



**Investigation into the death of a man
at HMP Wakefield in February 2012**

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

July 2013

This is the report of the investigation into the death of a man at HMP Wakefield in February 2012. He was 57 years old. The cause of his death was a pulmonary thromboembolism (also known as deep vein thrombosis) after having surgery for a fractured hip. I offer my condolences to his family and friends.

One of my investigators conducted the investigation and a clinical reviewer carried out a review of the man's care at Wakefield. Wakefield prison cooperated fully with the investigation. I apologise for the delay in issuing our report.

The man fractured his left hip after a fall in the exercise yard on 11 February. A doctor instructed staff to send him to hospital, but it took three and a half hours before he left the prison. When he returned to Wakefield on 17 February, after an operation on his hip, he was admitted to the prison's healthcare centre as an inpatient. On a morning in February, healthcare staff helped him out of bed and assisted him to the toilet but shortly afterwards found him unconscious on the floor. Efforts to resuscitate the man were unsuccessful and paramedics pronounced him dead at 9.24am.

We are satisfied that the man received a good standard of care at Wakefield for his long term conditions, such as diabetes. However, when he injured himself and a doctor advised that the injury was possibly life-threatening, there was a lengthy delay while staff sought advice and made security arrangements for him to leave the prison. In hospital, despite his injury rendering him immobile, restraints were used, including during treatment. While the man was convicted of very serious offences, the level of restraint does not appear to have been justified by a considered assessment of the actual risk he posed. On his return to the prison after his operation, care plans lacked detail and poor documentation makes it difficult to determine how well the risk of blood clots was managed in the days leading up to his death.

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

July 2013

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SUMMARY

1. The man was 57 years old and had been in prison since 1993. He had lived in HMP Wakefield since March 2008. He had been sentenced to life imprisonment with a whole life tariff. He was a diabetic, but did not always cooperate with treatment and often ignored medical advice. This led to complications associated with poorly managed diabetes, such as poor vision.
2. During icy weather on 11 February 2012, the man fell in the exercise yard. A nurse who examined him concluded he had a hip injury and recommended that he should go to hospital. The wing principal officer and the duty governor did not call an ambulance, but asked the nurse to consult an out of hours doctor. A protocol is in place for an out of hours GP to attend the prison and the investigation heard that this must be considered in the management of Category A prisoners. The doctors advised that he should be taken to hospital as the injury was likely to be a fractured femur, which could be potentially life threatening. Initially, the managers insisted a doctor should attend the prison to examine him but they then sought authorisation for him to leave the prison and called an ambulance. These protracted discussions meant it took three and a half hours after his injury before he was taken to hospital.
3. The man had an operation for a fractured hip and remained in hospital until 17 February. When he returned to the prison, he was admitted to the inpatient unit in the healthcare centre because he had limited mobility and needed regular observations and treatment.
4. On a morning in February, staff went into the man's room at approximately 8.40am, to help him get out of bed and use the toilet. They left him for a few minutes and when an officer returned to check on him, he was found him collapsed on the floor. Resuscitation attempts by staff and paramedics were unsuccessful and the man was pronounced dead at 9.24am. The post-mortem report concluded that the cause of his death was a massive pulmonary thromboembolism arising from deep venous thrombosis of the left leg. The pathologist considers this was related directly to the man's hip fracture and surgery.
5. The investigation found that the man received appropriate care for his diabetes and related medical conditions, although on 6 February 2012, there was a long delay in sending him to hospital with eye problems. Similarly, there was a lengthy delay in sending him to hospital after his fall on 11 February, in spite of advice from a doctor that his injury was possibly a life-threatening fracture of the femur. Restraints were used at hospital during treatment and we are not satisfied that this was justified by a risk assessment which took full account of his physical incapacity. Owing to poor record keeping, the details of his care plan, actions taken to assist his mobility and medication given after he returned to the prison were unclear. We make recommendations about these matters.

