

**Investigation into the circumstances surrounding the
death of a man at Queen's Medical Centre, Nottingham,
while a prisoner at HMP Whatton,
in July 2008**

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

April 2009

This is the report of an investigation into the death of a prisoner at HMP Whatton. The man died on 7 July 2008 at Queen's Medical Centre, Nottingham. He was aged 81. I offer my sincere sympathy and condolences to all those affected by his loss.

The man was already 78 years old when he was first sent to prison in 2005, and he already had significant health problems. He suffered from asthma, diabetes, had received skin cancer treatment, and often had chest pain and chest infections. He continued to suffer from these health problems throughout his time in prison, but was well supported by prison healthcare and NHS healthcare staff. In early July 2008 he was admitted to hospital, and died five days later.

The investigation was carried out by one of my colleagues. The man's medical care in prison was independently reviewed by a doctor on behalf of Nottinghamshire County Primary Care Trust. As ever, I am most grateful to the doctor for his assistance.

I would also like to thank the Governor and staff of Whatton for their full and ready co-operation during the course of the investigation. I am particularly grateful to the support and liaison officer who provided such a good service to my investigation team.

I make two recommendations in this report, one of which is an amended version of a recommendation I made in a previous investigation report in June 2008. This concerns the use of restraints - and the very difficult balance between the needs of security and what is decent and civilised in the care of an elderly patient at the end of his life. The Prison Service has accepted both these recommendations and I have included their comments at the end of this report.

Stephen Shaw CBE

April 2009

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SUMMARY

The man was sentenced to 12 years imprisonment by Truro Crown Court on 27 May 2005. After his initial admission to HMP Exeter, he was transferred to HMP Bristol and HMP Dartmoor. On 10 May 2006, the man transferred to HMP Whatton where he spent the remainder of his time in prison before he died in hospital in Nottingham in July 2008.

The man was already aged 78 when he was sentenced and came to prison with a number of health problems. Despite this, he managed to adapt to prison life quite well and was described by staff as a quiet, co-operative, elderly man who rarely gave any cause for concern except regarding his health.

Before the man was sentenced to imprisonment, he had been diagnosed and treated for skin cancer. It recurred in January 2008, and he was placed under the care of a consultant dermatologist at Nottingham University Hospital. He also had diabetes before he arrived in prison, and the condition became progressively worse so that he required insulin injections rather than tablets to control it. The man also suffered from asthma and contracted chest infections regularly whilst in custody.

In July 2008, the man felt unwell and the local community paramedic team were called to review his medical condition. They undertook an ECG (an electrical tracing of his heart), and found that there were some changes to his heart rhythm but that he did not require admitting to hospital on this occasion. A short while later, the man was seen by the prison doctor who thought it appropriate to have him admitted to hospital for further tests and treatment. He was taken to Queen's Medical Centre, Nottingham, under prison officer escort and admitted to a ward at the hospital. The man remained there for a further five days, becoming more and more unwell. He died from his illnesses one evening in July 2008.

