PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the death of a man at HMP Wakefield, who died in July 2010 at Pinderfields Hospital, Wakefield

Report by the Prisons and Probation Ombudsman for England and Wales

January 2013

The man died in July 2010, at Pinderfields Hospital, Wakefield. He had been transferred to hospital from HMP Wakefield on 6 July 2010 after becoming unwell. I offer my condolences to his family and friends for their sad loss.

The investigation was undertaken by a senior investigator supported by one of our family liaison officers. I apologise for the severe delays in the production of this report.

After a road traffic accident in 1971, the man's right arm and leg were amputated. By the time he entered the prison estate in 2000 he not only faced physical difficulties but also struggled to cope with prison. He threatened to harm himself several times but staff ensured that he remained safe.

The man also made several allegations that he was being bullied or abused by other prisoners. Several of these allegations occurred in 2006. When the allegations were investigated, staff were either unable to identify who was responsible or did not have enough information to resolve the matter.

In July 2010, the man became ill. He was taken to hospital, but his condition continued to deteriorate. He was diagnosed with pneumonia and septicaemia and although he was given antibiotics he died after several days in hospital.

A clinical reviewer was commissioned. The clinical reviewer included four recommendations in her report, and an action plan to address these recommendations has already been developed by the prison. As a result, the recommendations have not been repeated in this report. However, two recommendations for improvement are made regarding how to achieve a proper balance between security and dignity when using escort chains on a severely disabled prisoner and on the importance of thorough recording of bedwatch logs.

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 **January 2013**
Prisons and Probation Ombudsman

CONTENTS

SUMMARY

1. The man had a number of medical needs. After a road traffic accident in 1971, he had a double amputation. Doctors removed the man's right leg to above the knee and right arm to above the elbow. In that same accident the man also suffered significant chest injuries. The man used an electric wheelchair to enable him to be mobile.

2. In October 2001, the man was found guilty of serious offences and given an indeterminate public protection sentence (IPP) with a recommendation that he serve a minimum of five years. (An IPP sentence is one where the prisoner has to, at the end of their tariff, satisfy the Parole Board that the risk they pose to the public is acceptable, a prisoner with an IPP sentence has no automatic right to be released.)

3. The man was initially in custody at HMP Winchester before being transferred to HMP Bristol in February 2002. He was then transferred to HMP Wakefield in April 2003. While at Wakefield, he established a good rapport with several members of staff and developed friendships with a small circle of other prisoners who provided him with valuable assistance.

4. In October 2008, the man developed respiratory symptoms which did not respond to two courses of antibiotics. He was consequently referred for a chest X-Ray. In January 2009, he was admitted to Pinderfields General Hospital after suffering from breathlessness and low levels of oxygen in his blood. It was noted that the injuries he had sustained in the road traffic accident in 1971 had permanently affected his lung function, and made him much more susceptible to respiratory problems.

5. The man's respiratory condition remained stable until June 2010 when he was diagnosed with heart failure and a leg oedema, a build up of fluid in the skin tissues causing swelling. He was transferred to Pinderfields Hospital on 6 July, after his condition deteriorated again and he complained of chest pains. The following day, he was diagnosed with right sided pneumonia, a lung infection and septicaemia, an infection in the whole of the body. Medical staff discussed treatment options with his and with his consent a do not resuscitate form was completed. He died in July.

6. A post mortem found that the man died as a result of chronic obstructive pulmonary disease, a lung disease which includes chronic bronchitis (inflammation of the main air passages to the lungs) and emphysema (where the air sacs of the lungs are damaged). He also had ischemic heart disease meaning (a reduced blood supply to the heart muscle).

7. This report makes two recommendations relating to the use of escort chains and how their use is recorded in bedwatch logs.

THE INVESTIGATION PROCESS

8. After receiving notification from the Prison Service on the day that the man had died, the Ombudsman appointed a senior investigator to carry out the investigation. The senior investigator contacted the prison and arranged to travel there for the purpose of opening the investigation.