THE INVESTIGATION PROCESS

6. Notices were issued at HMP Wakefield informing staff and prisoners of the investigation. The investigator visited Wakefield on 24 February 2012 to speak to prison staff and collect the man's prison and medical records.
7. Wakefield District Primary Care Trust commissioned a clinical reviewer to review the man's clinical care in custody. The report of the clinical review was received on 15 February 2013.
8. One of our family liaison officers contacted the man's family on 21 March, to explain the investigation process. His family raised no concerns about his treatment in prison, but were surprised by the cause of his death and asked how this could happen following a routine operation.
9. The families' representative wrote to us in response to the draft report, this led to minor factual changes in the report and further issues have been addressed in separate correspondence.
10. The investigator contacted the local Coroner to inform him of the investigation and request a copy of the post-mortem and toxicology reports. A copy of this report has been sent to the Coroner.
11. The delay in issuing this report is regretted. The investigation was suspended on 19 April, at the request of West Yorkshire Police, pending the conclusion of their enquiries. It resumed on 6 November, but we were unable to complete our report at that stage owing to the late receipt of the clinical review.
12. On 13 December, the investigator returned to Wakefield to conduct interviews with prison staff and also spoke briefly with two prisoners who had contacted him while visiting the residential unit. He subsequently gave both verbal and written feedback to the Governor.

HMP WAKEFIELD

13. HMP Wakefield is one of eight high security prisons in England and Wales. It holds 750 Category A, B, and high security remand prisoners. There are four main residential wings, a healthcare centre segregation unit and close supervision centre. A doctor is available in the prison between 9.00am and 5.00pm, Monday to Friday. Outside these hours, a locum service is used.

Previous deaths at Wakefield

14. There have been a number of deaths from natural causes at Wakefield since the Ombudsman took responsibility for investigating deaths in custody in 2004. Other investigations found no other examples of delays in sending prisoners to hospital because of security issues. However, following another investigation in July 2012, we made a recommendation to the Governor of Wakefield relating to the use of restraints.

Her Majesty's Inspectorate of Prisons

15. HM Inspectorate of Prisons carried out an unannounced full follow-up inspection of Wakefield in May 2012. The report found that:

“Health care facilities were generally good. A variety of providers was involved. There were no vacancies and staff had a good skill mix. All prisoners received a comprehensive reception screening. Our survey indicated prisoners were generally satisfied about access to and the quality of health care apart from the availability of a GP. A good range of clinics was available, but for routine appointments there could be unacceptably long waits to see a GP. Older prisoners and those with lifelong conditions were well supported ... In-patient facilities were very good, with appropriate staffing and a good level of care planning.”

Independent Monitoring Board (IMB)

16. Each prison has an Independent Monitoring Board (IMB), of unpaid volunteers from the local community, to help ensure that proper standards of decency are maintained. In its annual report for 1 May 2011 to 30 April 2012, the IMB notes: “Although the Healthcare Unit continues to provide a comprehensive service that meets the needs of the prison population, there remains underlying problems”. The Board explains that these relate to staffing issues.

