Investigation into the death of a man in May 2009 at a hospital whilst in the custody of HMP & YOI Swinfen Hall

Report by the Prisons and Probation Ombudsman for England and Wales

December 2009

This is the report of an investigation into the death of a man, a 21 year old prisoner at HMP & YOI Swinfen Hall. The man who is the subject of this report died in May 2009 in a hospital from natural causes. He had been admitted to hospital on 13 April for an operation to replace a valve in his heart.

The man already had a heart condition when he came into custody. He had had a number of operations on his heart and been fitted with a pacemaker.

I would like to add my personal condolences to those already expressed to the man's family on behalf of this office by one of the Ombudsman's Family Liaison Officers.

This investigation was undertaken by one of my investigators. In addition a clinical reviewer was asked by South Staffordshire Primary Care Trust to undertake a review of the man's clinical care. I am grateful for the assistance they both received from staff at HMP & YOI Swinfen Hall and would ask the Governor to pass on those sentiments.

The man's family expressed serious concerns about his care and treatment which I have considered carefully. The clinical reviewer for South Staffordshire PCT concludes that the man's care was equivalent to what he would have received in the wider community. However, her review raises a number of learning points that the prison health partnership will need to consider seriously.

Like his family I am concerned that when the man awoke from the general anaesthetic on 14 April, restraints were applied before he was fully conscious. I believe that this action could have been delayed until the man was fully awake and I make one recommendation relating to the use of restraints. However, like the clinical reviewer, I am satisfied that applying the restraints did not cause his fatal heart attack.

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

Jane Webb
Deputy Prisons and Probation Ombudsman **December 2009**

SUMMARY

The man who is the subject of this report was born in April 1988. He was just 21 years old when he died at hospital in May 2009. The man's death was due to natural causes as a consequence of a heart attack caused by heart disease.

The man was remanded into custody at HMYOI Glen Parva on 25 July 2008. He was sentenced to seven years imprisonment on 16 January 2009 at Crown Court. The man transferred to HMP & YOI Swinfen Hall on 16 February. At his first health screening interviews it was recorded that the man had a history of heart disease. He had been diagnosed with Shone's syndrome as a child. (The disease affects the valves and passageways on the left side of the heart and progresses over time.) The man's condition meant that he had a number of operations on his heart, including valve replacements and fitting a pacemaker. Whilst he was in custody the man's heart condition was monitored regularly and he went to a number of appointments with his consultant at hospital.

The man was taken to hospital on 13 April for an operation to replace a valve in his heart. The initial security risk assessment concluded that restraints were to be used and two officers were to be present at the man's bedside. On 14 April, the restraints were removed whilst the man had his operation. As he awoke from the anaesthetic after his operation, the officers re-applied the restraints. The man lost consciousness soon afterwards and suffered a heart attack. The restraints were removed to ensure that hospital staff had easy access and were not re-applied. The man was then kept sedated for the following month whilst his condition slowly deteriorated.

The man was pronounced dead on an evening in May 2009.

After the man died, the prison activated its death in custody contingency plan. The police were informed and visited hospital. They found no suspicious circumstances and the man's body was released to the undertakers. The coroner's officer informed the Governor of Head of Performance Management who was managing the prison's response following the man's death, that he had died from natural causes.

The clinical review carried out by the clinical reviewer for South Staffordshire PCT identifies a number of issues relating to the care provided for the man. The review highlights areas of practice that could be improved, and makes two recommendations. I have made one recommendation relating to the use of restraints.

The man's family were concerned that the anxiety experienced when the restraints were applied after his operation led to him having a heart attack. Neither the investigator nor the clinical reviewer found any evidence that this was the cause of the heart attack.

THE INVESTIGATION PROCESS

1. The investigation was opened on 19 May 2009 by one of the Ombudsman's investigators. He issued notices announcing the investigation both to staff and to prisoners. The notices included an invitation to anyone who wished to submit information relating to the man's death to make themself known. In the event, no one came forward. The investigator also studied all the relevant prison records, which included the man's main prison record and his medical records.

2. The South Staffordshire Primary Care Trust commissioned a Quality and Performance Manager to carry out an independent review of the man's clinical care. I am grateful to her for undertaking the review most expeditiously.

3. The investigator visited Swinfen Hall on 1 July 2009 and discussed aspects of the man's treatment with staff. He interviewed a Principal Officer and an officer. In response to concerns raised by the man's family, the investigator also asked the officer and a further officer to complete statements about their recollection of events whilst they were on bedwatch duty.

