PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the death of a man in December 2011, at hospital, while a prisoner at HMP Swaleside

Report by the Prisons and Probation Ombudsman for England and Wales

January 2013

This is the report of an investigation into the death of a man, at hospital in December 2011. At the time of his death he was a prisoner at HMP Swaleside, where he had transferred from HMP Maidstone. He was 63 years old. The cause of death was recorded as septicaemia, ischaemic heart and cerebral vascular disease. I offer my condolences to his family and friends.

The investigation was carried out by an investigator, with the full cooperation of Maidstone and Swaleside prisons. A review of the man's clinical care in custody was carried out by a clinical reviewer on behalf of the local Primary Care Trust (PCT). I am sorry that the report has been delayed

The man arrived at HMP Maidstone in April 2010. He had multiple health needs, including diabetes. He suffered a stroke in September 2011 and spent a prolonged period in hospital. After some delay, he was eventually discharged to HMP Swaleside because Maidstone did not have an inpatient facility to provide the 24 hour care he required.

While at Swaleside, the man received extensive support with his daily needs, including the maintenance of his personal hygiene, assistance with his meals and ensuring he took his diabetic medications. However, the clinical reviewer considers that the management of his diabetes at Swaleside could have been improved and that there should have been better investigation of his frequent vomiting, which was later established to be caused by gastroenteritis. Nevertheless, the investigation found that his sudden deterioration on the night he died could not reasonably have been foreseen. Finally, it is of concern that it was thought necessary to restrain such a frail and ill man when he was taken to hospital.

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 **January 2013**

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SUMMARY

1. The man transferred from a Scottish prison to HMP Durham in April 2010 and then to HMP Maidstone where he arrived on 24 April 2010. He had type 2 diabetes. On 20 September 2011, he suffered a stroke and was admitted to hospital. He became immobile but would not cooperate with the hospital treatment designed to help him recover his mobility. The hospital therefore made plans to discharge him from their care.

2. Because the man needed 24 hour nursing care, which Maidstone was unable to provide, alternative accommodation was found at Swaleside, which has an inpatient facility. He transferred from the hospital to Swaleside on 9 November 2011, but Maidstone agreed to remain responsible for him and it was hoped that he would eventually be well enough to return there.

3. While at Swaleside, healthcare staff assisted him with his daily needs, including his personal hygiene, helping with his meals and ensuring he took his diabetic mediations.

4. He began to vomit frequently and the prison doctor believed this was due to gastric reflux[1]. His medication was reviewed and he was prescribed medication to alleviate his symptoms. It was not until 20 December, that it was established at hospital that his vomiting was due to gastroenteritis. Until that point, although his blood sugar levels were checked, his condition had not been monitored by regular blood and tests.

5. In late December, the man appeared very lethargic and had vomited. His blood sugar level was low. The on-call doctor was contacted and advised that one of his diabetic medications should be stopped temporarily. He was given something to eat and drink and continued to be monitored. His condition deteriorated and an ambulance was called. Paramedics thought he might have had another stroke and he was taken to hospital at about 9.30am. At around midday his condition became very serious and he died at approximately 1.20pm.

6. We make recommendations about care of diabetic prisoners and the use of restraints.

[1] Gastric reflux occurs when a weakening of the muscular ring between the stomach and oesophagus allows the acidic stomach contents to pass up into the oesophagus, resulting in heartburn.

THE INVESTIGATION PROCESS

7. As HMP Maidstone regarded the man as one of their prisoners, the investigator visited Maidstone on 10 January and issued notices announcing the investigation to staff and prisoners. She visited the wing and cell where he had lived before his admission to hospital. She spoke to a member of the prison's Independent Monitoring Board and provided initial feedback to the Governor.

8. A clinical review of the man's time in custody was carried out by a clinical reviewer on behalf of the local Primary Care Trust. He conducted joint interviews with the investigator of three members of staff at Swaleside and was provided with a copy of his prison medical records.