9. The senior investigator formally opened the investigation on 20 July 2010 by meeting with members of staff and obtaining copies of the man's full prison records including medical records, wing history sheets, security information, hospital bed watch logs and the family liaison log. A bed watch log is a history recorded by escort officers of events whilst a prisoner is an in patient at hospital outside the prison. Governor A was appointed as the senior investigator's liaison officer. The senior investigator also visited Wakefield on 3 September and 3 November 2010 to conduct further interviews.

10. A clinical review into the care the man received while he was in Wakefield was commissioned. A clinical reviewer was appointed to conduct the review, which was received in October 2010.

11. In conducting his investigation the senior investigator carried out six interviews with prison staff, all of which were recorded. The transcripts of these interviews are attached to this report as annexes. He has also met a senior prison manager to feedback what had been identified. He followed up the feedback by writing to the Governor. The issue of this report has been delayed after the report was given to another investigator to complete. We apologise for the unacceptable delays that have been the result.

12. One of my senior family liaison officers wrote to the man's family to inform them of the investigation and provide them with an opportunity to ask any questions or raise any concerns about the care the man received. At the time of issuing this report, the man's family have not raised any specific issues. The draft report has been shared with those members of his family who wished to receive it.

HMP WAKEFIELD

13. The prison is located in Wakefield very close to the city centre. There has been a prison on the site since 1594. It is a high security prison and most of the prisoners are serving life sentences or have been convicted of serious offences.

14. Since taking over responsibility in April 2004 for the investigation of all deaths in custody, there have been 37 deaths at Wakefield (prior to the issue of this report), including that of the man. Although the number appears high, it should be recognised that Wakefield prison holds a number of elderly prisoners, which inevitably brings about a higher incidence of deaths. There are no similarities between those cases and the circumstances of the man's death.

Her Majesty's Chief Inspector of Prisons

15. Her Majesty's Chief Inspector of Prisons, reports on all Prison Service establishments. The majority of inspections are pre-announced and allow the prison being reported on to prepare for inspection. The most recent inspection was carried out in December 2008 by the former Chief Inspector of Prisons.

16. In the introduction to the report of the inspection, published in February 2009, the former Chief Inspector of Prisons said the prison had improved considerably over the previous five years and that she was pleased the improvement had been sustained. She said there was still work to do in aspects of safety and staff prisoner relationships and activities, including engaging offenders in treatment programmes.

17. In the main body of the inspection report, it was noted that, despite provision for five hospital visits per day, "too many" outside hospital appointments were cancelled with no record kept of the reasons why. The inspection team also noted that many "older prisoners and those with disabilities were dissatisfied with the support they received". The inspectorate report also noted that some disabled prisoners complained of excessive noise and some bullying and intimidation although they could find few comments in wing files to evidence such occurrences.

Independent Monitoring Board (IMB)

18. Each prison has an Independent Monitoring Board (IMB) which is made up of members from the local community. Their role is to monitor the prison and report any concerns that they have regarding the prison or how prisoners are treated. In the first instance, the Board report to the Governor, or, if necessary, can report directly to Parliament. Board members are able to visit any area of the prison at any time and have direct access to any prisoner who they wish to see, or who requests to see them. The Board holds regular meetings in the

prison, with the Governor attending for part of the meeting. The Chairperson of the Board produces an annual report to the Secretary of State for Justice.

19. In its most recent report, covering the period 1 May 2009 to 30 April 2010, the Board said that overall the Health Care Unit provides a comprehensive service that meets the needs of the prison population. The care of disabled offenders continued to be a challenge that was being met by dedicated staff. The IMB noted that staff tried to encourage disabled prisoners to participate in available activities.

