

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at hospital in
October 2012, while in the custody of HMP & YOI
Chelmsford**

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 October 2012 at hospital. He had been taken ill at court just after he was sentenced and was legally in the custody of HMP Chelmsford. He was 63 years old. He died from a blood clotting disorder, heart disease and high blood pressure. I offer my condolences to his family and friends.

A clinical reviewer was carried out of the man's medical care in custody. Chelmsford prison cooperated fully with the investigation.

The man was sentenced to 14 months imprisonment on 1 October 2012 at Crown Court. While detained at court, he complained of chest and heart pains. Court staff responded quickly to his discomfort and he was taken to hospital by ambulance. He remained in hospital until he died, after an operation on his heart.

Although the man was never physically in custody at Chelmsford prison, the prison was responsible for his security at the hospital. We agree with the clinical reviewer that he received medical care comparable to that required by any individual with his severity of cardiac problems. However, we are concerned that there was a 25 minute delay in the ambulance leaving the Crown Court, caused by Serco escort staff seeking authorisation to reduce his level of restraint. He was initially restrained by an escort chain in hospital. The level of escort and restraint at the hospital was eventually reduced and allowed him to die with dignity, but we consider this could have been done earlier.

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

October 2013

CONTENTS

Summary

The investigation process

Key events

Issues

Recommendations

SUMMARY

1. In May 2012, the man was diagnosed with a serious heart condition, for which he needed surgery. On 1 October, he was sentenced to fourteen months imprisonment at Crown Court. While in the court cells he told a custody officer that he had heart and chest pains. An ambulance was requested immediately and a paramedic arrived quickly. After assessing him the paramedic considered he needed hospital treatment.
2. Thirty minutes later an ambulance arrived and the ambulance staff asked for the man's handcuffs to be removed to aid his treatment. There was then a delay taking him to hospital while Serco staff contacted their regional manager to get permission to remove them. Although it is impossible to determine whether this made any difference to his condition, it is unacceptable that Serco's security procedures caused such a delay and we have made a recommendation about this.
3. The man was admitted to hospital that afternoon, where medical staff told him that he had suffered a heart attack and would need to remain in hospital. The prison took over escort responsibilities from Serco that evening and the level of restraint was reduced to an escort chain. The next day, 2 October, a senior officer at the prison reviewed the risk assessment and recommended that all restraints should be removed and the escort reduced to one officer. This Governor agreed to this the next morning but his restraints were not removed until later that afternoon, nearly 24 hours after the initial recommendation. We see no reason for this delay in removing restraints from a prisoner with severe heart problems who had been assessed as no risk of harm to the public and a low risk of escape.
4. On 6 October, the man transferred to another hospital for heart surgery. This took place on 9 October, but there were complications and he died a few days later.
5. The clinical reviewer considers that the man received a level of care comparable to anyone with his severity of cardiac problems. We agree that, with the exception of the delay in seeking removal of restraints after his court appearance, the actions of staff were responsive and timely in seeking medical assistance when he became unwell.

THE INVESTIGATION PROCESS

6. This office was notified of the man's death on 11 October 2012. Notices were issued, inviting staff and prisoners to contact the investigator with any relevant information. No one came forward.
7. Another Prisons and Probation Ombudsman (PPO) investigator collected the relevant documents relating to the man from HMP Chelmsford on 18 October. The investigator visited Chelmsford on 5 December and met the Governor. She interviewed three members of prison staff and two employed by Serco.
8. The local PCT commissioned a clinical reviewer to carry out a clinical review of the healthcare the man received. She completed her review on 1 February 2013.
9. Her Majesty's Coroner for Essex and Thurrock was notified of the investigation and has been sent a copy of this report. The Coroner provided the man's post-mortem report which recorded his cause of death as severe coagulopathy (a problem with blood clotting), aortic valve disease, ischaemic heart disease (resulting in reduced blood supply to the heart muscle) and pulmonary hypertension (high blood pressure).
10. One of our family liaison officers spoke to the man's wife to explain the investigation process. His wife identified no specific issues that she wished the investigation to consider. The family received a copy of the draft report as part of the consultation process however had no further comments to add.

