B said that he asked the SO if he should call a code blue and was told no.
107. We consider that Mr Nilsen's symptoms did not fall clearly into the list of symptoms that should give rise to a code blue call. This was a borderline decision and we do not criticise the officers for not calling a code blue when they found Mr Nilsen. Mr Nilsen was confused and we do not, therefore, consider that it would have been inappropriate to have called a code blue, because healthcare staff could have stood the ambulance down if they did not think it was necessary. But the situation was not clear cut and we do not consider that it was unreasonable in the circumstances for the officers to seek advice from the wing SO and from healthcare rather than calling a code blue.
108. When the officers continued to express their concerns to the wing SO, we consider that he should have gone to see Mr Nilsen himself and decided whether or not to call a code blue. Instead the SO introduced a delay by calling a CM and telling him he was concerned about Mr Nilsen.
109. We make the following recommendation:

The Governor should ensure that all staff are aware of their responsibilities when dealing with emergency situations and the calling of emergency codes.
110. The CM insisted that healthcare staff see Mr Nilsen. A prison GP saw Mr Nilsen at about 4.50pm and immediately recognised that he had a possible ruptured AAA and needed to go to hospital as an emergency. She should have called a code blue at this point or asked a CM to do so. However, her inexperience as a prison GP meant that she did not communicate the urgency clearly and an ambulance was not called until 5.20pm (30 minutes after the GP first saw Mr Nilsen), an emergency ambulance was not requested until 5.35pm (nearly 45 minutes after she first saw Mr Nilsen) and a code blue was not called until 5.52pm.

111. Paramedics did not reach Mr Nilsen until 6.13pm, almost an hour and half after a prison GP had first seen him. This delay, caused by a GP's ignorance of emergency procedures in a prison, was unacceptable.
112. We cannot say whether the outcome for Mr Nilsen would have been different if a prison GP had called a code blue when she first saw him in his cell, but it would certainly have meant that he would have been taken to hospital sooner.
113. We recommend:
- The Head of Healthcare should ensure that all healthcare staff are aware of their responsibilities when dealing with emergency situations and the calling of emergency codes.**
114. We are also concerned that although the GP suspected that Mr Nilsen had a life-threatening AAA rupture, she left him without a member of healthcare while he waited for the ambulance. The evidence suggests that it was 10 minutes or more before a nurse was free to join Mr Nilsen in the cell. Given the seriousness of Mr Nilsen's condition, we are concerned that he was left for any period of time without a healthcare professional in attendance. We recommend:
- The Head of Healthcare should ensure that seriously ill prisoners are not left without medical assistance.**
115. We are also concerned that, although a nurse was trained in basic life support, she was not a general nurse and that she was left alone with Mr Nilsen for 30 to 40 minutes between a GP leaving the cell and the ambulance paramedics arriving. We question whether this meets the requirements of Spectrum's contract to provide 24-hour healthcare at Full Sutton.

Support for staff

116. We are concerned that the nurse involved in the emergency response and Officer A (who had expressed his concern about Mr Nilsen's deteriorating health) were not offered support after Mr Nilsen's death. We make the following recommendation:
- The Governor and Head of Healthcare should ensure that support is offered to all staff who were closely involved in events leading to the death of a prisoner.**

**Prisons &
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Independent Investigations