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 at University Hospital Coventry in February 2012, while in the custody of HMP and YOI Onley.

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 report of an investigation into the death of a man in February 2012, while a prisoner at HMP and YOI Onley. The man died at University Hospital, Coventry, after suffering a severe stroke. I offer my condolences to his family and friends.

The investigation was carried out by one of my investigators. A clinical reviewer was commissioned to carry out an independent clinical review of the man's care in prison. Following the post-mortem, the coroner commissioned a consultant neurologist, to review the paramedics' response to the man's collapse. Staff at Onley cooperated fully with the investigation.

The clinical reviewer considered that the standard of care the man received in prison was at least equivalent to, if not better than, the care he could have expected in the community. This was particularly commendable as the man required significant support for his adult onset deafness could also be a difficult patient and sometimes refused treatment which may have exacerbated his risk of a stroke.

The emergency response by staff at Onley was timely but the consultant neurologist has recommended that the ambulance service review its approach to transferring stroke victims to hospital. Finally, I am concerned that restraints were used on the man for the emergency transfer to hospital after his collapse and these were not justified by an appropriate risk assessment.

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 **March 2013**

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SUMMARY

1. The man was sentenced to eight years in prison on 26 January 2011 and went to HMP Leicester.

2. The man was deaf (adult onset deafness) and communicated by lip reading and sign-supported English. He had asthma and had been diagnosed with a chronic kidney condition in October 2009, while at HMP Haverigg. However, he was released from prison shortly after his diagnosis and chose to not receive treatment for his kidney condition. The man had been diagnosed with a personality disorder, although there was disagreement about whether this could be treated. He harmed himself a number of times while in prison and was subject to self-harm monitoring for most of his time in custody.

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3. The man transferred to Onley on 1 April 2011. On arrival, he complained to healthcare staff that his kidney condition had not been treated and day surgery for a catheter insertion had been cancelled four times. (This was because of a court appearance, security reasons or because he refused to attend.) The catheter was eventually inserted on 12 August. On 26 September 2011, the man refused to take his blood pressure medication and continued to refuse until he died.

4. On 31 January 2012, the man saw a prison doctor, as he had a constant cough, was producing sticky white sputum and was breathless after walking short distances. He had an X-ray on 7 February, which showed that his lungs were clear but that he might have a hernia. A CT scan on 13 February confirmed this, and also showed that he had a fatty liver.

5. The man was taken to hospital at 12.30am on 23 February, after his urinary catheter came out. He returned to the prison at 7.30am after his catheter was re-inserted. He was due to attend a cardiology appointment at hospital later that day but said that he was too tired. At 5.00pm, another prisoner, the man's friend walked past the man's cell and found the man collapsed in his chair and making strange noises. A nurse attended and requested an ambulance.

6. The paramedic 'first responder' car arrived at 5.33pm, and the ambulance (which came from some distance away) at 6.43pm. The ambulance crew remained at the prison until 7.25pm before taking the man to hospital, where they arrived at 7.43pm. Although he had suffered a suspected stroke and was semi-conscious, the man was restrained using handcuffs and an escort chain. Restraints were removed the next day as he was in a coma. A CT scan confirmed that the man had suffered a severe embolic stroke (a stroke caused by a blood clot forming in the body travelling to the brain causing a blockage in one of the blood vessels) which had caused a bleed on the brain. His life support machine was switched off at 5.22pm and the man died four days later.

THE INVESTIGATION PROCESS

7. The investigator visited Onley on 9 March 2012, and collected copies of the man's prison files and medical records. She met the Governor, the Head of Residence and Safety, the Disability Liaison Officer and the Head of Healthcare. Notices were issued announcing the investigation to staff and prisoners, and asked anyone with information about the man's death to contact the investigation. No-one came forward.

8. The investigator visited the man's cell and introduced herself to the staff on the wing. She met a friend of the man who had found him collapsed on 23 February, but he did not wish to be interviewed formally.

9. The investigator returned to Onley on 28 June, to interview three members of staff. Another nurse, Nurse A was no longer employed at the prison so the investigator wrote to her on 3 July, asking if she would be willing to answer some questions to assist with the investigation. The nurse responded on 23 July. She confirmed her role during the emergency response and gave brief details of the care given by paramedics.

