

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in September 2013 at
HMP Holme House**

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 in September 2013 of a prisoner at HMP Holme House. The man was 78 years old and died from heart disease . I offer my condolences to the man's family and friends.

An investigator was appointed and a clinical reviewer reviewed the man's clinical care at Holme House. The prison cooperated with the investigation.

The man was in poor physical health when he first arrived at Holme House on 1 June 2013. He had a number of medical conditions, including diabetes, kidney disease and also had mobility problems. On 27 September 2013, a prison officer and a nurse were helping the man back to his houseblock from a stay in the prison's healthcare centre when the man suddenly collapsed. Paramedics were called and took the man to North Tees Hospital. Sadly, resuscitation efforts were unsuccessful and the man was confirmed dead on arrival.

I am satisfied that the man's death could not have been foreseen or prevented. In general the man's long term conditions such as his diabetes appear to have been well managed at the prison, but the clinical reviewer has noted that there were some areas of his care which could have been better, including assessing his mental health and ensuring there was appropriately coordinated social care. I am concerned that the restraints were used when the man was taken to hospital, without a fully justified risk assessment which took into account his medical condition at the time, a matter I have raised with Holme House before.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

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CONTENTS

| | |
|---------------------------|----|
| Summary | 5 |
| The investigation process | 6 |
| HMP Holme House | 7 |
| Key events | 8 |
| Issues | 14 |
| Recommendations | 18 |
| Action Plan | 19 |

SUMMARY

1. On 1 June 2013, the man was remanded to HMP Holme House. He had a number of medical conditions, including diabetes, kidney disease and mobility problems. Healthcare staff checked his prescribed medication with his community GP, but did not request his community medical records.
2. The man did not manage his diabetes well, and had a number of falls and was admitted to hospital once because of his low blood sugar level. Restraints were used during his hospital stay which were not satisfied were justified by a fully considered risk assessment. Some staff considered that not all his reported falls were genuine but was attention seeking behaviour. No one referred the man for a mental health assessment to determine if this might be as a result of any mental health problem or to help determine his level of capacity and understanding in relation to managing his diabetes and personal hygiene which were poor.
3. The man was admitted to hospital for tests on 19 September and returned to the prison on 24 September. A meeting was held to decide the most appropriate place for the man in the prison and what help he needed with day to day living. There is no record of who attended this meeting or what decisions were reached, but the investigator was told that arrangements were made to have additional handrails fitted in the man's cell on houseblock three. While this work was being done he stayed in the prison's health care inpatient unit.
4. On 27 September, a prison officer and a nurse took the man back to his houseblock in a wheelchair. He had to get out of the wheelchair to climb five steps to get to his landing. As he got to the third step he told the nurse and prison officer who were accompanying him that he did not feel steady and then collapsed suddenly. The staff requested assistance and began to attempt resuscitation. An emergency ambulance was called and paramedics arrived quickly. The man did not regain consciousness and was pronounced dead when he arrived at North Tees Hospital.
5. While the man's death could not have been predicted or prevented, the clinical reviewer found that the man's standard of care at the prison did not match that he could have expected to receive in the community, principally because of the lack of coordinated social care at the prison. She also found room for improvement in obtaining medical histories from community GPs and in clinical record keeping. We make recommendations about these matters and the need to ensure that a prisoners' medical condition is properly considered when managers authorise the use of restraints in hospital.

THE INVESTIGATION PROCESS

6. The investigator issued notices informing staff and prisoners at HMP Holme House of the investigation and asking anyone who had relevant information to contact her. No one responded.
7. The investigator obtained copies of all the man's prison and prison medical records. She visited HMP Holme House on 13 November, and met the Governor, visited the houseblock where the man lived, the healthcare unit and spoke to staff and prisoners who knew the man. The investigator interviewed eight members of staff and gave her initial findings to the Governor and followed this up in writing. The investigator subsequently interviewed four members of staff by telephone.
8. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.
9. The investigator contacted North East Ambulance Service who provided details of the contact they had with the prison on 27 September.
10. The investigator informed HM Coroner for Teesside about the investigation, and the Coroner provided the post-mortem report. We have sent the Coroner a copy of this investigation report.
11. One of the Ombudsman's family liaison officers contacted the man's brother, to explain the investigation. The man's family did not have any specific questions for the investigation to consider.
12. The man's family received a copy of the draft report. They did not make any comments. The prison considered our draft report and recommendations and has accepted these. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included at the end of the report

