



**Investigation into the circumstances surrounding
the death of a man at HMP Holme House
in January 2012**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

October 2012

This is the report of an investigation into the death of a man, a prisoner at HMP Holme House, who died in January 2012. He was 78 years old. The post mortem report shows that he died of a urinary tract infection due to a stone in the bladder. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. The local PCT commissioned a clinical review of the man's clinical care, which was carried out by a clinical reviewer. HMP Holme House cooperated fully with the investigation.

The man was waiting for surgery for the removal of a bladder stone when he arrived at Holme House in June 2011. An operation scheduled for October was cancelled by the hospital and a new date had not been set at the time of his death. He suffered from urinary problems and in January he was taken to hospital and treated for a urinary infection. The next morning he was discovered unconscious in his bed by a member of prison staff at a roll check. Despite efforts of staff and paramedics he could not be resuscitated.

In the clinical reviewer's opinion, the level of care the man received in prison was at least as good as he might have expected in the community. When he was found collapsed, the emergency response was quick, although he could not be resuscitated.

While the man received a good standard of health care at Holme House, I am concerned that the prison should have considered it necessary to use restraints when he was taken to hospital on 18 January. The Prison Service has a responsibility to balance the needs of security with the duty to treat prisoners with humanity and to maintain their dignity and privacy. In his case, this balance was not achieved. At the time he was taken to hospital, he was virtually immobile and the use of restraints was out of proportion to the security risks involved. In addition, there was no formal, considered risk assessment and requests by medical staff for the restraints to be removed were inappropriately refused. The Governor of Holme House needs to ensure a more balanced approach in future.

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.

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Prisons and Probation Ombudsman

October 2012

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SUMMARY

1. The man was imprisoned for serious offences on 24 June 2011, when he was 78. This was his first conviction and custodial sentence. Following his sentencing he was taken to HMP Holme house.
2. When the man arrived at the prison, a prison nurse took his medical history and recorded that he was waiting for surgery to remove a bladder stone. He was initially identified as at risk of suicide or self harm and, for a short period, he was monitored under the Prison Service's self-harm and suicide prevention measures.
3. In July 2011, the man's planned surgery for the removal of a bladder stone was cancelled by the hospital at short notice. After some prevarication, he agreed to be placed on the waiting list for another date for surgery. The operation had not taken place by the time he died.
4. On 18 January 2012, the man was transferred to the prison healthcare department to have a catheter inserted, as he was unable to pass urine. That procedure was unsuccessful and so the prison doctor arranged for him to be taken to hospital that same day.
5. At hospital the man was diagnosed as having an infection. He was prescribed antibiotics and taken back to the prison a few hours later. When he arrived at the prison it was noted that he was in discomfort. He was given painkillers and admitted to the prison inpatient unit.
6. At about 5.00am the next morning the man was found unconscious in his bed. Resuscitation procedures were started by a nurse and a prison manager. An emergency ambulance was called and arrived soon after.
7. Resuscitation continued for about 20 minutes after which it was decided to stop any further attempts to revive the man. At 5.31am, he was pronounced dead.
8. We make four recommendations concerning the appropriateness of putting very ill prisoners on report, balanced risk assessment of prisoners attending outside hospital, refreshing resuscitation training for healthcare staff and updating of local policy to reflect current practice in certifying death.