10. A review of the clinical care the man received in prison was conducted by the clinical reviewer. The final review was received by the investigator on 20 September 2012.

11. A post-mortem examination was carried out on 29 February. The coroner commented in his post-mortem report that he was aware that there had been an extended delay before the man was taken to hospital after his stroke and recommended that the clinical history be reviewed by a clinical neurologist or stroke specialist.

12. At the request of the coroner, a consultant neurologist was provided with the man's clinical records and post-mortem and toxicological results. He was asked to consider the extent of the man's stroke and whether a delay of two hours while he was treated at the prison might have made a material difference to his survival. This investigation was suspended pending this additional report, which was received on 30 October 2012.

13. One of the Ombudsman's family liaison officers contacted the man's sister, his nominated next of kin. She explained the investigation process and asked her if there were any issues she wished to be considered as part of the investigation. She spoke positively about how her brother's death had been handled by the prison and about how helpful the staff at the prison had been. The man sister did not raise any issues at the onset of the investigation and said that she did not wish to receive a copy of the draft when ready.

HMP AND YOI ONLEY

14. HMP Onley is an adult male category C prison, near Rugby. It can hold up to 710 prisoners, over 12 wings. Northamptonshire Healthcare NHS Foundation Trust provides the healthcare services. The healthcare department provides a range of services including primary care, mental health, dental services and drug treatment scheme. There are daily weekday GP clinics.

HM Inspectorate of Prisons (HMIP)

15. HMIP last conducted an inspection of Onley in June 2012. Inspectors noted that health care provision was very good overall, with a good range of clinics. They found the role of the health improvement nurse and use of health champions to be impressive. Prisoners with disabilities were identified and some reasonable adjustments had been made for individual prisoners. HMIP commented that the prison provided a safe and secure environment reducing the risk of self-harm and suicide. Prisoners at risk were identified at an early stage and given the necessary support.

Independent Monitoring Board (IMB)

16. Every prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who monitor standards to help ensure that prisoners are treated fairly and humanely. The most recent IMB annual report for Onley covers the period March 2011 to February 2012.

17. The IMB reported that the main issue for healthcare was staffing vacancies which had had a significant effect on the operational effectiveness of the team, particularly in mental health services. They commented that, “the low number of ACCT documents open at any one time indicated a safe environment.”

Previous deaths at Onley

18. The man was the first prisoner to die of natural causes at Onley since 2004, when the Ombudsman began investigating all deaths in prison. Another prisoner has died since the man. There are no similarities between the causes of death, but both investigations identified similar issues in relation to risk assessments for the use of restraints.

KEY EVENTS

19. The man was sentenced to eight years imprisonment on 10 July 2006. He was released from prison on licence on 20 November 2009, but recalled to prison on 10 January 2010. He was released again on 5 February 2010, but recalled to custody again on 12 March 2010, after being evicted from his temporary accommodation. He had made threats to harm himself at that time. The man later admitted that, while on release, he committed further offences. He was convicted and sentenced to a further eight years on 26 January 2011 and went to HMP Leicester.

20. The man had been diagnosed with bilateral chronic hydronephrosis (a blockage preventing urine draining from the kidney) in October 2009, when he was at HMP Haverigg. While waiting for treatment he was able to catheterise himself (a catheter is a thin plastic tube inserted into the bladder to drain urine when required). When the man was released from prison on licence in November 2009, one month after his diagnosis, he chose not to attend his outpatient appointments to receive treatment for the kidney problem.

21. After arriving at Leicester, the man saw a consultant urologist at Leicester General Hospital on 17 March 2011. The consultant urologist said that he would arrange for the man to have a general anaesthetic cystoscopy (where a doctor looks into the bladder with a special telescope) and insertion of a urethral catheter.

22. Two weeks later, on 1 April, the man transferred to HMP Onley. He was seen by Nurse B for a reception health screen who noted that he had urinary incontinence, high blood pressure, asthma and gastric reflux. It was noted that he was taking amlodipine (for blood pressure), omeprazole (for gastric reflux) and used serotide and ventolin inhalers for asthma.

23. Before being transferred to Onley, the man was on a waiting list for treatment of his hydronephrosis. A healthcare administrator contacted Leicester General Hospital on 4 April, to chase up his appointment. She was told that the man had been removed from the waiting list after the hospital had been told by Leicester prison that he had been transferred. They agreed to put him back on the waiting list for surgery.