HMP HOLME HOUSE

13. Holme House is a local prison for up to 1,212 male adult prisoners. The majority of its prisoners are remanded into custody or recently convicted by courts in the local area. The prison also holds a small number of young adults, aged 18 to 21. Care UK provide health services at Holme House. Nurses are on duty 24 hours a day. There is a vulnerable prisoner unit for men, such as sex offenders, who might be at risk from the general population.

HM Inspectorate of Prisons

14. The most recent inspection of Holme House was in August 2013. The Inspectorate was concerned that many prisoners could not maintain even basic levels of personal care. Access to showers had deteriorated with the introduction to restricted access to association. Inspectors noted that the prison had started a social care agenda and health services staff were assessing the level of service required. Inspectors found that the overall standard of healthcare was good. There was a reasonable skills mix of healthcare staff, with 10 nurse prescribers. Health services were delivered from a health centre and wing based rooms, which were generally of a reasonable standard.

Independent Monitoring Board

15. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure prisoners are treated fairly and decently. In its most recently published annual report for the year to December 2012, the IMB said that healthcare services were delivered to a high standard, and were at least equivalent to the services offered in the community. Concern was raised about the ageing population and that disabled access was only available on houseblock seven, although most older prisoners lived on houseblock three.

Previous deaths at Holme House

16. The man's death was one of four natural cause deaths at HMP Holme House in 2013. This was the third death at Holme House in a week, the other two deaths were self-inflicted, one of which was earlier the same day. There are no significant similarities between the findings of the investigations into those deaths and that of the man.

KEY EVENTS

17. The man was remanded into custody on 1 June 2013, awaiting trial at Teesside Crown Court, and taken to HMP Holme House. The man was located in houseblock three, the vulnerable prisoner unit, at his own request due to the nature of his alleged offences.
18. During his initial healthscreen the man said that he had mobility problems and used a walking stick. He was given a wheelchair to help get about the prison. He was diabetic and had been fitted with a pacemaker to regulate his heartbeat. The man said he was taking warfarin (to prevent blood clots) and metformin (medication for diabetes). The prison doctor examined the man later the same day. While waiting for confirmation from his GP about the medication he was prescribed, the doctor admitted the man to the prison's inpatient unit for observation. Staff did not request the man's community health record.
19. On 3 June, the man's weight was recorded as 106.6kg (which was considered overweight for his height), his blood pressure was within normal range at 120/75 and his pulse was raised at 96 beats per minute. The man said he did not want to stop smoking. The next day, the doctor confirmed the man's medication and he moved to houseblock three. The man was given an adapted cell with a specialist bariatric bed, for those who are overweight with limited mobility.
20. At 11.50am on 20 June, staff found the man on the floor of his cell. The nurse recorded his blood sugar as 1.6, which is low (the normal range for blood sugar is between 4 and 7). The nurse examined him and found no injuries. He explained to the man the importance of checking his blood sugar before meals, to ensure his diabetes was better managed. Later the same day another nurse was called to the man's cell as he again had low blood sugar and was sweaty and clammy. The nurse reminded the man that he needed to eat regularly.
21. Over the next few months, healthcare staff saw the man daily on the houseblock, and checked his blood sugar levels and warfarin levels regularly. On 30 June, staff found the man on the floor of his cell and he had been incontinent. Female nurses who attended reported that he had behaved inappropriately towards them and the security department was notified. The investigator was unable to clarify in what way the man had been inappropriate. On 3 July, the nurse noted that the man's cell was dirty and his personal hygiene was poor. A care plan was started for healthcare staff to help the man shower and dress, although they encouraged him to maintain his independence. His care arrangements were not implemented consistently. A care plan was also started to monitor his insulin use. There are several entries in the medical record noting that the man refused assistance and he appears that he was often difficult to manage. The man was found on the floor of his cell again on 11 July. No injuries were recorded and healthcare staff were satisfied that he had not fallen or had collapsed. The man told them that he had felt shaky, but did not say why he had chosen to lie on the floor instead of the bed.
22. The next day the man was admitted to the inpatient unit for an assessment of his ability to manage daily living activities. He had a swollen right leg (known as