THE INVESTIGATION PROCESS

9. The Ombudsman's office was notified of the man's death on 19 January. An investigator was appointed. Notices were issued to staff and prisoners, and anyone with information was invited to contact the investigator. No one came forward as a result.
10. On 23 January, the investigator visited Holme House and met the Governor, Head of Security, Head of Healthcare and the investigation liaison officer. He arranged to return to the prison the following month to continue the investigation.
11. The local PCT commissioned a review of the clinical care the man received in custody. A clinical reviewer was appointed to carry out the clinical review. The investigator and clinical reviewer discussed aspects of the man's treatment and carried out joint interviews on 20 and 22 February.
12. Before leaving the prison on 22 February the investigator met the Duty Governor and fed back his provisional findings, which he followed up in writing to the Governor.
13. On 20 January, the investigator contacted Her Majesty's Coroner to inform him of the investigation, and to ask for a copy of the post mortem and toxicology reports. The post mortem report was made available in June 2012 for the purposes of this investigation. This investigation report will be sent to the Coroner to assist with his enquiries.
14. One of our family liaison officers contacted the man's daughter to inform her about the investigation and our role. She had the following concerns.
 - She wanted to know what happened when her father was taken to hospital and wondered whether her father got a lesser standard of care because he was a prisoner. She was concerned because her father had been returned back to Holme House within three hours of being taken to hospital.
 - She said her father was admitted to hospital on three occasions and his family would have appreciated being told about this.
 - When her father was unwell he had found it difficult to speak on the telephone, she was concerned and rang the prison. She left a message about her father's health, but never got a response.

After her father's death she said that they had received exceptional support and the prison's Family Liaison Officer had tried to answer all her questions. All her father's property was returned.

15. This report was issued in draft to the man's daughter and family, which they said they found difficult and distressing to read. His daughter explained that she had contacted the prison on several occasions about her father's health

issues and had significant difficulty in getting any replies before or after her father's death. She still remains concerned about the treatment her father received and believes his care was not comparable with what he would have received in the community.

HMP HOLME HOUSE

16. Holme House, near Stockton on Tees, opened in 1992. It holds up to 1212 prisoners with a mixture of young adult offenders and adult males on remand or sentenced.
17. The man lived on houseblock 3 (HB3) a vulnerable prisoner unit with a maximum capacity of 183 beds. Vulnerable prisoners are those who need protection from other prisoners for a range of reasons, including that the nature of their crime makes them targets for victimisation.

HM Inspectorate of Prisons (HMIP)

18. HMIP last inspected Holme House in July 2010. The report described Holme House as a challenging prison to run. Inspectors noted that, in many areas, the experience and the perception of vulnerable prisoners on houseblock 3 were not as good as for prisoners elsewhere, but that relationships between staff and prisoners were good. Older prisoners and those with a disability who did not work were not always allowed out of their cells during the day. It was reported that healthcare services had been modernised and were improving. A senior nurse was responsible for the care of older prisoners and she had access to appropriate specialist continuing professional development. Resuscitation equipment, including external automatic defibrillators, was available in healthcare and on each house block and checked weekly. Health services staff were resuscitation trained and up to date. Inspectors found no problem with prisoners accessing hospital appointments in the community.

Independent Monitoring Board (IMB)

19. Each prison is monitored by an Independent Monitoring Board of independent, unpaid volunteers from the local community. Board members monitor all aspects of prison life to ensure that proper care and decency are maintained.
20. In their latest report covering January to December 2011 the Board said the prison was well managed and that prisoners were treated with respect. The Board raised concerns about the way the transfer of healthcare to Care UK in April 2011 was handled, particularly in relation to staff welfare and the impact on patients. Many prisoners had their prescriptions altered or withdrawn during a review by the new provider. The Board comments that at one time there were over 50 complaints about healthcare awaiting reply, but also states that credit should be given to staff for maintaining a good level of service during a time of considerable change.
21. The investigator met a member of the IMB on 22 February 2012. She said the healthcare contract had been taken over by Care UK and had previously been held by the National Health Service Trust. She raised a number of concerns, which had been reflected in the Board's annual report and do not impact on this investigation.

Prison Disciplinary System – Adjudications

22. Adjudications are internal disciplinary hearings held to decide whether a prisoner has broken Prison Rules. If a prisoner is found guilty he can be cautioned or receive a range of punishments, such as reductions or stoppage of pay or access to privileges, confinement to cell or a combination of all of these. Prisoners can be charged with an offence (“placed on report”) by any member of prison staff but adjudications are decided by senior operational managers (governors). More serious cases can be referred to an independent adjudicator – a district judge.