24. The man was on an open ACCT when he arrived at Onley. (ACCT is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves.) On 4 April, he was seen by a mental health nurse A. The man said he was angry that he had not been treated for his kidney problem and felt that he had been failed by the prison system. He said he had “no sympathy for those he had robbed” and that he thought about self-harming constantly but had refrained from doing so. The nurse saw him again two days later, when he said that he had no thoughts of suicide or self harm.

25. On 13 April, the manager of the wing contacted healthcare. He explained that the man was incontinent at night and needed his bed sheets changed daily. Healthcare arranged for a nurse from the specialist incontinence service to visit the prison to assess the man.

26. Prison doctor, Dr A saw the man on 25 May, after he complained that his legs were swollen. The doctor referred the man to a nephrologist (a specialist in kidney disease). The man saw a consultant urologist on 3 June, who advised that he would need a long term catheter fitted.

27. An appointment was arranged for the catheter to be fitted on 28 June. However, when the man attended Leicester General Hospital, he refused to be treated when he was told the procedure would be done under general anaesthetic. The man told healthcare that he did not want any further treatment and wanted to move prisons as soon as possible.

28. The man continued to refuse treatment. On 12 August, it was reported that he had been unable pass urine for over 24 hours and had chronic urinary retention. Onley sought advice from a local hospital, who said that a suprapubic catheter (a catheter that could be inserted into the bladder through a small hole in the stomach) could be fitted under a local anaesthetic. The man agreed to this and had the procedure that day. He remained in hospital overnight.

29. On 15 August, the man reported that he had blood in his urine and that his legs were still swollen, causing him pain and reducing his mobility. He threatened to pull out his catheter if he was neglected. The Head of Healthcare discussed the man with one of the prison doctors, and they agreed that he should return to Leicester for a short while so he would have access to 24 hour healthcare support. The man was transferred to Leicester prison on 19 August, and spent 17 days in the inpatient unit before returning to Onley.

30. On 26 September 2011, the man refused to take his evening medication. Three days later, on 29 September, the man told Nurse C that he was refusing to take his medication because he wanted to sue healthcare as he felt he was not getting the care he needed. Healthcare staff continued to offer the man his medication and a meeting with the Head of Healthcare was offered (with a sign language interpreter) on 2 October, so that any issues he had could be resolved. The man declined this meeting and refused to engage with healthcare.

31. The man attended University Hospital, Coventry, on 12 October, to see the urologist. He was accompanied by a signing interpreter. The urologist explained that he thought he had high pressure chronic retention and discussed different types of catheters. The man was advised that he would have his new catheter fitted as an outpatient at a later date.

32. During an ACCT review the following day, on 13 October, the man said that he had no current thoughts or plans to harm himself or end his life but took things one day at a time. He then said that he knew when to abuse the ACCT process and that, if his demands were not met, he would threaten to harm himself.

33. Six days later, on 19 October, the man agreed to take omeprazole but continued to refuse his blood pressure medication. He was transferred to HMP Blundeston the same day. However, when he arrived the prison doctor, Dr B, thought that he was not well enough to remain there. Due to his incontinence, the man needed washing facilities in his cell, he needed to be

on the ground floor because of his swollen legs and he required increased medical supervision. The man was transferred back to Onley on 28 October.

34. On 2 November, the man asked to be transferred to a prison with 24 hour healthcare. The man was advised by the Head of Healthcare, that a transfer could not be supported on medical grounds. She explained to the man that they aimed to mirror community services as far as possible and that he would not qualify for a full time carer if he were in the community.

35. On 23 November, the man threatened to pull out his catheter as he felt healthcare were not providing the care he needed. He would not specify the treatment that he thought he was not getting.

36. The man's catheter came out on 22 December and he was taken to hospital where it was re-inserted. The hospital discharge paperwork showed that he was still waiting for a permanent catheter to be fitted as an outpatient, which had been booked for 10 February 2012.

37. The man attended an ACCT review on 16 January 2012. Prison records show that the man was receiving weekly support through counselling services and visits from 'Deaf Connect' in Northampton, an organisation providing support for people with a hearing impairment.