4. The investigator contacted HM Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner.

5. One of the Ombudsman's Family Liaison Officers contacted the man's family. This gave them the opportunity to discuss the purpose of the investigation and raise any concerns or questions that they wanted to be addressed. When they met with the Family Liaison Officer and the investigator, the family said that they were concerned about why restraints had been applied so soon after the man's operation. The family stated that Swinfen Hall did not respect their request that the officers, who were present immediately after the man had his operation, were not allocated to any more bedwatch duties. The family were also concerned about the behaviour of some of the staff on bedwatch duty and their lack of understanding of the man's medical condition, his needs and what his family described as "learning difficulties". The investigator has attempted to address the issues raised by the family. I hope that my report provides them with a better understanding of the events leading up to the man's death.

HMP & YOI SWINFEN HALL

6. HMP & YOI Swinfen Hall is a closed young offenders institution and a category C adult prison. It is located near Lichfield, Staffordshire. It had an operating capacity of 624 prisoners at the time of the man's death. It holds male long term prisoners serving from four years to life and long term young offenders (aged from 18 to 25). There are nine residential units (A-J) and prisoners live in single cells.

7. Healthcare services at Swinfen Hall are commissioned by South Staffordshire Primary Care Trust. A full range of primary health care services are provided including dental, optical and auditory specialists. General practitioners (GPs) work at the prison every day. A team of nurses is based in the healthcare centre and provide a triage service and nurse led clinics for prisoners. There are no inpatient facilities at Swinfen Hall.

8. A risk assessment must be completed when prisoners attend hospital inpatient and outpatient appointments. This is to determine the level of escort and the restraints (handcuffs) required for the safe custody of the prisoner. Restraints are applied if the risk assessment states they are necessary and prison staff are allocated to carry out an escort for the prisoner. If a prisoner is admitted to hospital prison staff will carry out a bedwatch duty and complete a log of activities. A regular management check of the bedwatch will be carried out by a duty governor. Visits from family may be allowed but these will be closely monitored to ensure that they do not impinge on the security of the bedwatch.

9. The risk assessment will consider the following:

    i. The prisoner's medical condition. When there is doubt the prison medical officer will be asked to advise on any medical objections to the use of restraints.
    ii. Behaviour in prison.
    iii. Home circumstances.
    iv. The nature of the offence (criminal history), the risk to the public and hospital staff, including the risk of hostage taking.
    v. The prisoner's motivation to escape, likelihood of outside assistance and their conduct whilst in custody.
    vi. The physical security of the hospital.
    vii. Assessment of visits restrictions.

10. According to the policy for performing hospital bedwatches adopted by Swinfen Hall at the time that the man was in hospital in April and May 2009, the following options were available to the Governor:

    i. Escort and bedwatch with two officers or more, with restraints.
    ii. Escort and bedwatch with two officers or more, without restraints.
    iii. Escort and bedwatch with one officer, without restraints.
    iv. If eligible, release on temporary licence under Prison Rule 9 (YOI Rule 6).

v. … exceptionally temporary release for remand prisoners if they are so seriously ill or incapacitated as to be incapable of escaping and for who there is no danger of assisted escape (this power is allowed under Section 22(2)(b) of the Prison Act 1952).

The level of security necessary for all prisoners should be kept under review to take into account their medical condition, the physical surroundings in which they are located, and any new information.

Independent Monitoring Board

11. Each prison has an Independent Monitoring Board (IMB). IMB members are independent and unpaid. They monitor day-to-day life in their prison and ensure that proper standards of care and decency are maintained. Each IMB produces an annual report. The most recent annual report by the Swinfen Hall IMB covers the period May 2007 to April 2008.

12. The Board reported they were:

> "… pleased to observe the positive manner in which the new South Staffordshire PCT has supported the Healthcare Team, ensuring staff have access to a wide range of training opportunities and 'information sharing' forums. There has also been a closer working relationship with other prisons with the PCT enabling shared good practice between establishments."

Her Majesty's Chief Inspector of Prisons

13. The most recent inspection of Swinfen Hall by Her Majesty's Chief Inspector of Prisons was an unannounced inspection in April 2008. In her report the Chief Inspector found that:

> "Swinfen Hall remained a safe, respectful place, focussed on resettlement, and that much progress had been made in the provision of purposeful activity ... Staff-prisoner relations remained very good, supported by a sound personal officer scheme and a meaningful incentives and earned privileges system."