oedema, caused by the accumulation of fluid) which was cleaned and dressed. The man remained in the inpatient unit and had further blood tests, but told staff that he wanted to return to his houseblock. He returned to houseblock three on 15 July but there is no discharge record on his medical record. On 16 July, the results of blood tests showed that the man had developed stage 4 chronic liver disease and had severely reduced kidney function caused by his diabetes.

23. At 11.45am on 25 July, another prisoner saw the man fall out of his wheelchair and alerted staff who found him on the floor of his cell. Healthcare staff came quickly and recorded the man's blood sugar was recorded as low (2.8). He was again advised about eating regular meals. The doctor told houseblock staff that without treatment the man could have died, and it was recorded as a serious incident. The next day there was a similar incident.
24. The doctor examined the man on 31 July, who said that he had had diarrhoea for six weeks. In addition to stool tests, the doctor made an urgent referral under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks. The doctor also asked for tests to determine if the man was suffering from heart failure. The next day at about 5.00am, staff found the man on his cell floor. A nurse recorded that he had no injuries, and that the man had told her that he had lowered himself to the floor. Prison staff were concerned about the man's safety on the houseblock and the man was given a personal alarm to wear on his wrist, so he could alert staff if he fell and could not reach the cell bell.
25. On 9 August, the man had an ECG (an electrocardiogram, used to diagnose problems with the heart) at the prison. That day the hospital contacted a healthcare administrator at the prison to say that the man had not attended for his 'two week rule' appointment for a colonoscopy. The administrator said that there was no record of the appointment but the hospital said it had been booked with an administrator the week before and all necessary bowel preparation had been explained. The Head of Healthcare told the investigator there was no record on the system of this appointment and healthcare staff had not been notified. However, the doctor had prescribed suppositories on 5 August, and noted on the man's medical record this was in preparation for a hospital appointment on 9 August. The appointment was rearranged for 20 August, although this was not noted in the man's prison medical records.
26. On 11 August, the nurse was called to houseblock three as the man was on the floor. She has noted that the man was not injured and was 'laughing and joking'.
27. A prison doctor examined the man's feet and legs on 13 August and noted that they were 'in a terrible condition' and referred him for an urgent diabetic foot assessment. He was then admitted to the prison's inpatient unit, his legs were treated and dressed and checked twice an hour during the night.
28. On 14 August, the man refused to take his antibiotics, unless staff took them to him in his cell. A nurse recorded there was no reason why the man could not collect his medication from the door and therefore recorded that he had refused it. The next day, a nurse tried to encourage the man to take more responsibility

for his own care. At 10.05am, the nurse recorded that the man walked towards her and a colleague, and then fell to the floor. The man refused to get up from the floor or allow her to take his clinical observations. She recorded this as 'manipulative behaviour'. At 11.05am, a nurse was trying to encourage him to comply, when the man 'kicked out' at her. The doctor saw the man at 12.20pm and recorded that he had low blood sugar. At 1.18pm the nurse recorded that the man's blood sugar was still low at 2.8 but this increased to 3.8 after she gave him glucose and a hot sugary drink. He became more compliant, accepted assistance and had his observations taken. His blood pressure was recorded as 95/65 and pulse 72 bpm, both within normal range.

