Investigation into the circumstances surrounding the death of a male prisoner on 12 October 2006 in hospital, while in the custody of HMP Gartree

Report by the Prisons and Probation Ombudsman for England and Wales

November 2007

This is the report of an investigation into the circumstances surrounding the death of a male prisoner. It raises some significant issues.

The man died on 12 October 2006 in hospital, while a prisoner in the custody of HMP Gartree. He had been admitted to hospital on 10 October after complaining of abdominal pain. The hospital discovered that the man was suffering from peritonitis as a result of a perforated bowel, but he was too ill to undergo surgery and died two days later.

I would like to offer my condolences to the relatives and friends of the man who died. He was an elderly man who had been in poor health for some years. Nevertheless, his relatively sudden death came as a shock to his wife and family. Losing someone while they are in custody only adds to the pain of any bereavement.

The investigation was led by one of my investigators. One of my family liaison officers contacted the man's family to ask them if they had any questions or concerns about his death. In addition, an independent review into the man's medical care and treatment was undertaken by a local GP. I am most grateful to this GP for his assistance. I am also grateful to the Governor, staff and prisoners of Gartree prison for their co-operation with this investigation.

The clinical review makes seven recommendations and highlights a particular concern about the triage policy in operation at Gartree. Although the delay in taking the man to hospital cannot conclusively be said to have hastened his death, there is a real concern that healthcare staff are making diagnoses and prescribing treatment they are not qualified to make. I am also very critical of the fact that the man remained chained to one of his escorting officers until some 35 minutes before he died. He was gravely ill throughout his brief stay in hospital, and I consider that use of the escort chain in these circumstances was unnecessary and distressing for the man who died, his family and the attending officers.

I make six further recommendations endorsing those arising from the clinical review and addressing the issue of the use of restraints on prisoners during hospital escorts and bedwatches.

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SUMMARY

The man who is the subject of this report was 80 years of age when he died. He had been sentenced to life imprisonment in 1999 with a minimum time to serve of ten years. He suffered from numerous chronic medical conditions, including heart disease, lung disease and diabetes, and used a wheelchair. He was transferred to HMP Gartree in March 2001 and was initially located on the healthcare centre before being moved to a specially adapted cell on G wing in June 2005.

On 6 October 2006, the man complained of abdominal pain and vomiting. Several prisoners and staff were concerned about his condition. He was seen by a member of healthcare staff on the same morning and diagnosed as suffering from food poisoning. He was seen again on 7 and 8 October by the same member of staff, and on 9 and 10 October by another healthcare officer. The initial diagnosis of food poisoning was not changed and the man was not referred to a more senior member of the healthcare team. Despite the fact that the man was complaining of severe abdominal pain, neither of these members of staff performed an abdominal examination. Both are trained mental health nurses.

On the morning of 10 October, the man was found to be in a “dire” state. At 8.40am, he was referred to hospital and was taken to the healthcare centre while the prison waited for a hospital bed to become available.

The man was taken to a local hospital at 12.30pm where he was diagnosed as suffering from peritonitis as a result of a perforated bowel. He was considered by the hospital doctors as too ill to survive an operation. His wife visited him on Wednesday 11 October and he died at 9.37am on 12 October. The post mortem gave the causes of death as peritonitis, perforated small bowel diverticulum, ischaemic heart disease and chronic obstructive pulmonary disease (lung disease).

The clinical review makes seven recommendations which I endorse. In particular, I draw attention to the comments made about Gartree’s triage policy. The review concluded that this system had failed the man who died in that the severity of his illness was not discovered for some five days. The review also concluded, however, that an earlier admission to hospital would not have prevented the perforation of the man’s bowel and, given his underlying chronic medical conditions, would have been extremely unlikely to have prevented his death.

Apart from three brief periods on 11 October, the man was chained to an escorting officer with an escort chain until some 35 minutes before he died. Circumstances such as these are distressing for the deceased, their family and the officer who remains chained to a dying person. I make a recommendation to the Governor of Gartree that she review the prison’s guidance to staff to bring it in line with the requirements of the National Security Framework (NSF). I also make a national recommendation to the

Prison Service to review the NSF to give guidance on the removal of restraints from dying prisoners on compassionate grounds.

THE INVESTIGATION PROCESS

1. I was notified of the man's death on 12 October 2006. Notices were issued to staff and prisoners at Gartree telling them that an investigation would be taking place and inviting those who wished to see the investigator to make themselves known. The Coroner was contacted and a copy of the Post Mortem report was requested and received.