KEY EVENTS

17. The man was remanded into custody at HMP Brixton on 24 July 1993, charged with murder. He subsequently pleaded guilty to five murders and was sentenced to life imprisonment in December 1993. He was given a 'whole life tariff' which meant he would never be considered for release.
18. The man transferred to Wakefield prison in 1994. After moving between Wakefield and several other prisons, he returned to Wakefield in 2008.
19. In February 2000, the man was diagnosed with type 2 diabetes. Healthcare staff reviewed him frequently, as well as giving him advice about his lifestyle and how best to manage his condition. However, he was reported to be quite stubborn about adhering to medical advice. He refused regular blood tests as he found them intrusive and declined additional medication to stabilise his glucose levels. Nevertheless, he attended several hospital outpatient appointments and underwent surgery a number of times to treat conditions apparently related to his poorly controlled diabetes.
20. One of the complications of the man's condition was diabetic retinopathy (damage to the retina) and he had retinal detachment in 2010 and 2011. Despite his earlier poor attitude to managing his condition, during an appointment in the diabetic clinic at Wakefield on 14 November 2011, a doctor recorded that the man was now taking a progressive approach to healthy living. He was exercising for 30 minutes each day by taking brisk walks and making changes to his eating habits.
21. On 6 February 2012, he reported a loss of vision. An out of hours GP recommended that the man be taken to hospital as the cause was likely to be another incident of detached retina which the GP would be unable to treat. The prison initially insisted that the GP attend the prison. After further telephone calls between the prison and the GP, and a delay of six hours from the time he reported the problem, the man went to hospital for treatment. He was returned to the prison the same evening.
22. On 11 February 2012, the weather was bad and snow and ice were causing problems. A principal officer (PO) who was on duty that day, told the investigator that, to ensure safety, a member of staff checked the exercise yard first. She said that on 11 February, staff from the prison works department cleared a path and put salt down so that prisoners could walk around the yard. She said that there was nothing to suggest that prisoners should not use the yard.
23. The man went out for exercise as usual on 11 February, with a number of other prisoners and was seen walking briskly around the yard. A prisoner who was on the yard at the time told the investigator that the man came up behind a group of prisoners who were walking slower and, rather than waiting, he attempted to cut across the grassed area in the centre of the concrete path. The grass was wet and muddy and he slipped over. The investigator was told

that as he fell his legs seem to go in opposite directions. Another prisoner said that it was obvious that he had hurt himself.

24. Staff immediately went to assist the man, who tried to stand up, but was unable to do so. They radioed for medical assistance and a nurse attended. She said that the man complained of pain in his left hip and thigh and was unable to stand. She asked for a wheelchair to be brought to the yard and he was taken back to the wing.
25. The investigator viewed CCTV footage, which shows the man walking around the yard, before cutting across the grass area and falling over. The response by the staff was immediate and the nurse attended within a few minutes.
26. The man returned to his cell, where the nurse examined him. She recorded that there was slight shortening in his left leg indicating a hip injury and his foot was rotated outwards. She contacted the principal officer (PO) who consulted the duty governor. The PO told the nurse that the duty governor said that a doctor would have to attend the prison to assess the man to confirm the nature of the injury before he could be taken to hospital. The PO was unable to explain why a further medical opinion was required and whether emergency ambulance staff could have provided it, but said that she did not have the authority to send a category A prisoner outside the prison for treatment.
27. The nurse contacted the out of hours general practitioner (GP) service at 12.10pm, who returned her call at 12.26pm. She outlined the man's condition and was told that, from the description given, it was potentially a fractured femur. The doctor said this could be life threatening and that the man should be sent to an outside hospital's accident and emergency department.
28. Despite this, the duty governor advised that due to his security category, a doctor would have to physically assess the man before he could be sent to hospital. He said that the man was a high profile category A prisoner, who was likely to attract media attention if he was escorted outside of the prison and was considered to be a high risk to the public.
29. The duty governor for that day told the investigator that the PO had explained the events leading to the man's injury and had told the nurse that a GP needed to attend the prison. He was asked whether it was standard practice for a GP to be asked to attend the prison before a category A prisoner would be sent out to hospital. He said that there would be issues with sending out such a prisoner, including consideration of whether the prisoner would need a police escort. He said that while he fully supported the "decision" taken by the PO, he was also mindful of the time parameters from requesting a GP, to one attending. He was aware that a GP was due to carry out clinics that afternoon and hoped that they would be in a position to assess the man further.
30. He said that although he was the duty governor, he had to seek authorisation to send a category A prisoner outside the prison. Therefore, he had tried, unsuccessfully, to contact the relevant on-call manager at headquarters, rather than just wait for a GP. He eventually contacted the duty director who gave him

verbal authority for the man to be taken to hospital. The duty governor asked staff to call an ambulance and arranged for escort staff. The man went to hospital nearly three and a half hours after he first fell and injured himself. The clinical reviewer notes that it does not appear that the man received any pain relief during this time.

