PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man in hospital in February 2012, while in the custody of HMP Whatton

Report by the Prisons and Probation Ombudsman for England and Wales

September 2012

This is the report of an investigation into the death of a man, a prisoner at HMP Whatton. He died at hospital in February 2012, having been admitted from prison three weeks earlier. He was an older prisoner, aged over 60. A post mortem established the course of death as inflammation of the bile duct caused by gallstones. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. A review of the man's clinical care in custody was carried out by a clinical reviewer on behalf of the PCT.

The last two years of the man's life were dominated by investigations into, and treatment of, his gallstones and a serious heart condition. Surgery was recommended for both, but could not be proceeded with because of the clinical risks associated with undergoing one while the other was still unresolved. Some treatment was delayed as he deferred agreement till a late stage. I am satisfied that staff at Whatton did all they could to encourage him to engage with his treatment plan.

The investigation found that the man received appropriate health treatment during his time in prison, but it is disappointing that it is necessary, once again, to criticise security arrangements for an infirm and relatively immobile man. The primary responsibility of the Prison Service is to hold prisoners securely but it must also balance this with the duty to treat them with humanity and to maintain their dignity and privacy. The level of restraints used to escort him to and from hospital and to manage him during his stays there were out of proportion to the evident security risks. This was particularly so when he was undergoing invasive investigative procedures, including on at least one occasion when hospital staff asked for restraints to be removed and staff refused.

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 **September 2012**

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SUMMARY

1. The man was transferred to Whatton from HMP Manchester in October 2008. At the time of this move, he took medication to control long term conditions including angina and high blood pressure. He had also been diagnosed with chronic schizophrenia (a mental illness that affects the way people think and behave).

2. During his time at Whatton, the man visited hospital on many occasions for investigations into and treatment of a variety of medical conditions. In August 2010, he was diagnosed with gallstones which needed to be removed by surgery. Before this surgery could go ahead, he was diagnosed with a serious heart condition that required further investigation. These investigations took place in 2011 and resulted in a recommendation that he undergo heart valve replacement surgery. However, neither surgery was able to go ahead because of the risks of going ahead with one without satisfying certain conditions associated with the other.

3. At the same time, many of the required investigations were delayed owing to the man regularly deferring scheduled appointments. Throughout his time at Whatton, he put off going to hospital for a variety of reasons, including a fear of the procedures and potential outcomes, embarrassment at being identified in hospital as a prisoner, and discomfort at being handcuffed during procedures. It is apparent that he had a good relationship with staff in the prison's mental health team and he was able to talk over these concerns with them and other staff. Eventually, he usually agreed to the necessary hospital admissions and treatment although, as the clinical reviewer notes, this was often "at the point of crisis" when treatment options were more limited. We are satisfied that healthcare staff at Whatton did all that could be expected to encourage him to comply with his treatment plan.

4. Many of the investigative procedures that the man required involved the use of an endoscope (a long thin fibre optic tube inserted into the body) or similar device. The use of restraints during these procedures was inconsistent, sometimes involving the use of an escort chain and sometimes not. Our view is that restraints during such invasive procedures were not necessary and the risk assessment involved did not appropriately take into account the man's age, health and mobility and the consequent effect on his risk to the public and risk of escape. Handcuffs were usually used on the journey to and from hospital.

5. On 18 January 2012, the man was admitted to hospital following a deterioration in his health. He remained in hospital until his death in February. Throughout most of his time in hospital, until 8 February, he was restrained using an escort chain. Daily management visits before then reported that the man was in considerable pain and with very limited mobility. We consider that he should have been managed in hospital without restraints.

6. In addition to recommendations about the risk assessments for the use of restraints, we also make recommendations about the need for prisoners with limited mobility to be assessed by the disability liaison officer and that the

possibility of release on temporary licence should be considered when a prisoner is very seriously ill in hospital. We agree with the clinical reviewer's conclusion that the man received equivalent medical care in prison to that he might expect to receive in the community.

THE INVESTIGATION PROCESS

7. On 13 February 2012, the investigator issued notices announcing the investigation to staff and prisoners. The notices included an invitation to those who wished to submit information about the man's death to make themselves known. No one came forward.

8. The investigator visited Whatton on 16 February. During the visit he saw the wing on which the man had lived and spoke to two of his friends. He visited the healthcare centre and spoke to a nurse who knew him. He also met the prison's family liaison officer, the Vice Chair of the local Independent Monitoring Board (IMB, a body of unpaid local people who independently monitor and report on the prison), and spoke with the senior manager on duty. He was provided with copies of the man's prison records, including the medical record. The prison was unable to provide some of the bedwatch records.

9. A clinical review of the man's time in custody was carried out by a clinical reviewer on behalf of the local PCT. His final report was completed following consultation with the investigator.