14. Her Majesty's Chief Inspector of Prisons also found that:

> "Swinfen Hall had seen the doubling of its population, some turbulence arising from the rapid influx of large numbers of prisoners serving indeterminate sentences of public protection and the need to integrate different age ranges effectively. Nevertheless, it had been able to sustain the generally safe and respectful atmosphere, focused on resettlement, that we have previously applauded. Commendably, it had also addressed the deficits we identified in our last visit in the provision of purposeful activity. It is once again, a very impressive prison."

KEY EVENTS

15. On 7 January 2008, the man was released from HMP & YOI Onley on Home Detention Curfew (HDC). (HDC is also known as “electronic tagging”. A small electronic "tag" is fitted to the ankle. The tag sends a regular signal to a monitoring centre that confirms the presence of the person in their place of curfew. If they are absent or try to tamper with the equipment the monitoring centre is alerted and the breach investigated.)

16. Just over six months later, on 23 July, the man was arrested for drug related offences. As he had breached one of the conditions of his licence, which stated: “be well behaved, not commit any offence and not do anything which could undermine the purposes of your supervision”, his licence was revoked. He returned to custody and was taken to HMYOI Glen Parva on 25 July.

17. At the man’s first health screen interviews it was noted that he had a history of heart disease and had been diagnosed with Shone’s syndrome as a child. The man took medication (Warfarin) every day to thin his blood. The following entry was made, on 31 July, in the man’s prison medical record: “Had a long chat with [the man] regarding effect of stimulants and depressants, particularly associated with the heart and in relation to his own heart condition”.

18. On 4 December, the man went to an appointment with a consultant cardiothoracic surgeon at outside hospital.

19. Around two weeks later, on 22 December, the man told staff that he had chest pains and so he was taken to healthcare. When he arrived there, it turned out that he only wanted some cream for his face. After it was explained that this was the incorrect way of doing things, the man threatened to hit a member of staff.

20. In his letter to the man’s solicitor dated 14 January 2009 , the consultant cardiothoracic surgeon wrote:

> “We have been offering him [the man] surgery for about one year and he has proved difficult to convince that this is both necessary and urgent. He is at continued risk of sudden death. At our last consultation last month he said that he would have the operation but not when he is in prison.”

21. The man was sentenced at Crown Court on 16 January 2009 to seven years imprisonment for drug offences.

22. In his letter dated 30 January to the man’s solicitor, a prison doctor at Glen Parva wrote:

> “[The man] has a history of cardiac operations at [hospital] and is under their regular follow ups. He has a recent letter from the Cardiothoracic Surgeon at [the hospital] suggesting that he needs a heart operation fairly soon. I had a discussion with [the man] in the clinic at Glen Parva

regarding this; he is objecting to receiving the operation mainly due to his desire to transfer to a long-term prison from Glen Parva."

23. On 16 February, the man transferred to HMP & YOI Swinfen Hall and his previous medical history was noted.

24. Just under a month later, on 12 March, the man was taken to hospital for an out-patient appointment and he returned to the prison later the same day. On his return to the prison the following entry was made in the man's medical record: "[The man] does not want surgery whilst he is an inmate but is in serious danger of sudden death so has agreed".

25. The man had another appointment with his consultant on 2 April. He also had blood tests and an electrocardiogram (a graphical recording of the electrical activity of the heart) carried out whilst he was in the hospital. He returned to Swinfen Hall the same day.

26. The next appointment at hospital was on 13 April for an operation to replace a valve in the man's heart. The operation took place the following day, 14 April, and afterwards he was moved to the Critical Care Unit.

27. Whilst the man was in hospital, a bedwatch was carried out by prison staff. The initial security risk assessment completed by the duty governor concluded that restraints (handcuffs) were to be used and (due to his previous threats to injure staff) three officers needed to be at the man's bedside. The number of staff on bedwatch was subsequently lowered to two officers when the man was taken into the operating theatre. The assessment was later revised, on 24 April, by the duty governor and concluded that restraints were not to be used. The following entry was made in the risk assessment: "Currently in intensive care on a ventilator, heavily sedated, no physical ability to escape at this time".

28. A log of activities was maintained by the officers on bedwatch duty and checked regularly by a visiting duty governor. The man's family were allowed to visit him whilst he was in hospital.

29. At approximately 7.40pm on 14 April, a male and female officer took over the bedwatch duty. Around 20 minutes later, they were informed by nursing staff that the man was going to be brought round from unconsciousness. When the nursing staff confirmed that he was no longer sedated, an escort chain (this is a set of handcuffs which are linked by a chain) was applied to his left wrist and attached to the male officer's right wrist.