ACCT and F2052SH

20. ACCT, the Prison Service process for supporting and monitoring those prisoners thought to be at risk of harming themselves, was introduced in 2007. (Before this, the equivalent system was called F2052SH). An ACCT plan can be opened by anyone working in the prison if they have any concerns that a prisoner might have tried, or, in the future, might try to harm himself. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of observations (where staff must check the prisoner) and interactions (where staff must have a conversation with the prisoner) are flexible and can be set according to the perceived risk of harm. If staff perceive the risk of harm to be very high, the prisoner may be constantly observed, with a member of staff positioned outside their cell at all times. Where the perceived risk is lower, the level of observations may be several times an hour or day. Observations also take place during the night.

KEY EVENTS

21. The man was born in 1940. After leaving school with no qualifications, he found employment on a local farm.

22. In 1971, the man was involved in a road traffic accident. As a result, his right leg (above the knee) and his right arm were amputated and he also suffered significant chest injuries. The man was reliant on an electric wheelchair to help him move around.

23. The man had several convictions for various offences in the years following the accident. It is not clear from records whether any of these convictions attracted a prison sentence. In 2000, he was arrested and charged with various offences. He was remanded into custody to await trial.

24. Whilst on remand, the man commented to staff on five occasions that his situation was causing him such distress that he could not see any positive outcomes. In August 2000, staff opened a Self Harm at Risk Form (F2052SH) document after the man said that he struggled to see how he would cope in the future. He was described as being "extremely tearful" and was offered support through the Listener scheme (Listeners are prisoners trained by the Samaritans to offer support to their peers).

25. In early 2001, the man became frustrated by the legal delays resulting in his case being put back by some months. In March 2001 staff found that he had been hoarding medication in his cell and opened an F2052SH. He was referred to the Health Care Centre. After his mood started to improve, it was decided that he should remain in healthcare.

26. When the man attended Bristol Magistrates' Court in June 2001, custody staff at the court were concerned that he was depressed and believed that he might harm himself if he was again remanded. Another F2052SH was opened and it was recorded that the man was quiet and withdrawn. However the F2052SH was closed a week later.

27. In September 2001, the man became particularly anxious about the sentence he might receive. He also raised a concern with staff that he might be moved from the Health Care Department to the main prison. Again, he remained on an F2052SH for a week. Staff closed it after this time as they were satisfied that he would not harm himself

28. In October 2001, the man was given an IPP (indeterminate sentence for public protection) sentence with a recommendation that he serve a minimum of five years in prison. After he was sentenced, an F2052SH was opened by staff as they were concerned with how he would cope with receiving an IPP sentence. Although he was distressed, staff were satisfied that he was planning for his future and looking positively

to what he could achieve in custody. The F2052SH was closed within forty-eight hours.

29. The man served the early part of his sentence at HMP Winchester before being transferred to HMP Bristol in February 2002. He was then transferred to HMP Wakefield in April 2003, returning to HMP Bristol for a brief period in 2005 to allow accumulated visits to take place (accumulated visits allow a prisoner to be moved to a prison nearer home for a short period to make it easier for family and friends to visit).

30. Following sentencing, however, it is clear from his prison records that during 2002 and 2003 the man remained unhappy. In October 2002, staff became concerned that he might be hoarding medication and noted that he was threatening to kill himself. Staff searched his cell and, although no drugs were found, he was placed on supervision for a brief period and received support from the chaplaincy and the Samaritans.

31. In May 2003, the man told staff he was distressed because of bad news that he had received during a visit. He also told staff that he felt he was only "existing" at Wakefield and had started to think about hanging himself. An F2052SH was opened but was closed shortly afterwards. The man assured staff that he was feeling much better and regular assessments were established with the Health Care Department.

32. Later that year, in November 2003, staff opened another F2052SH after the man told staff he was very stressed by legal action that his solicitor was taking on his behalf against the Prison Service. Additional support was arranged by the Health Care Department and this F2052SH was closed by staff after forty-eight hours.

33. The man also became concerned in that he may be transferred from Wakefield. To reduce the likelihood of such a move, in November he threatened to drive his electric wheelchair over the stairs and pour boiling water over himself. He was assessed by a consultant psychiatrist who acknowledged that the man was unhappy but did not consider that he was suffering from a depressive illness.