10. The investigator returned to Whatton on 19 April and with a colleague interviewed two members of staff. They also met the Governor to provide feedback on the investigation, and followed this up in writing.

11. One of the Ombudsman's family liaison officers telephoned the man's sister, his nominated next of kin, on 15 March, to explain the investigation. His sister did not have any issues to raise, but wanted to know more about her brother's illness and why he died. We hope this report helps in that respect. As part of the consultation period she received the draft report, and did not wish to make any comments about the findings. I would like to thank her for taking the time to consider the report.

12. The report was also sent in draft to the Prison Service. Their response to the recommendations is included and other comments have been included as appropriate in the report.

HMP WHATTON

13. Whatton is a category C prison which holds up to 841 adult male sex offenders. (Category C prisoners are those who cannot be trusted in open conditions but who do not have the resources and will to make a determined escape attempt.) The average age of prisoners at Whatton is higher than most prisons. The man lived on A wing, a newer residential unit with single cells. Prisoners on A wing who need help with everyday tasks (such as collecting meals and cleaning their cell) can be assigned another prisoner to help them (known at Whatton as a 'disabled prisoner coordinator').

14. Healthcare services are commissioned by NHS Nottinghamshire and provided by Nottinghamshire Healthcare Foundation Trust. The healthcare centre is open daily from 7.30am to 6.30pm Monday to Friday and 8.00am to 12.30pm at weekends. A local out of hours service providing cover at night. Specialist clinics are provided for older prisoners and those with life long conditions. There are no inpatient beds at Whatton.

15. HM Chief Inspector of Prisons conducted an announced inspection of Whatton in January 2012. The Chief Inspector found that health services at the prison were generally good and prisoners had good access to the GP and to a wide range of clinics. A senior nurse led the care for older prisoners, and there was effective care planning of the needs of older prisoners.

16. In their annual report for 2010-11, the IMB reported that they were impressed with various areas of healthcare provision, including the management of long term health needs. They also commented that the standard of accommodation on A wing, where the man lived, was very good.

17. We have investigated a number of deaths at Whatton, most of which were of older prisoners. Many of the men who died at Whatton had, like the man, significant long term medical conditions. He was the fourth man of five to die at the prison since January 2011. Our reports into the first two of these deaths reflected well on Whatton. Our report into the death of the third man commented that his chronic diseases were managed well at the prison. However, we identified some incidents when staff on A8 residential unit (the same unit on which the man lived) did not respond to the man's ill health in the required manner. We do not raise any such concerns in this investigation.

KEY EVENTS

18. On 9 February 2007, the man was sentenced to an indeterminate sentence for public protection (IPP) for sexual offences, with a minimum term to serve of two and a half years. (This means that the earliest point he could be released from prison was two and a half years after sentencing, but that he could be held indefinitely if the Parole Board believed he was still a risk to the public.) He arrived at HMP Manchester on the same day. He had previously served a two month prison sentence in 1981 and had spent five days on remand in March 2006.

19. At the time of his imprisonment, the man had been diagnosed with various medical conditions. He suffered from angina, for which he carried a spray to ease the pain as needed, and took medication to control his blood pressure and cholesterol. He was also asthmatic, for which he used an inhaler. He had been diagnosed with chronic schizophrenia several years previously. (Schizophrenia is a mental illness that affects the way people think, feel and behave.) He took antipsychotic medication to control his symptoms. During his time in prison, he saw mental health professionals regularly.

20. The man was at HMP Manchester for a year and a half. During this time he reported several angina attacks. On two occasions he was advised to go to hospital for further investigation, but declined. He moved to Whatton in October 2008. This was a progressive move, to enable him to carry out the courses set out in his sentence plan aimed at reducing his risk of reoffending.

21. A few weeks after his arrival at Whatton, the man reported that he had coughed up blood. A referral was made to a local hospital under the two week rule for suspected cancer (a national target whereby patients who are suspected of having cancer are required to be seen within two weeks of referral). He declined to attend the subsequent appointment (his reasons for this are not recorded) but was persuaded by prison healthcare staff to go to a rebooked appointment. Investigations at this appointment revealed that he did not have a lesion, although further tests were recommended.

22. A follow up biopsy was arranged, but the man said he was very worried about what it might find and because he had to go to hospital in handcuffs. As part of the Prison Service's duty to protect the public prison escort staff routinely use restraints when prisoners are taken out of the prison. An individual risk assessment should be completed on each occasion. The assessment will consider the offences and the risk of further offending while out of the prison, as well as the prisoner's health and mobility.) It was determined that he would have the biopsy while restrained by an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner's wrist and the other to a member of staff). The type of lung biopsy that he had is known as a bronchial brushing, which means that a bronchoscope (a long thin fibre optic tube with a small camera on the end) is inserted into the lungs via the mouth or nose. The examination found no cancerous cells.