30. When interviewed as part of this investigation, the female officer said:

> "The nursing staff told us that they were going to bring him round from sedation shortly. So we cuffed him because we were aware that he was going to come round. We didn't know how long it would take for him to come round."

31. In her interview with the investigator, the female officer confirmed that the man's family came to visit whilst he was still coming round from the anaesthetic and after the restraints had been re-applied. The female officer said:

> "[The man] slowly was coming round and started to wake, he was suggesting things with his hands because he could not verbally speak at this point. He was sort of coming round and he was making gestures with his hands suggesting, it looked as though he was trying to say that he wanted to phone call, he was sort of doing a phone gesture to his ear. … He found his voice and then he was asking, he was very concerned about a phone call to his solicitor and his mum was explaining to us that he was going through an appeal. I don't know what he was appealing against. The family were telling him it was quarter past eight at night, there was nothing more that they could do that day. I think his aunt was saying that she'd been in contact with the solicitor, everything was alright. They were just trying to reassure him, and the longer this went on [the man] started to be abusive towards his mother. He was swearing at her, he was calling her different things. So I suggest that possibly it might be worth them perhaps just going for a walk and come back you know, in an hour, just to let [the man] calm down, and themselves calm down really because they were all getting in a state."

32. In his statement to the Governor completed on 20 August, the male officer wrote:

> "Shortly after the restraints had been applied [the man's] mother and aunt arrived at his bedside and began conversing with [the man] who at this point was not able to talk properly and was making hand gestures and pointing to his mouth. [The man's] mother asked him if he was thirsty and he nodded in the affirmative. [The man's mother] then turned to the escorting staff and in an aggressive tone asked "Can you take the cuffs off?" I informed [the man's mother] as sensitively as possible that unfortunately I could not do that as it was standard procedure that cuffs are applied when an escorted prisoner is conscious. [The man's mother] was not happy about this however [the man's] aunt tried to explain that it was not the staff's fault as we're only doing our job."

33. The male officer confirmed in his statement that [the man's] mother and aunt were asked to leave for a short while. This was after the man started to become abusive towards them and they were becoming upset by his actions (According to the bedwatch log they left around 8.25pm.) The male officer wrote:

> "… at approximately 20.40 hours an alarm sounded which the nurse silenced and then set about investigating why it had sounded. [The man] was quiet and still at this point but his hands did show occasional movement in the form of small twitches. The alarm sounded a further two times at which point the nurse called for assistance. A doctor

> appeared and went to the head end of the bed and introduced himself as an anaesthetist. The doctor stated that [the man] had "arrested". I then asked him to confirm that [the man] was not conscious which he did. I then removed the restraints immediately and moved just outside of the bay as a very large medical team were now in attendance."

34. In her statement to the Governor completed on 20 August 2009, the female officer confirmed that the man was revived around 9.05pm and that nursing staff then attempted to locate his family. The female officer wrote:

> "I was asked by a nurse that when the mother and aunt appear can I keep them away for the bed where [the man] was until a member of the nursing staff could talk to them. At approximately 21.10 both the man's mum and aunt arrive[d] on the unit and I informed them that just after they both left [the man's] condition deteriorated and that the medical and nursing staff were doing all that they could. I did my best to reassure them both and told them that a nurse or doctor would speak to them shortly and would explain what had happened to [the man]. At about 21.22 nursing staff took them to the 'quiet room'. … At approximately 21.38 [the man] is taken off hand ventilation and ventilated through a machine. At approximately 22.35 [the man's] mother and aunt come and see [the man] and say goodnight to him. This was brief and they leave the unit. Nursing staff inform us that [the man] will remain heavily sedated throughout the night and don't anticipate any change. [The man] remained heavily sedated for the remainder of the night and nursing staff confirmed that he is not stable and is very poorly."

35. On 15 April, the following entry was made in the hospital nursing notes about a telephone conversation with the man's aunt about the re-application of restraints the previous day:

> "I [an unidentified member of hospital staff] explained that the cuffs were needed because he became aggressive as he woke-she said he was not an aggressive person and I explained that often people can be agitated when they wake up form an anaesthetic. She also said that she was concerned that the prison officers had caused [the man] to be distressed and he had a panic attack causing him to need to go on the ventilator. I explained that this was not the case and it was his heart condition that caused him to need to go back on the ventilator. She said that his mum would not visit today as [the man] is not awake."

