Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Eric Stringer, a prisoner at HMP Wormwood Scrubs, on 23 August 2024

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

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 Eric Stringer died in hospital of lung cancer on 23 August 2024, while a prisoner at HMP Wormwood Scrubs. He was 78 years old. We offer our condolences to Mr Stringer's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Stringer received at Wormwood Scrubs was of a good standard and equivalent to that which he could have expected to receive in the community. However, she found that Mr Stringer was not referred to the local authority social care department or the pain clinic, staff did not create a food or fluid chart to monitor his diet and they did not use the malnutrition universal screening tool as they should have done. The clinical reviewer concluded that these concerns did not contribute to Mr Stringer's death.

5. The clinical reviewer made four recommendations about matters not directly related to Mr Stringer's cause of death but which the Head of Healthcare at Wormwood Scrubs will want to address.

6. Healthcare staff were not involved in the decision to restrain Mr Stringer on 22 June. This is particularly concerning as we found that this is standard practice for all emergency hospital escorts, and we have previously made recommendations to address this issue.

Recommendations

The Governor and Head of Healthcare should introduce a robust quality assurance process to assure themselves that:

- **in line with policy, a thorough escort risk assessment is completed for every non-life-threatening emergency hospital escort;**
- **healthcare staff are routinely involved in the escort risk assessment process, taking a prisoner's current medical condition into consideration, including how this impacts on their ability to escape;**
- **all staff involved in the escort risk assessment process receive training on the Graham judgment and have a clear understanding of how it applies to the Prevention of Escape – External Escorts policy framework; and**

- **staff are using the current escort risk assessment template, as outlined in the policy framework.**

The Investigation Process

7. HMPPS notified us of Mr Stringer's death on 25 August 2024.

8. NHS England commissioned an independent clinical reviewer to review Mr Stringer's clinical care at HMP Wormwood Scrubs.

9. The PPO investigator investigated the non-clinical issues relating to Mr Stringer's care. She interviewed two members of staff on 1 and 23 October 2024.

10. The Ombudsman office wrote to Mr Stringer's next of kin, his wife, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.

11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and this report has been amended accordingly.

Previous deaths at HMP Wormwood Scrubs

12. Mr Stringer was the fourteenth prisoner to die at HMP Wormwood Scrubs since 23 August 2021. Of the previous deaths, seven were from natural causes, four were self-inflicted, one was drug-related, and one was unascertained. We have previously made a recommendation about the need for staff to take into account a prisoner's medical condition when they consider using restraints for emergency hospital journeys. We also recommended that all staff undertaking risk assessments should understand the legal position on the use of restraints.

13. HMP Wormwood Scrubs agreed to implement our recommendations and told us that a review of local policy and risk assessments would be conducted by February 2024 to ensure that escort risk assessments for emergency hospital escorts are completed appropriately, taking into account the prisoner's medical condition when deciding the level of restraints. They also told us that all managers involved in the risk assessment process would receive training on the Graham judgment.

Key Events

14. On 3 May 2024, Mr Eric Stringer was sentenced to three years and nine months in prison for sexual offences and was sent to HMP Wormwood Scrubs. A nurse completed his initial health screen. She noted that Mr Stringer was prescribed medication for angina and high blood pressure, and that his mobility was reduced, and he walked with a crutch.

15. On 8 May, a nurse saw Mr Stringer to monitor his vital signs as he had multiple health conditions. She recorded that his blood pressure was slightly low. She encouraged him to drink fluids.

16. On 25 May, a nurse saw Mr Stringer and he reported abdominal pains. She checked his vital signs and advised him to drink warm water.

17. On 17 June, a nurse visited Mr Stringer to help to move him. He reported that he was in a lot of pain and was unable to move around his cell without help.

18. On 18 June, a nurse saw Mr Stringer for a welfare check. She recorded that he was alert and had no tenderness to his abdomen. She took his observations which were all within normal limits.

19. On 20 June, Mr Stringer did not attend his nurse clinic appointment.

20. On 21 June, a nurse saw Mr Stringer for an in-cell welfare check as he was unable to get out of bed. He took Mr Stringer's observations, which were stable, and asked prison staff to monitor Mr Stringer closely.

21. At 12.32pm on 22 June, a nurse saw Mr Stringer in his cell after he complained of abdominal pain. He had been unable to get out of bed and eat since the previous day. She checked Mr Stringer's vital signs and asked for a second opinion from a senior member of the healthcare team.

22. At 5.53pm, a prison paramedic attended Mr Stringer's cell to examine him. Due to Mr Stringer's recent deterioration, confusion and reduced mobility, she decided that he should be admitted to hospital as she suspected he had a urinary tract infection. Mr Stringer was restrained with an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer) and taken to hospital by ambulance. A Custodial Manager (CM), who attended the escort and decided on the level of restraint, told us that escort risk assessments are not completed for emergency hospital escorts.

23. On 23 June, the Head of Security completed an escort risk assessment which stated that Mr Stringer should be restrained with an escort chain while in hospital. She told us that as Mr Stringer was in hospital at this point, healthcare staff did not contribute to this decision.

24. On 24 June, a nurse contacted the hospital. They told her that Mr Stringer was awaiting test results for suspected cancer. The healthcare team remained in regular communication with the hospital throughout his admission.

25. On 27 June, healthcare team contacted the hospital, and they said that Mr Stringer had a confirmed diagnosis of lung cancer. There were no plans to discharge him as he was awaiting further tests and examination. The bed watch log noted that Mr Stringer was irritable and shouting at nurses.

26. On 30 June, a new risk assessment was completed which stated that Mr Stringer should be unrestrained as he was unable to sit up, stand or walk and bed watch officers removed Mr Stringer's restraints.

