PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in May 2013 while in the custody of HMP Preston.

Our Vision

‘*To be a leading, independent investigatory body,*
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’

This is the investigation report into the death of a man, a prisoner at HMP Preston, in May 2013 at hospital. He was 79 years old. The cause of death was bronchopneumonia and an acute kidney infection. I offer my condolences to his friends and family.

A clinical reviewer was appointed to conduct a review of the man's clinical care in custody on behalf of the local PCT. HMP Preston co-operated fully with the investigation.

The man was sentenced to prison in April 2012 and spent his entire sentence either as a patient in the healthcare centre at HMP Preston or in hospital. Even though he was unwell, his death came suddenly. The clinical reviewer found that overall the care he received was of a standard that he could have expected in the community.

I am satisfied that the man received a generally good standard of care at the prison. However, liaison with his family could have been better and I am concerned that there was inadequate justification for an elderly and infirm man to be restrained by an escort chain in hospital.

Moreover, it is inhumane that the man remained handcuffed by a chain to an officer until after he died. This was obviously distressing for his family and, no doubt, the escorting staff. I am pleased that the Governor has apologised to his family, but there is a need to ensure that future escort risk assessments for prisoners going to hospital from Preston fully take into account their health and condition.

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 **November 2013**

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SUMMARY

1. In April 2012 the man was convicted of sexual offences and sentenced to two years in prison. This was his first conviction.

2. In the community the man had lived in sheltered accommodation and had a care worker. He had a number of ailments and used a motorized wheelchair because of mobility difficulties. He suffered from chronic arthritis, osteoarthritis of his spine, had suffered a stroke in 1995 and had undergone heart bypass surgery in 1998.

3. He was admitted directly to the healthcare unit at HMP Preston and spent the remainder of his time in prison there. On 21 May 2012, a prison doctor diagnosed him with costochondritis (inflammation of the rib cartilage) and on-going angina (chest pain because the blood supply to the heart is being restricted). On 23 May, he spent a night in hospital with symptoms of chest pain.

4. The man attended several hospital appointments during his time at Preston and had three lengthy stays in hospital. On 6 July 2012, the prison GP fitted a catheter as he had difficulty urinating. (In September, a permanent catheter was inserted at hospital.) On 12 July, he was admitted to hospital after blood was found in his urine and he was having problems swallowing. He was diagnosed with a urinary tract infection and discharged on 18 July. On 29 November, he was taken to hospital by ambulance and had an exploratory operation. He was discharged on 12 December. On 24 February 2013, he returned to hospital for a week when healthcare staff at the prison became concerned about his condition.

5. In May the man's condition deteriorated and he was taken to hospital as an emergency. Despite his immobility and very poor health he was restrained by an escort chain. His family were advised of his condition, and were with him when he died the next morning.

6. He was still restrained when he died.

7. The clinical reviewer concludes that the standard of care received in Preston was the equivalent to that the man could have expected to receive in the community. However, we are not satisfied that the use of restraints was properly justified and it is unacceptable that he died while still restrained, for which the Governor has apologised to the man's family. More effective liaison with his family during his time at the prison would have helped resolve a number of problems.

THE INVESTIGATION PROCESS

8. The investigator obtained all documents relating to the man's time in prison. She visited HMP Preston with an Assistant Ombudsman on 6 June. They viewed the healthcare centre and spoke to the healthcare manager, the Head of the Inpatient Unit, and the Governor.

9. The local PCT commissioned a clinical reviewer to review the clinical care the man received at HMP Preston.

10. A copy of this report has been sent to HM Coroner.

The man's family

11. One of the Ombudsman's Family Liaison Officers (FLOs) contacted the man's family to explain the scope of the investigation and she and the investigator visited them on 10 June.

12. The family raised the following issues which they wished the investigation to consider:

- What induction did he receive and what understanding did he have of prison procedures?
- Why were they not informed of his longer stays in hospital?
- Was he given help to fill out visiting orders and write letters?
- Should they have been able to visit him in the healthcare centre as he had very limited mobility and remained in bed?
- Why did he develop bedsores?
- How and when did he receive his permanent catheter?
- Was his mental health considered while he was at Preston?
- Why was he restrained and still in restraints when he died?