38. Another prison doctor, Dr C, saw the man on 19 January, after he complained of smelly and cloudy urine. Tests showed that his potassium levels were raised. A urine infection was suspected and he was prescribed antibiotics. Three days later, the man complained of pain and blood in his urine but refused to provide a urine sample for testing.

39. Nurse D saw the man on 25 January, for an asthma review. She noted that he had a constant cough. The man told her that he was using his asthma inhaler up to nine times a day and she referred him to the doctor in light of his high inhaler usage. On 31 January, the man saw Dr C who noted that he was still smoking around 15 cigarettes per day despite receiving smoking cessation advice. His cough was now producing sticky white sputum and he complained of being breathless with chest discomfort after walking short distances. The doctor suspected mixed airways disease, commenting in the man's medical notes that he

> "would be a candidate for both COPD [chronic obstructive pulmonary disease, a disease of the lungs in which the airways narrow over time] and IHD [ischemic heart disease, a disease characterised by reduced blood supply of the heart muscle, usually due to coronary artery disease] as a heavy lifelong smoker, central obesity and poor general health".

40. The man was referred to the rapid access chest pain clinic for evaluation. He was taken to the Hospital of St Cross, Rugby, on 1 February, for a chest X-ray but then refused to have the X-ray when he found there was no signing interpreter. When he returned to the prison, he was told that an interpreter was not required as he was not having a consultation. He then agreed to attend a rescheduled X-ray appointment.

41. The man had his chest X-ray on 7 February, at University Hospital, Coventry. This indicated that he might have a hernia but his lungs appeared clear. A further CT scan was recommended.

42. On 8 February, University Hospital contacted the healthcare department to confirm the man's cardiology appointment (rapid access clinic) for 23 February. They explained that they would be cancelling the man's catheter operation for 10 February until the outcome of his cardiology investigations. The man had his CT scan on 13 February, which confirmed the presence of a hiatus hernia and fatty liver changes.

43. The man was taken to hospital at 12.30am during the night of 23 February, after his urinary catheter came out. The risk assessment showed he was of medium risk to the public. Single handcuffs were used for the escort and an escort chain was authorised for comfort breaks and during his medical appointment. (An escort chain is a light chain about six feet long with a single handcuff at each end attached to the prisoner and an officer which allows some privacy) He returned to the prison the same day at 7.30am after his catheter was re-inserted. The man was due to attend a cardiology appointment at hospital later that day but said he was too tired to attend after the earlier visit.

44. The man's ACCT document shows that he was seen by Officer A at 3.00pm that day. (As part of the ACCT, staff were required to interact "as much as possible" with the man.) No concerns were raised as to his physical or mental health at that time.

45. At 4.45pm, during an association period, the man's friend, walked past the man's cell. He said he saw the man standing by his cupboard writing something. He did not speak to the man at this time. The mans friend said in his police witness statement that he had spoken to the man earlier that day, but because he was a Listener he was not willing to disclose what they had spoken about. (Listeners support prisoners who may be at risk of suicide and/or self-harm. They are trained, selected and supported by Samaritans to offer confidential emotional support to other prisoners.)

46. The man's friend walked past the man's cell 15 minutes later, at 5.00pm. He was sitting in his chair and he thought the man was choking, as he was making strange noises. The man's friend went into his cell to check on him but he was unable to get a response from the man so he went to the wing office to alert Officer B.

47. Officer B went to the cell and noticed that the man appeared to be having a fit as his lips and fingers on his right hand were turning blue, his eyes were rolling in his head and he was struggling to catch his breath. The officer explained that every time the man tried to take a breath he coughed a deep chesty cough as if something was preventing him from catching his breath. He could not get a response from the man, so called for Hotel 1 (the radio sign of the emergency response nurse) to attend immediately. The emergency response nurse was unavailable so Nurse C attended and arrived at 5.05pm.

48. Nurse C said that when she arrived, the man was in his chair with his eyes closed. She checked his clinical observations and found his blood pressure to be high, at 200/104. The nurse waited for five minutes before repeating the observations, when his blood pressure had reduced to 170/82. The man then opened his eyes and coughed up large quantities of yellow phlegm. At 5.22pm, the nurse asked Officer B to call for an emergency ambulance.