2. My investigator visited Gartree on 17 October 2006. She met the Governor, and a representative from the Independent Monitoring Board. She was provided with the prison record of the man who died, and copies of the notices, reports and other records associated with his death. She visited the wing and saw the man's cell and spoke informally to some prisoners and staff. My investigator had a long telephone conversation with the Head of Healthcare at Gartree on 19 October.

3. On 6 November, my investigator received a letter from a prisoner at Gartree telling her that several prisoners would like to speak to her about the man's death. She spoke to this prisoner on the telephone on two occasions. She then visited Gartree on 28 November and interviewed eight prisoners.

4. A clinical review of the medical care of the man who died while he was a prisoner in Gartree was commissioned from Leicestershire County and Rutland Primary Care Trust. A local GP conducted the clinical review.

5. One of my family liaison officers contacted the man's family. My family liaison officer and my investigator subsequently visited the man's wife, eldest son and daughter in law.

6. The man's family was concerned that the hospital had not made it clear to them how ill he was when he was admitted on 10 October. Only his wife had visited him in hospital before he died, and the family was upset as they said they would have all visited had they known how ill he was. The man's daughter in law was disappointed that, when she had called the hospital to find out how ill he was, a nurse had passed her on to one of the prison officers escorting her father in law.

7. The man's family was concerned that he had been ill for some time and should have been admitted to hospital earlier. They thought he had been feeling ill since Friday 6 October. His wife said she had been worried because he always rang her every evening, but she had not heard from him during the week before he was admitted to hospital.

8. The man's wife was also upset that her husband had been "chained up" while in hospital. The family expressed surprise that this had been necessary as the man had been unable to walk, had been attached to several tubes and had needed an oxygen mask to breathe. The man's wife said that the escorting officers had obviously been uncomfortable

with the “chains”, and one of them in particular had been very keen to take them off.

9. The man’s family said that prison staff had attended his funeral and had brought a wreath. The prison’s family liaison officer had been helpful and had offered practical assistance. They had found it especially helpful to visit the prison and see the man’s cell. His family said they had been touched by the concern of the other prisoners and a wreath that one of them had placed on his cell door.

HMP GARTREE

10. Gartree is a category B prison whose principal function since 1997 has been to accommodate and rehabilitate adult male mandatory life sentence prisoners. The average tariff (minimum time to serve) for these prisoners is 15 years. Around 18 per cent of the population now consists of prisoners sentenced to indeterminate sentences for public protection.

11. Gartree is part way through a major refurbishment which will continue for the next two years. When complete, it will give Gartree a certified normal accommodation of some 680 prisoners and make it the biggest lifer centre in Europe. The rebuilding project and the associated disruption has caused some uncertainty among staff and prisoners, and staffing levels have been lower than expected for some years. Staffing levels have recently begun to increase and the Governor told my investigator that the psychology department alone now stands at 43 members. Gartree runs more courses for prisoners than any other prison in the country, although the waiting lists for these remain very long.

12. The death of the man who is the subject of this report was the second of five deaths to have occurred at Gartree since I was given the responsibility for investigating all deaths in prison custody in April 2004. In my investigation into the first death, the clinical reviewer made similar comments to those of the GP in the current case about the difficulties of understanding prisoners' medical records at Gartree. At the time of writing this report, the clinical reviews into the other deaths were not available.

KEY FINDINGS

From 6 October until the man was taken to a local hospital on 10 October

13. The man who died first complained of feeling ill on 6 October 2006. His medical record shows he was seen by a qualified mental health nurse (RMN). The man complained of vomiting and stomach pain and was diagnosed with food poisoning. In the GP's clinical review, he says that the RMN recalled in interview that the man said he had eaten some pilchards which had been kept in his cell unrefrigerated for four days. There is no formal record of this. The man's pulse, blood pressure, respiratory rate and temperature (his 'baseline observations') were taken and found to be normal.

14. On 7 October, wing staff contacted the healthcare centre after the man complained that he was still being sick and still had abdominal pain. They called the healthcare centre an hour later because the man's condition was worsening. The man was seen on the wing by the RMN again and was reassessed. The man said that he had drunk plenty of water and was given sachets of oral rehydration powder. His baseline observations were taken and found to be normal. He was advised to stay in bed and alert staff if he felt worse.

15. The man's medical record shows that he was seen again on 8 October by the same RMN. The only detail of the assessment is that his baseline observations were again normal.

16. On 9 October, a second RMN was on G wing assessing another patient. Wing staff asked her if she would see the man. The second RMN wrote in the man's medical file, "still complaining of D + V [diarrhoea and vomiting], given more dioralyte [oral rehydration powder], to see doctor in morning." In interview, she told the GP who conducted the clinical review that the man's baseline observations were taken and were normal, but there is no record of this on his medical file. The second RMN told the clinical reviewer that she remembered contacting the first RMN and accepting his diagnosis of food poisoning. The second RMN said she was happy with the man's clinical condition and did not feel the need to involve more senior staff.