34. In December 2003, the man told staff he was being bullied by other prisoners on the wing. A security report was raised by staff and following its review anti-bullying measures were put in place by wing staff. Part of these anti bullying measures included a review of a further accusation of bullying made by the man in January 2004. After careful scrutiny security staff considered the allegation to be without foundation.

35. On 31 December, the man told staff that he could see no point in carrying on. Another F2052SH was opened and a multi disciplinary

team was established to provide him with support. Staff also reviewed which programmes the man could be offered to help him cope with prison. The F2052SH was closed on 2 January 2004

36. The man's mood continued to cause concern in 2004. Between April and June, and again in August, staff, were concerned as he attempted to both hang and harm himself. On both occasions, staff opened F2052SH documents which were closed once his outlook became positive and he had convinced staff that he would not endanger his life again

37. In June 2005, while at Bristol on accumulated visits, the man again attempted to hang himself. An F2052SH was opened by staff and he was closely monitored by staff. Staff made particular efforts to ensure the man made use of association times and that he received support from the chaplaincy and the Samaritans. This F2052SH was not closed until July as staff at Wakefield wanted to ensure that he was properly supported as he settled into the new regime. This was the last occasion that the man attempted to hang himself.

38. On his return to Wakefield, the man was assigned a cell that had been adapted for prisoners with physical disabilities. This, along with his electric wheelchair, allowed him to maintain a significant degree of independence. The disability co-ordinator at Wakefield was there for much of the time that the man was there. When she was interviewed by the senior investigator, she explained that the man was the only prisoner with an electric wheelchair and that without it he was effectively immobile. She explained that while the maintenance programme for the man's wheelchair was good, there were occasional problems.

39. The man also had an electric bed in his cell that he could adjust for his comfort and health needs. The man often needed medication to reduce oedema, an excessive accumulation of watery fluid, to his left foot. This is a normal occurrence for some-one suffering from reduced mobility.

40. In April 2006, the man raised a landing alarm after he had boiling water thrown over him. He told security staff that the water had been thrown from the Remand Centre. Staff investigated the incident but they were unable to identify who had assaulted the man.

41. In September 2006, the disability co-ordinator wrote a memo about the man. She recommended that he be given a period of respite in healthcare, as the man had increasingly behaved inappropriately towards other prisoners, usually by using inappropriate language. Some prisoners had retaliated by throwing food over him. She said the man's outbursts were inevitably followed by him being very emotional and crying when prisoners responded in a manner which caused him distress. He had also stopped shaving and sometimes slept in his

clothing, meaning that he sometimes appeared dirty and unkempt. She said she had gone into the man's cell on several occasions to find him sitting in semi-darkness and staring into space. She was particularly concerned that as a result of his behaviour the man was starting to become isolated.

42. As a result of the disability co-ordinator's concerns, staff opened both an Assessment of Care and Custody Teamwork (ACCT) and a care plan. This was closed on 18 October after a review conducted by staff. The man was also involved in this review.

43. The next month, on 17 November, the disability co-ordinator spoke to the man in his cell. He told her that staff and prisoners had both abused him, referring to his disabilities. She asked him several times to identify the individuals concerned but, again, he refused to do so.

44. During February 2007, the disability co-ordinator bought her concerns directly to the attention of the deputy governor. She said that the man now appeared dishevelled as he wore grubby clothes and had not had his hair cut for some time. She said had spoken to the man about her concerns and he had told her that he felt he was "going to seed". The man acknowledged to her that he would vent his frustration by finding fault with anyone he came into contact with and told her that he felt he was not making any progress.

45. The man developed respiratory problems in October 2008. As the problems did not respond to antibiotics, the man was referred for a chest X-ray. In January 2009, he was admitted to Pinderfields General Hospital as he was suffering from breathlessness and low levels of oxygen in the blood (low oxygen levels in the blood can cause shortness of breath, headaches, fluid retention and insomnia). A consultant physician in general and respiratory medicine obtained the man's X-rays from 1971 and compared them with the X-rays taken at Pinderfields. As a result, the man was diagnosed with compensated type 2 respiratory failure, meaning that the man's breathing was so poor that carbon dioxide accumulated in his body. He had also developed right sided acquired pneumonia.

