PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man in hospital in October 2011 while in the custody of HMP Channings Wood

Report by the Prisons and Probation Ombudsman for England and Wales

October 2012

This is the report into the death of a man who died in October 2011 at hospital, while in the custody of HMP Channings Wood. He was 67 years old. A post mortem report recorded that his death was caused by cancer of the liver and bile ducts. I extend my condolences to those affected by his death.

The investigation was carried out by an investigator. The local PCT commissioned a clinical reviewer to review the clinical care the man received while in custody. Channings Wood prison cooperated with this investigation. I apologise for the late issue of this draft report.

The clinical reviewer considers that the man's medical care was equal to that he might have expected in the community and makes no recommendations.

However, I was concerned to learn that, although clearly very unwell and unable to move far from his bed without assistance, the man was kept handcuffed by a chain to a prison officer until he died. I consider that the decision to continue using handcuffs in his final days and hours was unnecessary, not justified by adequate risk assessment and, ultimately, inhumane.

In too many cases recently, my investigations have found that prison staff failed to achieve a proper balance between the needs of security and decent treatment in the application of restraints to very ill prisoners. The man's case is another example from which the National Offender Management Service needs to learn.

The man's family were given the opportunity to see and comment on this report at the draft stage, but did not respond. The National Offender Management response is included under each recommendation.

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.

Nigel Newcomen CBE

Prisons and Probation Ombudsman **October 2012**

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SUMMARY

1. The man was 67 years old when he died at hospital, while in the custody of HMP Channings Wood. In 1969, he was sentenced at Crown Court to life imprisonment after being found guilty of manslaughter. He had been in prison custody for a long time, but this investigation covers the period from when he first reported medical symptoms related to his terminal illness in October 2011.

2. He first reported his symptoms to a prison doctor on 10 October 2011. The doctor was concerned that he was jaundiced and made an urgent referral to the hospital. He had an appointment at the hospital three days later. He was subsequently diagnosed with terminal cancer. He deteriorated rapidly and was admitted into hospital on 20 October, where he remained until his death several days later. The clinical review finds that the medical intervention was appropriate, well managed and equivalent to that available in the community.

3. However, although the man was diagnosed as terminally ill two days before his death and was unable to move unaided, prison managers did not review the hospital escort security arrangements and he died while handcuffed by a chain to a prison officer.

4. There is little evidence that prison managers acted upon information received about the man's condition, read important information contained in the bedwatch records or demonstrated appropriate compassion.

5. This investigation has identified a number of areas for improvement and makes four recommendations covering: effective information sharing, improved escort arrangements, appropriate risk assessment of prisoners in hospital, establishing procedures for the safe management of prisoners in hospital and routinely debriefing of staff.

THE INVESTIGATION PROCESS

6. The Ombudsman's office was notified of the man's death on 30 October 2011. The investigator issued notices to staff and prisoners and anyone with information was invited to contact him. No one came forward as a result. He examined the man's relevant prison and medical records.

7. The local PCT commissioned a clinical reviewer to review the clinical care the man received while in custody.

8. In November 2011 and April 2012 the investigator visited the prison to carry out interviews. He met the Governor and gave him feedback on his findings, including concerns about appropriate risk assessment, management checks and use of restraints on prisoners in hospital. The Governor undertook to act on these. On 6 April, he followed up the feedback to the Governor in writing. The Governor subsequently wrote to the investigator setting out his response to the initial feedback and the actions he had taken.

9. On 12 April, the investigator wrote to the Coroner informing him of what had been identified during the investigation. He also forwarded the Coroner a copy of the feedback letter sent to the Governor.

10. Her Majesty's Coroner, Torbay and South Devon District, carried out an inquest into the man's death on 20 April, and the finding was that he died of natural causes.

11. One of our family liaison officers contacted the man's family to explain the purpose of this investigation and invited them to ask any questions or raise any issues for consideration. His family raised no issues of concern at the outset of the investigation. We are sorry for the late issue of this draft report which has been delayed by work load pressures in this office.

12. The family were offered the opportunity to see the draft of this report and to raise any questions or comments. They did not respond.