27. On 3 July, Mr Stringer had a biopsy and an endobronchial ultrasound (to help determine the stage of lung cancer). Two members of staff were appointed as family liaison officers (FLOs), and they contacted Mr Stringer's wife to tell her he was in hospital. Arrangements were made for his wife to visit him.

28. On 8 July, the FLOs facilitated a visit between Mr Stringer and his wife at the hospital. During Mr Stringer's hospital admission, Wormwood Scrubs organised and paid for twice-weekly transport for his wife. Both FLOs attended the hospital for each visit to ensure she could find Mr Stringer and to arrange her taxi home.

29. On 10 July, the hospital told healthcare staff that Mr Stringer had been diagnosed with stage 4 lung cancer, which could not be treated. They said that only supportive care could be provided.

30. On 11 July, Mr Stringer was transferred to another hospital for inpatient palliative radiotherapy. He was given a prognosis of a few months.

31. On 22 July, Mr Stringer's palliative radiotherapy was complete.

32. On 2 August, Mr Stringer was granted release on temporary licence (ROTL), which meant that he no longer required supervision from bed watch staff. An application for Mr Stringer's early release on compassionate grounds (ERCG) was submitted to HMPPS' Public Protection Casework Section (PPCS).

33. On 16 August, the Secretary of State refused Mr Stringer's ERCG application as they were not satisfied that Mr Stringer had addressed his offending behaviour, his risk had not been reduced and there was no evidence that his current health needs were not being met.

34. On 20 August, healthcare staff discussed Mr Stringer in a multi-agency meeting. He remained on ROTL, on a palliative care pathway, and was awaiting a hospice placement.

35. At 23.18pm on 23 August, Mr Stringer died in hospital.

36. At 7.33am on 24 August, a FLO visited Mr Stringer's wife to tell her that Mr Stringer had died.

Post-mortem report

37. A hospital doctor gave Mr Stringer's cause of death as squamous cell lung cancer which had spread to other parts of the body. The Coroner accepted this cause of death, and no post-mortem examination was carried out.

Inquest

38. At an inquest held on 26 March 2025, the Coroner concluded that Mr Stringer died of natural causes.

Non-Clinical Findings

Restraints, security and escorts

39. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 (the Graham judgment) made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when he has a serious medical condition. It said that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

40. An escort risk assessment must be completed for every hospital escort and healthcare staff must always be included in this process. If an emergency escort is dispatched without a full escort risk assessment due to a life-threatening situation, an emergency escort risk assessment must be completed, and the prisoner escort record (PER) must be annotated with 'no restraints to be used' and the risk assessment must be completed within 18 hours.

41. When Mr Stringer was escorted to hospital on 22 June 2024, an escort risk assessment was not completed, and healthcare staff were not involved in the decision to apply restraints. Therefore, the decision was solely based on perceived risk and did not take his medical condition and ability to escape into consideration.

42. The Head of Security told us that as Mr Stringer went to hospital on an unplanned emergency escort, there was not time to do a thorough risk assessment, which would involve input from healthcare staff. However, Mr Stringer was admitted to hospital with ongoing confusion and reduced mobility. Therefore, it was not a life-threatening situation and healthcare staff were already present, so there was sufficient time for a risk assessment to be completed and for healthcare staff to be involved.

43. The CM was unable to recall how Mr Stringer was transported to the ambulance, but he thought it was either by a wheelchair or stretcher. He told us that the only situation where somebody would not be restrained was if the restraints impeded medical treatment. He said that he was not aware that Mr Stringer had a personal emergency evacuation plan in place or that he used a walking aid, however, that would not stop him from applying restraints. He told us that mobility was not something he factored into his decision unless the prisoner was completely unable to move.

44. While the Head of Security confirmed that she had an understanding of the Graham Judgment and had received training on it a long time ago, she said that further training would be helpful, and the CM said he was not aware of it. This is concerning, as we were told that all managers involved in the escort risk assessment process would receive training on the Graham Judgment by February 2024. We were told that the escort risk assessment process would be reviewed by

February 2024 to ensure that a prisoner's medical condition is taken into consideration. However, this has still not happened.

45. Additionally, Wormwood Scrubs did not use the current hospital escort risk assessment template as outlined in the Prevention of Escape – External Escorts July 2023 policy framework (annex H) which has a mandatory healthcare section.

46. The Deputy Head of Healthcare confirmed that as Mr Stringer went out on an unplanned emergency escort, healthcare information would not be provided as part of an escort risk assessment. She said in these cases, healthcare staff would only provide a brief summary of the prisoner's condition to the paramedics.

47. The CM and Head of Security were solely responsible for the decisions to apply restraints for the escort risk assessments completed on 22 and 23 June. Without input from healthcare staff, Mr Stringer's current ability to escape was not assessed and any medical objections to the use of restraints were not considered. This is the case for all unplanned hospital escorts at Wormwood Scrubs. We therefore make the following recommendations:

The Governor and Head of Healthcare should introduce a robust quality assurance process to assure themselves that:

- **in line with policy, a thorough escort risk assessment is completed for every non-life-threatening emergency hospital escort;**
- **healthcare staff are routinely involved in the escort risk assessment process, taking a prisoner's current medical condition into consideration, including how this impacts on their ability to escape;**
- **all staff involved in the escort risk assessment process receive training on the Graham judgment and have a clear understanding of how it applies to the Prevention of Escape - External Escorts policy framework; and**
- **Staff are using the current escort risk assessment template, as outlined in the policy framework.**

Good practice

48. Wormwood Scrubs facilitated and paid for multiple visits between Mr Stringer and his wife while he was in hospital. The family liaison officers also bought flowers and a rose bush for his wife's garden and helped scatter Mr Stringer's ashes there.

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

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100