9. One of the Ombudsman's family liaison officers wrote to the man's next of kin to explain the investigation. His family had no issues which they wished the investigators to take into account.

10. We are sorry that this report has been delayed due to work pressures and staff absences.

11. As part of the consultation process, the man's family received the draft report. His sister told the family liaison officer that there was some information in the report that she had not previously been aware of. The report was also sent in draft to the Prison Service. Their response to the recommendations is included.

HMP MAIDSTONE

12. HMP Maidstone is a category C training prison holding almost 600 men. Medway, the wing where the man spent most of his time holds up to 101 prisoners in single cells.

13. The prison's healthcare unit has no in-patient facilities and does not provide 24 hour cover. General Practitioner (GP) services are provided by the NHS Foundation Trust and three GPs provide cover on a rota basis. GP surgeries are held each weekday morning.

Her Majesty's Inspectorate of Prisons (HMIP)

14. The last inspection of Maidstone was an unannounced inspection from 19 - 23 September 2011. In relation to healthcare, HMIP found that low healthcare staffing levels impacted on their ability to be involved in wider prison meetings. The range of primary care services was appropriate, with short waiting times to see a GP. Prisoners with chronic diseases were managed individually as there were no formal clinics.

Independent Monitoring Board (IMB)

15. Each prison in England and Wales has an Independent Monitoring Board, made up of unpaid volunteers from the local community, who help to ensure that prisoners are treated fairly and humanely. In the most recent IMB report for the year ending 29 February 2012, the IMB said about healthcare:

> "there are no major shortcomings ascertained in the provision of healthcare to the prisoners in custody at Maidstone. The timeliness of appointments and range of services available in general is at least as favourable as that experienced by the public locally.

HMP SWALESIDE

16. HMP Swaleside forms part of the Sheppey group of three prisons, together with Elmley and Standford Hill. The prison is primarily a centre for life-sentenced prisoners. The healthcare centre has an 18-bed inpatient unit, providing 24-hour care for the most seriously ill prisoners. There is a GP service Monday to Friday, with out of hours care provided by a healthcare provider.

17. Since 2010 there have been eight deaths at Swaleside. There are no similarities with the circumstances of the man's death.

Her Majesty's Inspectorate of Prisons (HMIP)

18. HM Inspectorate of Prisons last inspected Swaleside in July 2011. HMIP noted that the healthcare department had been refurbished since the previous inspection and was a good environment for the treatment and care of prisoners. Inspectors found that prisoners had satisfactory access to primary

care services, healthcare staffing levels were good and there was an improved culture of open access to health services. All healthcare staff had received annual updating in cardiopulmonary resuscitation.

Independent Monitoring Board

19. In their report for the period May 2011 to April 2012, the IMB at Swaleside noted that there had been a period of uncertainty for staff working in healthcare because of a re-tendering process for the primary healthcare service. The IMB noted there were difficulties recruiting staff and many agency nurses were employed. All areas of healthcare were described as very clean and the staff were helpful and cooperative when IMB members dealt with issues about individual prisoners.

KEY EVENTS

20. The man was sentenced at the High Court in Edinburgh in January 2009 to seven and a half years for serious offences. At his request he transferred to Maidstone via Durham prison in April 2010. At Durham, on 15 April 2010, his reception health screen noted that he had been diagnosed with type 2 diabetes[2] in 2008 and had suffered a stroke in 2009. As a result, he had spent periods in hospital. He also had ongoing dermatology (skin condition) problems and back pain.

21. On 29 April 2010, the man arrived at Maidstone. His reception healthcare screening identified that he had been diagnosed with diabetes, suffered from diabetic dermopathy and cellulites[3] of his shins and had reduced physical mobility. He used a walking frame and it was recommended that he be allocated a ground floor cell and have access to the disabled showers. He was also prescribed a number of medications to control his diabetes. Flucloxacillin (a penicillin antibiotic used for bacterial infections) was prescribed for his skin condition.