29. On 17 August, the man was found unconscious on his bed, with laboured noisy breathing on 17 August. His blood sugar was very low at 1.3 and his pulse and blood pressure were raised (124bpm and 174/90). An ambulance was requested and the man was given glucose to increase his blood sugar. The man regained consciousness, was taken by ambulance to North Tees General Hospital.
30. When prisoners have to travel outside of the prison to a hospital, a risk assessment is conducted to determine the nature and level of any security arrangements, including any restraints. The escort risk assessment completed when the man was admitted to North Tees Hospital on 17 August stated that he was a low risk escape, but medium risk to the public and staff as he had been violent towards a nurse on 15 August. The doctor told the investigator that the man's behaviour on 15 August would very likely have been affected by his low blood sugar. (Very low blood sugar can cause a diabetic to become disorientated, confused and in some cases agitated). There is no mention of this by healthcare staff on the risk assessment or the security notes. A member of staff countersigned the risk assessment and decided that the man did not need to be restrained, but he was to be escorted by two prison officers.
31. The escort risk assessment was reviewed the next day. The medical section was completed by a senior nurse, but there was only limited information about the man's physical condition or mobility and the impact this had on his risk of escape. A custodial manager reviewed the assessment and it was countersigned by the duty governor who authorised that an escort chain should be used while the man was in hospital, and a single handcuff should be used when he was being transported. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). There was nothing written to explain why restraints were now needed. An officer noted in the escort log at 5.45pm that the custodial manager had instructed that an escort chain to be applied. The manager told the investigator that she understood that all prisoners staying in hospital had to be restrained.
32. While in hospital the man was seen in the orthopaedic department, as it was likely that he would have to have a toe amputated (as a result of his diabetes and poor circulation). The man had an ultrasound on 19 August, and further blood tests were ordered. He had a catheter fitted and was on an intravenous drip. Healthcare staff at Holme House notified the hospital that he had a pre-arranged appointment with the colorectal surgeon. (This was the re-scheduled urgent

referral appointment from 9 August). The man was taken to the clinic, by wheelchair because of his poor mobility. A surgical registrar examined him.

33. The registrar suggested in a letter to Holme House that he had been unable to examine the man properly because he was handcuffed to the wheelchair. The investigator interviewed both escort officers who said that the man was restrained by an escort chain and had not been handcuffed to the wheelchair. The officers said that a doctor had not asked them to remove the escort chain. The doctor told the investigator that it is possible that the escort chain appeared to be attached to the wheelchair. He had not asked for the restraints to be removed because he did not feel the examination was vital at the time.
34. On 20 August, the escort officers noted that the man had been told that he would have a colonoscopy when his kidneys were functioning better and that an X-ray had detected a fracture in his left leg, which might require plastering. (The next day he was told that he would have to wear a tubi-grip, and undertake some physiotherapy.) On 21 August, the man had an ECG which indicated that he had borderline heart failure. He had a further scan the next day but there is no record of what this scan was for, or the result. There is very little information noted on the man's medical record during the time the man was in hospital. The man was discharged from hospital back to prison on 24 August.
35. Over the next few weeks the records show that the man was encouraged to maintain his personal hygiene and healthcare staff assisted him when showering. On 17 September, he fell in his cell twice, and he continued to have problems with his feet. Due to concerns about his ability to keep himself safe, he was admitted to the prison's inpatient unit.
36. On 19 September the man was admitted to North Tees Hospital for a colonoscopy. The hospital had not asked the prison to stop his warfarin medication (which he was taking to prevent blood clots) and his INR levels were too high to perform the procedure. (INR is the international normalised ratio – a measure of how the blood clots.) The man remained in hospital for a few days while his INR was stabilised. On 23 September, he was discharged back to Holme House inpatient unit. The doctor examined him the next day and decided there was no clinical need for the man to remain as an inpatient. He returned to houseblock three that day.
37. A discharge letter from North Tees Hospital received on 25 September stated that the colonoscopy had been re-arranged. The man's warfarin medication needed to be stopped and he was to be admitted on 2 October.
38. On 26 September, a meeting was held to discuss the man's care needs. The meeting was not documented but it apparently decided that the man should return to the inpatient unit for one night while additional handrails were fitted in his cell on houseblock three.