Previous deaths at Holme House

23. In 2010 and 2011 there were six deaths at Holme House in addition to that of the man. Three were of natural causes and three self-inflicted. There appear to be no similarities with the circumstances of his case.

KEY EVENTS

24. On 24 June 2011, the man was sentenced at Crown Court to eight years imprisonment for serious offences, four years custody and the remaining four years on extended licence.
25. Due to comments made to his offender supervisor at the court, the man was regarded as being at risk of suicide or self harm. At court a "Suicide and Self-Harm Warning Form" was opened by a Prison Custody Officer. She said he considered the prison sentence to be excessive and that he had said he did not know how his partner would cope. He told the officer that he was going to refuse any medication given to him and that he had nothing to live for, adding that he had lost his family. The officer went on to say that he believed he had prostate cancer and that he would die in prison. It is not clear why he believed this.
26. Following the court appearance, the man transferred to HMP Holme House, where he had a routine health screen. A nurse saw him and decided he was at risk of suicide or self-harm and so opened an Assessment, Care in Custody and Teamwork (ACCT) plan. (The Prison Service process for supporting and monitoring prisoners thought to be at risk of harming themselves.) She noted in the ACCT plan that he had not been in prison previously and that he had been upset at the sentence. She recorded that he had said he would commit suicide and did not want to live. The immediate action plan was to locate him to houseblock 3 (for vulnerable prisoners) for his own safety. The support available was explained to him. The level of observations was set at "frequent but irregular observations at least four times per hour day and night".
27. The nurse took notes about the man's medical history. He told her that he had a single large bladder stone which his consultant urologist had said was so large that it needed to be removed by an "open operation" under local anaesthetic. He was on a waiting list for the operation. He said he had previously been prescribed comodart (to assist with bladder function). The clinical reviewer, in his clinical review, notes that comodart is sometimes used when there is a suggestion of an enlarged prostate gland.
28. On 25 June the first of two ACCT review meetings were held. At the meeting, the man told the case manager that he still had thoughts of ending his life, but was unsure if he could actually do it. He told the officer that he would stop taking his medication as a "possible way of ending his life". He added that he had the full support of his family and partner, something which he said was "keeping him going".
29. Seven days later, on 1 July, the second review meeting was held. At that meeting the man told the case manager that he had settled down in houseblock 3 and had come to terms with his sentence. He told him that he had no intention of ending his life, or of harming himself. It was agreed that the ACCT plan could be closed. On 8 July, a post closure meeting took place and it was agreed that monitoring was no longer necessary.

30. Prison records show that the man settled down and gave no further cause for concern. His prison case history notes have a number of positive entries and comments made by prison staff. They describe him as a mature prisoner who mixed well with others, always polite, requiring minimal supervision and that he enjoyed using the prison library.
31. An appointment had been made for the man to be admitted to hospital on 26 July, for the removal of his bladder stone. However, on 22 July, the consultant's secretary contacted the prison to say the appointment had been cancelled and that a new date would be sent to the prison. After receiving the news that his appointment had been cancelled, he decided he no longer wanted the surgery. His decision was passed to the consultant.
32. On 22 September, the consultant urologist wrote to the man expressing concern about his decision. He told him that to ignore the bladder stone indefinitely would cause further deterioration of his kidney function and that his pre-operative blood tests had shown a degree of renal (kidney) disease. He said he would like to have a face to face discussion with him.
33. Prison healthcare staff discussed the consultant's letter with the man on 5 October, following which he changed his mind and agreed to have the surgery. On 22 October, the consultant wrote to the prison confirming that he would add him to the waiting list once again.
34. The bladder stone caused ongoing symptoms and problems for the man. The symptoms were pain, difficulty passing urine along with poor flow and when tested the urine would show that blood and infection were present. His urine was infected and as well as the pain caused by the stone irritating the bladder neck, control of the bladder function was poor and that his urine was "strong and offensive in odour". The infections were treated with antibiotics but the intervals between infections were short. Urine would dribble from his bladder and despite the use of incontinence pads it was a cause of embarrassment to him. In response, he isolated himself and cancelled two visits from family and friends to avoid being incontinent while away from his cell.
35. No new date for an operation was received. On 12 January 2012, the man was issued a new antibiotic prescription as he had blood in his urine. As a result, an urgent referral was made to the hospital on 13 January under a "suspected cancer pathway" (specific timescales to provide timely cancer care for patients) which meant he would be reviewed within two weeks.
36. The following day the man reported to prison healthcare that he was having difficulty passing urine. Tests showed that the urine did not contain any blood. However, he was experiencing pain in his lower abdomen and in his penis. As a result, he was admitted into the prison inpatient unit for observation. Clinical observations showed that he did not have a fever and his pulse and blood pressure were within normal range. He was given a bottle so that nurses could measure his urine output against input and a sample of urine was sent for analysis.