22. He attended healthcare clinics frequently for treatment of his diabetes and skin condition during 2010. On 23 November 2010, a consultant specialist in diabetes examined him because of reoccurring cellulitis on his legs which the consultant noted was primarily a result of his diabetes. His diabetic control was noted as not good and his blood pressure (220/100 at the time) was often higher than the normal expected range[4]. The consultant increased his diabetic medication and prescribed a course of antibiotics for his cellulitis. He was prescribed further blood pressure medication to add to that already prescribed and a statin to lower his cholesterol level.

23. Healthcare continued to monitor the man's diabetes and skin condition. He had ongoing problems with the skin on his legs and it was noted on occasions that his legs were inflamed and hot. They were cleaned and treated, and saline was applied to the wounds. By June 2011, an improvement in the condition of his legs was noted, although medication was still prescribed to control soreness and dryness.

24. On 15 September 2011, he attended the accident and emergency department at hospital suffering from back pain, deteriorating mobility and tingling and numbness in his fingers, hands and parts of his body. The orthopaedic surgeon who examined him found no features of spinal canal senosis[5] which had been suspected. He was referred the next day to the stroke clinic in the hospital and diagnosed as suffering from post-stroke depression from the stroke he had in 2009. It was recorded that he had an obvious left facial

[2] Type 2 diabetes develops when the body can still make some insulin, but not enough, or when the insulin that is produced does not work properly (known as insulin resistance).

[3] Cellulitis is a skin condition which makes the skin scaly and patchy.

[4] Normal blood pressure range is between 90/60mmHg and 140/90mmHg

[5] Spinal stenosis is an abnormal narrowing (stenosis) of the spinal canal that may occur in any of the regions of the spine. This narrowing causes a restriction to the spinal cord, resulting in a neurological deficit. Symptoms include pain, numbness, paraesthesia and loss of motor control.

weakness and residual weakness on his left side. His blood pressure was raised (160/100) and his medication was altered accordingly. He returned to the prison.

25. On 16 September, healthcare staff noted that the man had wet himself during the night. He said he had been unable to move from his bed. He was examined and found to have good strength in all his limbs and demonstrated no signs of extreme weakness. On 18 September, he told healthcare staff he had slept on the floor all night because he had fallen off his bed. On examination, he was able to move all his limbs on request and had no apparent injuries or pressure areas associated with being in one position for a prolonged period.

26. On 20 September 2010, a healthcare review noted that there was some evidence that he might have had a further stroke. He was referred to hospital and admitted to the stroke unit, where it was confirmed he had experienced a stroke.

27. The man remained in hospital and, on 10 October, the hospital's physiotherapist and occupational therapist assessed him in the stroke unit, in conjunction with Maidstone prison's disability liaison officer. Hospital staff said that despite providing support and encouragement to him to improve his mobility, he had made little progress following his stroke. It was noted that he required 24 hour nursing care and he was incontinent. Because of his lack of engagement, the hospital intended to discharge him but Maidstone prison did not have an inpatient unit or anywhere to care for him. It was agreed he would be transferred to HMP Swaleside's inpatient unit.

28. The hospital sent an occupational therapy report dated 13 October, to Maidstone prison outlining the man's physical needs. The report noted that he would require an electric profiling bed[6], slide sheets, urinal bottle, bed pan, wheeled commode, rota stand[7]/full hoist with slings and a wheelchair.

29. On 14 October, he transferred by ambulance to Swaleside. His medical history was noted, including details of his stroke. It was recorded that, although his hearing and speech were okay, he was very immobile. The Swaleside Healthcare Ward Manager saw him and noted that he had severe occupational therapy (OT) needs and required specialist equipment, including a powered bed and a hoist. Swaleside had not received the occupational therapy assessment from the stroke unit at hospital and did not have the equipment needed to provide the care and support he needed. He therefore returned by ambulance to hospital around 6.30pm.