KEY EVENTS

11. In May 2012, the man was diagnosed with severe three vessel disease (blockages in the blood supply to the heart), severe aortic stenosis (disease of the heart valves) and pulmonary hypertension (high blood pressure in the arteries of the lungs). He was treated with various medications and referred to hospital for heart surgery. In July a consultant cardiologist at the hospital assessed him, who agreed to heart surgery.
12. The man was sentenced to fourteen months imprisonment for fraud at around 10.15am on 1 October at Crown Court. This was his first custodial sentence. A pre-sentence report prepared for the court noted that he was unwell and was waiting for triple heart bypass surgery. Due to his ill health and fear of a custodial sentence, he had told the report author that he was “feeling down” and he thought his GP had prescribed antidepressants.
13. Serco provide the custodial services at that particular Crown Court. The man had previously been on bail but his security became the responsibility of Serco, once he was sentenced. At 10.20am, his medication was taken from him and he was told he should request it if he needed it. The prisoner’s property record kept by Serco notes that he had “numerous” medications in his possession. There is no record that he requested any of this medication that morning. He was offered a meal and a drink and checked at least once every twenty minutes. The intention was that he and other prisoners would be held in court cells until they were taken to prison later that day.
14. A Prisoner Custody Officer (PCO) was working in the court cells that morning. He told the investigator that the regular observations were standard procedure to check on prisoners’ welfare and to see if they needed anything, such as a drink or to speak to their legal representative. The checks identified no concerns about the man during the morning.
15. When the PCO checked at 12.08pm, the man complained of chest and heart pains. He told the officer that he had had previous bypass surgery. The PCO, who like all PCOs had regular first aid training, was concerned about his symptoms and went straight to the Senior Custody Officer (SCO) to report them. They called an ambulance at 12.14pm. Another PCO remained with him until a paramedic arrived at 12.20pm.
16. After assessing the man, the paramedic decided at 12.46pm that he should go to hospital. An ambulance arrived half an hour later. He got into the ambulance at 1.19pm to go to hospital. He was escorted by three custody officers and “double cuffed” to one of them. This meant that his wrists were handcuffed together in front of him and then he was handcuffed to an officer. The Head of Custody Services for Serco explained that this was standard procedure and therefore no risk assessment had been conducted. He added that while the prisoner’s medical condition needed to be taken into account, so did the safety of his staff, and the fact they would be travelling by ambulance rather than in a cellular vehicle.
17. The ambulance staff asked if the handcuffs could be removed so that they could have better access to treat the man. In line with Serco policy, the escort staff first sought approval from a senior manager to remove the double cuffs and put

him on an escort chain (a long chain with a handcuff at each end attached to the prisoner and an officer). It took 25 minutes before this was agreed, which delayed the ambulance leaving the court. The investigator did not become aware of this delay until January 2013, when the clinical reviewer forwarded the ambulance records of the emergency response. Therefore, she did not have the opportunity to include this in her interviews with the escort staff but subsequently emailed the Head of Custody Services about the issue. The response is dealt with later in the report.

18. A Person Escort Record (PER) accompanies each person when they move between a police station, court and prison and includes information about their risks and needs. The PER indicated that the man left the court at 1.50pm and arrived at hospital at 1.58pm.
19. The man was prescribed paracetamol, oramorph and ibuprofen (all painkillers) at the hospital at 2.27pm. He had X-rays and blood tests that afternoon. At 4.15pm he was told he had had a heart attack and would need to stay in hospital for a few days. Several members of his family visited him that evening in hospital and the police attended to help the escort staff.
20. The arrangement with escort services is that prisons take over responsibility for escorts within four hours of a prisoner being admitted to hospital. Just after 8.00pm, Chelmsford prison took over the escort from Serco. The man was due to be transferred to another hospital for a heart operation within a few days.
21. A Senior Officer (SO) told the investigator that the prison has 24 hours to complete a risk assessment on a prisoner after they have gone to hospital as an emergency. (The national audit baseline for risk assessments for escorts states that, "in an emergency a full escort risk assessment must be completed as soon as is practicable but in any event within 24 hours.") The SO said that until this assessment was completed the man was restrained by an escort chain attached to one officer with another officer present. This was the standard level of escort and restraint when the prison has no particular concerns about the prisoner escaping. Chelmsford obtained more information about him, including his previous convictions, the following morning.
22. At 10.24am on 2 October, Chelmsford completed a risk assessment for the man's hospital escort. The healthcare department's input noted that he was not incapacitated as a result of his condition but that it was life threatening. They said that restraints would need to be removed during surgery and X-rays. The security section indicated that he did not present a risk of harm to the public and there was no intelligence to suggest he would try to escape.
23. Although the risk assessment indicated that the man was not a risk to the public and not a risk of escape, the SO recommended that he should be double cuffed to two officers when being escorted from the hospital and on an escort chain with two officers during consultation or treatment at the hospital. The assessment did not state a specific level of risk. An operational manager authorised this assessment. The escort logs show a number of medical interventions such as an electrocardiogram (ECG), blood tests and injections but it does not appear that the escort chain was ever removed during his first 36 hours in hospital.