46. The man was then prescribed furosemide (a diuretic used in the treatment of heart failure), and sabutamol and seretide inhalers (to help his airways to remain open). His condition was monitored as a matter of routine by the medical staff at Wakefield and Pinderfields and subsequently remained stable.

47. In April 2010, the consultant physician undertook an assessment to consider the man's future long term use of oxygen. In order to conduct this assessment, he needed arterial blood samples which in the normal course of events would be taken from a patient's arm. As the man had only one arm, the risks of the procedure were increased and the decision was taken that the samples should be taken by a doctor. The

Governor gave the consultant physician permission to bring appropriate equipment into the prison to undertake the procedure and ensured that blood samples could be taken immediately back to the hospital for laboratory testing.

48. Two months later, the man developed an increased leg oedema and was diagnosed with heart failure as his heart was having trouble pumping enough blood around his body. Hospital staff requested an additional electric socket to be installed in the man's cell so that his bed and wheelchair could be plugged in at the same time. This meant that the man could always then elevate his foot.

49. The man's personal officer at the time submitted a maintenance request for the installation, marking it urgent. As it was taking some time to action, staff asked the man if he would move across the landing to another cell which contained more electric sockets to ensure prompt remedial action. The disability co-ordinator recalled at interview that the man refused to move cell. Although his condition improved, his leg remained swollen.

50. In July 2010, the man's condition deteriorated again and he asked to be transferred to the health care centre as he was having difficulty dressing and going to bed. He also said he was not eating properly. On 2 July, staff decided he should be moved to the health care centre. On 4 July, staff started to treat the man with oxygen but he continued to be reasonably independent. On 6 July, the man reported that he was experiencing chest pain and that it felt like the room was spinning. Nursing staff discussed their concerns with the doctor who made the decision that an ambulance should be called and he was taken to the Accident and Emergency Department at Pinderfields.

51. The man was transferred without his electric wheelchair, effectively rendering him immobile. The duty governor, consulted security staff (the signature is illegible) and decided that an escort chain should be used. The senior officer in the Health Care Department explained to the senior investigator that he had advised that there were no medical objections to the use of restraints and that the decision to use restraints had been made by staff in the main prison. This decision was made after a review was conducted to the requirements of the National Security Framework which makes it clear that it is important to maintain decency.

52. On 7 July, the man was diagnosed by the consultant physician with right sided pneumonia and septicaemia (blood poisioning) and was given antibiotics and fluids through a drip. This meant they entered the blood stream much more quickly and were able to take effect promptly. The consultant physician discussed treatment options with the man and explained to him that because of his medical history he was not a candidate for resuscitation or for admission to critical care facilities where he might receive ventilation. The man told the consultant

physician that he wanted his two sons to be told about his medical condition and then signed his consent to a completed “a do not resuscitate” form. Duty governor B at Wakefield, contacted members of the man’s family to inform them that he was in hospital, that his diagnosis was extremely poor and that he had asked for his family to be told what was happening.

53. It was noted in the bedwatch log that, at 3.30 pm on 7 July, Governor A and Governor B authorised Officer A to remove the restraints. However, it is not clear whether the escort chain was removed at that time. A note on the bedwatch log at 10.10am on 8 July, made by Officer B, states that “Duty Gov C gave permission for removal of restraints”. Officer A also confirmed at interview that restraints were still in place on 8 July.

54. The senior investigator interviewed Officer B, one of the escorting officers. He explained that 10.10am on 8 July he had asked Governor C, the duty governor that day, for permission to remove the escort chain. After a prompt review of security requirements, the escort chain was removed shortly afterwards.

55. At 11:30 am on 8 July, one of the man’s sons contacted the prison staff at the hospital to ask after the man’s health. Prison staff arranged for a member of medical staff to return the call. The man’s other son spoke to prison staff that afternoon.