31. The duty governor said that, if the man had been unconscious, the procedures would have been different. He would have immediately authorised sending him to hospital and completed the normal procedures retrospectively. He said that the focus is always the preservation of life, but as the man was conscious, he was obliged to follow the correct procedures.
32. The senior healthcare officer was not on duty that day, but told the investigator that on the information recorded by the nurse, he would have expected an emergency ambulance to be called and that a three-hour delay was excessive. He said that, depending on the severity of a prisoner's condition, nurses had the authority to call an emergency ambulance and arrangements would then be made for the prisoner to be taken out of the prison to hospital.
33. An operational support grade member of staff completed the initial sections of a security risk assessment for the man to be taken to hospital. This recorded that he was on the highest level of the privileges scheme, there was no problem or intelligence to suggest any escape motive or access to outside resources. However, it was noted that he was a high profile offender and was assessed as of high risk to the public. Risk to hospital staff, risk of hostage taking and escape potential were assessed as medium and likelihood of outside assistance was low. The justification given for the levels of risk was that he was a category A offender in the high security estate. The form also indicated, in error, that his last escorted visit to hospital was in February 2011 (in fact it had been on 6 February 2012, just the week before.)
34. The senior manager who authorised the risk assessment agreed that restraints should be used, comprising a single handcuff and an escort chain (a length of chain with a handcuff at each end one attached to the prisoner and the other to an officer) while in the ambulance. The restraints could be removed during treatment but otherwise the escort chain should remain in place throughout the man's admission to hospital. The escort record indicates that the escort chain remained while he received intravenous (in the vein) therapy. A further annotation on the escort record, dated 13 February, states "Operation is planned to begin at 14.00 (13/2) [he] is going to have an epidural injection, but escort chain needs removing if any complications arise and general anaesthetic is required".
35. The man had an operation to replace his fractured left hip at outside hospital on 13 February, 2012. He remained in hospital until Friday 17 February. At the hospital, he had daily physiotherapy to improve his mobility and the hospital provided a list of required medications to the prison. When he returned to the prison on 17 February he was admitted to the prison's healthcare centre as an inpatient because of his limited mobility and need for assistance with his personal care.

36. On 18 February, a nurse recorded that the man had slept most of the night and had said that he did not require any further pain relief. Later that morning, he was given his prescribed medication. There are a number of potential complications following surgery on a hip fracture. One of these is blood clots, which can form in the deep veins of the legs, due to reduced mobility. It was noted that a care plan was put in place to ensure that he was encouraged to keep mobile and assisted by nurses. However, the actions arising from the care plan were not well documented and it is not apparent what was done to assist his mobility.
37. The senior healthcare officer told the investigator that, although he had not personally issued his medication, he was aware from colleagues that the man had declined both pain relief and medication prescribed for his diabetes after he returned from hospital. He confirmed that the hospital had prescribed additional medication to help thin the man's blood, but he was not able to say whether the man had cooperated with taking it. Healthcare staff recorded that although he refused to take some medications, they continued to advise him of the importance of taking them. On 20 February, a nurse recorded that he had managed to persuade him to take his pain relief and Simvastatin (to reduce cholesterol and often prescribed to diabetics).
38. A member of healthcare staff told the clinical reviewer that they believed the hospital had given the man medical compression stockings to reduce the chances of developing blood clots after surgery. However, there was no record to indicate that staff and the man were aware of their importance and how long they should be worn. Entries in his medical record show that the man would get up and sit in a wheelchair, but there is no description of how and when staff helped him with his mobility. As he was discharged from hospital on a Friday, he had no physiotherapy over the weekend. A physiotherapist visited him on 20 February and went through a number of post-operative exercises and advised him about his recovery.
39. The clinical reviewer subsequently compiled a list of the 11 medications prescribed to the man and whether or not they had been administered between his discharge from hospital and his death. It appears that no prescribed medication was given to him the day before his death. Records indicate that he had refused some medications in the past, but no explanation was recorded for the day before his death.