23. The man was admitted to hospital in June 2009 after blood tests of his liver function were found to be abnormal. He was diagnosed with an obstruction in his cystic duct (the passage that links the gallbladder to the common bile duct). He returned to hospital to have a stent (artificial tube) inserted to widen the cystic duct. This procedure was carried out using an endoscope (a similar procedure to a bronchoscopy). As previously, he was restrained using an escort chain during the procedure. Standard handcuffs were used during the journey to and from hospital.

24. In July and August, the man returned to hospital for scans of his lung to follow up the previous biopsy. On both occasions the restraints were removed during the procedure. The scans showed no significant problems and no further follow up was required.

25. The man was due to return to hospital in November 2009 for removal of his stent. Like the insertion, the stent would be removed using an endoscope. The man refused to go to hospital, and told staff that the procedure was too degrading in handcuffs.

26. In March 2010, the man began to experience more regular chest pain. A prison doctor proposed referring him urgently to a cardiologist (heart specialist). He refused initially, but said he would think about it. The following month, he told the doctor that he was still not sure if he wanted to see the cardiologist as he said he was too embarrassed to go out escorted. A mental health nurse, who saw the man regularly, offered to see the cardiologist with him for reassurance, but he remained undecided.

27. Over the following months, the man continued to experience regular angina. This culminated in his agreement to go to hospital on 23 July 2010, after he experienced increased shortness of breath and an increased heart rate. He was admitted to hospital as an emergency case and remained there for four nights. The man was prescribed warfarin (medication to prevent the formation of blood clots) by the cardiologist. Restraints were used during his time in hospital.

28. After his return from hospital, the man became constipated and experienced further shortness of breath. He had a six night inpatient stay in hospital in August 2010, when a gallstone was identified in his common bile duct which could not be removed using an endoscope (the usual method). An escort chain was used throughout his time in hospital and there is no record that it was removed during the endoscopy. As the stone could not be removed, the man was listed to return at a later date for surgery to remove his gallbladder.

29. During a review with the mental health nurse on 24 August, the man said he was aware he needed surgery but did not wish to return to hospital. He said this was because he had experienced derogatory comments from the public during his recent inpatient stay on account of being a prisoner (as a result of which he had been moved to a side room). He said he also did not like having to walk to the bathroom on the escort chain as this made him feel paranoid that people were looking at him. He said that he was happy to meet the prison doctor to discuss

the consequences of not having surgery. She noted that this demonstrated that he had the capacity to consider his decision.

30. Following a meeting with a doctor and nurse on 31 August, the man agreed to have his gallbladder removed. The surgery was subsequently scheduled for mid-October. However, in early October, the man changed his mind and said he no longer wished to have the procedure. He told the nurse that this was because a member of his family had died following similar surgery. The following month he changed his mind again and said that, having considered the long term implications of not having surgery, he would now like the procedure.

31. Later in November, the man agreed to go to hospital after experiencing chest pain. During a six night stay, he underwent surgery to replace the stent inserted the previous year. As previously, an escort chain was used during his stay in hospital, and it is not clear from the records if this was removed during surgery. During his stay in hospital, it was reiterated to he that he needed surgery to remove his gallbladder.

32. In December, the man told the nurse that he no longer wished to go to any hospital appointments. This was because of an incident during his previous inpatient stay, in which he said he was asked by a doctor what his offence was and how much longer he had to serve on his sentence. He said that a lady in the ward started "screaming hysterically" when she overheard his answer to this question. The nurse advised the man that he could make a complaint about the doctor if he wished, but he said he did not wish to pursue this.

33. The man continued to express reluctance to return to hospital. He was assessed by a psychiatrist on 21 January 2011. He told the psychiatrist that he understood that he would have to return to hospital at some stage and was now happy to do so. The psychiatrist concluded that he could not see "any indication of [the man's] decisions about his health being seriously influenced by his mental disorder".

34. The man's shortness of breath increased in the early part of 2011. He now required a wheelchair to cover significant distances around the prison. He was encouraged to go to hospital for investigations, and agreed to do so on 2 February. An escort chain was used when he was an inpatient. During his week long stay in hospital, the prison mental health nurse twice visited the man to give him support. The man spoke of positive experiences with hospital staff and other patients, but chose to discharge himself against advice on 10 February. However, his symptoms were now reported to be better controlled on account of a change to his medication.

35. Later in the month, the man was assessed by an occupational therapist. He was offered a four wheel walker to reduce his reliance on the wheelchair, but declined. The occupational therapist recorded that the man was able to walk 40 to 50 metres without assistance and was able to carry out activities of daily living (such as washing, dressing, collecting meals) without assistance. Later in the year (the exact date is not recorded) he was assigned a disabled prisoner coordinator to help with these activities.