Events on 27 September

39. At about 3.20pm on 27 September, an officer and nurse took the man back to houseblock three in a wheelchair. At the entrance of the lower landing on houseblock three the man had to get out of the wheelchair and walk up five steps. He used the handrail and his walking stick and began to go up the stairs slowly. The officer positioned the wheelchair behind the man in case he fell backwards and also used his hand to support the man from behind. The nurse said that at first the man did not appear to have any particular difficulty managing the steps.
40. When he reached the third step, the man said that he could not manage any more. The nurse was to the side of the man helping him and was there when he stopped. She said that the man had not complained of any pain, his breathing appeared normal and he was warm to the touch.
41. The man remained standing on the third stair for a short time, before he suddenly collapsed and fell backwards. The officer protected the man's head as he fell, although he was knocked over by him and the man fell across his legs. The officer and nurse placed the man in the recovery position and the officer shouted for assistance from nearby staff. A code blue was called over the radio at 3.35pm (a code blue is used to indicate a medical emergency such as when a prisoner is unconscious or has breathing difficulties. An ambulance should be called automatically when the code is called.) A nurse who was working on houseblock three heard the shout for help and quickly joined them.
42. The man was breathing, but was unresponsive. The nurse checked the man's blood sugar, which was within normal range. Another nurse said that the man then extended his body and appeared to stop breathing. She could not find a pulse and started resuscitation. The doctor had also responded to the emergency call and inserted an airway. A defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest) was attached to the man and administered a number of shocks. Resuscitation attempts continued until paramedics arrived.
43. North East Ambulance Service confirmed that they received an emergency request for an ambulance at 3.35pm. Paramedics arrived at Holme House prison gate at 3.42pm, and got to the man at 3.47pm. The paramedics assessed him while the prison staff continued with the resuscitation attempts. The man remained unresponsive and was taken to hospital.
44. The man did not respond to resuscitation and was pronounced dead at the hospital at 4.53pm.

Liaison with the man's next of kin

45. The same day the prison's family liaison officer and a colleague informed the man's brother of his death in person at 6.00pm that evening. The family liaison officer kept in contact with the man's family over the subsequent days. The prison contributed towards the funeral costs, in line with national policy. The man's funeral was held on 10 October. The prison chaplain conducted the service, at his family's request.

Support for staff and prisoners

46. The Governor issued a notice informing staff and prisoners of the man's death and reminding them of the support available. All prisoners subject to suicide prevention monitoring were reviewed and offered additional support in case they had been affected by the man's death.
47. The duty governor held a debrief for the escort staff who had been with the man at North Tees Hospital. Most other staff had gone off duty by the time the news of the man's death was received, however the duty governor spoke to other staff including the nurses over the weekend.

Post-mortem report

48. A post-mortem examination concluded that the man died of ischaemic heart disease and coronary artery atheroma (narrowing of the arteries to the heart resulting in reduced blood flow and causing a heart attack) and diabetes mellitus.

ISSUES

Clinical care

49. The clinical reviewer concluded that the man's death could not have been foreseen or prevented. Holme House provided a holistic approach to managing the man's diabetes. He was referred appropriately to podiatry and eye clinics, and self-care interventions were prompted. He was also appropriately referred for tests in relation to his ongoing heart failure. However the clinical reviewer found that there were areas where his overall care could have been better.

Mental health assessment

50. There were some indications that the man's mental health might have been impaired, but he was not referred to the mental health team for assessment. The man had difficulties maintaining his personal hygiene and managing his diabetes. He was an elderly man and sometimes he was found on the floor of his cell, apparently having put himself there. There is no evidence of how staff satisfied themselves that he fully understood how to manage his diabetes or considered anything other than that his behaviour was manipulative with regard to his falls. The clinical reviewer considers that when a prisoner's decision making and self-care appears to be compromised this should prompt a mini mental state examination. We make the following recommendation:

The Head of Healthcare should ensure that when elderly prisoners' self-care and decision making abilities, including compliance with medication, appear impaired, they should be referred for a mental health assessment.