36. The man remained sedated and three days later, on 18 April, the following entry was made in the nursing notes: "[The man] is awake and opening eyes at times, reassurance given. Very anxious and requiring sedation … Aware that on ITU and to stay asleep today". The man remained under sedation in hospital for the next month and his condition continued to deteriorate. Two officers remained on bedwatch duty but restraints were not re-applied. The man's family were able to visit him every day as they had been provided with accommodation in the hospital's grounds.

37. Around 7.30am on the day of the man's death, two officers attended outside hospital to carry out bedwatch duties. They relieved the two officers who were carrying out bedwatch duties at that time.

38. In his statement to the Governor completed five days later, one of the officers who attended to take over bedwatch duties confirmed that at their handover with one of the officers who were being relieved of bedwatch duties, they were informed that the nurses were monitoring a rise in the man's body temperature. The officer who attended to take over bedwatch duties wrote:

> "This remained the situation throughout the day until approx 1630hrs when the nurse advised us that [the man] has started to resist the assistance of the ventilator. At approx 1800hrs [a] PO [principal officer] had arrived to complete a management check. This coincided with the nurse informing us that they were struggling to keep [the man] alive. [The principal officer] made a call to the prison to inform the duty governor of the situation. At approx 1845 we were positioned just outside [the man's] room due to the nature of the situation, when the nurse informed us that [the man] had passed away. [The principal officer] made the relevant phone call to the duty governor to activate the relevant contingency. We were advised by [the principal officer] at approx 1930hrs to return back to the prison along with the officers that had arrived to relive us for the night shift of the escort."

The man's family were not present at this time as they had visited him earlier in the day.

39. When interviewed as part of this investigation, the principal officer said:

> "He [the man] started to cough again and staff arrived to sort of deal with it, I don't know exactly what they did but it did not seem unusual because I have seen this sort of thing going on before. It soon became clear that there was a problem and the NHS staff seemed very, very concerned to the point where the help button on the wall was pressed and further help arrived in the form of other ward staff. They made some checks and some observations and decided to call for further help so the button was pressed again, although it seemed as it was. By this time there was a lot of staff in attendance and a lot of machinery was arriving, a lot of equipment. So I instructed the two officers to grab their equipment, their bags and any security equipment that was in the room and to get out of the way, to allow the hospital staff to do their work. So by this time there was myself and the two escorting officers plus the equipment just outside of the ward, outside of the side room, I should say. We remained there for probably about 30 minutes and the NHS staff continued to work on [the man] and I could hear voices coming from the room. At one point I heard a male doctor ask for any further ideas and I realised that things were not going to have a clearly happy ending. It would have been probably 20 to, quarter to 7 by this time and I was informed by, I think it was a Ward

Sister that came out of the room that there was not a lot of hope in saving [the man's] life."

40. As the hospital staff were unable to resuscitate the man, the resuscitation attempts were abandoned and he was pronounced dead at 6.45pm. The principal officer then informed Swinfen Hall that the man had passed away. When the man's family returned to see him they were informed by hospital staff that he passed away.

41. A Principal Officer was appointed as the prison Family Liaison Officer. She maintained contact with the family and assisted with the funeral arrangements. Swinfen Hall also offered financial assistance with the costs of the funeral. The man's funeral took place on 1 June.

42. The prisoners on B wing were told the following morning about the man's death. Staff on the wing asked prisoners whether they required anything or wanted to speak to a Listener. (Listeners are trained by the Samaritans to provide confidential emotional support to fellow prisoners in distress.) When the bedwatch officers returned to the prison they were offered support from the prison's care team.

43. The post mortem report records the man's death as being due to natural causes, as a consequence of an acute myocardial infarction (heart attack) and pulmonary hypertension (high blood pressure) caused by congenital heart disease.

ISSUES CONSIDERED

44. When visited by the Ombudsman's investigator and family liaison officer, the man's family told them that they had concerns about the care he had received whilst in custody. I set these out in the paragraphs that follow.

45. Although the man died in May 2009, his family believe he had already died a month earlier following the stress of being handcuffed whilst recovering from an operation and anaesthetic. They wanted to know why the man was restrained so soon after his operation and why this could not have waited for 30 minutes until he had the opportunity to come round from the anaesthetic.

Clinical care

46. As noted above, a review of the man's medical care was undertaken on behalf of South Staffordshire Primary Care Trust by a clinical reviewer. My investigator informed the clinical reviewer of the concerns raised by the man's family. The clinical reviewer reviewed the man's medical notes and the interventions of healthcare staff. She also interviewed a number of clinical staff. In order to evaluate the action of clinicians involved in the man's care, the clinical reviewer also consulted with members of the South Staffordshire's death in custody panel.