THE INVESTIGATION PROCESS

1. This investigation was undertaken by one of my investigators. They first visited HMP Whatton on 10 July 2008 where they were shown around the prison and given access to the man's prison records. They met members of the local branch of the Prison Officers' Association (POA) and the Independent Monitoring Board (IMB). (Each prison has an Independent Monitoring Board. IMB members are independent and unpaid. They monitor the day-to-day life in the prison and ensure that proper standards of care and decency are maintained. The IMB produces an annual report on their prison.) Neither the IMB nor the POA had anything specific to bring to my investigators' attention at this time, but both said they would help wherever they could for which I am grateful. Whilst on this visit, my investigator held informal discussions with a number of prison staff who had known the man.
2. Nottingham County Primary Care Trust (PCT) was asked to undertake a clinical review of the care the man received while in custody. A doctor was appointed to carry out this review on their behalf. My investigator asked the doctor to judge specifically whether the care afforded the man was of an equivalent standard to what might have been expected for an 81 year old man if he were not held in custody.
3. One of my Family Liaison Officers contacted the man's son, as his listed next of kin, to discuss the aims of the investigation and to offer the family the opportunity to raise any concerns or questions they wished to be considered in my investigation. The man's son asked about the return of an item of his father's property. I understand this matter has since been resolved. I hope this report helps the man's family better understand the events leading to his death.
4. Once the draft report had been issued, the man's family raised one additional matter which my investigator has endeavoured to answer. When the man's family visited him in hospital, they were distressed at him being looked after on the general ward, with two officers in uniform beside the bed at all times. This made private conversation very difficult. As the family appreciate, it is for the hospital to determine where in a hospital a patient is looked after, but the prison do try and ask for side rooms where possible. In respect of uniform, it is the Local Security Strategy that staff on outside escort should wear uniform for security reasons (to be easily identified in the case of emergencies).
5. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem and the toxicology reports. Upon completion, a copy of my report was sent to the Coroner to assist his enquiries into the circumstances surrounding the man's death. The inquest was held on 25 February 2009. The jury concluded that the man died of natural causes.

HMP WHATTON

6. Whatton is a category C training prison for sex offenders. It currently has capacity for 841 adult male prisoners. Since May 1990 it has held sex offenders who participate in the Sex Offender Treatment Programme.
7. In 2006, new accommodation opened, resulting in an increase in the prison's population and significant changes to the type of offender held. Previously, the prison only took sex offenders who had agreed to address their offending behaviour. Having undergone a large expansion programme, Whatton now accommodates a mixture of sex offenders, many of whom are in denial of their offences.
8. HM Chief Inspector of Prisons, Dame Anne Owers, wrote in her report following an announced inspection in January 2007 that the prison had undergone a period of dramatic and rapid change. She commented that the management of the prison had not had very long to accommodate those changes. Ms Owers said that, "there is much excellent work to build on, but clearly a lot more to do." Her inspection report also said that "care for the disabled and the elderly, was well managed" and that "as a national sex offender resource, managers at Whatton also deserve national support to embed change and overcome the evident teething problems." In June 2008, Ms Owers reported in her follow-up to the thematic review of older prisoners from 2004 that Whatton was the only prison where she found evidence of care plans for older prisoners being written and shared with wing staff. She also commented on the good entries made by discipline staff in wing files about elderly and disabled prisoners.
9. The latest available Independent Monitoring Board's report (for the period June 2006 – May 2007) made generally favourable comments about the prison healthcare services, but raised concerns in two important areas. The first was in the commissioning arrangements from the local PCT. The IMB felt that the PCT fell short of its duty of care at the time. The second area was that of social and palliative care. In their report the IMB said:

"The IMB considers that the social and palliative care in the prison is inadequate. We are in particular concerned about the palliative and social care of terminally ill prisoners – highlighted by the death from cancer of a prisoner earlier this year.

"A second prisoner died from cancer in a local hospice some months later but was only permitted to remain there before his death because the prison management refused to accept him back to the prison.

"A third terminally ill prisoner is currently being held at the prison and is receiving care that is as inadequate as that experienced by the two prisoners highlighted above. Prisoners are asked to look after him and currently he has no means of contacting staff when he needs assistance as his bell is on the other side of the cell to his bed. Officers informed the IMB that 'if he needs help he will shout and

someone will attend'. We question whether this is suitable care for a terminally ill prisoner. We note, however, that the prison is working with the PCT on new palliative care arrangements and are pleased to report that the prison management have negotiated a greater level of care under such circumstances."

Healthcare

10. Healthcare within the prison is provided by Nottinghamshire County Teaching Primary Care Trust (NCtPCT). There is no 24 hour healthcare service in the prison and no medical staff work on site during the evening or overnight. An out of hours service is provided under contract by Nottingham Emergency Medical Service (NEMS).