37. On 16 January, the result of the urine test was received. It showed white and red cells were present, which the pathology report said was in keeping with an infection that was getting better, due to the prescribed antibiotics. The man's medical notes also show that he was no longer in pain and had been well enough to take a shower. Because his symptoms had improved, he was discharged from the inpatient unit and he returned to his cell on HB3.
38. On 16 January 2012, the man was found to have defecated on the floor of his cell. His medical records were checked to confirm whether or not he was incontinent and as there was nothing to suggest he was, he was charged with an offence against prison rules. The next day he attended an adjudication hearing conducted by one of the prison senior managers. She took advice from healthcare staff and dismissed the charge. Although the charge was dismissed, we consider the use of the disciplinary system in this way was reprehensible and does not reflect well on Holme House's care for older prisoners.
39. The following day, 18 January, and in response to the two week urgent referral a hospital appointment was received for 26 January. That morning a prison officer noticed that the man had not collected his breakfast and went to his cell to check on him. He said there was a strong smell of urine in the cell, that he was still in his bed, and he was mumbling and incoherent. His cell mate said he had remained in his bed all night.
40. The cell mate told the investigator that he had shared a cell with the man since October 2011. He had told him that he had prostate problems and was waiting for an operation. The cell mate said the man was passing blood in his urine and on one occasion showed him a quantity of blood in the toilet bowl. He said the man saw a doctor and was given medication, which he said had improved the condition. He said that when the man returned to their cell he looked unwell and kept going to toilet. He went on to say that the man had been taken back to the prison healthcare in a wheelchair on 18 January. He said the man looked ill and drawn, and that was the last time he saw him.
41. An officer said he left the cell to speak to a member of healthcare staff. He said there was a nurse on HB3 who examined the man, after which she told the officer he would need to be moved to the prison inpatient unit, but before doing so she would have to speak to the prison doctor. The officer said a prison doctor arrived soon after and decided to admit him to the inpatient unit. The doctor's plan for him was to have a catheter inserted and if that failed to relieve the problem, then he would arrange to transfer him to outside hospital. The doctor made the following entry into his medical record:

"Large abdominal herniation (hernia), soft and non tender, large painful full bladder palpated."
42. Clinical observations taken at the time show that the man's pulse rate was up and there was a note stating that his pulse was "irregularly irregular". His blood pressure had dropped and the clinical reviewer's opinion was that the reading was in keeping with "clinical hypotension". (Hypotension is

abnormally low blood pressure.) His bladder was found to be enlarged and painful with urine passing in dribbles. The doctor diagnosed “retention” and so re-admitted him back into the prison healthcare.