Events on the day of the man's death

40. On a morning in February, just after 8.30am, the senior healthcare officer (SHCO) went into the man's room to help him get out of bed. A PO helped him assist the man to the toilet. The man also used a walking frame to assist his mobility. To give him privacy, the SHCO told the man that they would leave him and come back in a few minutes to check on him. The SHCO told the investigator that he went back to the man's cell to take in a clinical waste bin. The man was still on the toilet, so he left him again, and went to check on other patients.

41. The investigator viewed CCTV footage from the man's cell. This showed him slumping forward onto his walking frame, moments after the SHCO had left his cell. The CCTV footage shows he fell to the floor at 8.42. Within a few minutes, an officer, who had been asked by the SHCO to look in on the man, opened the door. When he saw the man collapsed he immediately went to tell the SHCO.
42. The SHCO went straight to the cell and saw the man lying unconscious on the floor. He said that it was obvious that it was a serious situation and he called for further assistance. He could find no signs of life: no pulse, breathing or pupil reaction. He turned the man over and began cardiopulmonary resuscitation (CPR) at 8.43am. This is confirmed by the CCTV footage. The officer who had first discovered the man collapsed assisted with the resuscitation attempt and the SHCO radioed for an emergency ambulance to be called.
43. Other nurses arrived quickly bringing emergency medical equipment, including a defibrillator and oxygen. Nurses rotated the administration of CPR and the SHCO inserted an airway and administered oxygen. The defibrillator was attached but indicated that there was no shockable rhythm to restart the man's heart and advised that CPR should continue.
44. Paramedics arrived at the man's cell within 15 minutes and took over the resuscitation attempts from nurses at 8.58am. They continued for approximately 30 minutes, but he did not respond and was pronounced dead at 9.24am.

Events after the man's death

45. After the man's death, a staff debrief was held for those involved. Prisoners on his usual wing as well as those in the inpatient department were informed. The prison's safer custody team ensured that prisoners subject to suicide and self-harm monitoring were spoken to and offered support if required.
46. An officer acted as the prison's family liaison officer. As his family lived in another part of the country, the prison asked the local police to visit them and break the news of their relative's death before it was reported in the press.
47. The prison's family liaison officer and a colleague left the prison at approximately 11.30am on the morning of the man's death and arrived at his family's home at around 3.00pm. The family liaison officer outlined to the man's mother the circumstances of his death. She explained that an investigation would take place, and offered financial support with funeral expenses.
48. The man's family were concerned about press intrusion once his death was made public and the family liaison officer reassured them that the prison would help if they could. To avoid press interest in their home area, at his family's request, the prison arranged the funeral.

ISSUES

Clinical care

49. The clinical reviewer reviewed the man's medical care in custody. She commented on a number of issues some of which relate to his treatment at outside hospital and are not within the PPO's remit. The PCT will share the clinical reviewer's findings with the secondary care providers.

Management of the man's existing medical conditions

50. The man was not always compliant with advice from nurses about how best to manage his diabetes. Nevertheless, he attended a prison based diabetic clinic and was treated for the complications of his diabetes both inside and outside prison.
51. The clinical reviewer questioned whether the man's partial sightedness as a result of his diabetes and a previous injury to his hip made him more vulnerable to the possibility of falling in the exercise yard and whether an individual risk assessment should have been made.
52. The investigator spoke to two prisoners who knew the man and lived on the same residential wing. They both described him as very able. They said he attended to his daily routines such as cleaning his cell and went to exercise without any difficulty. The investigator also clarified with the managers at Wakefield that an assessment of the exercise yard was made during inclement weather, and the man had the option of whether to attend or not. We are therefore satisfied that appropriate arrangements were made.