HMP CHANNINGS WOOD

13. HMP Channings Wood is a category C prison in Devon. (All prisoners are allocated a security category based on factors including their offence, risk of escape and risk to the public if they did escape. Category C prisoners are those who, typically, could not be trusted in open conditions, but who are thought unlikely to escape). The prison holds a maximum of 731 prisoners.

14. Healthcare services are provided by a Partnership Trust. There is nursing cover during the day between 5.00am and 7.45pm from Monday to Thursday, and until 5.00pm on Friday and at weekends. The GP service is provided by an external company.

Her Majesty's Chief Inspectorate of Prisons (HMIP)

15. The last inspection of Channings Wood was a short follow up inspection in July 2010. The then Deputy Chief Inspector of Prisons, in his foreword, said that Channings Wood continued to be a "reasonable training prison, providing a generally safe and purposeful environment".

16. Inspectors commented positively on a clinic for older prisoners, with all men over 55 offered an assessment and a policy for older prisoners based on the National Service Framework for older people. They found that healthcare was "better integrated into the work of the prison" than it had been in 2007, and that, overall, services were reasonably good.

Independent Monitoring Board (IMB)

17. Each prison has an Independent Monitoring Board made up of unpaid volunteers from the local community. Their role is to monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained.

18. In their latest report, covering the period from 1 September 2010 - 31 August 2011, the Board raised concerns about hospital escorts saying: "The board is greatly concerned that escort officer shortages could lead to pressure for hospital appointment prioritisation by inappropriate staff. Clearly either a doctor must be willing to make the prioritisation decision, or the prison service must find the extra escort officers."

Previous deaths at Channings Wood

19. Since the Ombudsman took on responsibility for investigations in 2004.there had been eight deaths at Channings Wood before the man's. There have been two since. None of the previous deaths were similar to that of his; however one investigation into a death in January 2012 also identified a need to ensure that escort arrangements and the use of restraints are proportionate to risk and subject to ongoing risk assessment when a prisoner is in hospital.

KEY EVENTS

20. The man was born in Carlisle in 1943. He served a number of custodial sentences between 1961 and 1969. On 21 April 1969, he was sentenced at Crown Court to life imprisonment for manslaughter. He was released on licence in 1980, 1999 and 2004. On each occasion he broke the conditions of his licence and was returned to prison. The last occasion he was released on licence was from September 2004 until May 2008, when the Home Secretary revoked his licence and recalled him to prison. On 9 November 2009, he transferred to Channings Wood

21. This report concentrates on the period from when the man was first identified as being seriously ill in October 2011. His medical record shows that he had been previously been given advice on smoking cessation and had undergone routine tests for bowel cancer, which were negative. The clinical review has not identified anything of significance before October 2011.

22. The man did not appear to have contact with anyone outside the prison and officers reported that he did not correspond with anyone or have any visitors. He had been in prison a long time and the records show that he was compliant with the prison regime and until October 2011 had no significant health concerns.

23. On 10 October 2011, he attended an appointment with one of the prison doctors and Clinical Lead for Devon prisons. He was worried that he had lost weight and had been vomiting after meals. The doctor examined him and was concerned that he appeared jaundiced and referred him to hospital with suspected cancer.

24. Three days later on 13 October, the man was examined at hospital by a Gastroenterology Consultant. He had an ultrasound of his biliary system (related to the liver) the same day. The scan revealed a suspected biliary cancer. To confirm the cancer, the doctor asked for a Computerised Tomography (CT) scan. (CT scans are a special type of X-ray which provide a very detailed image). The CT scan could have been carried out that day, but hospital staff could not give a definite appointment time and prison escort officers decided to take him back to the prison.

25. In his report, the clinical reviewer said “There was some confusion around the decision to return to prison and not wait for the CT scan”. The clinical reviewer adds that a doctor at the hospital confirmed to him that the scan could have taken place that same day, although there may have been a lengthy wait. He said in his report that having the CT scan on the same day would not have affected the clinical outcome. He adds that the CT scan was re-requested on 17 October.