Previous deaths at Whatton

11. At the time of issuing this report, there had been 16 deaths of prisoners at HMP Whatton since 2004 when I became responsible for investigating all deaths in prison custody in England and Wales. The death of this man is the 13th due to natural causes (in part, a reflection of the number of elderly prisoners held at Whatton). The issue I raise in this report regarding the use of restraints is one I have highlighted in a previous investigation. Aside from this, there are no concerns identified in the man's death that occurred in the other investigations I have conducted to date.

KEY FINDINGS

12. The man was sentenced to 12 years imprisonment on 27 May 2005 at Truro Crown Court and arrived at HMP Exeter the same day. He was transferred from Exeter to Bristol on 2 June and on 2 August arrived at Dartmoor.
13. The man's wing file shows that he settled well at Dartmoor. The file states that he was very active for his age and got used to the prison routine. He started work in one of the workshops and had a good work record throughout his time at the prison. However, he was not prepared to admit the offences for which he had been imprisoned and therefore he could not be put forward for the Sex Offender Treatment Programme (SOTP) or casework. The man was not seen as a problem at Dartmoor and was said to have been polite to staff.
14. Notes in his wing history sheet say that he was interviewed by a psychologist on 23 November and was accepted to go to the new unit at HMP Whatton in March 2006.
15. A note in his wing file of 19 February 2006 said that he was pursuing grievous bodily harm (GBH) charges against certain people from Truro Crown Court, and asking for help from his probation officer regarding his wife selling his house.
16. The man received confirmation on 3 April 2006 that he would be transferring to HMP Whatton in the near future. On 15 April, the wing file notes state that a melanoma (a growth) on the man's forehead was benign and he was very happy about that. (he had been treated for skin cancer in December 2004 and had follow-up appointments with a dermatologist.) However, the notes also say that the man was unhappy about the outcome of proceedings in Truro Crown Court regarding the GBH charges. The wing file states that the man was "a feisty old man who said he won't let it lie".
17. On 4 May, the man was informed that he would be going to Whatton on 10 May. On 5 May, a note in his wing file said that he was unhappy about moving to Whatton. He had applied to see a wing Principal Officer (PO) and he was contacting his solicitor for advice. On 10 May 2006, the man did transfer to Whatton.
18. The man had a spirometry test (a test of his breathing capability) on 22 May which showed him to have mild asthma and a little difficulty breathing. He was prescribed inhalers for this condition.
19. On 29 June, he had chest pain during the night and was assessed by the prison doctor the following day after an electrocardiograph (ECG). The results showed nothing of significance, and the man reported he had felt better after he had taken his inhaler. The prison doctor advised him to return if he had further problems of this nature.

20. The man was seen a number of times by healthcare staff in September and October 2006 because of chest infections. He was successfully treated with antibiotics on each occasion. However, in November, he was also diagnosed with angina following further episodes of chest pain.
21. On 16 November 2006, the man's chest pain was sufficiently severe to require that he be taken to the local hospital. He was admitted to the Queen's Medical Centre in Nottingham where he was diagnosed as having suffered a mild heart attack. Whilst in the hospital, the man developed a chest infection. He remained in hospital until 27 November.
22. The man stayed well for the next few months until, in February 2007, he again started to suffer with infections. He was prescribed antibiotics on 7 February for a chest infection. He also had an infection of the skin of his left leg (cellulitis) which required treatment on 21 February. On 23 February, he was admitted to Nottingham City Hospital because his cellulitis was no better and the prison doctors thought he might have a deep vein thrombosis (DVT – a blood clot).
23. The hospital doctors checked the man for other ongoing medical complaints and, after many tests, diagnosed that he was suffering from Barrett's oesophagus (an inflammation of the lower gullet which is potentially precancerous). He was discharged back to prison on 28 February 2007.
24. A personal officer review on Tuesday 27 March states that the man had no problems on his wing and was looking forward to his solicitor visiting him on Friday. The man was making enquiries into some unresolved issues with his ex-partner. His wing file also says that he was awaiting medication from healthcare but he had said he had been feeling a lot better lately.
25. On 12 May, the man had an incentives and earned privileges (IEP) review and was said to have no problems on the wing and was happy.
26. The man attended the Hand Clinic at Queen's Medical Centre on 21 June where he was seen by a specialist registrar at the hospital. He examined the man's left hand which had developed a lump on the middle and ring fingers. The registrar diagnosed that the man had a flexor sheath ganglion that would be suitable to be removed under a local anaesthetic procedure in a day surgery some time in the future. The man was put on the waiting list for this minor operation.
27. In his wing history report of 23 June, the man is reported as saying he was still awaiting a few health scans. He was due to have the minor operation to remove the lump on his left hand. He was also thinking about an appeal to reduce his sentence and his solicitor was working on this and other issues regarding his ex-partner.
28. The man's blood sugar levels were reported to be high on 1 July. A doctor was telephoned and nursing staff were advised to check his blood sugar levels hourly and then every two hours. The doctor was to be called again if