Care after the man's return from hospital on 17 February 2012

53. The clinical reviewer focuses on two main issues. The lack of detailed recording of clinical interventions and care plans on the man's medical record, as well as the quality and appropriateness of the administration and recording of medications.
54. The man was discharged from hospital on Friday 17 February, where he had been prescribed a number of medications. These were handwritten on a piece of paper and the clinical reviewer says they were not transferred to the appropriate prescription and administration document, nor was this signed. However, the investigator noted that the medications were listed on his prescription chart. The prescription chart indicates that he was given medication to prevent blood clotting on 18 and 19 February, along with diabetic medication. The prescription chart also shows which medications he refused. There is no indication that he received any type of medication the day before his death and no reason is given.
55. Because of his operation and immobility, the man was at risk of venous thromboembolism. Yet no risk assessment for this was undertaken, no

provision was made for him to receive any physiotherapy over the weekend and staff did not record specific action to mobilise him. The clinical reviewer highlights that National Institute for Health and Clinical Excellence (NICE) guidelines advise that: "Patients are mobilised 12-18 hours post op and receive therapy input over weekends."

The Head of Healthcare should ensure that healthcare staff conduct risk assessments for venous thromboembolism for prisoners discharged from hospital after operations, particularly when they are immobile and that arrangements are made to ensure continuity of care at weekends.

56. While the majority of the medical record was completed well and the man's medical history is easy to follow, many of the entries after he returned from hospital on 17 February appear to have been in the form of templates set up on the medical computer system. Care plans were said to have been put in place when he returned from hospital and a standardised care plan template is in his medical notes. However, the clinical reviewer considers that more detailed entries should have been made, to inform all nurses of the individualised care to be provided to the man and how often he was expected to mobilise, rather than relying on the standard template.
57. We are satisfied that healthcare staff provided appropriate clinical care for the man's existing medical condition (diabetes) over several years. However, the investigation found a number of shortcomings in record keeping during the three days between his discharge from hospital and his death. This has made it difficult to determine the standard of care and medication given during that period, but it seems that care plans were generalised, no arrangements were made for physiotherapy and important blood thinning medication might have been overlooked on the day before his death. The two latter omissions are key measures to prevent blood clotting. We make the following recommendations:

The Head of Healthcare should ensure that care plans are specific to the individual needs of the prisoner for whom they are prepared.

The Head of Healthcare should ensure that all healthcare staff accurately and contemporaneously record actions, in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

The Head of Healthcare should ensure that healthcare staff prescribe, dispense and administer medication in line with professional standards of medicine management.

Emergency response on 11 February

58. When a prisoner is taken outside a prison, security procedures are put in place to prevent the possibility of escape. The man was classified as a standard risk category A prisoner. Although not directly related to his security risk, he was

regarded as a high profile prisoner because of publicity surrounding his offences.

59. The investigator consulted a member of staff at NOMS Headquarters who monitors the movements of category A prisoners about the policy on moving such prisoners in an emergency. He was told that there are national guidelines, but each prison should also have local procedures. Ultimately, the focus in a medical situation should be on the preservation of life.
60. Wakefield's local policy, "Category A hospital escorts – out of hours", sets out the procedures to be followed if a prisoner has to be taken to hospital as an emergency. It states that for standard risk category A prisoners in "extremely urgent" cases, staff should contact the duty governor for approval and authority. They define such cases as, "The Medical Officer states it is a matter of life or death and immediate action is essential", However, "these escorts should not be delayed pending approval if you have difficulty contacting the duty governor."
61. Staff interviewed during the investigation gave contradictory accounts about the procedures for authorising the transfer of a prisoner to hospital. The senior healthcare officer (SHCO) explained that in an emergency, nurses would ask the control room to call an ambulance and would then consult the manager in charge directly or ask someone else to do so. The principal officer, whom the nurse consulted about sending the man to hospital, said she did not have the authority to approve this and the operational manager acting as duty governor took the decision. At interview, the duty governor acknowledged that preservation of life was paramount but said he endorsed the "decision" taken by the PO to request the attendance of a doctor and that she was "insistent that a GP attend". The duty governor would not take a decision without speaking to a duty director at Prison Service headquarters. This might have been a reasonable precaution in some circumstances but it led to an unreasonable delay in attending to the man's urgent health needs.
62. When the man fell on the 11 February and on a previous occasion the week before on 6 February, prison staff did not follow the advice of out of hours doctors to take him to hospital. Prison staff initially tried to insist that a doctor should attend the prison to confirm the diagnosis rather than act on the advice. No reasonable explanation was given as to why they could not accept the judgement of the nurse, the doctor on the telephone, or any attending ambulance staff. We do not believe that staff gave sufficient priority to attending to the man's health needs on 11 February. It appears it was his notoriety rather than his risk to the public which led to the reluctance to authorise his being taken to hospital, rather than concern about his risk to the public. As he was immobile because of his injury, his risk of escape was negligible.
63. The clinical reviewer says: "... The time between him breaking his leg and ultimate admission to hospital could have been crucial..." We consider it unacceptable that, after a suspected fracture of his femur (a condition described as life-threatening by the doctor consulted), the man had to wait