47. The clinical reviewer notes that before the man arrived in custody, the cardiac surgeon at outside hospital had identified the need for a further heart valve replacement. The surgeon deemed that the need for the valve replacement was urgent as the man was 'at risk of imminent death' without the operation. This view was supported by the hospital registrar who agreed that in their opinion the man could suffer with a gradual heart and consequent lung failure without further surgery. The clinical reviewer records that the man initially refused to have the operation, wanting to wait until he was released from prison. He then agreed on the condition that he was transferred out of HMYOI Glen Parva.

48. In her review, the clinical reviewer records that healthcare staff at Swinfen Hall carried out regular reviews and monitored the man's condition and medication. His prison health records, both at Glen Parva and Swinfen Hall, indicate that healthcare staff ensured he adhered to his medication regime and the dosage was regularly monitored. The man had started a drug withdrawal programme (from the effects of illegal drugs) and healthcare staff tried to educate him about the extra strains that substance misuse could have on his heart.

49. The clinical reviewer records that the man regularly experienced chest pain, which usually passed within 20 minutes. She found that the prison doctor was informed on each occasion and regular electrocardiograms (ECG is a graphical recording of the electrical activity of the heart) were performed to check for any changes. Swinfen Hall also ensured that the man was able to attend his hospital appointments.

50. Following an appointment with his consultant, in March 2009, it was decided that the man needed to have emergency surgery. The clinical reviewer confirms that healthcare staff worked in co-operation with hospital staff to ensure that the man was prepared for his hospital admission.

51. However, the clinical reviewer finds that the man's mother was not treated as an integral part of her son's care, and appears to have been excluded. He was an independent adult, but consideration should have been given to involving his family in his treatment plans. The clinical reviewer suggests that this may have contributed to her lack of understanding of what had happened to her son. The clinical reviewer says:

> "Given that in this instance the prison was dealing with a young man who had been in receipt of long term care for a chronic condition little attention appears to have been paid to how he was used to being treated. Acknowledgment to his change into adulthood and the fact that he was a prisoner at the time of his treatment does mean that he would experience some changes in how he was cared for but it appears that his mother's expectations were not appropriately managed."

The clinical reviewer recommends that families are included in planning for long term treatment. Although the man's situation was unusual in that he was a young man with a serious long term condition, consideration should be given to the way other such prisoners are dealt with. I endorse the following recommendation to the Head of Healthcare at Swinfen Hall.

Careful planning with family involvement, particularly for prisoners with chronic, life threatening conditions, should be made before surgery. A record of these consultations should be made in order to protect those agreeing these plans. Information sharing is important but also security issues need to be considered and risk assessed.

52. The clinical reviewer records in her review that, when the man was in the community, he did not always attend for tests and treatments. When he was in custody, assistance was provided to remind him of appointments and to help him get there. In many ways I believe that he received more regular and consistent treatment when he was in custody. The clinical reviewer says that blood tests and treatments were timely, and health checks and support from nurses and doctors were readily available. The clinical reviewer concludes that staff at Swinfen Hall took a good medical history and helped the man to comply with his treatment. He was supported with his drug misuse issues and healthcare staff ensured that he attended hospital appointments. The clinical reviewer finds that his clinical care was deemed to be equitable to what he would have received in the community and I am pleased to support her judgement.

Use of restraints

53. When they met with the Ombudsman's investigator and family liaison officer, the man's family explained that he had learning difficulties and that his heart condition had led to him having to have a number of operations. They said that, on 13 April 2009, he had been escorted to hospital by officers, in restraints, to undergo another operation on his heart. His family attended the hospital to support the man through this operation. They were extremely distressed and concerned about the treatment they and he received from officers whilst he was in the hospital.

54. The family said that on the following day, 14 April, the man was taken down to the anaesthetic room accompanied by prison officers but they were not allowed to go with him (as they had done at previous operations when he had not been in custody). The family waited in the hospital canteen whilst the man was in the operating theatre. After they were informed that he was out of surgery, the family went to see the man. They found him in bed with a nurse and two officers at his bedside.

55. The family said that the man was coming around from the anaesthetic and kept asking for water. The nurse applied a sponge to his lips and explained that he would have to wait 30 minutes before he could have a proper drink. It was at this point that the family said they heard a click and noticed the man's left wrist had been handcuffed to a prison officer. The family recalled that the man became extremely distraught and upset and asked for the handcuff to be removed as it was hurting him. The family explained that, due to effects of the anaesthetic, the man was asking who the officers were and why no one was helping him. One of the family members went round to the side of the bed where the officers were located and they showed her that the handcuffs were not tight. The family said that the man then sighed, put his head back and collapsed into unconsciousness.

