Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Phillip Sheridan, a prisoner at HMP Full Sutton, on 21 July 2024

A report by the Prisons and Probation Ombudsman

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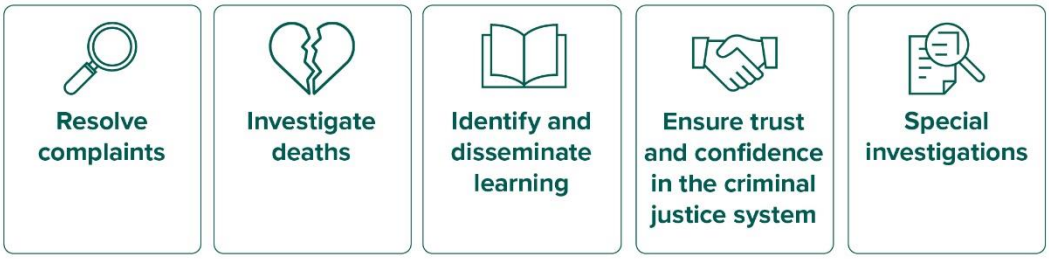
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

Summary

1. 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.

2. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. Mr Phillip Sheridan died of acute myocardial infarction (heart attack) caused by ischaemic heart disease (reduced blood flow to the heart) and severe coronary atheroma (fatty material builds up on the walls of the arteries which reduces blood flow). Diabetes mellites (disease that causes high blood sugar levels) and cerebrovascular disease (condition that affects the blood flow to the brain) contributed to but did not cause Mr Sheridan's death. Mr Sheridan was 70 years old when he died on 21 July 2024, while a prisoner at HMP Full Sutton. We offer our condolences to Mr Sheridan's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Sheridan received at Full Sutton was equivalent to that which he could have expected to receive in the community. The clinical reviewer made a recommendation about engaging with prisoners who refuse medical treatment and documenting these interactions. She also made a recommendation not related to Mr Sheridan's death which the Head of Healthcare will wish to consider.

5. Mr Sheridan told staff that he wanted to die and harm himself. Staff responded promptly and appropriately by beginning suicide and self-harm prevention procedures (known as ACCT). However, staff could not complete ACCT checks adequately due to a cabinet obstructing their view. The day after Mr Sheridan's death, the prison removed these cabinets from cells in healthcare for prisoners subject to ACCT checks. When staff found Mr Sheridan unresponsive, signs of rigor mortis were present, indicating that the previous ACCT checks had not fulfilled their objective of ensuring Mr Sheridan was alive and well.

6. There was a delay in radioing an emergency code when an officer found Mr Sheridan in his cell. However, this was minimal and did not affect the outcome for Mr Sheridan who had been dead for some time.

Recommendations

- **The Head of Healthcare and the Regional Manager for PPG should be assured that there is a refusal of care pathway in place which supports practitioners caring for patients who refuse treatment to a point of their self-neglect.**

- **The Governor should ensure that staff adequately assess a prisoner's welfare when doing ACCT checks.**

The Investigation Process

7. HMPPS notified us of Mr Phillip Sheridan's death on 22 July 2024.

8. NHS England commissioned an independent clinical reviewer to review Mr Sheridan's clinical care at HMP Full Sutton.

9. The PPO investigator investigated the non-clinical issues relating to Mr Sheridan's care.

10. She obtained and reviewed copies of relevant extracts from Mr Sheridan's prison and medical records.

11. The investigator and clinical reviewer interviewed four members of staff and a prisoner at Full Sutton on 12 September. They interviewed four more members of staff via MS Teams on 3 October. The investigator also contacted Safer Custody members of staff for further information on internal prison processes.

12. The Ombudsman's office wrote to Mr Sheridan's next of kin to explain the investigation and to ask if she had any matters she wanted us to consider. They did not respond.