26. The officer in charge of the escort told our investigator that the doctor could not confirm the CT appointment time, but had said they hoped it would be that day. He said he took the decision to take the man back to the prison, but

before doing so, had asked the doctor to send an appointment to the prison or, if the scan could be done that day, to contact the prison and he would be taken back to the hospital. The officer said he had decided not to wait at the hospital as the man was not feeling well, there was security to consider and that he was due to finish duty at lunchtime. He added that he would have remained on duty if necessary. Asked what he meant by security, the officer referred to the man's offence rather than any immediate threat to security or likelihood of escape.

27. Three days later, on 20 October, the man was examined at the prison by a doctor. He had suffered a rigor (exaggerated shivering which can occur with high temperature) and so the doctor arranged for him to be admitted to hospital. The clinical reviewer explained that this was because the doctor had suspected he was suffering from ascending cholangitis. (Ascending cholangitis is a bacterial infection of the biliary tract. It is usually caused by chronic obstruction, such as stones. The clinical reviewer considers that in this case, the potential obstruction was a cancer.)

28. Before the man was taken to hospital, a security risk assessment was carried out which identified that a minimum of two prison officers would be required. The assessment instructions required the escort staff to keep him handcuffed to an officer. It added that the handcuffs could be removed for medical treatment, but the duty governor's permission would be required. The exception to that instruction was that they could be removed in an emergency and the duty governor informed later. Further to this, the assessment instructed the officers to use an escort chain if he was admitted or required treatment. (An escort chain is a length of chain attached to an officer and the prisoner by a handcuff at either end.) He was assessed as being of 'normal' risk.

29. At about 8.35pm, the man was admitted onto Ward Seven at the hospital and the first of 11 daily 'bedwatch' records was started. (Escorting officers at hospitals known as the 'bedwatch' are required to keep a log of events while the prisoner remains in hospital.) The record shows that he had not slept well that night and had been given antibiotics. It also shows that he was handcuffed to an officer and, although not specifically mentioned, it is assumed this was by way of an escort chain.

30. The following day, 21 October, the first management check was carried out by a junior member of the prison management team. The record shows that she asked the man if he wanted his next of kin told that he was in hospital and that he declined.

31. An officer recorded in the bedwatch log that a doctor (unnamed) had spoken to the man and told him the he had a blood infection and that he might have liver cancer. He added that he had informed the prison but did not identify who was told. He also stated that he had not been concerned about the possible diagnosis.

32. Over the next two days the bedwatch record shows that the man was settled and eating well. It also shows that he was taking showers and using the toilet frequently. The record shows that he continued to decline offers to inform his next of kin that he was in hospital.

33. The bedwatch record shows that, at about 1.30am on 24 October, nurses attended to the man as he was experiencing difficulty in breathing and that he had a high temperature. He was given a nebuliser and his breathing improved. (A nebuliser delivers medication in the form of mist inhaled into the lungs.) An officer noted that the nurse had said he was “not well”.

34. The copy of the bedwatch record provided to the investigator for day six (25 October) is incomplete. Enquiries show that the original records had been sent to solicitors in preparation for the inquest concerning the man’s death and had not been copied correctly. The available record shows that between 5.45am and 10.00am there had been no concerns about him and that he appeared to be settled.

35. On 25 October, the man was taken for the CT scan which had been requested on 17 October. The result of the scan was suggestive of cholangiocarcinoma (cancer of the liver and bile ducts). Records show that the scan showed a suspected 5cm mass the appearance of which was suggestive of a tumour and a single gallstone.

36. The next day, 26 October, an officer recorded that a doctor (unnamed) had told the man that a lump had been found in his stomach and that it was possibly cancerous. The officer noted that the prison had been told, but did not record the name of the person to whom the information was provided.

37. Later that day at about 3.30pm, the man was moved to another ward at the hospital. The bedwatch record shows that the family of another patient in that ward had complained to nurses about seeing him handcuffed and had asked to move to a different part of the hospital. It also shows that a Senior Officer (SO), the manager carrying out the daily management check, had noted the complaint written in the record and that “the situation appeared to have calmed down”.

38. At about 6.30pm, the man experienced difficulty breathing and was given a ventolin inhaler (a fast acting medication to aid breathing). Unfortunately, the inhaler did not work correctly, so a nurse set up a nebuliser and soon after his breathing returned to normal. He was told that arrangements for an endoscopy procedure to examine his bile duct had been made for the following day.