36. A prison doctor contacted the cardiologist at the hospital on 31 March 2011, to clarify the man's treatment plan. The cardiologist explained that scans undertaken during his admission in February showed that he would benefit from heart surgery, including a heart valve replacement and bypass operation, and that various procedures would need to be completed before this surgery could take place. The surgery and associated procedures were described as being of high risk of serious complications. The following week the doctor discussed the situation with him, who agreed to consider his options. Later in April, he said he was prepared to see the cardiologist to get more information about the procedures.

37. The man subsequently saw a cardiologist on 12 May. Restraints were used during this consultation. The cardiologist recommended that he should have a type of scan called a transoesophagael echo (TOE, a type of ultrasound scan that gives accurate pictures of the structure of the heart). This investigation was the first stage in treatment of his heart condition, which would lead up to the required surgery. On his return from this consultation, he said he was more optimistic and keen to go ahead with the required procedures.

38. The consultant hepatologist (specialist in the gallbladder and other organs) at the hospital responsible for treating the man's gallstones wrote to the doctor on 13 June. The consultant explained that the heart disease meant that the risk of surgery to remove the man's gallbladder had increased. The consultant said that he would now try again to remove the gallstone using an endoscope (the same procedure that had previously been unsuccessful in August 2010). He added that he thought this should take place before any heart surgery, due to a risk of sepsis (blood infection).

39. On 12 July, the man went to hospital for his TOE scan. Entries made by escort staff in his person escort record (PER, a form that accompanies prisoners on all journeys to and from prison) state that the consultant asked that the escort chain be removed during this procedure, but was told by the escort staff that their procedures meant they could not do this. The scan went ahead and showed that one of the man's heart valves (through which blood flows between the heart chambers) was abnormally narrow. The consultant recommended that he return for heart catheterisation (a more advanced test to determine the reason why his heart valve was narrow, which involves insertion of a long thin tube into a blood vessel and threading it to the heart) with a view to replacing the valve through surgery at a later date.

40. The man returned to hospital on 2 August for the attempted removal of his gallstones by endoscope. On this occasion restraints were not used during the procedure. Again, the gallstones could not be removed. The consultant wrote to Whatton to explain that the options now were to leave the stent in place and only take further action if there were further problems, or to try other means of surgical extraction. It was left for the man to decide which route he preferred to take.

41. A prison doctor subsequently met the man on 25 August to discuss his preferred treatment options. The man said he was willing to have surgery to remove his gallstones because he sometimes found them painful. He also said he was willing to have the heart catheter. The doctor prescribed tramadol (a strong painkiller). The man was also worried that he would fail his offending behaviour course if he missed too many sessions because of hospital appointments. The following day, he was reassured that his place on the course was secure.

42. The consultant hepatologist wrote to the prison doctor again in September. In contrast to his previous letter, the consultant now thought that the man should have heart surgery before removal of his gallstone. He thought that the presence of a stent in the bile duct reduced the risk of infection sufficiently to allow heart surgery to proceed. The consultant added that there was no risk in waiting for gallbladder surgery until after this procedure.

43. The man's pain was well controlled over the following month, and he did not always need to take his full dose of tramadol. He went to hospital for the heart catheterisation procedure and an angiogram on 21 October, following which he was referred by the cardiologist for heart surgery. No restraints were used during these medical procedures, but they were used to take the man to the hospital and at all other times.

44. The man spoke to a member of the mental health team at Whatton, on 31 October. He said he was "petrified" of heart surgery. The nurse highlighted to him the reassurance he had received from the healthcare team and that he should focus on this rather than potentially negative outcomes.

45. Over the following month, the man's health was relatively stable. He experienced some angina but described this as "just the usual" and said it was relieved by his GTN spray. On 2 December, he reported increased pain in his abdomen and said he had vomited several times during the week. The man was advised by a prison doctor that he should be admitted to hospital, but refused to go. He said he would wait and see if there was any change to his condition. It was noted that nursing staff were asked to check on him over the weekend, although there is nothing in his medical record to indicate they did so.

46. The man did agree to go to hospital on 5 December, when blood tests showed a raised international normalised ratio (INR, a measure of the effectiveness of warfarin). He had an injection of vitamin K, to prevent his blood clotting, and returned to the prison. The man saw a doctor for review on 8 December, and told her he no longer felt pain and had stopped vomiting.

47. Five days later, the man saw the doctor and told her that he was feeling unwell and had passed a black stool the previous night. His blood pressure was low and the doctor noted that he appeared to be jaundiced (the yellowing of the skin and whites of eyes, caused by a build up of waste in the blood due to the liver not working properly). She told the man that he should be admitted to hospital, but he initially refused to go. After some persuasion, he agreed to go to hospital that afternoon.

48. Various tests were undertaken at hospital, including a gastroscopy (an examination of the stomach area using a similar technique to an endoscopy). Restraints were used during this inpatient stay, although it is not clear if they were removed for the gastroscopy. The results of the tests showed that there was some bleeding in the area around the man's stent, which was treated in hospital. He returned to Whatton on 19 December. In his discharge letter, the consultant highlighted that the man needed surgery to remove his gallbladder, but that this would not take place until after the heart valve replacement surgery.