13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Previous deaths at HMP Full Sutton

14. Mr Sheridan was the ninth prisoner to die at Full Sutton since 21 July 2021. Of the previous deaths, seven were from natural causes, and one was self-inflicted. Since Mr Sheridan's death and up to the end of October 2024, two prisoners have died of natural causes and one due to unknown causes. There are no similarities between the findings in our investigation into Mr Sheridan's death and these previous investigations.

Assessment, Care in Custody and Teamwork

15. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

Key Events

16. On 18 June 1987, Mr Phillip Sheridan was sentenced to life imprisonment for attempted rape, robbery and other offences. His tariff (the minimum amount of time he would spend in prison) was twelve years. Having spent time in several prisons, Mr Sheridan transferred to HMP Full Sutton in November 2011.

17. Mr Sheridan had been diagnosed with several health conditions during his time in prison: diabetes, asthma, a stroke, mobility issues, acute schizophrenia and paranoia associated with personality disorder. He was also incontinent in the last year prior to his death. Mr Sheridan often did not engage with treatment for his conditions. In particular, he had a long history of refusing insulin for managing his diabetes. Medical professionals believed that Mr Sheridan had the mental capacity to refuse treatment.

18. On 29 April 2020, Mr Sheridan said he did not want to be resuscitated if his heart or breathing stopped and signed an order to that effect (DNACPR - Do Not Attempt Cardiopulmonary Resuscitation). This document was valid at the time of death, but had not been reviewed since Mr Sheridan first signed it as it should have been.

19. On 8 August 2022, a GP assessed Mr Sheridan and noted he was moderately frail and no longer able to live an independent life. The GP also noted that Mr Sheridan was able to understand information and make decisions about his care.

20. On 5 June 2023, paramedics tried to convince Mr Sheridan to go to hospital to investigate a possible stroke, but he refused. A GP noted that he had the mental capacity to make this decision. Later that day, he agreed to go to hospital but discharged himself the following day. On 8 June, another GP reviewed Mr Sheridan and assessed that he had mental capacity to refuse treatment. He remained in the healthcare unit until 24 August.

21. Mr Sheridan's incontinence issues became worse during his last year. A prisoner said that often when Mr Sheridan's bed was changed, the linen was not disposed of appropriately in waste bags. He also said that Mr Sheridan did not have a buddy (a prisoner who supports another with their practical needs) once he was no longer allowed to be Mr Sheridan's buddy due to a risk assessment. However, we found that staff tried their best to find buddies for Mr Sheridan. When that was not possible, staff supported him within their capacity.

22. On 8 July 2024, Mr Sheridan complained about chest pain. Prison officers took him to the healthcare unit in a wheelchair. Mr Sheridan refused to stay in healthcare for assessment as he wanted to return to his cell to vape. Healthcare staff continued to monitor Mr Sheridan regularly and they had no acute concerns.

23. On 15 and 16 July, Mr Sheridan refused to take his insulin. On 16 July, when staff asked him why, he said he had had enough in this life and wanted to die. A Custodial Manager (CM) started prison suicide and self-harm monitoring, known as ACCT. He set Mr Sheridan's observations as 'sessionally' (this meant one observation in the morning, afternoon, evening and overnight).

24. On 17 July, a supervising officer chaired an ACCT review, with the Head of Healthcare and a healthcare officer also present. Mr Sheridan said he wanted to die

and refused to take his medication. He was hostile towards staff, which was common, and refused to elaborate on why he did not want to be treated. He also said he would stab himself in the stomach with tweezers. Staff removed the tweezers and pens from his cell. Staff present increased his ACCT observations to hourly.

25. On 18 July, Mr Sheridan's condition declined, he looked paler and frailer than usual, and a nurse assessed that he needed to go to hospital. However, Mr Sheridan refused to go.

26. On 19 July, Mr Sheridan accepted being transferred to the healthcare unit within the prison, but only agreed to receive support from healthcare for his incontinence issues. He continued to refuse treatment for his diabetes.

27. On 20 July, a nurse changed Mr Sheridan's incontinence pad and made him a drink. Mr Sheridan continued to refuse other treatment.