56. After receiving a chest scan, the man received the last rites at 3.30 pm from the Father. Officer B told the Senior Investigator that the man’s breathing was so laboured that it affected his ability to speak coherently. Shortly after this, bedwatch staff noted that although the man was still speaking, his health had markedly deteriorated.

57. The family liaison officer at HMP Wakefield spoke to members of the man’s family on several occasions on 8 July and explained that the man was extremely ill.

58. The man was seen by a doctor at 9.00am on the day the man died. The doctor told staff that the man had a few hours to live. After a scan, the man was moved to ward one. Staff informed a priest of the situation. As the man’s condition deteriorated further, he was given morphine as pain relief at 12.00 pm. The man declined lunch and as his health deteriorated again medical staff made the decision at 1:40 pm that he should be moved to Ward 3, Bay 5.

59. A nurse became very concerned about the man’s condition at 4.30pm and asked a doctor to attend. The doctor declared that the man had died at 4.42pm.

60. Following the man’s death, Duty Governor A attempted to contact the prison’s family liaison officer so that she could arrange to contact his

family. However, after the Duty Governor A could not get hold of her, he asked both HMPs Bristol and Eastwood Park if they could help. They could not provide any assistance. Duty Governor A then contacted Avon and Somerset Police, who agreed to visit one of the man's sons, but who then found that the address had been demolished. Eventually they obtained a telephone number and informed the man's family on 10 July. The Roman Catholic priest visited them later that afternoon.

61. A post mortem identified that the man had died from chronic obstructive pulmonary disease (non reversible lung disease) and ischemic heart disease (reduced blood supply to the heart). The man's son discussed the information he had received from the coroner with the prison's family liaison officer on 12 July.

62. Governor C at Wakefield authorised the payment of funeral costs. The man's family also attended a memorial service held for him at Wakefield. Staff and prisoners were informed by a Governor, and several of the man's friends were visited by prison staff. All staff were made aware of the services of the care team.

ISSUES

Clinical Care

63. A clinical review into the care the man received while he was at Wakefield was commissioned and a clinical reviewer appointed to complete the review, which is attached to this report. The clinical reviewer has concluded that the man received an acceptable level of general healthcare whilst in Wakefield. However, she described the care he received following the diagnosis of compensated type 2 respiratory failure in January 2009 as being of a "high standard".

64. The clinical reviewer made four recommendations in her clinical review. Three of these related to clinical record keeping, and the audit of these records, and the fourth to the compiling of a checklist to ensure that the disability suite meets the needs of individual prisoners. Because of the delay in issuing this report, we have already received Wakefield's response to these recommendations. They have accepted the recommendations and have developed an action plan as a result. As a result we have not repeated the recommendations in this report.

Equipment provided to the man to help manage his disability

65. While he was at Wakefield, the man had access to various pieces of equipment to help his mobility. These included an electric bed and an electric wheelchair.

66. The electric bed was provided to enable him to raise his leg and therefore alleviate the symptoms of oedema (swelling). However, in June 2010, it became clear that the man could not use the bed properly as he did not have enough electric sockets.

67. Although he was offered a move to another cell, the disability co-ordinator recalled that he had refused. A request was made for another socket to be installed, although it is not clear whether this was done before the man went to Pinderfields on 6 July 2010.

68. The man also had access to an electric wheelchair, which he charged using a socket in his cell. Although the man made a series of complaints about his wheelchair in 2008 (as the chair had flat tyres) this issue seems to have been resolved to his satisfaction. Officer C noted at interview that the man had not reported any problems to her. He explained that, when he did have problems, these were fixed but that it sometimes took longer than for manual wheelchairs, which could more easily be replaced.

69. It is clear that the man did occasionally have difficulty because of problems with the equipment provided for him. It also seems that these issues were resolved in a reasonable timescale.