49. The paramedic first responder arrived at the prison at 5.33pm, and reached the man's cell at 5.40pm. He repeated the clinical observations while taking a handover from Nurse C. The man's blood pressure was now 152/90 and his sugar levels were very low at 1.1mmols (normal sugar levels range from 4 – 5.9mmols for non-diabetics). The paramedic gave the man glucagon, to raise his blood sugar level.

50. When Nurse C tried to take a sample of urine from the man catheter bag for testing, she noticed that he had cyanosis in his toes (an abnormal blue discoloration of the skin due to the tissues near the skin surface being low on oxygen). The nurse alerted the paramedic to this and requested a second ambulance to take the man to hospital. This call was made at 6.02pm.

51. The ambulance had to come from some distance and did not arrive at the prison until 6.43pm. Paramedic staff were unable to establish the cause of the man's collapse. They gave him naloxone in case he had taken an overdose, and hypostop, a dextrose gel. The paramedics stayed at the prison with the man until 7.25pm and then took him to University Hospital where they arrived at 7.43pm.

52. An escort risk assessment was that the man was a medium risk to the public and low risk of escape, the same as for his previous hospital visits. Despite his condition, single hand cuffs and an escort chain were again used.

53. The man's blood pressure was again high, at 204/102, when he arrived at the hospital. He was sedated and placed into a medically induced coma while he had an ECG (a test that records the heart's electrical activity) and CT scan (a special X-ray that creates detailed images of the inside of the body). Prison escort records show that at 11.00pm that night the handcuffs were removed to allow medical staff to assess the man, and were reapplied at 11.05pm. At 11.20pm, escort staff called the prison to update them on the man's condition and were given authority to remove the restraints to allow medical staff unhindered access to him.

54. The man remained in an induced coma while tests were carried out. The risk assessment was reviewed the following day, 24 February, and it was agreed that restraints should not be used while he was unconscious. Escort staff were told that, if he regained consciousness, restraints would need to be reapplied.

55. The Head of Residence and Safety, and the prison chaplain visited the man's sister, his next of kin, on the morning of 24 February. They informed her that the man was in hospital in a medically induced coma after suffering a suspected stroke. The man' sister explained that she did not have a close relationship with her brother and had very little contact. She was due to go away the next day and would not be back at home until 20 March. She asked

the Head of Residence and Safety to contact her if her brother died that night, but otherwise to wait till her return. The man's sister said she did not want to attend or be involved in funeral arrangements, should her brother die.

56. The Head of Residence and Safety and the prison chaplain then went to the hospital to see the man. A hospital doctor; said that the man had suffered a severe embolic stroke (a stroke caused by a blood clot forming in the body travelling to the brain causing a blockage in one of the blood vessels) causing a bleed on the brain. The doctor advised that there was no treatment to offer and the clinicians had decided to turn off his life support machine. The Head of Residence and Safety telephoned the man' sister to update her on his condition.

57. The man's life support machine was switched off at 5.22pm on 24 February. The prison chaplain said a prayer for him before he and the Head of Residence and Safety returned to the prison. The next day, 25 February, the hospital escort was reduced to one officer. The man died at 2.51pm on 28 February. Listeners were sent to H wing where the man had lived to offer support to prisoners, and the Samaritans were contacted to offer the man's friend support if he required it.

58. A memorial service for the man was held in the prison chapel on 1 March 2012.

59. As requested, the man's sister was informed of his death on 20 March, after she returned home. The funeral was arranged in conjunction with the Coroner and the local authority, which has a statutory obligation in these circumstances.

ISSUES

Clinical Care – The man's kidney problems.

60. The man was diagnosed with hydronephrosis in 2009. While at Onley, The man complained that he had not received the appropriate treatment and surgery for his catheter insertion had been cancelled four times.

61. Prison medical records show that, on 15 March 2010 at Leicester (before his transfer) the man told healthcare staff that he did not want to attend any urology appointments. He was asked to sign a disclaimer but refused. On 7 May, he complained of kidney pain and asked to be referred to hospital. When healthcare staff contacted Leicester General Hospital they were told that the man had discharged himself from their care while he had been out of prison on licence a few months earlier.