the man's condition worsened. There is no record of the doctor needing to be called again. On 21 July, it was noted in the man's wing file that his blood sugar levels appeared to be satisfactory at the time. However, according to his medical record, he was referred to the diabetic specialists for consideration of changing his tablets to insulin injections.

29. The out of hours emergency service attended to the man on 29 July because he had a high blood sugar reading.
30. The next healthcare contact was on 6 September 2007 when the man was referred urgently to Nottingham City Hospital for assessment of possibly cancerous skin on his forehead.
31. On 10 September, the man was finally seen by the diabetic nurse specialist, and prescribed insulin injections. The injections began on 17 September, following some initial teaching and training on how to self-administer insulin. Checks on 23 October found that he was doing well with his new prescription. However, because of concerns about his diabetes, the local hospital had taken him off the list for proposed hand surgery. He was put back on the list on 9 January 2008.
32. An officer met the man on 14 January 2008 for an interview and OASys review. (OASys is the Offender Assessment System which is used by the Observation, Classification and Allocation department as part of the sentence planning process. It is a risk assessment tool to make proper assessment of needs, and to assist staff with selecting an appropriate prison for a sentenced prisoner.) At the interview the man maintained his innocence and therefore it was difficult to discuss targets relating to offending. The man also asked to move back to Dartmoor because his family lived in Cornwall and he did not receive any family visits whilst at Whatton. The wing record states:

“He is 81 years old and does not enjoy good health. He states that he does feel a bit DOWN sometimes due to no visits. He would like to maintain contact and visits with family but it is difficult here.”
33. The man was seen on 16 January by the skin specialist at Nottingham City Hospital, and diagnosed with skin cancer (a basal cell carcinoma).
34. Two weeks later, on 29 January 2008, the entries in the man's wing history record say that he was in a good mood as he had been accepted by Dartmoor.
35. Throughout February, March and April, he was still waiting to be moved to Dartmoor and it was noted that he remained a well behaved prisoner and was polite to staff.
36. On 9 May, an entry on the man's wing file states that he was worried about the cancer growth on his face and it appears that he had been awaiting an appointment for five months. An officer informed his healthcare colleagues about the delay and they undertook to look into the matter. Later that day, the

man was seen by the nurse on the unit and listed to see the doctor the following week. The man's medical notes also show an entry on 9 May that says "Chronic kidney disease stage 3" entered by the prison doctor.