13. The family received a copy of the draft report. They raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

HMP PRESTON

14. HMP Preston is a local prison holding up to 842 adult male prisoners. Healthcare is provided by Lancashire Care Foundation Trust. The healthcare unit has inpatient facilities which are used as a regional facility for up to 30 prisoners with mental and physical health problems. There is a full-time doctor between 9.00am and 5.00pm Monday to Friday. Between 5.00pm and 8.00pm there is a doctor in the prison's reception area. At night and weekends there is on-call cover.

Previous deaths at Preston

15. There have been nine deaths at Preston since 2010, seven from natural causes. None of the circumstances of the previous investigations are similar to those in this case.

Her Majesty's Inspectorate of Prisons

16. HM Inspectorate of Prisons made an unannounced short follow up inspection of Preston in April 2012. Inspectors noted that an appropriate range of health services were provided, primary care services had improved and inpatient services were satisfactory, with an improved regime for the prisoners there.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that prisoners are treated fairly and decently. In their 2012 annual report, the IMB noted that a number of patients had been looked after in the healthcare facility at the end of their lives and some had received commendable care.

KEY EVENTS

18. The man was sentenced to two years imprisonment at Crown Court on 23 April 2012, when he was 78 years old. He had not been to prison before.

19. In the community the man lived in sheltered accommodation and had an allocated care worker. His mobility was poor and he used a motorised wheelchair to get around outdoors. He was admitted directly to the healthcare unit at HMP Preston. Health checks in the prison noted that he had suffered a stroke in 1995, causing left-side weakness. He had undergone a heart bypass operation in 1998.

20. When the man arrived at Preston he was given a full, standard induction. The induction included information about the visits process and use of the telephone system, how to access support from other prisoners (known as Listeners) or the Samaritans, in addition to other information such as fire safety and anti-bullying procedures.

21. The man had difficulty moving and was referred to a physiotherapist on 13 May. On 21 May, he had pains in the upper left of his chest and left arm. The GP diagnosed costochondritis (pain caused by inflammation of the rib cage) and on-going angina (chest pain as a result of the blood supply to the heart being restricted). A troponin test for heart damage was taken the following morning. Levels of troponin are normally too low to show on a blood test but his results showed a high reading of 16. On 23 May, the test was repeated and the reading had risen to 19. He was admitted to hospital for one night on 23 May, after further episodes of chest pain.

22. The man initially relied on a wheelchair to get about in the healthcare centre. On 21 June, his family brought in a three-wheeled walker he had used at home.

23. On 4 July, the man complained of general body pain. The doctor noted that co-codamol was not effective and changed his prescription to tramadol, a stronger painkiller. On 6 July, he was unable to pass urine. The GP inserted a catheter and continued to investigate the cause, as he stated he would prefer not to be admitted into hospital.

24. On 6 July, the man's pulse was recorded as normal at 74 and his blood pressure was high (166/73). The GP examined him and decided to refer him to an urologist. A urine test taken in the healthcare unit on 11 July revealed blood clots and he was prescribed antibiotics. On 12 July, the GP was concerned about the blood in his urine and because he could not swallow or keep down medication. He was sent to the Rapid Assessment Unit at hospital and was given more antibiotics to treat a urinary tract infection. A renal ultrasound was normal and he was given tamsulosin (a medication used when a patient has difficulty urinating) so the catheter could eventually be removed. He was discharged on 18 July.

25. In August, the man became doubly incontinent. On 7 September, a trial to see if he could cope without the catheter, conducted at hospital, was unsuccessful. He had a long-term catheter inserted at the hospital. Another course of antibiotics were tried at the end of September and beginning of October.

26. On 18 October, the GP made an urgent two week referral to hospital for those suspected of having cancer. The man had an enlarged prostate, had lost two stones in six months and had problems swallowing. The hospital noted he was eating and drinking well, and had stated he only had problems swallowing tablets, which had been happening for a week. At the same time, he was referred to a gastroenterologist (a liver, intestine and pancreas specialist) and the urology service. An appointment was made at hospital for 2 November. The results of the hospital examination showed nothing unusual so a gastroscopy (a procedure to look inside the oesophagus and stomach) and CT scan of his chest, abdomen and pelvis was organised.