56. According to the family, the female officer told them to leave as the man had gone to sleep. The family recalled that, as they left, the machines connected to the man were making bleeping noises. A few minutes later the family were approached by the female officer who apologised for putting the handcuffs on the man and put her hand on the man's mother's back attempting to comfort her. She told the officer to leave her alone and said, "You've just killed him". The family were taken to a quiet room where they spoke to the surgeon who stated "this is a complete mystery". They said that the surgeon explained that the operation had gone well but the man was now in a critical condition.

57. The family said that during the following month the handcuffs were not re-applied and the officers on bedwatch duty were told by their Governor that, if he regained consciousness, the man was not to be restrained. The family praised some of the other officers on bedwatch duty, stating they were outstanding and respectful and allowed the family to have some privacy with the man.

58. However, the family said they had contacted the prison and requested that the two prison officers who were present when the man came out of his operation, the male officer and the female officer, were not allocated to his bedwatch. Three to four days later when the man's family were visiting him, the female officer was present. The man's mother became extremely agitated, upset and distraught about the female officer being there. The family said the man's mother was told by the other officer on the bedwatch, that if she carried on with her behaviour, she would be arrested. The man's aunt was able to calm the situation down and they apologised, as they were concerned they would be thrown out of the hospital and not allowed to see the man.

59. The Ombudsman's investigator wrote to the Governor of Head of Performance Management at Swinfen Hall, on 27 July and 12 August to make the prison aware of the concerns raised by the family. In his written response to the concerns raised by the family, the Governor wrote:

> "I have spoken to the Governor and he is unaware of any such request being made by the family [for [the female officer] and [male officer] to be excluded from the bedwatch]. I have spoken to [the female officer] who informed me that she had been out on the bedwatch on a number of occasions and at no time had been approached by any family member concerning her presence on the bedwatch."

60. The man's family visited him regularly and, although he was unconscious, they spoke to him as they believed he could still hear them. The man's mother was concerned about the conversations the prison officers were having in front of her son, when the family were not there. They gave an example where the officers informed them that they told the man what they had eaten. They thought this was insensitive. In response to this point, the Governor of Head of Performance Management wrote he was "unable to comment as [the] officers are not identified".

61. The family were concerned that the officers had no understanding of the man's condition or medical history and had no information about him as an individual, his needs or his learning difficulties. The investigator explained that officers would only be given basic information relating to the man's medical condition which was confidential. The family said that the man's mother had never been violent, was very humble and laid back. They felt that officers should have more training, knowledge and more sensitivity towards the family's needs.

62. In his written response to the concerns raised by the family, the Governor of Head of Performance Management wrote: "The officers were acting in accordance with the escort risk assessment and security protocols".

63. When the man was taken to hospital on 13 April, the risk assessment was that restraints were to be used and three officers needed to be in attendance. When he was taken to have his operation on his heart on 14 April, the restraints were removed and the escort was reduced to two officers. Around 8.00pm, as the man was being brought round from the anaesthetic, the restraints were re-applied. There followed a period of time when the man was

becoming conscious and he was reported by prison and hospital staff as being very restless, shouting and communicating with his mother about his solicitor. The following entry was made on 14 April in the hospital nursing notes about the events leading up to the man's health deteriorating:

> "After extubation [the process of removing a tube from an airway] tried to explain to the patient but he is restless and using bad words. Lot of psychological support given but once saw his family and police he is too restless, hypoxic [lack of oxygen] and hypotensive [abnormally low blood pressure] and deteriorated the level of consciousness, re-intubated him and put him on sedation. Failed extubation- Cardiac arrest – Had cardiopulmonary resuscitation for short time, re-intubated quickly."

64. As soon as it was recognised that the man's condition had badly deteriorated and he required urgent medical attention, the officers removed the restraints. They then moved out of the way, ensuring that they had the man in their sight at all times. According to the statements completed by the officers on bedwatch duty, the restraints were re-applied before the family returned to the man's beside. The officers also stated that his condition deteriorated after the man's family had been asked to leave.

65. The post mortem report does not indicate that the agitation experienced by the man after the operation on 14 April was the cause of his death. The report says:

> "The valve operation was technically fine, and there was no suggestion that it was related to the infarct [heart attack], as this likely occurred sometime after the operation; the coronary arteries were patent, but there was severe biventricular hypertrophy [enlargement of the heart] and pulmonary hypertension [high blood pressure] consequent upon congenital heart disease."