37. The prison healthcare administration department telephoned Nottingham University Hospital to pursue the man's referral by the consultant dermatologist.
38. On 5 June, a Governor received a telephone call from a friend of the man who was worried about the man's medical problems. The man was seen and he assured staff that he was fine. An officer received a further call from the same friend who accused staff of failing to give the appropriate care and attention that was expected.
39. In the early hours of the morning of 6 June 2008, the man collapsed in his cell. The out of hours service was contacted and advised that paramedics should be called. The paramedic team arrived at 6.30am and treated the man, but did not consider he needed admission to hospital. Nursing staff saw him later that morning and noted that he was still experiencing chest tightness and pain. The nursing staff thought he might have a chest infection and, because his inhalers had run out, had been unable to relieve his symptoms. They saw him later that day when he felt much better.
40. However, the paramedics were called to see him again the following morning at 7.15am. They diagnosed possible angina and a chest infection, and started antibiotics following a telephone consultation with the local out of hours doctor.
41. On 8 June, the man reported to the office and said he had coughed up blood in the morning. He was given the opportunity to attend healthcare but declined.
42. The man was seen by the doctor on 26 June, and diagnosed with another chest infection, possible cardiac failure, and also that his kidneys were not working as well as they should. He was given medication to rectify all these problems. He was reviewed and treated by the prison doctor on 30 June when he had a hypoglycaemic attack (a diabetic low sugar problem). This was the first time he had had such a problem (previously his diabetic problems had been caused by too much sugar in his system).
43. Wing staff called nursing staff to come and visit him on the morning of 2 July. He felt sick and dizzy, but was otherwise alert and well. The nursing staff called upon the services of the community paramedic team who found, following a tracing of his heart, that he had "no acute changes, though does have some flipped T waves. No specific reason for acute admission." (This means that the paramedics had carried out an ECG but they were not unduly concerned by the results and were happy not to admit the man to hospital, preferring instead that he should be reviewed by the doctor at Whatton later.)

44. A prison doctor reviewed the man later that morning, and decided that he should be in hospital. She therefore made arrangements for his admission to Queen's Medical Centre in Nottingham.
45. On 7 July, one of the officers taking part in the man's bed watch told my investigator that, even though he was not the man's personal officer, he knew him pretty well. (A bed watch is an escort to hospital whereby a prisoner is accompanied by Prison Service staff and admitted to a hospital bed.) When this officer was asked in interview how the man had seemed whilst in prison, the officer replied:
- "In my opinion he was fairly mobile. He made his own way to the servery to get his own tea, his own lunch, active enough for his age I would say. It was noted maybe his health was normal of an 83 year old. From my recollection he pretty much stayed watching TV and associating on the landing."
46. The officer told my investigator that he arrived at Ward D55 at Queen's Medical Centre about 6.50pm on 7 July, where he saw other officers, one of whom was due to do the bed watch with him. He noticed that this officer was in possession of the escort chain which was in his hand and gave an indication that something unusual had occurred. (An escort chain is a long chain with a handcuff at both ends. The officer is attached to the prisoner via this chain to enable the use of a toilet or to allow medical examinations when the prisoner is in hospital. It is often used when a prisoner is confined to bed in hospital to allow greater freedom of movement.)
47. The two officers leaving duty told the two remaining officers that the man's health had declined at about 6.30pm and they had requested permission to take off his escort chain as the medical staff needed to gain access to treat him. Through a gap in the curtain round the man's bed, the officer could see that the medical staff were quite busy attending to the man's care. The officer told my investigator that he decided to telephone the prison to ask that the cuffs be removed for the rest of the night. The officer could see that the cuffs would need to be taken off later and did not want to delay the process of care that the man was receiving.
48. The officer said that he spoke to a Principal Officer at the prison who informed him that permission had been granted by a Governor. It was part of the PO's duties as the Orderly Officer for the day (the senior uniformed officer in charge of the prison at the time) to give advice and guidance to more junior staff such as the officer on the bed watch.
49. The bed watch officer told my investigator that at about 7.30pm it became apparent to him that the man's health was declining further as more medical staff had started to work behind the curtain. The officer said:
- "... I could hear people trying to, they were saying things like 'come on', 'try and wake up', 'are you with me', so there was something going on there. And about 7.50pm, it seemed to go a bit quiet. Then some

medical staff came behind the curtain and I remember there was a charge nurse or one of the nurses there, he informed me that they'd failed to resuscitate the man and that they would get the doctor down to confirm that."

50. When the duty Governor was informed of the man's death, he arranged for staff involved in the care of the man to return to the prison where a debrief was arranged. The officers from the bed watch, together with the Governor and the night orderly officer, attended the debrief. Staff were offered the opportunity to see the staff care and welfare team at this debrief and the offer was repeated in the days that followed the man's death. A notice to inform prisoners of the death of the man was issued by the governor on 7 July and displayed on the various wings in the prison.