39. On 27 October, he was taken to theatre for the endoscopy. Before the examination took place, the officer in charge of the bedwatch a SO obtained permission from the prison to remove the escort chain. The escort chain was to be reapplied once the procedure was complete and he was no longer under sedation. The bedwatch log records that an unnamed nurse had said that his illness was terminal and that the care he would be receiving was to be

palliative. In addition to working as part of the bedwatch staff, the SO had carried out the daily management check. However, there is no record that prison management or the prison healthcare department were informed that his condition was considered terminal.

40. The investigator spoke to the SO who said that she had informed the duty governor but could not recall who it was that day. There are no records to confirm this.

41. In his clinical review the clinical reviewer writes that the man had a procedure known as Endoscopic Retrograde Cholangiopancreatography (ERCP). (ERCP is a procedure that uses an endoscope and X-rays to look at the bile duct and pancreatic duct.) The ERCP revealed a biliary stricture which was possibly malignant. A sphincterotomy procedure (operation to cut or stretch the muscles that control bowel movement) was carried out in an attempt to relieve the obstruction, and this had been partially successful. He said an attempt had been made to remove the blockage, after which a decision was taken by the surgeon not to investigate further. He notes that the procedure was not a cure but might have made him more comfortable. He adds that he remained unwell with intermittent fever and was being treated for heart failure and a chest infection.

42. At about 9.35pm, another officer took over the bedwatch duty for the night. The record shows that he received a handover from the SO. This included information about the diagnosis of the terminal illness. The officer telephoned the prison and spoke to an Operational Support Grade (OSG) in order to ensure the prison was aware.

43. The investigator spoke to the OSG, who said that he remembered the telephone call and that he told the night manager. The OSG said he was instructed by the night manager to telephone the duty governor and make him aware. He said he telephoned the duty governor but could not remember who it was. He said he had written this information down in the communication room log book. When the investigator asked to see the log book, it could not be found.

44. Prison records show who was the duty governor that day. The duty governor told the investigator that he had no recollection of being told about the man's medical condition. He added that, had this occurred, he would have made a judgement regarding the use of handcuffs based on that information.

45. The bedwatch record shows that the following day, 28 October, the man walked around the ward and used the toilet. During the walk he became breathless and distressed and sat on the floor to regain his breath. The record shows that nurses and doctors attended, after which he became calmer and settled. He was still restrained by an escort chain. Throughout the evening and night, his breathing is noted in the bedwatch record as laboured.

46. The management check that day was carried out by a Principal Officer (PO). He noted feedback in the bedwatch log from the ward manager which reads "in confidence v. ill". It also shows that the man was handcuffed using an escort chain.

47. Each day the duty governor completes the "Duty Governor's Check List" document and records any significant information, which is then shared with prison managers at the Governor's daily meeting. The meeting is normally chaired by the Governor or in his absence, the Deputy Governor. The information from the Duty Governor Check List and any other relevant detail from other managers is recorded as a "morning briefing" and shared with prison staff via the internal intranet.

48. The investigator identified that an entry was made on the Duty Governor's Check List which states "The man – terminal". The entry was made by the Head of Residence at that time. He told the investigator that he could not remember where he had received this information from.

49. The morning briefing information shows that the meeting was chaired by the Governor and, although the Head of Residence was also present, the terminal illness diagnosis was not shared. There is an entry from the prison healthcare manager which simply says "no medical information available for the man".

50. The duty governor told the investigator that the man's medical condition had been discussed by senior managers at the morning Senior Management Team Meeting. He said it had been agreed that he would try to find out exactly what the short term prognosis was so that an informed decision could be made about the use of handcuffs.

51. He also said he had spoken to a member of hospital staff that morning and that a discussion had taken place about the use of handcuffs. He said the use of the handcuffs would have been reviewed if it was felt that the man was at imminent risk of death. He said medical staff at the hospital told him that he was not at imminent risk and that they were uncertain about his state of health. He went on to say that medical staff would not confirm that his condition was terminal. Based on the information available, he said he decided it was right to keep him in handcuffs. He added that he reported his findings and decision back to a Senior Management Team Meeting that evening.