nearly three and a half hours before he was taken to hospital. Such a delay could jeopardise the life of a prisoner in future. We therefore make the following recommendation:

The Governor should ensure that when advised to do so by a doctor or other healthcare professional, staff call an ambulance promptly and that local escort procedures reflect this.

Use of restraints

64. 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 judgment 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 judgment indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process. It deemed that handcuffing a prisoner receiving chemotherapy (and, by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.
65. Prison Service guidance is that restraints are not normally necessary on an escort when the prisoner's mobility is severely limited. As the man had a broken femur, this would apply in these circumstances. There is no evidence to suggest that he presented a risk of escape or to the public that could not be managed by a two officer escort. In the light of his lack of mobility, we do not think the use of an escort chain was necessary or justified. He received both intravenous treatment, as well as an operation under an epidural anaesthetic while attached to an officer by an escort chain. British Medical Association guidance is that there should be a presumption that prisoners are examined and treated without restraints, unless there is a high risk of escape or the prisoner represents a threat to himself, the health team, or others. We acknowledge that public protection is paramount, but security measures must be proportionate to a prisoner's individual circumstances. We do not consider the risk the man presented warranted the use of an escort chain during these invasive procedures.

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

RECOMMENDATIONS

1. The Head of Healthcare should ensure that healthcare staff conduct risk assessments for venous thromboembolism for prisoners discharged from hospital after operations, particularly when they are immobile and that arrangements are made to ensure continuity of care at weekends.

The recommendation was accepted and the Prison Service said:

'...Intermediate healthcare provision has been commissioned by the NHS Commissioning Board to The Humber NHS Foundation trust. Primary care is provided by Spectrum community health CIC. They will provide risk assessments for venous thromboembolism for prisoners discharged from hospital after operations, particularly when they are immobile and that arrangements are made to ensure continuity of care at weekends. Training will also be provided ...'

2. The Head of Healthcare should ensure that care plans are specific to the individual needs of the prisoner for whom they are prepared.

The recommendation was accepted and the Prison Service said:

'... Intermediate healthcare provision has been commissioned by the NHS Commissioning Board to The Humber NHS Foundation trust. Further training will be provided for staff by the trust ...'

3. The Head of Healthcare should ensure that all healthcare staff accurately and contemporaneously record actions, in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

The recommendation was accepted and the Prison Service said:

'... Healthcare provision has been commissioned to providers and further record keeping training sessions are planned, as in any organisation, this is ongoing ...'

4. The Head of Healthcare should ensure that healthcare staff prescribe, dispense and administer medication in line with professional standards of medicine management.

The recommendation was accepted and the Prison Service said:

'... Healthcare staff must comply with administration of medication standards and NMC guidance. Regular updates and training is undertaken by Pharmacy and in house training ...'

5. The Governor should ensure that when advised to do so by a doctor or other healthcare professional, prison staff call an ambulance promptly and that local escort procedures reflect this.

The recommendation was accepted and the Prison Service said:

‘... Local protocols will be reviewed to take full account of PSI 03/2013 and specifically the requirement that staff “*should not delay summoning emergency assistance*” and that “*It is essential that an ambulance is called in all cases where there are serious concerns about the health of a prisoner and that access to both the prison and the individual prisoner is not delayed.*’

This will be highlighted to staff by way of an NTS and briefings as appropriate ...’

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

The recommendation has been slightly reworded from the draft and accepted by the Prison Service.