17. On 10 October, the man was seen again by the second RMN at 8.40am. His condition was described as "dire" with pallor, sweating and difficulty in breathing. He was referred to hospital and taken to the healthcare centre where he received oxygen therapy. He was taken by ambulance to a local hospital at 12.30pm when a bed became available.

The man's time in hospital between 10 and 12 October

18. Once the man had been referred to hospital, a hospital risk assessment form was completed at Gartree. This is a standard form which must be

completed in all cases when a prisoner is escorted to outside hospital. Its purpose is to ascertain the appropriate level of escort and type of restraint to be used. In the section to be completed by prison medical staff, it is recorded that there were no medical objections to the use of restraints in the case of the man who died. There is a note to the effect that a "closeting chain" should be used if possible. (A closeting chain is otherwise known as an escort chain. It is a length of chain attached to a single handcuff at each end. The prisoner wears one cuff and the escorting officer wears the other.) The security assessment was that the man represented a medium risk to the public, no risk to staff, a medium risk of taking a hostage and a medium risk of escape. The escort conditions were that the man should be accompanied by two members of staff and that restraints should be used at all times. The reason for this was recorded as "cat B prisoner serving life sentence." This level of escort and restraint was confirmed by the Head of Operations who wrote on the form:

> "Use of escort chain due to his mobility and illness. Staff to consult D/Gov [Duty Governor] if removal required."

19. The Prisoner Escort Record (PER) completed on 10 October shows that the man arrived at the hospital's Clinical Decision Unit at 1.10pm. The section on risk categories on the front of the form shows indicators for "medical condition" and "violence". The medical condition was explained as "heart". The indicator for violence was added because the man had been convicted of a violent crime (murder). The record of events section on the PER form shows that the man was seen by a doctor at 4.00pm, and that the doctor told the escorting staff that the man would be in hospital for "at least 24 hours" whilst tests were completed. The PER form shows that at 5.15pm the man had a catheter inserted. At 6.00pm, the escorting officers started a hospital bedwatch form. At 6.40pm, the man had x-rays taken and at 8.25pm a nasal tube was inserted.

20. A second hospital risk assessment form was completed by the Duty Governor, on 11 October. It is not clear at what time this was completed. The Duty Governor wrote that the escort chain was to be used at all times and should only be removed in a medical emergency or for routine treatment and with the permission of the Duty Governor. Family visits were to be allowed. The man was again assessed as presenting a medium risk to the public and a medium risk of escape. The reason for the use of restraints was given as "cat B prisoner serving life for murder", and the reason for the use of the escort chain as "due to illness and infirmity".

21. At 8.45am on 11 October, the man was seen by the surgeon and told he would be having a scan. The escort staff obtained permission from the Orderly Officer at Gartree to remove the escort chain during the scan, which took place at 10.25am. At 11.35am, the chain was again removed briefly with the permission of the Duty Governor to allow the man to have blood tests. At 1.35pm, the man received permission to call his wife.

The record shows he told her which ward he was on. At 2.30pm, he was visited by a worker from Age Concern and also saw the surgeon. The worker from Age Concern called the hospital at 3.30pm to confirm that the man's wife would visit at about 5.00pm.

22. At 4.45pm on 11 October, the bedwatch log shows that the surgeon told the man that he had suffered a "twisted bowel" and that there was a "very high" risk that he would die if he had surgery to correct it. The record shows that the man agreed to talk to his wife about the situation and would then make a decision about whether to have an operation or not.

23. The man's wife arrived at 5.15pm. The man is recorded as becoming agitated after being told the implications of surgery and at 6.20pm the escort chain was removed when he pulled out the tubes he was attached to. He then appears to have had a heart scan and the chain was replaced some 15 minutes later.

24. The man's wife told my investigator and my family liaison officer (FLO) that her husband was struggling to breathe when she visited and was wearing an oxygen mask. She said he found it difficult to talk and had "lots of tubes in him". She said she thought hospital staff thought that he would not survive an operation. She said her husband had wanted to go ahead with surgery and she had been asked about consent.

25. At 7.00pm, the surgeon told the man that he intended to insert a wire "to control heart rate before attempting any further operation". At 8.00pm, the man was again seen by the surgeon who explained to him all the risks of undergoing an operation. The man signed the necessary consent form. Throughout the rest of the evening he underwent further tests and was given morphine to ease the pain he was in.

26. At 12.45am on 12 October, the surgeon told the man who died that he was too unwell to undergo surgery. The GP who conducted the clinical review told my investigator that the hospital records showed that, although the surgeon was willing to operate on the man, the anaesthetist refused on the grounds that the man's heart condition meant he would not survive the operation.