27. On 12 November, the man went to the hospital as an outpatient for a gastroscopy. This showed that he had a hiatus hernia (a protrusion of the stomach through a tear in the diaphragm) and gastritis (an inflamed stomach). A follow up with the surgeon was planned once the pathology results were returned. From the 18 November, he was given a seven day course of antibiotics.

28. On 29 November, the man vomited blood twice and was taken to hospital by ambulance. He was diagnosed with severe gastritis and a CT scan showed a small bowel obstruction and an abnormal swelling on his right kidney. On 7 December, he had a laparotomy (a procedure for investigation of the body by cutting into the abdomen) to treat the bowel obstruction. The care plan from the hospital advised a high dose of proton-pump inhibitors to reduce gastric acid and help with his difficulties swallowing, with a follow-up outpatient appointment three months later. He remained in hospital until 12 December, when he was discharged and returned to the prison.

29. On 14 December, staff noticed that the man had a pressure sore. On 9 January 2013, a risk assessment was agreed with the prison's security department to allow healthcare staff to go into his cell at all times as part of his care plan. This enabled healthcare staff to turn him throughout the night and help prevent the development of further sores.

30. On 24 February, the man became poorly. The catheter was not draining his urine effectively, his bladder was swollen and he was finding it difficult to eat and drink. He was prescribed antibiotics and the GP was kept informed about his condition and in the evening advised that he should be managed in hospital. A risk assessment is completed each time a prisoner is taken outside prison to determine the level of security needed. He was assessed as being a low risk of harm to the public, hospital staff or of escape. He was taken to hospital in an ambulance, restrained by an escort chain (a two metre chain with one cuff attached to the prisoner and the other to the escorting

officer). During his stay in hospital, he had a CT scan. He was restrained throughout his stay. He was discharged back to the prison on 2 March.

31. On 4 March, the man went to hospital for a pre-planned prostate operation. This was cancelled as his haemoglobin levels (the blood particles that carry iron in the blood) were low, measuring 9.9 (the normal range is between 13-18). The hospital planned to re-list the surgery once this was treated.

32. The man continued to be cared for and seen daily by staff at the healthcare centre in Preston. On 19 May, he vomited twice in the early morning and felt lethargic. An ambulance was called and he arrived at hospital at 8.45am. An escort chain was used, authorised by the duty governor. His level of risk of escape, to the public and hospital staff was assessed as "normal". Healthcare staff at the prison indicated that they did not have any medical objections to the use of restraints, but that he would need an escort chain rather than handcuffs and that he had the ability to escape. Through the day, he became more unwell and his next of kin was called at 11.30pm. He was unresponsive for most of that time.

33. His family told the investigator that, after they arrived at the hospital, they asked for the restraints to be removed on more than one occasion as his condition deteriorated. It is recorded in the escort log that they asked at 1.35am and the prison's policy was explained to them. His family told the investigator that they were told the restraints could not be removed in any circumstance. The escort officers changed over at 5.00am. The family told the investigator that, around 6.45am the new escort officers said they could ask the governor for the restraints to be removed and they might get permission. One of the officers telephoned the duty governor just after 7.00am to ask for permission to remove the restraints. However, while they were discussing this, the man died at 7.05am. The restraints were removed at 7.08am.

34. The Governor and a family liaison officer (FLO) visited the hospital to brief the staff and offer support. The man's family had left so they visited them at home. The Governor apologised in person and in writing for the use of restraints and that they had not been removed before the man died. The prison maintained contact with the family and representatives attended his funeral. The prison provided financial assistance towards the funeral expenses, in line with national guidance.

ISSUES

Clinical care

35. In his clinical review, the clinical reviewer found that overall the man received a standard of care equivalent to that which he could have expected in the community. He found that his urinary problems were appropriately managed and that he had been prescribed the correct medication for heart disease and high blood pressure. He also found that the management of his final illness was appropriate and timely.

Pressure sores

36. The man spent so much time in bed that pressure sores became a greater risk. He first developed a sacral pressure sore when he was in hospital. Appropriate treatment began in December 2012, when healthcare staff were allowed to go in to his cell 24 hours a day and turn him, to relieve pressure on his body. A pressure mattress was ordered on 27 December 2012, although there is no mention that it was used until 13 January 2013. The pressure sores improved but treatment was made more difficult because he was doubly incontinent.