43. The officer said the man was taken back to healthcare in a wheelchair. He added that his skin colour was grey and ashen. The officer said he was a quiet, polite man and because he was a little deaf, prison staff had to shout to ensure he could hear what was said. The officer said he was “not very mobile” and because of his immobility, he had been allocated to a cell on the ground floor to ensure he did not have to climb any stairs. He added that he walked with the aid of a walking stick. The officer said that when he was taken to the inpatient unit it was the last occasion that he had seen him.
44. The officer said that, about two weeks earlier, it had been noticeable that the man had been walking much more slowly than usual and with a stoop. He added that he had continued to walk outside in the fresh air, but much slower than normal and that he did not participate in the wing association, preferring instead to remain in his cell.
45. The man was seen by a nurse in healthcare and monitored for what she described as “poor urine output”. She said he had complained of stomach pain and added that his stomach was swollen. The nurse said she was aware that he was awaiting the removal of a bladder stone, which was something he had previously declined, but had since changed his mind.
46. The nurse said she inserted a catheter until she felt resistance and that there had been no urine output, so the catheter was withdrawn. After discussing the issue with the doctor, the doctor arranged for an emergency ambulance to take the man to hospital for further tests. Asked if he was able to communicate, the nurse said he was and that he had managed to dress himself for the journey.
47. One of the officers who took the man to the hospital that evening at interview said he was transferred by ambulance and that he had been handcuffed to another officer using an escort chain. He said they were taken to the hospital Accident and Emergency Department. Prison records show the time of leaving the prison was at about 6.00pm. The officer said that when they arrived at the hospital a doctor asked the officer to remove the escort chain. The officer said his instructions were that the escort chain should not be removed and told the doctor that they would have to remain on. An escort risk assessment does not appear to have been completed.
48. The other officer told the investigator that the man was frail and unable to walk. He said that he and the other officer had to support the man underneath his arms and had lowered him into a wheelchair, as he was unable to do it for himself. The officer said he smelt strongly of urine.
49. The officer said that following an initial assessment a second doctor arrived from the Urology Department. He said the doctor told him that the man could

return to the prison as he had a urine infection, which would be treated with antibiotics.

50. The officer said they had to wait for a while before prison transport would be available to return them to the prison. He said the smell of urine was very strong and likely to have been noticeable to others. He said that to keep the man warm and protect his dignity he placed blankets over his shoulders. There is no evidence to show that hospital staff washed or cleaned him before he returned to the prison.
51. The officers told our investigator that the man was frail and unable to walk far, and needed a wheelchair to return to the transport. He arrived back at Holme House at 8.10pm and was admitted into the prison inpatient unit.
52. The man had been diagnosed as having a bladder infection and antibiotics had been prescribed. He complained of pain and was given a combination of paracetamol and a non-steroidal anti-inflammatory drug. The clinical reviewer said that once the hospital doctors were able to exclude retention they would have no reason to detain him, which is why he returned to the prison. A further urology appointment had been made for 26 January where his symptoms would be reviewed.
53. On duty that night in the inpatient unit were an Operational Support Grade (OSG) and a nurse. The OSG's duty was to patrol the unit and to be responsible for security. The nurse was responsible for medical care. The OSG said he met the man when he returned from hospital and that he had been allocated to cell number 12. He went to his cell and saw him sitting on the edge of his bed. The OSG confirmed that the man was able to communicate and he said he didn't need anything.
54. The nurse said she checked with the man whether he had had a catheter inserted, but he had not and had been prescribed antibiotics. The nurse said he was lucid. The nurse added that he told her that his condition made him "dribble" urine and so she offered him a medical pad, which he accepted. She said she offered to assist him with fitting it but he declined and said he could do it himself.
55. At some time during the early evening on 18 January, the man's daughter telephoned the prison to speak to one of the prison's senior managers about her father's condition. She was unaware that her father was being taken to hospital but, after speaking with him earlier, wanted to let the prison know that he was not well. We understand from the senior manager that she had previously spoken to him and that he had given her his telephone extension number for future use.
56. The investigator asked the senior manager whether he had received the telephone message from the man's daughter. He said that when she rang he had just left the prison for the day. She had left a message on his answer machine asking him to ring back. Unfortunately, he did not hear the message until the following day, after her father had died. Knowing that the prison FLO

was dealing with the death, he said he decided not to return the call so as not to upset the family further.