66. From the evidence presented by both the officers on bedwatch duty on 14 April, the notes made by hospital staff and the post mortem report it would appear that the application of the restraints did not cause the man to have a heart attack. The man had a pre-existing serious heart condition. He had undergone a number of major heart operations including heart valve replacements. Further valve replacement surgery was identified as being necessary but the man delayed this for over 12 months. The man had a history of poor attendance at appointments with his doctor, hospital and warfarin clinic. He also had a history of substance misuse since aged 15, including smoking, taking cannabis, heroin and crack. The reviewer suggests it is possible that all these may have contributed to the cause of death.

67. Policy and practice in the Prison Service in respect of the use of restraints on prisoner-patients in hospital is extremely risk averse. My own sense is that it has become too risk averse. In this case a young man, who had just undergone an operation on his heart, was slowly regaining consciousness when the restraints were re-applied. Any movement on the man's part could

have been life threatening and he did not constitute a likely escapee until he regained consciousness. I do feel that when the man was brought round after his operation, he should have been given a little more time to come round and, if there was a perceived risk of escape, consideration should have been given to increasing the number of officers on bedwatch.

68. In her clinical review, the clinical reviewer for South Staffordshire PCT says:

> "[The man] should have been prepared to expect that he would wake up from his operation to find a two person prison escort and that he would be on a closeting chain. What he was specifically distressed about when he awoke is not clear although there is some consensus of opinion that he wanted a drink of water. Nursing notes indicate that [the man] appeared to be distressed by both his mother and the prison staff; prison staff notes indicate that he appeared to be upset by his mother and wanted to make a phone call or for his mother to call his solicitor."

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69. The clinical reviewer recommends that all those involved in a prisoner's care, the prisoner and their family should be kept fully informed of when the prisoner will be handcuffed and in what circumstances they will be removed. This information should be recorded and available to ensure that both the prisoner and healthcare staff are fully aware of the procedure. The Governor of Swinfen Hall may want to consider taking these issues into account as part of a review of the management and conduct of hospital escorts and bedwatches.

The Governor should review HMP & YOI Swinfen Hall's policy for the management and conduct of hospital escorts and bedwatches.

70. Neither the investigator nor the clinical reviewer could find any evidence to support the family's assertion that the man had a panic attack when he saw the officers after waking from his anaesthetic and the restraints were re-applied. This view is supported by the hospital staff. I am satisfied that the officers removed the restraints as soon as it became evident that the man's condition had deteriorated and hospital staff needed to gain easy access to him. After receipt of the draft report, the man's family said that they were still extremely upset about the way he was woken up from his operation. They said he requested water three times and a nurse was rude to him. This prompted the man to get upset. The family also wanted to know why the male officer was pointing in the man's face and what was he saying to him. In response, the Governor of Head of Performance Management confirmed that the male officer denied that he had ever pointed a finger in the man's face. Swinfen Hall were unable to comment on the actions taken by the nurse in the hospital.

CONCLUSION

71. The man arrived in HMP & YOI Swinfen Hall in February 2009. He died in outside hospital in May 2009.

72. In her review of the man's clinical care, the clinical reviewer judges that the quality of care the man received was entirely equivalent to that he would have received outside prison. The clinical reviewer is not critical of any actions of healthcare staff and says that all appropriate clinical procedures were followed. However, the clinical reviewer draws attention to how procedures were explained to both the man and his family. She makes it clear that these should have been more inclusive.

73. I believe that the security arrangements at the hospital, although initially suitable, were not revised in the light of the man's specific circumstances. Swinfen Hall had the option of reviewing and revising the risk assessment. There should have been a careful risk assessment which paid attention to the man's heart problems. The option of removing the restraints and having three officers on bedwatch duty could have been a more appropriate response in this case.

RECOMMENDATIONS

1. The Governor should review HMP & YOI Swinfen Hall's policy for the management and conduct of hospital escorts and bedwatches.

   Accepted - A review will be undertaken taking into account National Security Policy and the Risk Assessment based approach.

2. Careful planning with family involvement, particularly for prisoners with chronic, life threatening conditions, should be made before surgery. A record of these consultations should be made in order to protect those agreeing these plans. Information sharing is important but also security issues need to be considered and risk assessed.

   Partially accepted - Careful planning with family involvement, particularly for prisoners with chronic, life threatening conditions will be considered before a prisoner undergoes surgery. The level of family involvement will be dependent on security requirements and the wishes of the prisoner. A record of these consultations will be made in order to protect those agreeing these plans.