37. From 24 February to 2 March, the man was in hospital. When he returned the pressure sores had become much worse. Prison healthcare staff referred him to a tissue viability nurse (who provides support and advice for complex wound management) and followed the nurse's advice. He was reviewed by the tissue viability nurse on 11 April, and it was noted there had been a 50-75% improvement over two weeks. The clinical reviewer concluded that staff managed his pressure sores appropriately and that the sores healed well.

Disability needs

38. The man did not have his three-wheeled walker for the first two months he was in prison, until his family brought it in in April. In the meantime, he used a wheelchair and was encouraged to use it on the wing each day. Healthcare staff prompted him to get out of bed and to mobilise. His ability to mobilise was closely recorded and it is apparent that it was variable. When he found it difficult to get out of bed, a winch was installed on 22 November so that staff could move him into a chair for a change of position. After his return from hospital in December 2012, it appears that he became bed-bound and unwilling or unable to move around. We are satisfied that healthcare staff tried to assist him to remain mobile and dealt with him sensitively when he was not.

39. The man's arthritis meant that he had difficulty writing. His family were concerned that this stopped him being able to fill in visiting forms and write letters to keep in touch. The investigator asked the healthcare manager about the help provided in such situations. She said that nurses or the prisoner cleaner helped patients who needed assistance with such tasks. He was

asked each week if he wanted to fill out a visiting order, but after a visit in February, he said that he did not want to do so.

The man's mental health

40. The clinical reviewer reviewed the man's clinical record to establish whether he had needed mental health intervention. He found that while he sometimes became confused and delirious when he had an infection, this improved after treatment. Staff were attentive to his moods and there are regular observations in his record on how he was feeling. Staff spoke to him when he was feeling down. The clinical reviewer did not find any reason why he should have been referred to the mental health team.

Family liaison

41. The man's family said that they found liaison with the prison difficult from the outset. They were not given a contact number from the beginning of his imprisonment and though his personal officer (a nominated officer assigned to prisoners to act as their first point of contact and support) was helpful, they found it difficult to contact the prison. They wrote to the prison in December 2012 to enquire about the possibility of early release for him because of his deteriorating health but they did not receive a response until March 2013. They found the response was curt and uninformative and the Governor subsequently apologised to them for the tone of this letter. (It does not appear that at the time he was likely to fulfil the criteria for early compassionate release.)

42. Chapter 11 of Prison Service Instruction 64/2011 which covers the management of prisoners who are terminally ill or seriously ill states that:

> *"Prisons must ensure that arrangements are in place for an appropriate member of staff to engage with the next of kin of prisoners who are either terminally or seriously ill.'*

43. While the man did not have a diagnosed terminal illness, because of his poor health, he spent all his time in prison in the inpatient healthcare unit during which time he also had a number of hospital admissions when he was seriously ill. We consider it would have been helpful and appropriate to have appointed a member of staff to engage with his family along the lines outlined by the PSI throughout his stay in the inpatient unit. Had the prison appointed a family liaison officer at this point, it would have helped prevent a number of the communication issues which arose later, including informing his family of hospital admissions and agreeing appropriate visits arrangements for both hospital and prison.

44. Prison Rule 22 requires governors to inform the prisoner's next of kin when a prisoner becomes seriously ill. Prison Rule 22(1) states:

> 'Notification of illness or death

> ‘22. - (1) If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed.’

45. The man’s condition was sufficiently serious for the prison to have called an emergency ambulance on more than one occasion. On three occasions, he remained in hospital for lengthy periods. We consider that each time, his family should have been notified once it was clear that he would be remaining in hospital.

46. On the final occasion that the man was admitted to hospital, on 19 May, one of the escort officers noted that it was expected that he would remain there for at least three days. It was apparent that he was seriously ill and his family should have been told that he was in hospital. During the day, a doctor and nurses at the hospital told the prison escort staff that he was very ill. At 10.20pm, a nurse told escort staff that he was not responding to medication and that his next of kin should be informed. His sister said that she was not called until 11.30pm, over 12 hours after he was first admitted.

47. We do not consider that the prison’s liaison with the man’s family was sufficient or timely, particularly when it was clear that he was seriously ill. As we have indicated, had a member of staff already established contact with his family, communication would have been much easier. We make the following recommendation:

The Governor should ensure that a nominated member of staff is appointed to keep families informed about elderly and infirm long term residents in the healthcare impatient unit and that families are told as soon as possible when a prisoner becomes seriously ill.