49. The man was relatively well over the following week but, on 29 December, vomited blood and was therefore admitted to hospital again. An escort chain was used during his inpatient stay. The man was again diagnosed with internal bleeding around the bile duct and was given a blood transfusion. He returned to Whatton on 4 January 2012.

50. On 16 January 2012, the man experienced an increase in pain, which he described as "more than ten" (on a pain scale of one to ten). He said he had taken all of his medication, but this had no effect. A doctor advised the man that he should be admitted to hospital, but he refused to go. The doctor also recorded in his notes that the cardiologist and hepatologist were trying to decide whether his heart surgery or gallbladder removal should take priority.

51. The man vomited several times the following day. He saw a prison doctor and nurse on 18 January, when it was recorded that he was in pain, appeared jaundiced and had low blood pressure. On this occasion, the man agreed to be admitted to hospital. He was accompanied by two officers and an escort chain was used on the journey to hospital and following admission.

52. Over the following week, the man was given oxygen and had a blood transfusion. A duty manager visited him in hospital each day to reconsider the risk with which he presented and whether any changes to the staffing or level of restraints was appropriate. The management entries were along broadly similar lines, indicating that he was in a lot of pain and had very limited mobility. Each entry concluded that the escort chain should remain in place. Similar entries were also made in the first week of February.

53. The man had an endoscopy on 26 January, which showed a possible cancer of the bile duct. (The post mortem examination conducted following his death found no evidence of cancer.) The escort chain was removed for this procedure and replaced following its completion.

54. On 30 January, one of the prison's mental health team visited the man in hospital. He spoke to staff at the hospital and asked that they contact him or his colleague if it was confirmed that the man had cancer, so that they could provide support when the news was broken. Although this was not required as investigations did not confirm cancer, this was a thoughtful and appropriate approach.

55. A second endoscopy took place on 2 February. As previously, the escort chain was removed for the procedure and replaced afterwards. Blood clots and other "debris" were removed from his bile duct and a new stent was inserted.

56. The man's sister visited him in hospital on 4 February. She had been in regular telephone contact with the hospital and with the man since his admission. This contact continued in the last week of his life.

57. A scan undertaken at hospital identified an aneurysm (a bulge in an artery caused by a weakening of the artery's wall) in a blood vessel that supplies blood to the liver. This was treated by surgery on 6 February, during which the escort chain was removed.

58. Over the following days the man's condition worsened. Following a review by the duty governor on 8 February, the escort chain was removed "on account of [the man's] deteriorating condition". By the following evening, he was described as "semi conscious" and the escort was reduced to one officer. The man's sister was contacted by hospital staff and told that his condition was now grave.

59. In line with his wishes, the man was visited by a Roman Catholic chaplain on 10 February and given the Last Rites. A family liaison officer was appointed. She visited the man in hospital at the same time as the chaplain and, later, telephoned his sister to update her on his condition. The man continued to deteriorate and died the following day. As had been arranged, hospital staff telephoned his sister to break the news to her. The duty governor later spoke to the officer who had been with him when he died and reminded her of the appropriate support services available.

60. The family liaison officer telephoned the man's sister the following morning to offer condolences. The man's funeral was arranged by the family liaison officer and took place on 7 March. The prison contributed to the costs in line with national guidance. A separate memorial service was held for staff and prisoners on 18 February.

ISSUES

Clinical care

61. The man suffered from two major physical health problems during his time in custody: gallstones and a serious heart condition. His gallstones could not be removed by conventional methods, and therefore surgery to remove the gallbladder was recommended. At the same time, his heart condition got worse and investigations revealed that he needed surgery to replace his heart valve. The man died of an infection of the common bile duct (the tube that carries bile from the liver to the gallbladder and intestines) which was caused by the presence of gallstones. The clinical reviewer explains that numerous attempts were made to clear the blockage of his bile duct created by the gallstones, but these were only a temporary measure. He also explains that the man's cardiovascular system (the heart and blood vessels) needed to be stable and his gallbladder free of infection for either of the surgeries to proceed. There was not a time when both conditions were satisfied, so the surgery could not be carried out.

62. The investigations into these problems and, therefore, the surgery required to correct them, were also delayed by the man regularly deferring his scheduled appointments. It is apparent that he spent much time thinking about his treatment. The clinical reviewer notes the man's decision making was affected by his chronic schizophrenia. However, he saw the mental health team at Whatton on a very regular basis and developed good relationships with several members, notably one mental health nurse. The man was able to clearly explain to them, and prison doctors, why he did not wish to attend appointments. Reasons for his non-attendance included discomfort at being handcuffed, embarrassment at being identified in hospital as a prisoner, and fear of the procedures and potential outcome of surgery. The healthcare team dealt with those issues within their control by requesting side rooms for him so he had more privacy in hospital, offering to accompany him for support, and giving him regular opportunities to discuss the risks and benefits of treatment with the mental health team, prison doctors and the hospital consultants. (We will later discuss in more detail the use of restraints in hospital.)