52. At about 5.30pm on 29 October, the Head of Residence carried out the bedwatch management check. The bedwatch record shows that he asked the man if he wanted his next of kin informed and that once again he declined. The record shows that he occasionally sat in a chair and that his breathing was again described as laboured. A further entry records that he had become distressed. It also shows that the escort chain was still attached to him and an officer.

53. On bedwatch duty that evening was two officers. When interviewed one officer described the man as "very poorly", unable to move and with very little

ability to communicate. He said that, when he did speak, he gained the impression that he did not know how ill he was, as he had told the officer that once the doctors know what is wrong, they could treat him. The officer said his breathing was laboured. He added that a nurse told him that he was critically ill.

54. The bedwatch record shows that at about 1.00am the man was experiencing breathing problems. It shows that he was being cared for by nursing staff and a hospital registrar.

55. At about 3.00am he woke up and wanted to use the toilet. By this time he was using a commode. He was still attached to the officer by an escort chain. The officer said it had been an effort for him to use the commode and that after using it he laid down and went to sleep, but kept waking up due to difficulty in breathing.

56. The officer said that, at about 5.30am, the man sat up in bed and was having difficulty breathing. He said the man leant forward, placed his head on the bed and stopped breathing. The officer said he pressed an emergency alarm button to attract medical attention and that, while waiting for assistance, he removed the handcuffs. He said nurses arrived quickly and after carrying out medical checks, confirmed that he had died.

Events following the man's death

57. Following confirmation that the man had died, the officer telephoned the prison to let them know what had happened. Both escort officers remained with him, intending to stay until he was moved from the ward, so that he would not be left alone.

58. However, at 6.00am two more officers arrived to take over the bedwatch. They were unaware that the man had died and unsure as to what to do. They contacted the prison for further instructions. In the meantime, they remained with him (and the previous escort officers left). The officers accompanied his body to the hospital mortuary, after which they returned to the prison.

59. The prison attempted to contact the man's next of kin. The only information available in his prison record was the name and address of his sister who lived in the Cumbria area. Because there was no telephone number and due to the distance from Channings Wood to Cumbria, the Governor asked Cumbria Police to assist. Additionally, he contacted the Governor of HMP Haverigg (which is in Cumbria) and asked for assistance in following up the police contact with her.

60. The Governor of Haverigg appointed one of his Family Liaison Officers (FLO) to contact the man's family on behalf of Channings Wood. The FLO said he telephoned the man's sister and that she made it clear to him that she had not been in contact with her brother for many years and that she did not want any further contact from the prison.

61. The Governor of Channings Wood also appointed his own FLO. She told the investigator that she had contacted the man’s family to offer support and to discuss returning his property. They asked for no further contact from the prison and said they did not want the property.

62. Whenever there is a death in a prison, all prisoners considered as being at risk of suicide or self harm and being monitored should be reviewed. This is to ensure they are safe and have not been adversely affected by the death. The investigator was told by the Head of Residence that all such prisoners were reviewed. Additionally, the prison chaplain was on the unit where the man had lived and available for prisoners when they were unlocked. He also offered prayers at the morning service. .

63. The staff interviewed as part of this investigation confirmed that the prison’s care team had contacted them and were available for support if they required it.

64. Following a death in prison custody a hot debrief (immediate meeting) should be held. The purpose of the meeting, which is usually chaired by a senior prison manager, is to identify any immediate issues arising and provide reassurance and support to staff. The Head of Residence told the investigator that a hot debrief did not take place in this case because the man had died in hospital. He said he had telephoned both officers on duty at the time of the death at their homes and spoken to the officers who had escorted his body to the hospital mortuary.

65. On 17 November, the chaplain officiated at the man’s funeral and he was joined by the Head of Residence. At the same time, a memorial service was held in the prison.

ISSUES

Clinical care

66. The clinical reviewer records that the man's illness was recognised as a potential cancer and that appropriate referrals were made. The post mortem examination indicates that the cause of death was due to cholangiocarcinoma. He concludes that his treatment was equivalent to that he could have expected in the community.

Information sharing

67. Although the clinical reviewer makes no recommendations, there appear to be occasions when information about the man's medical condition was not shared with prison healthcare staff. His prison medical records show that telephone calls were made by prison healthcare staff to hospital staff regularly during the period he was in hospital yet there was no reference to him being terminally ill.