Restraints

48. The Prison Service has a duty to protect the public when escorting prisoners to hospital and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which 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. It deemed that handcuffing a prisoner receiving chemotherapy (and, by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.

49. The man had difficulties with mobility and remained in bed from December 2012. This was partially his choice as his physiotherapists said that he was able to move. However, when he could move it was not very far, very fast, or for very long. Before December 2012, staff often helped him to walk short distances to the bathroom or to the medication hatch.

50. Although the man could move a little, for every hospital appointment he was transported in a wheelchair or on a stretcher. For each risk assessment, he was rated as either 'Normal' or 'Low' risk because of the nature of his offences and staff thought he had the ability to escape. There is no evidence that his presentation differed greatly before each visit to hospital and the risk assessments were inconsistent. On 19 May, he was very lethargic and vomiting but his risk was assessed as normal. On previous occasions, he had not been as unwell yet he was categorised as a low risk. The healthcare input on each hospital visit noted that he had the ability to escape. It is not apparent how this conclusion was reached. On one occasion, the author also noted that he was wheelchair-bound and could not transfer from the wheelchair without assistance. This suggests a lack of understanding of the risk assessment process. We are not satisfied that the use of restraints was ever justified.

51. In hospital, the man became unresponsive and the nurses requested that his next of kin should be informed. At this point, it was obvious that he was gravely ill and unlikely to recover. Despite his condition the escort officers on the first shift did not request permission to remove the restraints although his family had asked if this could be done. Only when the officers changed shifts was the removal of restraints requested, but this was not done before he died.

52. It is unacceptable that restraints were not removed until after the man had died. This showed a lack of dignity and respect towards him and would also have been distressing for the escort staff and distressing for his family. We make the following recommendation:

The Governor should ensure that risk assessments for prisoners taken to hospital are completed fully, take into account individual circumstances, are updated regularly and are based on the actual risk the prisoner presents at that time.

RECOMMENDATIONS

1. The Governor should ensure that a nominated member of staff is appointed to keep families informed about elderly and infirm long term residents in the healthcare impatient unit and that families are told as soon as possible when a prisoner becomes seriously ill.

2. The Governor should ensure that risk assessments for prisoners taken to hospital are completed fully, take into account individual circumstances, are updated regularly and are based on the actual risk the prisoner presents at that time.

ACTION PLAN: The Man – HMP Preston

No	Recommendation	Accepted/ Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Governor should ensure that a nominated member of staff is appointed to keep families informed about elderly and infirm long term residents in the healthcare impatient unit and that families are told as soon as possible when a prisoner becomes seriously ill.	Accepted	A system has recently been introduced whereby a nominated member of staff is appointed to keep families informed about a resident's condition in the event of serious or terminal illness. Healthcare currently has a register of elderly and infirm patients and, subject to the wishes of the patient and his care plan; families are informed when the condition of an elderly or infirm long term resident in the healthcare impatient unit deteriorates. Healthcare staff and duty managers will be reminded of the need to ensure that a nominated member of staff is appointed to keep families informed about elderly and infirm long term residents in the healthcare inpatient unit and that families are told as soon as possible when a prisoner becomes seriously ill.	Complete Complete 01/11/13	
2	The Governor should ensure that risk assessments for prisoners taken to hospital are completed fully, take into account individual circumstances, are updated regularly and are based on the actual risk the prisoner presents at that time.	Accepted	The Head of Security and Intelligence has met with the Head of Healthcare to discuss this requirement. As a consequence, healthcare staff now provide information on the risk assessment which is specific to the individual prisoner concerned. Hence, their comments will differentiate between prisoners with difficult health presentations. This will inform the level of cuffing required as a consequence. This issue has also been discussed within the Senior Management Team and the need to ensure that risk assessments take into account individual circumstances, are	Complete Complete	

			updated regularly and are based on the actual risk the prisoner presents at that time has been emphasised. The Head of Security and Intelligence will monitor compliance with this via the local Quarterly Assurance process. A Staff Information Notice will be issued advising staff of the need to contact the prison without delay in the event of a patient's health deteriorating while at outside hospital – thus enabling the risk assessment to be updated.	 01/12/13 01/11/13	