27. At 4.00am, an entry shows that the man's wife was informed that her husband was very unwell. It is not clear whether it was prison or hospital staff who made this call. The man's wife told my investigator that she was called in "the middle of the night" but that she was very drowsy as she had taken a sleeping tablet. The man's wife speaks relatively little English and she said that she did not understand that her husband was dying. She said she thought that the hospital told her to come in the next morning.

28. The hospital bedwatch log shows that the man who died was seen by a doctor at 8.24am who decided he should be moved to a side room. At

9.00am, another doctor asked that the escort chain be removed and permission to do so was given by the Duty Governor. The log shows that the prison was trying to contact the man's wife. The hospital chaplain came to the man's bedside at 9.31am. At 9.37am, the man was pronounced dead.

WHAT OTHER PRISONERS SAID

29. My investigator spoke to a number of the man's fellow prisoners. In interview, one prisoner said he had been on G wing "near enough since it opened" and had known the man who died since then. This prisoner is a wheelchair user and occupies the other specially adapted cell on G wing next door to the cell in which the man who died was located. The prisoner said that he spoke to the man who died on Thursday 5 October and he "was not quite himself". On 6 October, he remembered the man complaining of stomach pains. During the night of 6 or 7 October, he remembered hearing the man groaning loudly and coughing. He said he pressed his cell bell and asked the night officer to check on him. The night officer reassured him that healthcare staff knew the man was ill and he was under the impression that a doctor might have visited the man who died during the night. The prisoner who I spoke with said he saw the man who died on Sunday morning and noticed his stomach was very swollen. He said the man was in so much pain he could not speak.

30. The prisoner who my investigator spoke with said that he knew that healthcare staff thought that the man who died had food poisoning. By Monday 9 October, the man's stomach was "like a whale" and several prisoners were asking staff to do something to help him. He said the man looked very unwell before he went to hospital on 10 October. Prisoners were angry when they heard that he had died because they thought something should have been done for him sooner.

31. A second prisoner who my investigator spoke with said he had known the man who died for 16 months since G wing opened. He said the man had been very ill for five days before he died and had not come out for his meals which was very unusual. He said the man had complained about pains in his stomach and he had seen him holding his lower stomach.

32. A third prisoner who my investigator spoke with said the man had complained of feeling unwell about four days before he went to hospital and had looked "really unwell". This prisoner said that the healthcare department were good at sending staff out to the wings to see prisoners who were ill, but these staff were usually triage nurses and he thought that it would be more appropriate for more senior medical staff to be sent. He described his own experience of the triage system which involved seeing a nurse four times before being sent to see the doctor. He said the doctor diagnosed irritable bowel syndrome (IBS) but his symptoms persisted. He saw a triage nurse a further two times before he was referred to the doctor again. The doctor then referred him to outside hospital where he was diagnosed with diverticulitis. This prisoner added that, while he was in outside hospital, he had undergone an endoscopy while chained to a member of staff by an escort chain. He said that the doctor had asked the escort staff to remove the chain because he was to be sedated but staff had refused.

33. A fourth prisoner who my investigator spoke with said he had known the man who died since G wing opened in July 2005. He said that "about a week" before the man was taken to hospital he had taken some library books to him. The man had complained that he was not feeling very well. Over the following three or four days, the man did not come out of his cell and staff told the fourth prisoner that he was "resting". This prisoner said he heard the man moaning frequently because he had the cell directly below him.

34. A fifth prisoner who my investigator spoke with said he had known the man who died for about a year and had helped him clean his cell and change his bed. This prisoner said the man had been ill for five days before he was taken to hospital. He said he saw a nurse visit him once or twice during the five days, but thought that once it was "by chance" because the nurse had come to see another patient. This prisoner said that the man looked very ill and his face had changed completely. He said he was eating little and his stomach had become very swollen. Staff told him the man had food poisoning.

35. Three other prisoners who were interviewed told my investigator that the man who died had been ill for about five days before he was taken to hospital.

ISSUES CONSIDERED DURING THE INVESTIGATION

Medical record keeping at Gartree

36. In his clinical review, the author said the quality of the man's medical records was poor. He said there was no logical order to the filing system, and he found it difficult to find any relevant information regarding a particular condition without reviewing all the entries. Although the majority of clinical entries were appropriately dated, they were not always legible. This problem was compounded by the fact that staff signed the entries but did not also print their names. The author also commented on the large amount of non-clinical information filed in the man's medical record. He found that this made it even more difficult to follow the threads of the man's medical treatment. The problem of illegible signatures, and the difficulty of following the chronology of events in the medical record, are also raised by the clinical review in my investigation into Gartree's previous death from natural causes. As that review pointed out, "accurate, informative, contemporaneous and legible records are essential to support communication between staff and improve patient care."