63. The man's capacity to refuse treatment was assessed by a visiting psychiatrist, who concluded that he had capacity to make decisions about his health. We note that he was able to explain clearly why he did not wish to go to appointments and was willing to discuss these reasons with relevant professionals. The clinical reviewer comments that the man often only changed his mind about appointments or admissions "at the point of crisis", when his treatment options were more limited. The clinical reviewer adds that this non-compliance delayed the necessary surgery from taking place. He concludes:

> "[Prison healthcare staff] repeatedly told him that his health was at risk from cancelling investigations and deferring plans for surgery. There is no reason to believe he did not understand the implications of the choices he was making … [healthcare staff] did everything expected when it came to encouraging him to make positive choices about his own health."

64. The clinical reviewer found no shortcomings in the man's clinical management at Whatton and that his care was equivalent to that he might expect to receive in the community. We agree.

Referral to the disability liaison officer

65. All prisons are required to appoint a disability liaison officer (DLO). The role of the DLO is to act as a source of information and advice on issues of disability that affect prisoners. The DLO might arrange any necessary 'reasonable adjustments' to help a prisoner with a disability, such as providing handrails in their cell.

66. The DLO at Whatton told the investigator that he did not meet the man in his capacity as DLO. He explained that a prisoner can be referred to him following their arrival at the prison (when they complete a disability questionnaire), by staff on their wing, or by self-referral.

67. The man had limited mobility, required a wheelchair to cover longer distances around the prison and was allocated a disabled prisoner coordinator to help him with everyday tasks. We acknowledge that he was assessed by an occupational therapist in February 2011 and that there is no indication that he was unhappy with the support he received. However, we consider that he would have benefited from an assessment by the DLO to determine whether there were any adjustments that could reasonably be made to assist him with everyday activities.

    The Governor should ensure that all prisoners with limited mobility are offered an assessment by the disability liaison officer.

Restraints, security and bedwatch

68. The Prison Service has a duty to protect the public and prison escort staff routinely use restraints when prisoners are taken out of the prison for any reason. However, there is also a responsibility to balance the need to hold prisoners securely with the duty to treat them with humanity and to maintain their dignity and privacy. Individual risk assessment should be completed on each occasion and regular management checks should be made to ensure the level of restraints used are necessary in all the circumstances. The risk assessment should consider the risk of escape and the risk to the public taking into account factors such as the prisoner's health and mobility.

69. The man went to hospital on many occasions for investigative procedures. These included investigations involving endoscopes or similar devices, whereby a long flexible tube is inserted into the body, usually through the mouth. Patients are usually given a sedative before such a procedure to help them relax, or a local anaesthetic spray can be used. If a patient is unduly distressed then a general anaesthetic might be used, although there is no indication that this was ever the case for the man.

70. There was inconsistency regarding the use of restraints when the man underwent these investigative procedures. On some occasions an escort chain was used, and on others it was not. (There are also some occasions when it is not clear what, if any, restraints were used. In response to the draft report, Whatton explained that if restraints had been removed it would be documented. In all other instances it would be the default position that restraints would be applied.)

71. The Head of Operations at Whatton told the investigator at interview that the removal of restraints during a medical procedure is usually determined by the clinical staff at the hospital. He explained that if hospital staff think the procedure should not be carried out under restraint then they can ask the escorting officers to contact the prison to ask for removal. He went on to say that removal would usually be approved, unless there was intelligence of a security risk. He therefore surmised that any inconsistency in the use of an escort chain during the man's clinical procedures was likely to be caused by hospital staff not always asking for its removal.

72. We do not agree that the decision on the use of an escort chain during such procedures is one that should normally be led by hospital staff, although it is helpful when they do. Health professionals are often unsure whether they are entitled to ask for handcuffs and other restraints to be removed during assessment and treatment and whether they can ask officers to leave the room. Ultimately, security and the use of restraints are the prison's responsibility and it is the prison which should determine whether they are used in consultation with hospital staff. When a clinical investigation is pre-planned, as was the case with those undertaken by the man, the prison has the opportunity beforehand to consider the type of procedure that will be undergone and determine whether there are any risks associated with the individual that would necessitate the use of restraints during it. Arrangements should be discussed and agreed with the hospital in advance. The British Medical Association guidance is that there should be a presumption that prisoners are examined and treated without restraints, and without prison officers present, unless there is a high risk of escape or the prisoner represents a threat to himself, the health team or others.