62. The man was re-referred to Leicester General Hospital and a day surgery appointment was made for 1 June. This was cancelled when the man phoned the hospital and was told the date of his appointment, which was re-scheduled for 3 June. However, this appointment was also rescheduled after the man ate his lunch despite being told that he should not eat before leaving the prison for his surgical appointment.

63. The man had another appointment on 13 June, but had to attend court that day. The next appointment, on 4 November, was cancelled when the hospital were concerned that someone had called to find out the appointment date. (It is not clear from the medical records why there was a five month delay.) An appointment for 27 January 2011, was cancelled because the sign language interpreter was unavailable.

64. On 1 April, the man was transferred to Onley, which caused a further delay as the hospital then removed him from the waiting list. He attended hospital for surgery on 28 June, but refused to be treated when he was told the procedure would be done under general anaesthetic. He eventually had a suprapubic catheter inserted on 12 August.

65. There were obviously delays in the man receiving treatment for his kidney problem. However, some of the delays were caused by him refusing treatment or calling the hospital direct to establish the date of his appointment which led to security concerns. The Prison Service National Security Policy Unit which governs prisons' local security arrangements, is not specific about the cancellation of hospital appointments when a prisoner knows the time and date. It does not require that they should be cancelled automatically and it is expected that a prisoner's condition and the urgency of the treatment should be taken into account when the prison decides whether to cancel an appointment. We note that the man was regarded as low risk of escape.

66. Prisoners' access to necessary medical treatment should not be affected by the cancellation of appointments without proper consideration of whether the cancellation was necessary.

The Governor should ensure that prisoners' hospital appointments are not cancelled unless there are properly justified and recorded reasons.

67. The clinical reviewer noted that the prison continued to meet the man's needs, and referred him appropriately. He described the care given to the man as "at least equivalent, if not superior" to the care he would have received in the community and noted that prison staff persisted in trying to get him to accept treatment when in the community it would have been seen as his informed choice not to take treatment or attend hospital.

The man's refusal to take medication

68. On 26 September 2011, the man refused to take his evening medication. Three days later, on 29 September, he told Nurse C that he was refusing to take his medication because he wanted to sue healthcare as he felt they were not providing the care he needed. Healthcare staff continued to offer him medication and a meeting with the Head of Healthcare was offered (with a sign language interpreter) on 2 October, so that any issues he had with healthcare could be resolved. The man declined this meeting and refused to engage with healthcare.

69. On 24 October, the man agreed to take omeprazole but still refused to take his blood pressure medication. He continued to refuse his blood pressure medication until he died, in total for almost five months. The clinical reviewer commented that patients often refuse to take medication as it gives them some form of control over their treatment. However, he noted that the man was encouraged to take his medication, but still mostly refused to take it.

70. The clinical reviewer considered that the man's poor compliance with his medication would almost certainly have significantly increased his risk of stroke. While the man's blood pressure does not appear to have been taken regularly while he was at Onley, the clinical reviewer noted that the blood pressure readings taken before and after he stopped taking the medication suggested that he did not have high blood pressure.

The man's deafness

71. The man had adult onset deafness in both ears. The cause of his deafness is unclear. Prison records show that the man claimed that he suffered severe hearing damage while in prison in 1999, when a prison doctor syringed his ears, causing damage to his eardrums. The man claimed to have received more than £200,000 in compensation from the Prison Service for this, but a psychiatric report in his record indicated that this had been checked with the litigation department of the National Offender Management Service (NOMS) and the man had never received any compensation.

72. The man communicated using a combination of speech and "sign supported English". (Sign Supported English (SSE) is a method of communication that uses British Sign Language (BSL) signs but the structure and grammar is based on the spoken English language. This means the signs follow the exact order in which they would have been spoken.)

73. A consultant psychiatrist, interviewed the man in May 2010, so he could advise the court before sentencing. The consultant psychiatrist had seen the man three years earlier when he was asked to assess him to see if he

qualified for a transfer to a secure hospital for psychiatric treatment. In his report he commented on the man's deafness. He wrote

> "The man is not 'culturally deaf', that is regarding his deafness, as a human experience, rather than a disability and has not had the opportunity to integrate in the deaf community. He falls between the deaf and hearing communities. There is little doubt that he has special communication needs that have not been met in prison. He is isolated and unable to participate in conversation with other inmates".