37. The author also commented that the man who died did not appear to have undergone a healthscreen on arrival at Gartree. The man did arrive with a detailed summary from the medical officer at his previous prison (Whitemoor), but this does not seem to have been collated or referred to when the man experienced further ill health at Gartree. Although an elderly man with a long history of poor health, his GP records were not requested by Gartree, or by either of his previous prisons. The clinical reviewer concluded that staff at Gartree failed to appreciate that the man suffered from a chronic heart condition. For example, on four separate occasions between July 2002 and January 2004, episodes of shortness of breath were treated as asthma despite the summary provided by Whitemoor clearly stating a history of chronic obstructive airways disease and chronic heart failure. The clinical reviewer has indicated these were a more likely cause of the man's symptoms.

38. The clinical reviewer concluded that the poor record keeping at Gartree, and a lack of patient summaries from previous prisons and the prisoner's GP, undermines the ability of healthcare staff to adopt a co-ordinated approach to the treatment of chronic medical conditions. In this case, the man arrived at Gartree with chronic medical conditions of some years standing. As he was at that stage relatively new to the prison system, it would have been wise to have requested a summary from his GP.

The treatment of the man's chronic medical conditions

39. As noted above, the clinical reviewer concluded that healthcare staff at Gartree did not appear to be aware that the man suffered from chronic heart disease. The author also judged that, during the man's time in Gartree, the management of his diabetes and chronic obstructive airways

disease fell short of the National Institute of Clinical Evidence (NICE) guidelines of 2002 and 2004 respectively. The man who died does not appear to have had the required blood tests to check his diabetes control and cholesterol levels, or had the required retinal screening to monitor eye damage caused by diabetes. It is possible that some of the treatment and interventions for which the man should have been considered were in fact considered, but it is not possible to establish this from his medical record.

40. However, the clinical reviewer noted that, until 2005, GP provision at Gartree was provided on a sessional basis and the visiting doctors did not hold responsibility for chronic disease management. The author believes that nursing staff at Gartree have shown great dedication in the last few years to introducing a number of chronic disease registers and clinics, but they have been hampered by insufficient clinical input and leadership. The author concluded that the situation has improved since the tendering process for medical services in 2005. He has suggested that Gartree develop an annual audit system to demonstrate equity of service with a GP practice.

41. The clinical reviewer concluded that, for a variety of reasons not all directly under the control of the nursing team at Gartree, the treatment of the man's chronic medical conditions in prison fell below that he could reasonably have expected to have received in the community.

The treatment of the man's recent medical conditions

42. The clinical reviewer concluded that the details of the assessment and treatment of the man's recent medical conditions – those which appeared after he was transferred to Gartree – were appropriate. The man's referrals to clinics were timely and apposite and, for the new complaints, his medical treatment was comparable to that which he would have received in the community.

The treatment of the man's final illness

43. The clinical reviewer raised several concerns about the triage policy in operation at Gartree. This policy was introduced in 2005 with the aims of making sure that prisoners who are ill are sent to the appropriate practitioner, and ensuring a more effective use of scarce healthcare resources. I agree with the author that the founding principles behind this policy are laudable, and I commend what he found to be "the enthusiasm of the staff to react to the unique pressures of the Prison Service". I note also that one of the prisoners interviewed by my investigator confirmed that staff are quick to attend sick prisoners on the houseblocks. However, the author concluded that:

> "The system failed in the case of the man who died as the presumed diagnosis of food poisoning, which was likely from the history of unsafe food storage, was not balanced against the

many possible causes of abdominal pain and vomiting. The staff making assessments did not have sufficient clinical knowledge of alternative diagnoses, nor understand the implications of the man's chronic medical conditions, nor hold the clinical skill to make a full examination to support the diagnosis."

The clinical reviewer judged that there was some doubt that the man who died had had episodes of diarrhoea which made a diagnosis of food poisoning less likely. Neither member of staff who examined the man between 6 and 9 October performed an abdominal examination which was required to exclude surgical causes of abdominal pain and vomiting. The man did not have a chest examination. Moreover, given his history of chronic heart failure, poor oral intake would have affected the absorption of his daily medicines.

44. I am very concerned by the conclusion of the clinical reviewer, namely that neither of the assessing healthcare staff had the medical knowledge or the clinical skills to make a proper diagnosis in the case of the man who died. Although the Gartree triage policy itself correctly identifies the training and experience necessary for staff to undertake triage, these requirements have not been met. In this case, the healthcare officers who assessed the man were qualified mental health nurses and have not had the experience or training in minor ailments and prescribing required by Gartree's own policy document.