Medical records

51. The man told the nurse during his initial health screening on 1 June 2013 that he had a pacemaker, and suffered ankle oedema (swelling due to fluid retention as a result of heart failure). However, on 25 July the prison GP recorded that this information was not in his previous prison medical history. The clinical reviewer has noted that, based on the doctor's entry, it can be assumed the man's pacemaker was definitely not checked for almost two months and there is nothing in the records to show that his pacemaker was ever checked while he was in prison.
52. The clinical review states that the man had had diabetes for seven or eight years, had a pacemaker and ongoing symptoms of heart failure (such as ankle oedema) for which he was taking furosemide (a diuretic used in the treatment of congestive heart failure and oedema). All of which would have featured in his community medical records.
53. Prison Service Order (PSO) 3050 Continuity of healthcare states that efforts should be made to retrieve any information required from the prison's GP or other relevant service. Although the medication prescribed to the man was

checked with his GP, there is no evidence that his community medical history was ever requested. Obtaining his previous clinical records would have assisted the prison doctors not only in clarifying the man's medication, but also given them information about any previous investigations and past medical history, which would have helped make a more informed assessment of his ongoing symptoms.

The Head of Healthcare should ensure that GP records are routinely requested for any prisoner who has ongoing medical issues and is prescribed medication.

54. The man did not attend hospital on 9 August for a colonoscopy procedure, which had been arranged under the two week rule. The investigator was told that healthcare staff had not received this appointment. However, on 5 August the doctor had prescribed medication in preparation for the colonoscopy and referred to the appointment on 9 August. While this does not appear to have been recorded it does indicate that the hospital had informed the prison healthcare staff about the appointment. There should be a clear process for recording and monitoring prisoners' hospital appointments.
55. The man had been referred for diagnosis at the end of July to determine if he had heart failure. He had an ECG on 21 August, while an inpatient at North Tees General Hospital, but there is little clinical information in his medical record about the outcome of these diagnostic tests.
56. The clinical reviewer has concluded that clinical record keeping at Holme House needed improvement. A summary of the man's medical history was not recorded when he arrived at Holme House, and not all health information had been accurately recorded. There is little medical information in the records from the times that the man was in hospital, although we recognise that this is reliant on discharge summaries from the hospital. It is a serious concern that the urgent referral appointment scheduled for 9 August was not noted in the man's records.

The Head of Healthcare should ensure that all healthcare staff fully comply with the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council, and that there is a robust system for recording and monitoring hospital appointments.

Social care

57. The clinical reviewer noted that the man's care was predominately regarded as a social care issue. He needed assistance to get washed, dressed and showered but not always nursing care. The records show the man had a high level of social care needs, and the clinical reviewer found that although the prison has access to social care professionals through the healthcare provider, this is on a case by case basis and there was no evidence of a standardised approach.

58. The clinical reviewer concluded that the overall social care provided at Holme House was below a satisfactory level. While we recognise that healthcare staff assisted the man with many of his social care needs, CareUK, the healthcare providers, are not commissioned to provide social care, and there is no agreed protocol for identifying prisoners who require such assistance. Neither CareUK nor prison staff considered social care as their job and this left the man being cared for in an ad hoc manner. Sometimes a prisoner helper assisted the man with showering which is inappropriate. The Governor of Holme House responded to the investigator's written feedback about this and recognised that the provision of social care had been identified as a very important issue for Holme House, particularly with an ageing population. This issue has been identified as a development objective in the service level agreement between the prison and care provider for 2013-2014. We make the following recommendation:

The Governor should ensure that there is a system to identify prisoners who need social care and that those needs are met.