57. At about 2.00am the nurse looked into the man's cell to see how he was. She said that she could see he was breathing and appeared to be asleep. Three hours later, at 5.00am, the OSG began counting the prisoners in healthcare as part of the normal morning prison roll check. He told the investigator he looked into his cell and saw that he was covered with a blanket, but he could not see any sign of him breathing. The OSG told the investigator that he called his name, and kicked the cell door to attract his attention, but did not get a response.
58. Hearing the noise, the nurse, who was nearby, went to see what the problem was. She said she looked into the cell and could not see any sign of breathing so asked the OSG to alert the night manager by using the radio message "code blue" which indicates an emergency situation involving breathing difficulty. The system helps ensure that emergency responders take the correct equipment with them to an incident.
59. The Night Manager was in an office above the healthcare department and arrived very quickly. He went into the cell. The nurse said that, when she and the Night Manager entered the cell, the man was lying in his bed on his left side. She said they turned him onto his back and carried out checks which showed that he was not breathing and there was no pulse. The nurse said his pupils were fixed and did not react to light. She and the Night Manager began Cardiopulmonary Resuscitation (CPR – a mixture of chest compressions and rescue breaths performed in an effort to manually preserve blood flow and oxygen to the patient).
60. The nurse said she had used an ambu-bag to supply air into the man's lungs, but that she had to keep re-adjusting the mask because there had been no movement in his chest. (An ambu-bag is a hand held device which is used on patients who are not breathing or are breathing inadequately. It has a mouthpiece which fits over the patient's mouth and a bag which, when squeezed, pushes air into the patient.) She initially thought that she could see his chest moving, but later said she was not sure. At interview she was asked if there was a blockage in his airway; the nurse said she did not know.
61. The nurse went on to say that during her examination she had noticed two lumps in the man's stomach. She described one as being larger than a tennis ball and the other about the same size as a tennis ball.
62. As well as using an ambu-bag the nurse had attached electro cardiograph (ECG) equipment to the man. (An ECG is an electronic test that records the electrical activity of the heart.) She said it had shown a signal being detected whenever the chest compressions took place, but it was not a normal ECG rhythm and described it as being similar to a pulse.
63. A defibrillator was available but was not used. (A defibrillator can restart the heart in some cases of cardiac arrest by giving an electric shock. It detects

the electrical activity in the heart and gives automated instructions to the rescuer.) We were unable to clarify the reasons for this at a follow up interview with the nurse as she was away from work because of a long term illness. The Head of Healthcare said that a defibrillator can only be used when the patient's heart is in a particular rhythm. In the man's case it was not applicable, therefore standard CPR was used.

64. In the meantime, at 5.11am an emergency ambulance was called. Prison records show that first of two sets of paramedics arrived at the cell at 5.21am and took over the CPR. Four minutes later the second pair arrived.
65. The nurse said that in total, including the paramedic attempts, CPR had been continuous for 20 minutes during which there had been no sign of life detected. CPR and any further attempt to resuscitate the man stopped at 5.31am and the paramedics confirmed he had died.

Events following the man's death

66. Once paramedics had confirmed that the man had died, and in line with the prison's contingency plans, a telephone call was made to the "out of hours" medical provider for a doctor to attend and confirm the death. There was some difficulty in contacting a doctor and a misunderstanding on the prison's part that a doctor was needed to confirm the death.
67. Prison family liaison officers, an Administration Officer and an officer went to the man's home the same day to break the news to his family. They remained with his partner until other members of his family arrived. The family liaison officers continued to support the family in the days that followed.
68. Whenever there is a death in a prison, any prisoner considered being at risk of suicide or self and being monitored should be reviewed to ensure they are safe and have not been adversely affected by the death. The family liaison officer said that all those being monitored were checked and had their ACCT plans reviewed.
69. The man's cell mate told our investigator that a prison manager told him that the man had died and that he had not been surprised to hear the news. He said support was made available to him and that he was allowed to move into a different cell. He said the man had been treated well by prison and healthcare staff.
70. Staff we interviewed said they were contacted by members of the care team and had appreciated the support offered to them. There was a hot de-brief held and that those directly involved were invited to the meeting. (The purpose of a hot de-brief is to identify any issues surrounding the incident and to learn what went well and what could have been done better. It is normally chaired by a senior manager and allows those involved to give their account of what has occurred and discuss what happened.)