30. Over the next few days, the Healthcare Ward Manager and the discharge nurse co-ordinator from the hospital discussed the financial implications of

[6] Unlike standard hydraulic beds, the bases of electric profiling beds (EPBs) are sectioned so the mattress can be profiled to achieve various positions, the height can also be adjusted. Movement is powered and controlled via a bedside handset by care healthcare staff and if appropriate the patient.

[7] A rota stand provides assistance when a patient is moving from one seated position to another.

purchasing suitable equipment. Maidstone prison was also contacted for their input as Swaleside regarded him as Maidstone's responsibility.

31. The man continued not to engage with the treatment the hospital offered to help improve his mobility and he was therefore discharged from the physiotherapist's caseload. The hospital said he was blocking a bed that could be used for another patient and requested that the prison arrange accommodation for him as soon as possible.

32. On 19 October, the Governor of Swaleside and the Head of Healthcare visited him and had a case conference with his doctor, the occupational therapist and the bed manager. Assurances were made that they would work together to try and resolve the problem of his accommodation. He was told that as he had not engaged with his hospital rehabilitation plan, Swaleside would be looking for a suitable prison to meet his needs.

33. Swaleside made enquiries at all the prisons in Southeast England with in-patient unit facilities. None had the equipment or suitable cells for the man. An occupational therapist at Swaleside who had previously worked at the hospital, knew that it was possible to obtain the equipment required to manage him from a loan store for hospital equipment. She arranged to obtain the equipment needed at Swaleside, which Maidstone prison paid for.

34. On 9 November, the man was discharged from hospital to the inpatient unit at Swaleside. His reception health screen noted that he had had two strokes, had type 2 diabetes and neuropathy[8]. He was described as unmotivated and unable to reach his full potental since his last stroke. He was now considered "virtually immobile" and required asistance with personal hygiene and mobility. He went to ward one of the inpatient unit where the specialist equipment was now in place and was given a wheel chair.

35. He was discharged from hospital with a number of medications for his blood pressure, diabetes, depression and to treat his pain and help him sleep. (A full list is in the clinical review which is attached at annex one.)

36. A healthcare assistant at Swaleside told the investigator that she had a lot of contact with the man while he was at the prison. She said that after his stroke, he had suffered paralysis on the left side. He was receiving physiotherapy but was unable to support himself and had difficulty holding items on his left side. She said that his blood sugar level was taken twice a day and recorded on a board next to his bed. If the results were not within the recommended range of four to seven, this was brought to the attention of the nurse on duty, but this was not necessarily recorded on SystmOne, the electronic prison medical record.

37. On 10 November 2011, healthcare staff helped the man to have a shower, which required at least two members of healthcare staff to help him get up, dressed and out of the bed and into his wheel chair. When he was moved

[8] Neuropathy is damage to nerves caused either by diseases or trauma to the nerve or the side-effects of systemic illness.

from his chair to his bed later that day, he vomited and complained of feeling dizzy. He was assessed by a prison doctor at Swaleside, who noted no particular concerns but said that he should be monitored to see if his condition deteriorated. Because he tended to remain in one position for long periods, his skin was monitored for pressure points and soreness. Urine bottles were also placed in his cell at night within his reach. Throughout the night he was checked every 15 minutes through the hatch in his door. Healthcare staff went into his cell approximately every two hours and, when necessary, he was re-positioned for comfort.

38. The man appeared to settle on the ward and continued to take his medications as prescribed. He cooperated with healthcare and for short periods was moved from his bed to a chair so that he could watch television. On 16 November, some of his property arrived from Maidstone prison, including his four wheel walking frame. When he was reviewed by a doctor on18 November, no new concerns were noted.

39. At around 4.25am on 21 November, he called healthcare staff to his cell. He complained of having stabbing pains in his chest which radiated down his left arm. His jaw was tight, and appeared swollen and clammy. He vomited. He was taken by ambulance to hospital where he was diagnosed as having a lower respiratory chest infection. He returned to the prison later that afternoon with appropriate medication.