68. The investigator discussed with the Head of Healthcare the arrangements for sharing information between the prison and the hospital. It would appear that much depended on who was contacted and lacked formality. It is for this reason that we make the following recommendation.

The Head of Healthcare should agree a formal protocol with the local Primary Care Trust to ensure effective and appropriate sharing of medical information.

CT Scan 13 October 2011

69. In his report, the clinical reviewer writes that the CT scan could have been carried out on 13 October, although no definite appointment time could be given. The escort officer confirmed that he had been told it could take place that day, but there was no definite time. As a result, he and the other officer decided to return to the prison for a number of reasons.

70. It is clear that a scan could have taken place that day, albeit with a potentially lengthy waiting time. However, the officer (who was leading the bedwatch) did not telephone the prison to seek advice about what to do. Instead he made a decision which should have been taken by a prison manager. The result was a delay in the man receiving the CT scan. Although the clinical reviewer indicates this would not have affected the outcome, the officers involved would not have known the implications. As a result a second escort had to be arranged some days later.

The Governor should ensure that escorting officers appropriately consult the duty governor when decisions need to be taken in relation to prisoners escorted to medical appointments.

The use of restraints

71. In June 2010 the National Offender Management Service (NOMs) and NHS agreed a concordat about hospital escorts. The document states:

> "The overall purpose of this concordat is to provide a framework, with respect to prisoner escort and bedwatch functions that can be used locally by the NHS Local Security Management Service and the local prison, to develop procedures for the safe management of prisoners while at hospital".

72. In relation to the use of restraints on terminally ill or seriously ill prisoners, the concordat states:

> "Levels of restraint used on prisoners must at all times be proportionate to the perceived security risks and balanced by considerations of care and decency for the prisoner. Using handcuffs or other restraints on terminally ill or seriously ill prisoners is considered inhumane by the courts unless justified by security consideration.
>
> "Terminally or seriously ill prisoners may present a lower risk of escape and this should be considered as part of the assessment process. The use of restraints on terminally or seriously ill prisoners should be reviewed regularly taking into account clinical input, and the level of restraints should be adjusted in accordance with any deterioration in the prisoner's clinical condition or the intensity of the treatment that they are receiving."

73. The investigator asked one of the prison's security managers how often risk assessments were reviewed for a prisoner admitted into hospital. The SO said that they were reviewed weekly, or whenever there was a change of circumstance. However, the man was in hospital for ten days and during that time there was only one risk assessment recorded, on 20 October, before he was admitted to the hospital. Despite significant changes and deterioration in his medical condition, the risk assessment was not reviewed. All management checks confirm that the escort chain remained in use, yet an examination of the bedwatch records, which managers are expected to read, record the rapid deterioration in his medical condition. There does not appear to have been any review of the arrangements at any stage or any consideration by managers of whether the escort chain should be removed. A number of management checks were carried out by junior managers who would not have the necessary authority to authorise changes to security measures, although they should have been able to contact the duty governor for advice.

74. The duty governor said the man's medical condition had been discussed at the Governor's Senior Management Meeting on 28 October. However, despite notes being taken at that meeting there is no record of that discussion. He said he had discussed his condition with hospital staff and they would not confirm whether the illness was terminal.

75. It is clear is that on 28 October the diagnosis of terminal illness was known by a senior manager as the Head of Residence recorded this in the daily governor log. However, there is no evidence to show that he passed the information on to anyone else.

76. The investigator discussed the issue with the Governor. He said that he and the chaplain had visited the man and that he had not been handcuffed at that time. The bedwatch logs available to this investigation do not record the Governor and the chaplain visiting. It is possible the visit took place and is recorded in the missing records from log of 25 October or at a time when the handcuffs had been removed for a medical procedure, or was simply not recorded by the escort officers.

77. It is of considerable concern that, despite being terminally ill, unable to move far from his bed, distressed and short of breath it was considered necessary to keep the man on an escort chain up to the moment he died. As a result, he was treated in a disrespectful, undignified and inhumane way during his final hours.

The Governor should ensure that escort arrangements are proportionate to risk and that all relevant sections of the risk assessment are completed each day a prisoner is in hospital, so that full account is taken of a prisoner's health and physical condition and the impact this has on his actual risk.