45. The admitting consultant at the local hospital told the clinical reviewer that, once the perforation of the man's bowel had occurred, the outcome for him would have been grave due to his underlying medical conditions. It is therefore impossible to tell whether the delay in taking the man to hospital contributed to his death. It is also the case that the man's final diagnosis was obscure and not readily apparent to hospital staff. Although this in part excuses the delay in taking him to hospital, the underlying concerns about the inadequacy of the triage system remain. Unless these are speedily addressed, I fear the outcome in other cases may indeed prove fatal. I judged this issue to be of sufficient concern that I raised it with the Governor of Gartree prior to the publication of this report in draft.

46. The clinical reviewer made seven recommendations (listed in the recommendations section below) which address the issues of patient summaries, the management of chronic diseases, staff training, the triage policy, the out of hours service and the unacceptable drain on healthcare resources caused by 12 out of the 14 in-patient beds in the HCC being used as a solution to overcrowding on the houseblocks.

I endorse the recommendations of the clinical reviewer and recommend that the Governor of Gartree ensures that a comprehensive review of his report takes place within three months of the publication of this PPO report.

I recommend that, within this review, consideration of the triage policy should take place as a matter of urgency and measures put in place to ensure that staff who are required to operate it have up to date and appropriate training in identifying minor ailments and prescribing.

I further recommend that a priority should be to review medical record keeping and put measures in place to ensure that records are ordered logically, contain only clinical information and that all entries are signed and names printed alongside. Particular attention should be given to identifying prisoners with chronic medical conditions diagnosed prior to transfer to Gartree.

The use of the escort chain while the man who died was in Glenfield Hospital

47. The Prison Service National Security Framework (NSF) replaced the Prison Security Manual in 2004. It is available on the Prison Service intranet and gives guidance on the procedures for escorting prisoners on all occasions they leave prison and on the use of restraints. There is particular advice on hospital escorts and bedwatches, and when restraints should be applied or removed during medical treatment.

48. The section of the NSF relating to hospital escorts says that the prison must first undertake a risk assessment to decide the level of escort and restraint required for the safe custody of each prisoner. Factors which must be taken into account during this risk assessment include:
    - the prisoner's medical condition
    - the prisoner's security category
    - the nature of their offence
    - their risk to the public and hospital staff
    - their motivation to escape

49. According to the NSF, the normal arrangements for prisoners being escorted from closed establishments are that they will be accompanied by two officers and "restraints must be used unless there are medical objections". The NSF goes on to say:

    > "Restraints are applied when out of the prison up to the point of medical consultation or treatment. The restraints will be taken off at this point unless the risk assessment shows the risk of escape is too high."

50. Although this is the normal arrangement, the section on 'Escort options' which follows it says that other options are available to prison managers. These are:

    > "an escort with two officers or more with no restraints
    >
    > "an escort with one officer and no restraints (appropriate where the prisoner's medical condition or lack of mobility is such that he or she cannot escape unaided and there is no evidence that an escape attempt is likely)"

51. The section on 'Reviewing the escort arrangements' says:

    > "The level of security necessary in all cases must be kept under review to take into account the prisoner's developing medical condition, the physical surroundings in which the prisoner is located and any emerging intelligence."

52. The NSF section on 'Restraints' lists the circumstances in which handcuffs are not usually necessary. One of these circumstances is:

> "On prisoners attending for medical treatment outside the prison, if the prisoner's medical condition renders restraints inappropriate or a risk assessment demonstrates they are unnecessary in all the circumstances. Restraints will not normally be necessary when the prisoner's mobility is severely limited, e.g. when he or she is on crutches … "

53. The NSF section on 'Removal of restraints' says that restraints may be removed in certain circumstances during hospital treatment. It does not list these circumstances but refers back to the section on hospital escorts. It goes on to say that restraints may be removed, "when a medical professional requests their removal on health grounds." If necessary, escorting officers should first obtain the permission of the Duty Governor before agreeing to such requests.

54. Gartree's local policy on hospital escorts and bedwatches is comparatively stark and unhelpful. There is no mention that restraints may not be appropriate in certain circumstances, particularly when a prisoner's medical condition and lack of mobility is such that they are unable to escape unaided. There is no suggestion that reviews of the level of restraint should take into account the prisoner's developing medical condition. The sole reference to circumstances in which restraints may be removed is:

> "**Preservation of life** [bold in original]**.** Remember that if a prisoner is restrained by either handcuffs or an escort chain and the medical staff need to have them removed to administer **emergency/life saving treatment, they must be removed.** This is in compliance with the security manual."