40. On 29 November, the man vomited after taking his medication. He was advised by the nurse on duty to take his medication in an upright position and not lying down. He vomited again on 5 and 12 December. The doctor could find no cause for his vomiting and advised him to eat his meals and to lie propped up in bed. Despite encouragement to improve his mobility, he generally stayed in bed. He did not engage with a physiotherapist assigned to help him and would not do any exercises.

41. On 15 December, it was noted in his medical record that he had been persistently vomiting in the mornings. He was seen again by the doctor, who believed it could be due to gastritis[9] or possibly one of the pain killing tablets which had recently been added to his medications. His antacid medication was changed from lansoprazole to pantoprazole[10]. Maxolon, to treat and prevent nausea and vomiting, was also prescribed for two weeks. His diabetes was said to be well controlled at this time and, if he continued to vomit, a referral to the doctor or hospital would be necessary. He was again advised to sleep upright.

42. The Healthcare Ward Manager said that he was aware of the man vomiting frequently and believed doctors initially thought that this could have also been attributed to him always lying flat in bed. He had an electric bed but often refused to lift the back up so he could sit more upright.

[9] Gastritis is inflammation of the stomach.
[10] Pantoprazole is used for the treatment of gastroesophageal reflux

43. He again vomited twice on the morning of 19 December. Healthcare staff noted that he demanded a lot of their time. He complained a lot and was unhappy that some of his personal property had still not arrived from Maidstone. That night, he refused to take his prescribed medication as he said they made him sick. He continued to be monitored and had his observations checked, including his food and fluid intake.

44. The doctor saw him on afternoon of 20 December. He complained of pains in the centre of his chest lasting for about 30 minutes. He had vomited and had refused his daily medications. He was taken to hospital where he was diagnosed with gastroenteritis. He returned to Swaleside the next day with anti-sickness tablets.

45. On 22 December, the doctor saw him and observed that he looked well despite vomiting a small amount that morning. He noted that he should be referred for an ultrasound[11] investigation. Healthcare staff recorded that he had begun to accept his medication again.

46. When the man's observations were checked on 25 December, his blood pressure was 106/57. This was lower than the expected level. He had spent most of the day in bed and still needed lots of encouragement to move. He was reminded to drink more fluids. Two days later he was a little more active and was able to sit up in his chair while having breakfast. All his observations were normal: temperature 36.6, blood glucose level 4.1, pulse 92 and blood pressure 129/53.

47. The man vomited again at around 3.06am on 28 December. He was given metoclopramide, an anti-sickness medication. He was lethargic and his blood sugar reading of 2.2 was below normal[12]. He was given glucogel [13] at 4.36am and food to further increase his blood sugar level which marginally increased it to 2.7 when he was checked at 6.00am. At that time his blood pressure was found to be low at 110/50 but his oxygen saturation level[14] was normal at 98%.

48. Although he had been given food and glucogel, his blood sugar level remained low. The on-call GP was contacted for advice and suggested stopping his anti-diabetic drug, gliclazide. It was hoped this would help raise his blood sugar level to normal limits.

49. When the Healthcare Assistant started her shift one morning in December, she read in the observation book that the man had had an unsettled night and was poorly. When she unlocked his cell at approx 8.00am she said he appeared slightly pale, was "sluggish" in his verbal responses and lethargic. She informed the nurse in charge that she was concerned about him and the nurse asked her to take his observations.

[11] An ultrasound scan is a painless test that uses sound waves to create images of organs and structures inside your body
[12] The acceptable range for blood sugar readings is between 4 and 7.
[13] Glucogel is designed to increase the blood sugar.
[14] Saturation levels are the amount of oxygen being carried in the body.

50. The man's blood sugar level was still very low at 2.3 and his oxygen saturation level had markedly reduced to 80. The Healthcare Assistant recorded his blood pressure at 8.20am as 79/46 and pulse of 100bpm on a piece of paper. At 8.40am his blood pressure was 93/46 and pulse 101bpm. In view of this, he was given oxygen by the nurse and an ambulance was called.