71. As part of the normal procedure following a death in custody, the man's partner and daughter were invited to the prison to see where he died and also his cell. They accepted the offer and were also able to speak to healthcare staff.
72. The prison contributed towards the funeral costs in line with national guidance. Staff from the prison attended the funeral and flowers were sent.

ISSUES

Clinical care

73. The clinical reviewer said the level of care given to the man would be difficult to equal in the wider community. He said contemporaneous medical notes were of good quality and that there had been appropriate investigations done in a timely manner.
74. He said the only known pathology suffered by the man was a bladder stone. The reviewer noted that even though the stone could cause pain and misery, it would not be a cause of death.
75. The only anomaly identified by the clinical reviewer in the man's medical notes was the entry noting "irregularly irregular" pulse and blood pressure. He said this would appear to be an isolated finding, as it had not been noted by doctors at the hospital.
76. The clinical reviewer said the nurse had expressed uncertainty as to whether she had or had not seen visible evidence of chest movement during the resuscitation attempt. Although our enquiries show that she received Automatic Defibrillator training and Basic Life Support Training on 1 July 2011, he suggests that additional training would ensure greater confidence when the skills are next required. There is no suggestion that this would have altered the outcome for the man.

The Head of Healthcare should ensure that all nursing staff are competent and confident in resuscitation procedures, and undertake refresher training to an appropriate level where necessary.

Confirmation of Death

77. As part of this investigation the clinical reviewer was asked to consider the issue of confirmation of death and whether only a doctor can establish that death has occurred. In his report, he said he had contacted the out of hours service provider and asked for clarification of what happened.
78. In their reply to the clinical reviewer, they said their log showed that a telephone call had been received from HMP Holme House at 5.31am, but that the call had been terminated before a call handler had spoken to the caller. The letter shows that a further call was received at 5.36am and had been made by an officer. The officer had asked for a doctor to attend the prison to confirm the man's death. The clinical reviewer said the letter shows that the officer was told that the prison doctor would be contacted. He adds that at 6.15am a further call had been made to the out of hours service by another officer to say the doctor had not contacted the prison.
79. The clinical reviewer has considered the issue and, referring to the British Medical Association's guidance for GPs in England and Wales regarding "Confirmation and Certification of Death", said that a doctor's responsibility is

to the living. He said paramedics had established death and that no useful purpose would be served by the doctor seeing the patient. The doctor said paramedics can legally confirm death and requesting a doctor to perform the same function was unnecessary.

80. Many hospital Trusts now train and licence paramedics to verify death and it is not generally necessary to call a doctor to the scene solely to confirm death. This office has investigated many deaths in custody and is able to confirm that it is normal practice for trained paramedics to confirm death, after which they will leave the prison a “Recognition of Life Extinct” report. Most prisons have amended their local plans to reflect this. At Holme House the contingency plan said ‘if prisoner is deceased, ensure doctor had declared prisoner dead’. We make the following recommendation:

The Governor and Head of Healthcare should ensure that the local instructions following a death in custody are updated to include information on the appropriate confirmation of death.

Use of restraints

81. When the man was taken to hospital on 18 January he was handcuffed to a prison officer by means of 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). It is clear from this investigation that his condition on that day was such that he was almost immobile. Prison escort staff said he was so frail that he had to be assisted into his wheelchair, because he was unable to move unaided.
82. On arrival at the hospital, a doctor asked the officers whether the handcuffs were necessary and asked for them to be removed. The doctor was entitled to ask this but the officer said they had to remain on. In such circumstances he should have consulted the duty manager at the prison. The British Medical Association (BMA) guidance is that:

‘prisoners are entitled to the same standards of health care as the rest of society. This includes respect for the patient’s dignity and privacy. Outside prisons, 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 him or herself, the health team or others.’