73. The man was an older prisoner with limited mobility (in February 2011 it was determined that he could walk 40 to 50 metres without assistance). The risk assessment highlighted that he was a low risk of potential escape. We acknowledge that public protection is paramount, but we also take the view that security measures must be proportionate to a prisoner's individual circumstances. The clinical investigations that he underwent were particularly intrusive and we do not think that the risk he presented warranted the use of an escort chain during them.

    The Governor should ensure that the risk assessment undertaken before a prisoner visits hospital for an invasive clinical investigation gives thorough consideration to the type of procedure and the individual circumstances of the prisoner, including age, mobility and general health. Arrangements should be agreed with the hospital in advance with the presumption that

prisoners should be treated without restraints, and without officers present, unless an individual security risk assessment indicates otherwise.

74. Although the Head of Operations suggested that the removal of restraints ahead of a procedure was likely to have been determined by a request from hospital staff, there was only one occasion recorded in the man's notes where such a request was made. This was on 12 July 2011, ahead of the TOE scan. On this occasion, the consultant asked that the escort chain be removed during the procedure but was told by the escort staff that they could not do so.

75. Local guidance at Whatton on the removal of restraints on hospital escort gives the following instructions to escort staff:

> "Restraints must be removed if a healthcare professional seeks their removal because:
>
> i) There is an immediate risk to the health of the prisoner.
> ii) The prisoner is in pain or discomfort.
> iii) The restraints are impeding essential treatment.
>
> Restraints may be removed [only after prior approval of the duty manager] unless there is a risk of escape, if a healthcare professional seeks their removal because:
>
> i) Although essential treatment is not required, they are impeding examination or treatment."

76. On account of this guidance, the Head of Operations explained that he would expect the escort staff to have contacted the duty governor on 12 July and that any request would have been approved. We agree that this should have been done.

The Governor should ensure that escort staff adhere to local instructions when a healthcare professional requests the removal of restraints ahead of a medical procedure.

77. In mid January 2012, the man experienced an increase in pain, appeared jaundiced and began to vomit frequently. After initially refusing to go to hospital, he agreed to be admitted on 18 January. He remained in hospital for the rest of his life.

78. As is expected, a security risk assessment was produced ahead of his admission. A Senior Officer (SO) completed the main body of the report and recommended a two officer escort and that an escort chain be used. He was assessed to be a high risk to children "due to the nature of the offence". However, such risk assessments should not focus principally on the original offence but the likelihood of risk of escape and the actual risk to the public at the time the escort was taking place. It is difficult to see how he could have been regarded as such a high risk when his mobility was very poor and he was accompanied by two officers. The form also contains a section in which any

relevant medical information should be recorded for consideration. A nurse, who had examined him that morning and referred him to the doctor, completed this section and ticked a box to say there were "no medical objections to the use of restraints". A separate box in which "any other medical condition likely to influence the escort" should be detailed was left blank.

79. The recommended security measures were agreed by the Head of Operations, the countersigning manager. The Head of Operations explained at interview that these are standard arrangements when a prisoner is an inpatient. We accept that such arrangements are sometimes necessary, but suggesting that they are 'standard arrangements' which might apply to any prisoner indicates that insufficient consideration was given to the man's individual circumstances and his actual risk at the time. We think that further consideration should have been given to his personal circumstances, particularly his limited mobility and the amount of pain he was experiencing. These factors were not included on his risk assessment.

    The Governor and Head of Healthcare should ensure that a prisoner's health and mobility and actual risk at the time are fully considered on escort risk assessment forms and that these factors are fully taken into account in deciding the level of escort and whether restraints are needed.

80. The man remained in hospital until his death. As is standard practice, a duty manager visited each day. One purpose of the daily visit is to review the security arrangements in place. A form is completed by the visiting manager to outline, amongst other factors, the prisoner's medical condition and level of mobility, followed by the manager's recommendation on whether any changes to the current arrangements are required.

81. During the man's first three weeks in hospital, many of the daily management entries highlighted that he was in considerable pain and with very limited mobility. During this time he was treated and investigated for some very serious conditions, including an aneurysm and possible cancer. The escort chain was not removed until 8 February, following a further deterioration in his health. Given the daily management entries described, we consider that decision should have been made much sooner.

    The Governor should ensure that duty managers appropriately review risk assessments when making daily management visits to hospitals.

82. In response to the draft report, HMP Whatton made the following comment:

    > "HMP Whatton does not agree with this view. Mobility levels are a key factor in the dynamic assessment of the risk a prisoner poses to those around him."

83. We agree that mobility levels are a key factor in the risk assessment process. As we have made abundantly clear in this report, the man was reported to be in considerable pain and with very limited mobility during this inpatient stay. We do not consider that he posed a significant risk at this time and certainly not one that required the use of restraints in addition to two escorting officers. We therefore

stand by our conclusion that the escort chain should have been removed much sooner.