51. After assessing him, the paramedics said that his right side was not responding well and thought there was a possibility he had had another stroke. He was transferred as an emergency to hospital at 9.28am.

52. Before he was taken to hospital the security department carried out an initial risk assessment based on his index offence and security categorisation. The conclusion was that he should be escorted by two members of staff and be handcuffed to one of them at all times by means of an escort chain.[15] The escort risk assessment indicated that he was a medium risk to escort staff, hospital staff and to the public. He was assessed as being a high risk to children. The removal of restraints for medical treatment could only be removed with authorisation from the duty governor. The assessment did not take into account his medical condition and lack of mobility and how this impacted on his risk.

53. Swaleside escort prison officers were replaced by prison staff from Maidstone at around 10.40am. They kept the Governor of Maidstone updated on the man's condition.

54. Around 11.50am, the man went into a septic shock and his kidneys failed. Escort staff removed the restraints so he could receive urgent medical attention. His condition was considered serious and, it is noted in the escort record at 12.15pm that the hospital doctor advised that his next of kin should be contacted. Escort staff contacted the duty manager at the prison and gave an update on the seriousness of his condition. He died at 1.20pm.

55. An officer from HMP Maidstone was assigned as the prison family liaison officer (FLO). The man's partner was listed as his next of kin. As her address was near HMP Isis, in Southeast London, the family liaison officer at Isis was contacted and agreed to visit her at her home to break the news, but was unable to find anyone at home. The police also tried to locate his partner or other family, but on 4 January 2012 established that his partner had recently died.

56. It was then discovered that the man had a daughter in Scotland and, on 7 January, the Scottish police informed her of his death. The FLO later spoke to her, who agreed with other family members that the prison would take care of funeral arrangements. His personal possessions were to be posted to his family in Scotland.

57. The funeral took place on 25 January 2012.

[15] An escort chain is a long chain with a handcuff at each end.

Post- mortem

58. A post-mortem on 3 January 2012, indicated that the man's death was as a result of septicaemia[16] and ischaemic heart[17] and cerebral vascular disease[18].

[16] Septicaemia is presence of numerous bacteria in the blood, which are actively dividing. This results in a systemic response leading to organ dysfunction.
[17] Ischaemic (or ischemic) heart disease is a disease characterized by reduced blood supply to the heart
[18] Cerebrovascular disease is a group of brain dysfunctions related to disease of the blood vessels supplying the brain

ISSUES

Clinical care

59. The clinical reviewer noted that the man had been in very poor health. He had had a series of strokes which had left him immobile and he had been diabetic for many years. He noted that the man was reasonably well the day before his death, when he was eating normally and sitting in a chair. His observations, including temperature (36.6), blood glucose level (4.1), pulse rate 92 and blood pressure 129/53 were within normal limits. He concludes that the rapid deterioration in his health could not have been prevented or diagnosed earlier. He does, however, consider that aspects of his care could have been better managed.

Repeated Episodes of Vomiting

60. The man had multiple episodes of vomiting during most of the time he was at Swaleside. This was thought by healthcare staff to be due to gastric reflux. Staff therefore encouraged him to sit up while eating and taking his medication to help prevent his stomach contents being regurgitated. His vomiting was later diagnosed by the hospital on 20 December 2011 as being due to gastroenteritis.

61. As long-term diabetic, the clinical reviewer notes that the man should not have been left to vomit so long without further and earlier investigations being made. This is because there is a considerable risk that a diabetic's condition could rapidly deteriorate and lead to a coma. As no definitive diagnosis had been made about his vomiting, it would have been good medical practice to refer him to hospital for further investigations at an earlier stage to try and prevent this cycle of vomiting. The clinical reviewer judges that his vomiting did not contribute to his death. Nonetheless we make the following recommendation:

    The Head of Healthcare at Swaleside should ensure that repeated episodes of vomiting, particularly when a prisoner is suffering from diabetes, are fully investigated.