Events overnight 20 - 21 July

28. There is no CCTV in the healthcare unit so the following account is taken from documentation. Overnight from 20 July to 21 July, an officer checked Mr Sheridan every hour, even though he was under the impression the checks only had to be conducted once overnight (sessionally), as this was noted on top of the page where he was recording the times of the observations. He was worried that Mr Sheridan might fall out of bed, so he checked Mr Sheridan at 7.30pm, 8.30pm, 9.00pm, 10.00pm, 11.00pm, 12.30am, 1.30am, 2.30am, 3.30am, 4.30am, 5.30am and 6.00am to check that he had not fallen. He noted that Mr Sheridan was asleep all night, but that it was difficult to see him because Mr Sheridan's chest did not move a lot as he was breathing and there was also a cabinet partially obstructing the view.

29. On 21 July at 7.00am, another officer checked Mr Sheridan. In interview, he told us that he could not see Mr Sheridan's face because a cabinet had obstructed his view, but he could see Mr Sheridan's chest going up and down and was satisfied that he was alive.

30. At 8.15am, an officer checked Mr Sheridan and thought he was asleep. The officer believed it would be cruel to wake Mr Sheridan in his poor health condition so early in the morning to confirm, especially as this was typical behaviour from Mr Sheridan.

31. A few minutes after 9.00am, an officer went to give Mr Sheridan his breakfast. In interview, the officer said that he did not respond when she called. When she entered the cell, she saw that Mr Sheridan's eyes were open and she could not see any signs he was breathing.

32. The officer was not carrying a radio, so she left the cell to ask for support from healthcare staff, who were in an office upstairs. On her way up, she spoke to another officer and asked him to lock a prisoner in the exercise yard (he was a difficult prisoner and she was concerned he would interfere with the emergency response) and told the officer that she thought Mr Sheridan was dead. This officer had a radio but did not use it at this point.

33. The officer continued upstairs and told a nurse that Mr Sheridan was not breathing. The two officers then went into Mr Sheridan's cell while the nurse radioed a code blue at 9.10am. Control room staff immediately requested an ambulance. In interview, the officer was not sure how long it took from the moment she saw Mr Sheridan to the code blue being called, but she referred to only stopping briefly to ask for the door to be closed.

34. Several members of staff went to Mr Sheridan's cell to assist. The nurse remembered he had a DNACPR in place, and a member of staff located it from an office upstairs. The nurse assessed Mr Sheridan and noted that signs of rigor mortis were present. Staff did not try to resuscitate Mr Sheridan, both because there were unequivocal signs of death and in accordance with his wishes.

35. Initially the ambulance was given the highest priority. However, once prison staff updated the 999 handler that Mr Sheridan had no signs of life and a DNACPR was in place they lowered the priority of the call. Paramedics attended and confirmed Mr Sheridan's death at 10.30am.

Post-mortem report

36. The post-mortem report concluded that Mr Sheridan died of acute myocardial infarction caused by ischaemic heart disease and severe coronary atheroma. Diabetes mellitus and cerebrovascular disease were also listed as contributory factors.

Findings

Clinical care

37. The clinical reviewer concluded that Mr Sheridan's healthcare was equivalent to that he could have expected to receive in the community. She noted that healthcare staff repeatedly told Mr Sheridan about the dangers of not taking insulin and other medication. She concluded that he was aware of the potentially life-threatening consequences. Appropriate care planning was in place for the management of Mr Sheridan's long-term conditions and he was regularly reviewed by healthcare staff. The clinical reviewer concluded that while Mr Sheridan's behaviour was sometimes challenging, healthcare staff treated him with respect and compassion.

38. The clinical reviewer was satisfied that there was sufficient evidence that Mr Sheridan had capacity to refuse treatment. However, she noted that there should be a more robust process to have ongoing discussions about consent and record that the patient understands the consequences of not being treated. We endorse the clinical reviewer's recommendation that:

    The Head of Healthcare and the Regional Manager for PPG should be assured that there is a refusal of care pathway in place which supports practitioners caring for patients who refuse treatment to a point of their self-neglect.