Restraints, security and escorts

59. 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 (the Graham judgement) 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.
60. The man's medical condition was not documented on the risk assessment of 17 August when he was taken to hospital. However, it was agreed that restraints were not necessary as the man was noted to be 'old/infirm'. The revised risk assessment the next day had little information about the man's medical condition and the impact this has on his risk of escape and there is no explanation of why it concluded that restraints should be used when the one the day before decided they were unnecessary. We are concerned that one of the managers involved in the assessment considered that all prisoners in hospital need to be restrained which is contrary to the guidance in the Graham judgement. When the man went to hospital on 19 September, the healthcare section of the risk assessment indicated that he should be handcuffed on his left wrist as he needed an arm crutch to walk. A single cuff was used for the escort and he was restrained in hospital until 23 September when it was agreed they could be removed. On 27 September, the man collapsed and was taken by ambulance to North Tees Hospital, the emergency risk assessment has no medical information and authorised restraints to be applied. Despite the assessment, restraints were not used. .

61. Security measures must be proportionate to a prisoner's individual circumstances which must be fully considered, taken into account and balanced against the security risks. We are not satisfied that the risk assessments when the man was restrained in hospital was justified by risk assessments that fully took into account his physical health, poor mobility and frailty into account as the court judgement requires. Following an investigation into a previous death at Holme House in January 2013, we made a recommendation about the use of restraints. This was accepted by the prison who undertook to ensure all managers were aware that "levels of restraint used on prisoners must at all times be proportionate to the perceived security risks and be balanced by consideration of care and decency for the prisoner." We are not satisfied that this has happened and make the following recommendation:

The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that when elderly prisoners' self-care and decision making abilities, including compliance with medication, appear impaired, they should be referred for a mental health assessment.
2. The Head of Healthcare should ensure that GP records are routinely requested for any prisoner who has ongoing medical issues and is prescribed medication.
3. The Head of Healthcare should ensure that all healthcare staff fully comply with the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council, and that there is a robust system for recording and monitoring hospital appointments.
4. The Governor should ensure that there is a system to identify prisoners who need social care and that those needs are met.
5. The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

ACTION PLAN

| No | Recommendation | Accepted/Not accepted | Response | Target date for completion and function responsible | Progress (to be updated after 6 months) |
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| 1 | The Head of Healthcare should ensure that when elderly prisoners' self-care and decision making abilities, including compliance with medication, appear impaired, they should be referred for a mental health assessment. | Accepted | Individual prisoners are now assessed via a Multi-discipline team of both healthcare and mental health nursing staff on a case by case basis | Completed Head of Healthcare | |
| 2 | The Head of Healthcare should ensure that GP records are routinely requested for any prisoner who has ongoing medical issues and is prescribed medication. | Accepted | Medical records are now regularly requested from GP surgeries for prisoners with chronic or long- term medical conditions. | Completed Head of Healthcare | |
| 3 | The Head of Healthcare should ensure that all healthcare staff fully comply with the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council, and that there is a robust system for recording and monitoring hospital appointments. | Accepted | The system for organising external hospital appointments has been reviewed and is now working effectively. All Doctors and administration staff have been reminded of the importance of effective communication with regard to recording of all medical appointments appropriately. | Completed Head of Healthcare | |

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| 4 | The Governor should ensure that there is a system to identify prisoners who need social care and that those needs are met. | Accepted | A system is now in place within the reception process to identify prisoners with potential social care needs. A mini needs assessment is completed which is forwarded to the establishment's social care lead). A copy is also given to the establishment's Safer Prisons and Equality manager. Local authorities are contacted to provide a social care assessment of the individual prisoner's needs. A care package is then implemented from the findings of the assessment. (Stockton adult social services have agreed to conduct all assessments). | Completed Head of Social Care / Governor | |
| 5 | The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time. | Accepted | The Prison and Probation Ombudsman's learning lessons update from February 2013 was re-circulated to all Duty Governors and Custodial Managers on 18 th February 2014. Extracts from this update were highlighted to remind staff of the legal obligations. This update is now on a circulation list to be reissued annually. | Completed Head of Resettlement/ Governor | |