83. In June 2010, a concordat on escorts and bed watch was agreed between the National Offender Management Service and the National Health Service. The concordat makes clear that the medical condition of the prisoner should be considered as part of a risk assessment. The levels of restraint used must be proportionate to the “perceived security risks” and balanced by considerations of care and decency. The concordat says:

“Using handcuffs or other restraints on terminally ill or seriously ill prisoners is considered inhumane by the courts unless justified by security consideration”.

84. We accept that the Prison Service has a primary 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. The level of restraints used should be 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.
85. A formal written escort risk assessment was not available in relation to the man. We understand that this was because the escort to hospital was made at short notice. We were told that if, completing a full risk assessment would delay an escort leaving the prison, then the document would be completed at the earliest opportunity. However, the prison has confirmed that, on this occasion, it did not happen.
86. Although it is accepted that the man was convicted of serious offences the most relevant factors to consider were his likelihood of escape and his risk to the public. At the time he was taken to hospital, he was a very ill, 78 year old, frail and immobile man, who was incapable of getting himself into a wheelchair. Prison officers had to hold him under his arms to support and lower him into his wheelchair. In these circumstances, it is very hard to see how any use of restraints could have been justified, whether or not a formal risk assessment had been completed. The medical condition of a prisoner needs to be fully considered as part of the decision making process and levels of restraint must be proportionate to actual security risks, balanced by considerations of care and decency. We cannot dismiss the possibility that the fact that he was chained to a prison officer impeded some of the basic care which the hospital might otherwise have provided.

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

The Governor should ensure that escort staff consult a senior manager whenever a healthcare professional requests the removal of restraints.

CONCLUSION

87. The man's medical history and condition were properly recorded and assessed in the prison. In addition, his initial potential for suicide or self harm was identified and correctly managed. The clinical reviewer said his medical care in prison would be difficult to equal in the wider community. He found that his medical notes were good quality and show that medical interventions were carried out in a timely manner. The emergency response was swift but, sadly, he had died and could not be revived.
88. However, we are concerned about the unnecessary use of restraints when the man was taken to hospital and that the escorting officers refused to remove them when asked to do so by a hospital doctor, without consulting managers at the prison.

RECOMMENDATIONS (*Response from Service included*)

1. The Head of Healthcare should ensure that all nursing staff are competent and confident in resuscitation procedures, and undertake refresher training to an appropriate level where necessary.
Accepted: *Care UK has a mandatory training programme in CPR which all clinical staff have to undertake annually. If staff are unable to demonstrate proficiency in this area after three attempts during the mandatory training session, the member of staff will be referred to a senior nurse for assessment and support. All requisite staff have successfully completed the mandatory training for 2011/12 and training has recommenced for 2012/13. Care UK keeps all training records for its staff.*

2. The Governor and Head of Healthcare should ensure that the local instructions following a death in custody are updated to include information on the appropriate confirmation of death.
Accepted: *Holme House uses trained paramedics to confirm death. The local contingency plans for Death in Custody are in the process of being updated to reflect this and include information on the appropriate confirmation of death.*

3. The Governor should ensure that a prisoner's health and mobility and actual risk at the time are fully considered and that these factors are fully taken into account in deciding the level of escort and whether restraints are needed.
Accepted: *The Security Department has issued a revised emergency risk assessment document. It is mandatory that this document is completed for all emergency escorts. It includes information on current risk such as a prisoner's mobility, health and actual risk to public. This information is taken into account prior to the level of escort and restraints requirements being decided, approved and documented.*

4. The Governor should ensure that escort staff consult a senior manager whenever a healthcare professional requests the removal of restraints.
Accepted: *The revised emergency risk assessment document includes the instruction to staff to consult a senior manager whenever a healthcare professional requests the removal of restraints.*