62. As part of the management of his diabetes, the man should have had regular blood tests. Many things can affect blood sugar levels (such as certain medications, illness, or stress) and any abnormal blood result test would need to be investigated immediately. Poorly controlled blood glucose levels can increase a person's chances of developing diabetes complications such as damage to or disease of a kidney and cardiovascular diseases.

63. There were no recorded blood tests in the man's medical records covering the period when he was at Swaleside, other than regular random blood sugar readings. He had not had a renal function test to check the function of his kidneys, since 25 July 2011. As he had diabetes and had been vomiting, the clinical reviewer considers this test should have been carried out more frequently. The clinical reviewer also notes that he should have had his blood

count measured to see if there was any sepsis[19] present. We make the following recommendation:

The Head of Healthcare at Swaleside should ensure that diabetic prisoners have regular blood tests, the results are clearly documented, and appropriate follow up action taken.

Use of restraints

64. The Prison Service has a duty to protect the public when escorting prisoners to hospital, but also a responsibility to treat prisoners with humanity and maintain their dignity. The level of restraints used should be necessary in all the circumstances. They should be based on a risk assessment which considers the risk of escape, the risk to the public and also takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process.

65. When the man was taken to hospital in December he was assessed as a medium risk of reoffending and he was handcuffed to an officer by an escort chain. However, there is no evidence that his medical condition and mobility were taken into account to assess how this had impacted on his risk of escape and risk to the public. He had been bed bound for a considerable period of time, was incontinent and could not walk. When he was taken to the hospital by ambulance he was noted to be "very weak", with low blood sugar, low blood pressure and low oxygen saturation levels.

66. The man went to the hospital at 9.20am and remained in restraints until a doctor asked escort staff to remove them at 11.50am. It is noted in the escort record that the doctor said he was in "septic shock and had several staff working on him".

67. It is clear that he was in extremely poor health with very limited mobility before he went into hospital in December. We consider that it was inappropriate for him to be restrained at all that day. It is difficult to envisage what risk he posed that could not have been adequately managed by the presence of two officers.

The Governor of Swaleside should ensure that when a prisoner is taken to hospital the prisoner's health, mobility and actual risk at the time are considered and taken fully into account in deciding the level of escort and whether restraints are needed.

[19] Sepsis is an illness in which the body has a severe response to bacteria or other germs

CONCLUSION

68. The man had a chronic disease of diabetes and had suffered two strokes. He received a lot of medical attention and while his diabetes was considered initially to be controlled, he later suffered from a prolonged period of vomiting. This should have attracted earlier intervention to determine its cause and to monitor its effect on his diabetes. Nonetheless, the rapid deterioration in his health could not have been foreseen.

RECOMMENDATIONS

1. The Head of Healthcare at Swaleside should ensure that repeated episodes of vomiting, particularly when a prisoner is suffering from diabetes, are fully investigated.

   Accepted – An algorithm for the monitoring and treatment of repeated vomiting in prisoners suffering with diabetes including blood glucose levels (BM) should be initiated and the results recorded on System 1.

2. The Head of Healthcare at Swaleside should ensure that diabetic prisoners have regular blood tests, the results are clearly documented, and appropriate follow up action taken.

   Accepted – The reinstatement of specialist nurse lead diabetic clinic with regular HBAIC tests every six months to be recorded on System 1.

   In addition regular blood tests to be taken and recorded on System 1.

3. The Governor of Swaleside should ensure that when a prisoner is taken to hospital the prisoner's health, mobility and actual risk at the time are considered and taken fully into account in deciding the level of escort and whether restraints are needed.

   Accepted – Prisoners health and mobility is to be considered and recorded on the escort risk assessment by the duty governor or duty manager prior to the discharge of the escort.

   This assessment to be reviewed by the duty manager carrying out the initial bed watch management check.