ISSUES

Concerning the man's clinical care

51. The doctor reports in his clinical review that:

“The medical care of this man at HMP Whatton was on the whole appropriate. The man had multiple medical problems. He required regular routine follow up appointments at healthcare for his ongoing diabetic, cardiac and asthma needs. He also required emergency input whenever he suffered a relapse of his chronic conditions.”

52. The doctor's only criticism is in relation to the length of time it took for the man's referral to the local diabetic nurse specialist team to be acted on. It took from 12 July 2007, when the referral letter was written, until 17 September when the man had his first insulin injection.

“If there can be any criticism, then it is with the commencement of insulin therapy, which was protracted. However, this had no bearing on his death. Indeed, at the time of his last illness his average sugar, blood pressure and cholesterol were all well controlled and within the target levels for his condition.”

53. The doctor writes that prison healthcare staff should be trained to manage prisoners with diabetes, and especially those who are recently diagnosed. At the moment the prison relies on external diabetes specialists and he recommends that prison healthcare staff receive appropriate training.

The healthcare department should consider having some of its staff trained to a higher level to allow them to give better care for diabetics, including those prisoners newly diagnosed.

54. There is a similar theme of delay when it comes to the man being followed up by the consultant dermatologist. The man was seen on 16 January 2008 and diagnosed with a basal cell carcinoma on his forehead. The letter received by Whatton on 24 January says: “His histology and reports from previous excisions and previous radiotherapy suggest that this is going to be a difficult lesion to treat and I have arranged for him to come into our multi-disciplinary clinic to be discussed with the plastic surgeons, as he may well need inpatient treatment with general anaesthetic to remove the tumour. I will let you know the outcome of that discussion.”

55. Nothing happened until early May when an entry in the man's wing history sheet reports that he was concerned about the cancer on his forehead. Prison staff asked healthcare staff what was happening about his appointments. Healthcare staff then tried a number of times to follow up the enquiry with the local hospital. Despite their efforts, the man was not actually seen before his death. The Clinical Review doctor was unable to ascertain exactly why the delay occurred. However, I observe that, had the healthcare record system at Whatton been more sophisticated, the absence of further

information from the Consultant Dermatologist would have been noticed long before May. I hope the recent introduction of an electronic records system at Whatton will mean this type of problem will not recur in the future.

Concerning Prison Service related matters

56. There is also an apparent time lapse in respect of the man's transfer to HMP Dartmoor. The man appears to have first requested a move back to Dartmoor on 14 January 2008. He heard that he had been accepted by Dartmoor on 29 January, but does not appear to have learned anything more before his death on 7 July.
57. My investigator spoke with Prison Service Headquarters Population Management section, and the allocations department at Whatton who handled the man's request for a transfer to Dartmoor. Both departments said that the man's move was dependent upon a place being available at Dartmoor, and none became available for the man in that time. Whatton's allocation centre also made the valid point that the man was undergoing frequent hospital attendances which might have had a bearing on his circumstances.
58. All of this may be true but, having accepted that it was appropriate for the man to move back to Dartmoor on grounds of being closer to his family, I judge that it took the Prison Service too long to arrange the transfer. I am all too aware that the prison population is extremely high, and that pressures on individual prison places can be acute. Nevertheless, the man was an 81 year old, far from his family, and unable to receive visits. I do not think it was acceptable that he was left waiting more than six months for a transfer.
59. Population Management added that the man could (and perhaps should) have been offered the opportunity to be transferred to Exeter for a short period of accumulated visits. Prisoners on accumulated visits return to a local prison near their home so that their family can make a number of visits to them in a concentrated period of time, usually a month. It does not appear that this option was considered for this man.
60. In other reports, I have reflected extensively on the issue of the use of handcuffs for prisoners who are elderly, frail or very unwell. The man was transferred to hospital on 2 July under restraint. He was maintained on a bedwatch, with two members of staff, and had an escorting chain applied for much of his stay in hospital. On 7 July, the day of the man's death, an officer came on bedwatch duty and:

“... noticed that [another officer] was in possession of the closet chain and that it was in his hand and this gave him [the reporting officer] an indication that something unusual had occurred. [The officer's going off duty] told him that the man's health had declined at about 6.30pm and that they had requested permission to take off his handcuffs as the medical staff needed to gain access to help him [the man].”