55. When the man who died left Gartree on 10 October, it was not known how ill he was or whether he would be admitted to hospital. The level of escort was set at two members of staff and the use of the escort chain was specified instead of handcuffs in view of his poor health and mobility problems. I am satisfied that this was a reasonable decision in the circumstances. This level of escort and restraint remained in place until the man was seen by the doctor at 4.00pm and staff were told that he would be admitted for "at least 24 hours". Oscar 1 (the code for the Orderly Officer, the officer in charge of the prison at that time) was informed at 4.25pm. There is no documentary evidence that a further review of the level of escort and restraint was done at this time, but I presume that a decision was taken not to change it.

56. The situation was reviewed by the Governor on the morning of 11 October. By this time, the man who died had a catheter and a nasal tube inserted. The Governor decided that the level of escort should remain at two members of staff and that the man should continue to be chained to one of them using the escort chain. The reason given on the risk assessment form was that he was a category B prisoner serving life for

murder. At 4.45pm, the man was informed by the surgeon that there was a high probability that he would die during the operation he needed. He was asked to discuss with his wife whether he was prepared to take the risk of surgery. When the man's wife visited some 30 minutes later, she said her husband was using an oxygen mask and could hardly speak because his breathing was so laboured. At 12.45am, the man was given the news that his potentially life saving operation would not be taking place because he was too ill to survive it. He remained cuffed to staff by the escort chain until a doctor asked staff to remove it some 35 minutes before he died later the same morning.

57. It seems clear from the bedwatch log and from what the man's wife said that the man was gravely ill throughout his brief stay in the local hospital. I understand the importance of security on bedwatches and realise that, for often valid reasons, the current climate in the Prison Service is risk averse. However, the man who died was both chronically ill and 80 years old. He was at best unsteady on his feet and at worst unable to move without aid of a wheelchair. Within hours of his admittance to hospital, he was fitted with a catheter and a nasal tube and needed an oxygen mask to breathe. I do not believe that the man required to be chained to an escorting officer, and quite probably did not need more than one member of staff in attendance. The man's wife told my staff that the escorting officers were obviously uncomfortable that her husband remained chained when he was so ill. It is a situation which is undignified for the prisoner and distressing for his family and the escorting officers.

58. I do not consider that Gartree's policy reflects the National Security Framework as required. It is outdated and appears to be based on the contents of the Prison Security Manual which became obsolete in 2004. The NSF (and indeed its predecessor, the Prison Security Manual) makes it clear that prisoners should not normally be restrained during medical treatment. I make no criticism of the individual staff involved in the case of the man who died. All staff complied with Gartree's local policies. However, the local policy needs urgent review to more fully reflect the requirements of the NSF.

I recommend that, within three months of the publication of this report, the Governor of Gartree ensures that a review of local escorting procedures and the local instructions for staff on a bedwatch takes place to more fully reflect the standards set by the National Security Framework. Specifically, the review should seek to expand the policy to encompass the circumstances in which restraints may not be appropriate and give the Duty Governor discretion to remove restraints from gravely ill or dying prisoners without waiting for a request from medical staff.

I further recommend that the Governor of Gartree reminds escorting staff that restraints should normally be removed

from all prisoners during medical consultation and treatment.

59. In a recent report of an investigation into a death of a prisoner from HMP Birmingham, I was critical of the lack of flexibility in the local policy on bedwatches. I made a recommendation that the Governor amend the policy to allow the duty governor discretion to authorise the removal of handcuffs in non-life threatening situations. A lack of flexibility in the local policy is again a feature of this case but I think the problem is deeper. Prison managers must base their local instructions on the standards set by the National Security Framework. The NSF does not deal specifically with procedures for dealing with gravely ill or dying prisoners in outside hospital or hospices. There is no allowance for prison staff to make a decision to remove the restraints from gravely ill or dying prisoners on compassionate grounds when the risk of escape is clearly much reduced. I know of cases where Governors have nevertheless given permission for restraints to be removed on compassionate grounds and I have always commended them for doing so. However, I now think consideration should be given to building this into the NSF so the practice may become more widespread.

I recommend that, within three months of the publication of this report, the Director General of the Prison Service ensures that a review of the escorts, restraints and bedwatch sections of the National Security Framework takes place, with a view to providing advice to staff on the removal of restraints from gravely ill or dying prisoners on compassionate grounds when their risk of escape is much reduced.

60. Finally, I would like to add that I am pleased to see that the family of the man who died was appreciative of the help they received from the HMP Gartree after his death. From what I have learned, this was an example of good practice and should be recognised as such. Although I make no formal recommendation in this regard, the Governor and her Area Manager will wish to ensure that my comments are brought to the attention of those concerned.