Hot debrief

78. Prison Service Order 2710 Follow up to Deaths in Custody (now replaced by PSI 64/2011) gives guidance and instructions on what to do in the event of a death in custody. There is a requirement for a hot debrief following a death in custody

> "There must always be a hot debrief immediately after the incident and provision for this should be made in local contingency plans. A senior member of staff must act as de-briefer and a duty care team member must also attend."

79. The Head of Residence informed the investigator that there had not been a hot-debrief because the man had died in hospital, although he added that the officers were contacted at home. Irrespective of the fact that he died in hospital, he remained a prisoner throughout his hospitalisation and a hot debrief should have taken place. Had this occurred, it is likely that the issue of him dying while handcuffed by an escort chain to an officer would have been discussed. It is a concern that the Governor was apparently unaware of this until our investigation. It would also have been an opportunity to identify the lack of review of risk assessments.

The Governor should ensure that a hot debrief is carried out following any death in custody in line with PSI 64/2011 so that issues and learning can be highlighted and acted upon.

CONCLUSION

80. We are satisfied that once the man had been examined by the prison doctor on 10 October, his symptoms prompted the proper medical response. He was appropriately referred by the prison doctor to hospital and seen only three days later, on 13 October. In his clinical review, the clinical reviewer said the man's medical treatment was equal to that he would have received in the community. .

81. Although it did not affect the outcome in the man's case, we are concerned that at the 13 October appointment officers decided, without seeking senior management advice, not to wait at the hospital for a CT scan which the doctor had requested.

82. The man was admitted to hospital on 20 October and died there several days later. Communication between the hospital and the prison appeared to be poor, as was communication between prison managers about the seriousness of his condition. The risk assessment which was completed on 20 October before he went to hospital was never reviewed despite his rapidly deteriorating condition which was well documented in the bedwatch log. This meant that he was still handcuffed to an officer by an escort chain when he died which was unnecessary and not justified by an up to date risk assessment.

RECOMMENDATIONS

The prison's response to each recommendation is printed below

1. **The Head of Healthcare should agree a formal protocol with the local Primary Care Trust to ensure effective and appropriate sharing of medical information.**

   Accepted: *The NHS Trust fully accepts and understands the need for the appropriate and legitimate sharing of information with health and to others as required.*

   Every member of staff receives training on Information Governance and safeguarding training which protects the rights of patients in relation to information given and shared.

   The Trust has the following policies in place:
   - *Information governance, policy and strategy*
   - *Access to health records policy*
   - *Confidentiality policy*

   These policies clearly detail guidelines for accessing health records, confidentiality practice, freedom of information, records management, information sharing and provides a risk management strategy. We have formal protocols in place for information transfer to the police and social care services and a concord 'The information sharing agreement between statutory and non-statutory partners' which allows a passage of information between agreed parties to ensure continuity of care in a safe manner.

2. **The Governor should ensure that escorting officers appropriately consult the duty governor when decisions need to be taken in relation to prisoners escorted to medical appointments.**

   Accepted: *A Governors Order has been issued for escorting staff and a copy placed in the escorting bags, reminding staff that they MUST ensure they seek advice from the Duty Governor before any decision to return to the establishment is taken, especially when waiting for medical appointments. The two members of staff have been issued with advice and guidance regarding this matter.*

3. **The Governor should ensure that escort arrangements are proportionate to risk and that all relevant sections of the risk assessment are completed each day a prisoner is in hospital, so that full account is taken of a prisoner's health and physical condition and the impact this has on his actual risk.**

   Accepted: *All bed watch risk assessment paperwork has now been reviewed. Managers tasked with undertaking management checks have been reminded to review risk assessments if there are any reported changes of circumstances regarding the well being of the prisoner concerned.*

4. **The Governor should ensure that a hot debrief is carried out following any death in custody in line with PSI 64/2011 so that issues and learning can be highlighted and acted upon.**

   Accepted: *The Deputy Governor confirmed that the members of staff concerned were spoken to, but this was not recorded as a hot debrief. All governor grades at Channings Wood have been advised of the correct procedure to be followed regarding hot debriefs.*