74. While at Onley, the man received visits from the 'Deaf Connect' service. The Disability Liaison Officer worked with the man to help ensure his needs were met. He was provided with a signer for meetings with probation and outpatient hospital appointments. He also had the use of a 'text phone'. (Textphones can be used to communicate if you are unable to hear on an amplified telephone. Depending on the model you choose you can either type or speak your part of the call and receive text back that you can read on the textphone's screen).

75. We are satisfied that appropriate efforts were made to meet the man's hearing disability needs while he was at Onley.

The emergency response

76. After the man was discovered in his cell prison staff called an ambulance at 5.22pm. Prison records show that the first responder car arrived at the prison at 5.33pm and the paramedics reached the man's cell seven minutes later, at 5.40pm. On arrival, the paramedic repeated the clinical observations while taking a handover from Nurse C and then gave the man glucagon to raise his blood sugar level. Nurse C noticed cyanosis in the man's toes, and the paramedic decided to call for additional help from an ambulance. Both the first responder and the ambulance crew remained at the prison until 7.25pm (almost two hours after the first paramedic arrived), administering naxolone and hypostop before taking the man to hospital.

77. The post-mortem report was completed on 11 May 2012. It identified several areas of severe ischemia (a restriction in blood supply to tissues) in the brain and in the thalamus, cerebellum and brainstem structures and thought that these were secondary to a haemorrhagic infarction (bleed on the brain) and brain swelling. It recommended that a clinical neurologist or specialist in strokes review the treatment given to the man to establish whether the delay while he received treatment from the paramedics before being taken to hospital was important. At the request of the Coroner, a consultant neurologist examined the man's clinical records and post-mortem and toxicological results.

78. The consultant neurologist commented in his report that he thought that Nurse C summoned help very quickly after completing her observations and noted that the first paramedic arrived 18 minutes later. He said that "the paramedic, and then the full ambulance crew appeared to have followed standard practice in assessing and stabilising the patient [the man]". The consultant

neurologist said that even after arriving at the hospital the man's diagnosis was not clear, and that he required a CT brain scan.

79. The consultant neurologist did not consider that the man's treatment was delayed. However, he added that "nevertheless the balance of probabilities has to be that even timely thrombolysis [the breakdown of blood clots using medication] in such a severe stroke would not have salvaged enough brain tissue to lead to a meaningful recovery". He recommended that the ambulance service should review their policy about how quickly potential stroke patients should be transferred to hospital.

Restraints

80. 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, the prisoner's category and which also takes into account factors such as the prisoner's health and mobility.

81. 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.

82. The man was very ill when he was taken to hospital on 23 February, and, in his condition, it would have been highly improbable that he would have been able to escape from two prison officer escorts and reoffend. The level of escort and restraint was the same as when he was mobile and not seriously unwell and even then he had been regarded as a low risk of escape. Shortly after he arrived, he was placed in a medically-induced coma, making escape or re-offending even more implausible. In these circumstances he should not have been restrained. Escort risk assessments should take into account the prisoner's current health condition and how that impacts on his risk at the time. We have recently made a recommendation on this issue to Onley, which they have accepted, indicating that medical restrictions will form part of the risk assessment. We repeat that recommendation here:

The Governor should ensure that use of restraints for prisoners being taken to hospital is fully justified by risk assessments that take into account and record how the prisoner's health and physical condition impact on his risk while outside the prison.

RECOMMENDATIONS

To the Governor

1. The Governor should ensure that prisoners' hospital appointments are not cancelled unless there are properly justified and recorded reasons.

   The National Offender Management Service responded with,

   Accepted – (by the Governor of HMP Leicester) A system will be introduced to ensure that all relevant factors are taken into account when considering the cancellation of a hospital appointment. Any decision which results in cancellation will be fully justified and recorded.

2. The Governor should ensure that use of restraints for prisoners being taken to hospital is fully justified by risk assessments that take into account and record how the prisoner's health and physical condition impact on his risk while outside the prison.

   The National Offender Management Service responded with,

   Accepted - Governors responsible for completing escort risk assessment and authorising cuffing arrangement have been made aware of the ombudsman's observations. Medical restrictions form part of the generic form and therefore we will ensure that it has been given due consideration as part of our risk analysis leading to cuffing instructions to the escorting officers