Use of restraints

70. When the man was taken to Pinderfields on 6 July 2010, an escort chain was used as a restraint, following a risk assessment. Authority to remove the chain was given by Governors A and B on 7 July when his condition deteriorated. However, it seems that the chain was not removed until 8 July when Officer B spoke to Governor C.

71. There are two issues here. One is that the chain was seemingly not removed on 7 July despite authorisation being given (Officer B has confirmed that the chain was still being used on 8 July, and there is nothing in the logs to dispute this). There was clearly some confusion, and it would have helped had officers noted explicitly in the bedwatch log that they had removed the chain, and not only that they had sought authority to remove it.

72. More importantly, however, is that an escort chain was used in the first place. While a risk assessment was carried out, and the decision to use an escort chain was based on "the most recent and up to date intelligence available", the assessment did not seem to explore the man's individual circumstances in any great detail, other than noting that he was in a wheelchair. However, this was not an electric wheelchair, which meant he was effectively immobile.

73. Risk assessments will, by their nature, always contain an element of personal opinion. However, on this occasion, it seems strange that an escort chain was used when the man was effectively rendered immobile without his electric wheelchair. Although the full extent of his illness was not apparent when he was admitted to hospital, he was clearly ill. Further, although it appears that authorisation to remove the escort chain was given on 7 July, it seems that the chain was only removed the next day. As a result, we make the following recommendations:

    The Governor should ensure that risk assessments take full account of individual's circumstances when deciding the level of restraint

    The Governor should ensure that, when restraints are removed, staff explicitly record this in bedwatch logs

Reports of bullying

74. In December 2003, the man told staff that he was being bullied by other prisoners. In 2006, there were two events which suggested that the man might have been subject to bullying by other prisoners. In April, he reported that a prisoner had thrown boiling water over him. Staff were unable to identify the perpetrator. In September, the disability co-ordinator noted that, after the man had used some inappropriate language, prisoners had thrown some food over him.

The man also told her in November that he had been abused by both members of staff and prisoners, with the abuse relating to his disabilities. On the last two occasions, the man refused to name the people who were abusing him.

75. It is impossible to investigate these allegations many years after it is claimed that they happened. However, we have examined the responses to the allegations, and believe that that they were dealt with appropriately. In particular, the disability co-ordinator encouraged the man on several occasions to give her more details in order that the allegations could be further pursued.

CONCLUSION

76. The man had clear physical problems when he first came into prison. Generally, his needs were well met, although at times there were issues about the equipment provided for him.

77. In 2010, his health deteriorated extremely quickly. Medical staff acted appropriately. However, during his transfer to Pinderfields Hospital, an escort chain was used. Given how ill the man was and that he was effectively immobile without an electronic wheelchair, this does not seem to have been an appropriate risk assessment.

RECOMMENDATIONS

1. The Governor should ensure that risk assessments take full account of individual's circumstances when deciding the level of restraint

   Not Accepted

   All prisoners are individually risk assessed with due regard to all available information.

   It is clear that the man's medical condition as an individual, coupled with his current intelligence and record of offending was taken into consideration when the use of just an escorting chain was authorised. In line with the report, it would have been unclear to duty Governor A at that time exactly what the man's medical condition or capabilities would have been. As an emergency blue light escort, the governor would not only have to consider escape potential and Risk of Serious Harm to the Public should he escape, but also the risk presented to the public by the man on attendance at Hospital.

   At the time of his death the man had failed to engage in any work to address his offending behaviour and failed to evidence any risk in his very substantial Risk to the Public.

   All of the above factors would be taken into account in the determination of the appropriate restraint arrangements, in addition to the fact that the man would most likely be located in a ward within hospital, with the associated risk of coming into contact with an unsupervised child whose carer's attentions may well be otherwise focused.

2. The Governor should ensure that, when restraints are removed, staff explicitly record this in bedwatch logs

   Accepted

   Once the man's condition had been further assessed and permission for the removal of restraints authorised this should have been annotated in the log and actioned.

   This is standard operating procedure for staff on Bedwatch duties and a notice to staff will be circulated reminding staff of their responsibilities.