61. My investigator enquired if the prison has a protocol for considering the removal of handcuffs during external escorts to hospitals. I have investigated and reported on a previous occasion on the use of restraints for prisoners at Whatton. I recommended then that changes in a prisoner's circumstances should lead to new risk assessment being completed. In this man's particular circumstances, an escort risk assessment form was completed when he first went to hospital. I could find no evidence that the initial risk assessment was formally reviewed when it became clear he would be staying in hospital. At that point, prison staff had more time to make an informed decision about the real risk he posed.
62. My investigator spoke with the duty governor of the day who gave permission for the removal of restraints on the afternoon of 7 July 2008. He told my investigator that it had been done because of a request from the hospital staff to undertake medical interventions on the man. These interventions would have been made more difficult with the presence of an escorting chain. His understanding was that the removal of restraints was to be a temporary measure. He expected the chain to be replaced at some point, once the medical staff said they did not require further interventions to be made. As it happens, it is unclear whether the chain was ever re-applied, but the principal reason for removal was for a medical intervention – not a consideration of dignity and decency, balanced with risk.
63. Policy and practice in the Prison Service regarding the use of restraints on prisoners in hospital is extremely cautious, and I am aware that the balance between decency and security can be a difficult one to find. The nature of this man's offences would, of course, have needed to be considered, particularly in relation to his risk to the public. Nevertheless, my own sense is that the Service has become too risk averse and that an elderly man with limited mobility, in serious ill health, and with no geographically close relatives or associates, did not constitute a remotely likely escapee. (I am certainly not aware of any specific evidence to suggest the man was an escape risk.)
64. I do understand the decision taken by Whatton given the prevailing climate and the expectations of the Service as a whole. However, I also wonder whether the staff undertaking the managerial bedwatch checks are able to balance risk and concern for decency at the end of life in a timely manner. I judge that restraints could have been safely removed sooner, and that the presence of two prison officers would have been an adequate safeguard for the public. I therefore repeat my earlier recommendation (in a revised format to meet this man's circumstances).

A full risk assessment, including an assessment of the use of restraints, should be prepared by staff and considered by the Duty Governor when a prisoner is admitted to outside hospital, and should be reviewed at least every 24 hours or when the prisoner experiences a significant change in circumstances.

65. Although I criticise the decision to keep the man restrained until the last day of his life, I also recognise that staff at Whatton were compassionate and caring

in respect to most other aspects of the man's care. They looked after an elderly man through many illnesses with kindness and consideration for his condition. They engaged him in appropriate activities, and treated him with respect. I am sure this is in part due to the systems in place at Whatton that were commended by Dame Anne Owers in her recent follow-up review.

RECOMMENDATIONS

The Prison Service accepted the draft report recommendations with the following comments:

1. The healthcare department may wish to consider having some of its staff trained to a higher level for diabetes initiation therapy.

One nurse has already completed training and another started in January 2009.

2. A full risk assessment, including an assessment of the use of restraints, should be prepared by staff and considered by the Duty Governor when a prisoner is admitted to outside hospital, and should be reviewed at least every 24 hours or when the prisoner experiences a significant change in circumstances..

The current policy is for a risk assessment to be carried out prior to a prisoners discharge to hospital. The use of restraints and the staffing level of the escort is considered at this point and also includes consideration for any comments recorded on the assessment by a member of the healthcare department. This is approved by either the Head of Operations or the Duty Governor. Once the escort becomes a bedwatch a management check is carried out during each 24 hour period. During each management check consideration is given to the level of restraint required and to releasing the prisoner on temporary licence. In light of the recommendations by the PPO a review of our procedures is to take place. The conclusions from this review will be included as an instruction in the prisons LSS [Local Security Strategy].