Head of Healthcare to note

39. On 29 April 2020, Mr Sheridan said he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect (DNACPR). This document was valid at the time of death, but it had not been reviewed annually as it should have been. The clinical reviewer made a recommendation about this which the Head of Healthcare will wish to address.

40. Mr Sheridan's incontinence issues became worse during his last year. The clinical reviewer recommended that soiled bedsheets are dealt with appropriately which the Head of Healthcare will consider.

Management of Mr Sheridan's risk to himself

41. Staff opened an ACCT on 16 July, when Mr Sheridan said he no longer wanted to take insulin because he wanted to die. Initially staff set his observations at sessionally. During an ACCT review the following day, Mr Sheridan also said he would self-harm, so staff increased his observations to hourly. Staff acted appropriately in opening an ACCT and continued to encourage Mr Sheridan to take his insulin and explained the dangers if he did not. The only review that took place had a SO, nurse and healthcare officer present and staff completed an appropriate care plan for Mr Sheridan.

ACCT checks

42. The officer checking Mr Sheridan overnight from 20 July to 21 July believed he only needed to check him once but still checked on Mr Sheridan hourly as he was concerned he might fall out of bed. These ACCT checks were done at predictable intervals but since the officer did not believe they were ACCT checks this was understandable. However, after this they continued to be completed on the hour. At the top of the page where staff recorded the ACCT checks, someone had incorrectly written "sessional". We have not been able to find out who wrote this. Staff should check the frequency of ACCT checks from the ACCT plan section. We highlight these issues to the Governor.

43. Staff also told us that there was a cabinet partially obstructing the view of Mr Sheridan, so they were not able to see his whole body, and importantly, could not see his head. After Mr Sheridan's death, the prison identified this as an issue and removed cabinets from healthcare cells holding prisoners on an ACCT. We welcome this decision and encourage the Governor to consider removing the cabinets from all healthcare cells, so staff can easily see these prisoners with healthcare concerns and carry out adequate welfare checks.

44. Day staff took over Mr Sheridan's ACCT checks at 7.00am. The officer who did this check said that he could see Mr Sheridan's chest going up and down. The officer doing the next check said that he thought Mr Sheridan was asleep. When staff discovered Mr Sheridan unresponsive, shortly after 9.00am, he had signs of rigor mortis. It is not possible to determine exactly how long it takes for rigor mortis to set in but Mr Sheridan had most likely been dead for a few hours. This suggests the checks done most recently that morning were insufficient to ensure Mr Sheridan was alive and well. We recommend that:

    The Governor should ensure that staff adequately assess a prisoner's welfare when doing ACCT checks.

Governor to note

45. Prison Service Instruction (PSI) 03/2013, *Medical Emergency Response Codes*, states that when staff find a prisoner unresponsive, they should immediately alert the control room using a medical emergency code to ensure a timely, appropriate, and effective response to medical emergencies. The control room should then automatically call an ambulance.

46. The officer was not carrying a radio when she went into Mr Sheridan's cell on 21 July. In interview, she said that there are two radios for officers on the unit. The Head of Safer Custody said that there are not enough radios for all staff to have one. He also explained that even if there were, it would not be feasible to use so many radios as it would overload the network, making raising alarms difficult and confusing. He also said that, in the healthcare unit, healthcare staff carry radios and that officers are expected to share two radios between them, one upstairs and one downstairs.

47. The other officer could have radioed a code blue as soon as the officer told him that Mr Sheridan was unresponsive. However, he was focused on locking another prisoner away and getting to Mr Sheridan's cell. The delay in calling a code blue

was minimal and made no difference to Mr Sheridan in the circumstances. We therefore make no recommendation but bring the matter to the Governor's attention.

Adrian Usher
Prisons and Probation Ombudsman **February 2025**

Inquest

The inquest hearing was held on 4 September 2025. The Coroner concluded that Mr Sheridan died of natural causes.

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