Release on temporary licence

84. Release on Temporary Licence (ROTL) is the process by which prisoners are released from custody on a temporary basis in order to carry out specific activities that cannot take place in the establishment. It is most often used at open prisons, where some prisoners are able to work outside of the establishment or visit their family. There is also a temporary compassionate licence which can be used for urgent medical treatment. Release on temporary licence for a prisoner receiving treatment in hospital would mean that he could remain in hospital without having to be accompanied by a prison officer.

85. The man's condition steadily worsened following his admission to hospital on 18 January 2012. However, for most of this time there was an expectation that he would return to prison following treatment. It was only in the last two days that it became apparent that he might not survive. At this point, release on temporary licence might have been appropriate.

86. The Head of Operations explained at interview that his view was that it was more beneficial for the man to have the support of an officer in hospital rather than be released on temporary licence. We note that his sister had visited him in hospital but was unable to do so for extended periods, and was kept informed of his condition by the hospital and prison family liaison officer.

87. We agree that it is usually beneficial for a dying man to have support in the last few hours of their life. However, this would depend on the individual's wishes and it is likely that many prisoners would prefer to be released. It is possible for a prison officer to stay to provide support if a man is released and that is often done. As the man had regularly expressed his unhappiness at going to hospital under escort over the previous three years, he might have preferred that option. .

88. There is no indication that this matter was discussed with him to determine his wishes. We accept that, in the final two days of his life, he was semi-conscious and is unlikely to have been able to have such a discussion. However, his wishes could have been sought at an earlier stage or his sister could have been contacted to determine her views. .

The Governor should ensure that the possibility of release on temporary licence is fully considered when a prisoner is seriously ill in hospital, taking into account the wishes of the prisoner and his family and all the relevant risk factors.

CONCLUSION

89. During his time at Whatton, the man often refused hospital admissions and investigations into the gallstones and heart condition that dominated the last two years of his life. He was clear about the reasons why he did not wish to attend appointments and, following input from the healthcare team at Whatton, usually changed his mind with persuasion. As the clinical reviewer notes, the man's agreement often came at the stage when only limited treatment options were available.

90. At the same time, the man's conditions were clinically complicated and it took some time to investigate them and reach a decision on the necessary treatment. The required surgery could only go ahead when the risks associated with each condition were satisfied. These issues could not be overcome before his death.

91. We conclude that he received healthcare in prison equivalent to that he might expect to receive in the community. However, we do not consider that appropriate account was taken of his individual circumstances and risk factors when using restraints when he was in hospital, including during numerous invasive procedures.

RECOMMENDATIONS

1. The Governor should ensure that all prisoners with limited mobility are offered an assessment by the disability liaison officer.

   "Accepted – all prisoners with limited mobility are seen by healthcare upon arrival. A disability questionnaire is made available to all prisoners with limited mobility and on this they will be offered an assessment by the disability liaison officer."

2. The Governor should ensure that the risk assessment undertaken before a prisoner visits hospital for an invasive clinical investigation gives thorough consideration to the type of procedure and the individual circumstances of the prisoner, including age, mobility and general health. Arrangements should be agreed with the hospital in advance with the presumption that prisoners should be treated without restraints, and without officers present, unless an individual security risk assessment indicates otherwise.

   "Partially accepted – recommendation 4 deals with specific requirements for the escort risk assessment, which is accepted. It is impractical for arrangements to be made in advance with the hospital as the condition of the prisoner can change during the escort and also the range of investigative procedures could not be reasonably known before the prisoner is discharged to hospital (if the illness is unplanned and/or unknown)."

3. The Governor should ensure that escort staff adhere to local instructions when a healthcare professional requests the removal of restraints ahead of a medical procedure.

   "Accepted – the Head of Operations will ensure escorting staff are reminded of the local instructions to ensure that when a healthcare professional requests the removal of restraints ahead of a medical procedure the request is referred to the Duty Governor for approval."

4. The Governor and Head of Healthcare should ensure that a prisoner's health and mobility and actual risk at the time are fully considered on escort risk assessment forms and that these factors are fully taken into account in deciding the level of escort and whether restraints are needed.

   "Accepted – the healthcare department have a section of the escort risk assessment to complete to indicate if the prisoner's health and/or medical treatment requires the removal of restraints. The Head of Operations will take into account this information when deciding the level of escort and whether restraints are needed."

5. The Governor should ensure that duty managers appropriately review risk assessments when making daily management visits to hospitals.

“Accepted – the Head of Operations will send out guidance on this point to remind staff to appropriately review risk assessments when making daily management visits to hospital.”

6. The Governor should ensure that the possibility of release on temporary licence is fully considered when a prisoner is seriously ill in hospital, taking into account the wishes of the prisoner and his family and all the relevant risk factors.

   “Accepted – this will be considered on all occasions when a prisoner is seriously ill.”