RECOMMENDATIONS

Recommendations from the clinical review

1. **A medical record summary should be obtained from the general practitioner of all new inmates in all instances. Information from previous prisons should be collated and summarised. There should be a formal review of all diagnoses, investigations and therapy, particularly as the inmates are likely to be drawn from a group of the population that has not fully accessed the health service. There should be a designated role for filing and upkeep of medical records, including a protocol for summarising important information regarding diagnosis and results.**

2. **The prison should identify funding for note summarising of all current inmates' records. The first phase should be for inmates on medications suggestive of significant chronic diseases and should be completed as a paper exercise prior to the installation of the prison Health IT system. These prisoners should have a summary sheet of all significant past medical conditions recorded in a prominent place in the medical record. This should be done as a matter of urgency. The prison should engage with the medical officers to determine the mechanism and priority of the summarising process. It is my opinion that the majority of prisoners without significant chronic disease issues should have their records summarised at the time of the introduction of the prison Health IT system to prevent unnecessary duplication of labour, providing there is no undue delay.**

3. **The same audit standards sought in the Quality Outcomes Framework (QOF) in general practice for chronic disease management should be applied to the health provision for prisoners at HMP Gartree. This would be a future marker of the quality of service provision. It is assumed that the new Health IT system will be able to deliver this recommendation; failing this the prison should make provision for audit clerks to perform the task manually. It is anticipated that there would be a delay caused by moving from paper to computer records before this is achieved.**

4. **A staff training needs analysis should be performed and matched to the needs of the service. Staff should be released to attend recognised training courses relating to chronic disease management and minor illness, then to consolidate knowledge in the general practice setting with sufficient backfill. Prison staff should be discouraged from working beyond their ability until they have received training and supervision comparable to their colleagues working in similar circumstances in primary and unscheduled care. The unique pressures of the prison should**

not be an excuse for staff to work beyond their scope of practice. Doctors at the local practice would be well placed to judge the competency of the nursing staff in these roles after training, although this role falls outside their medical contract.

5. **The triage policy needs urgent review with greater clinical input. Only staff demonstrating appropriate clinical experience and training should perform unsupervised triage. Staff should reflect on their roles to ensure they are not working beyond their scope of practice and highlight their learning needs.**

   There are software programs to support nurse triage, training sessions and audit tools to measure performance, in established use for the PCT out of hours service. The prison healthcare and PCT should explore the application of these systems in HMP Gartree.

6. **Closer liaison with the OOH service should be encouraged. Staff should be aware that they can get telephone advice from the triage centre. It may be useful to create a brief orientation pack for visiting doctors explaining the prison setting, to be carried in the visiting doctor's car.**

7. **Hospital wing inpatient facility staffing should be reviewed. Nurses should only be involved in the health needs of inmates in the two "medical" beds. This will allow nursing staff roles to expand into chronic disease management and allow for backfill for training. The healthcare staff should as far as possible be disengaged from the custodial function of the prison, in order to strive to provide independent holistic care. It would be useful to review the language used in the prison healthcare system such as "special sick parade" in order to refocus on the role of delivering modern efficient primary care to individuals.**

Recommendations from the PPO

1. **I endorse the recommendations of the author of the clinical review and recommend that the Governor of Gartree ensures that a comprehensive review of his report takes place within three months of the publication of this PPO report.**

2. **I recommend that, within this review, consideration of the triage policy should take place as a matter of urgency and measures put in place to ensure that staff who are required to operate it have up to date and appropriate training in identifying minor ailments and prescribing.**

3. **I further recommend that a priority should be to review medical record keeping and put measures in place to ensure that records are ordered logically, contain only clinical information**

and that all entries are signed and names printed alongside. Particular attention should be given to identifying prisoners with chronic medical conditions diagnosed prior to transfer to Gartree.

4. **I recommend that, within three months of the publication of this report, the Governor of Gartree ensures that a review of local escorting procedures and the local instructions for staff on a bedwatch takes place to bring them in line with the standards set by the National Security Framework. Specifically, the review should seek to expand the policy to encompass the circumstances in which restraints may not be appropriate and give the Duty Governor discretion to remove restraints from gravely ill or dying prisoners without waiting for a request from medical staff.**

5. **I further recommend that the Governor of Gartree reminds escorting staff that restraints should normally be removed from prisoners during medical consultation and treatment.**

6. **I recommend that, within three months of the publication of this report, the Director General of the Prison Service ensures that a review of the escorts, restraints and bedwatch sections of the National Security Framework takes place, with a view to providing advice to staff on the removal of restraints from gravely ill or dying prisoners on compassionate grounds when their risk of escape is much reduced.**