24. Later that afternoon, on 2 October, the SO reviewed the risk assessment and recommended to the operational manager responsible that the escort should be reduced to one officer and that no restraints should be used. She indicated that hospital staff had told her that the man had been polite and reasonable and that, although he was able to walk, he was connected to a number of monitors which would set off alarms if he removed any of them.
25. In the morning of 3 October, the man's provisional security category was assessed as category D. Category D prisoners are those who can reasonably be trusted to serve their sentences in open conditions. Later that morning the Governor authorised the risk assessment prepared by the SO.
26. Another SO visited the hospital at 2.45pm that afternoon to complete a standard daily management check. He told the escort staff that the risk assessment had been reviewed and the escort chain was now to be removed and only one officer needed to remain at the hospital. The SO also spoke to the man, who said he was okay and was happy as some of his family were visiting him at the time.
27. On 6 October, the man transferred to another hospital for an operation on his heart. His operation began at 3.00pm on 9 October and continued for twelve hours. There were complications during the operation and his blood did not clot as expected. On 10 October, he was moved to intensive care and the escorting officer was told that the outlook was not good. He was bleeding internally, on life support and was given only a 1% chance of survival.
28. The man's heart stopped beating around midnight and hospital staff resuscitated him. Hospital staff told the escort officer that they did not intend to resuscitate him again. His family were informed and were by his bedside. He was not expected to live for more than six hours.
29. A nurse told the escort officer that the man had died. The SO telephoned the prison and called his family, who had left just a short time before. At 8.30am, a hospital doctor certified his death. The escort officer returned to the prison and, later that morning, attended a debrief with the Head of Operations, who offered him support if he needed it.
30. An officer was appointed as the family liaison officer. He telephoned the man's wife at 9.30am to introduce himself and arranged to visit her later that day at 3.00pm. The officer and a colleague went to her home as arranged and returned his belongings to her. The Governor sent a letter of condolence. The officer did not offer assistance with the funeral expenses, but left his contact details and invited the man's wife to contact him at any time.

ISSUES

Clinical care

31. Before his trial, the man had been treated in the community for a serious heart condition and had expected to have surgery. After he reported his chest pains to court staff, they quickly called an ambulance and a paramedic was with him within eight minutes. The clinical reviewer concludes that the response to his pain by the court staff was immediate and the ambulance service arrived within their target time.
32. We agree with the clinical reviewer's conclusion that:

“The man did receive a level of service comparable to that required by any individual with his severity of cardiac problems. He was referred to and accepted for in patient aortic valve replacement as well as coronary artery bypass graft. He was transferred and treated at hospital where he had been seen 4 months previously.

Delay in ambulance leaving the court building

33. There was a delay of around 25 minutes before the ambulance was able to leave the court building on 1 October. Ambulance staff had asked Serco officers to remove the man's handcuffs so they could treat him effectively. It took Serco staff 25 minutes to get authority to do this from a senior manager.
34. In correspondence, the Serco Court Services Manager said that staff had followed Serco policy in requesting the authority from a senior manager to remove the handcuffs. He acknowledged that this caused a delay of 25 minutes in the ambulance being able to leave the court building, but noted that the ambulance had first been requested at 12.14pm, the paramedic had arrived at 12.20pm and decided that the man needed to go to hospital at 12.46pm and the ambulance arrived around half an hour later.
35. Regardless of these timings, a delay of nearly a further half an hour while Serco staff got managerial approval, after it was decided that the man needed to be taken to hospital, was unacceptable. The clinical reviewer indicated that it is impossible to conclude with any certainty whether the delay made a difference to his treatment and prognosis. Nevertheless, we make the following recommendation:

The Head of Custody Services for Serco should ensure that decisions and authorisations about the use of restraints do not affect or cause any delay to prisoners' treatment and transfer in a medical emergency.

Level of escort and restraint

36. After the man was treated by ambulance staff he was double cuffed again for his transfer to hospital on 1 October accompanied by two Serco officers. Once Chelmsford took responsibility for him that evening, the level of restraint was reduced to an escort chain and two officers.

37. The next morning, the prison completed a full risk assessment, which indicated the same level of restraint and escort was necessary. This was despite the man being assessed as no risk of harm to the public or escape. We believe that a recommendation for the removal of restraints should have been made at this stage. The Senior Officer said the prison had 24 hours to complete a risk assessment but the requirement is for them to be completed "as soon as practicable" with a maximum time of 24 hours. The healthcare section of the risk assessment noted that restraints should be removed during surgery and X-rays but it was recorded in the security section of the form that an escort chain should be used during consultation/treatment. The chain was not removed at any time during his treatment.
38. The Prison Service has a duty to protect the public when escorting prisoners to hospital and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process. It deemed that handcuffing a prisoner receiving chemotherapy (and, by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.
39. In addition, 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. The man had been convicted of a non-violent offence and had been granted bail until his conviction. Although no overall level of risk was assigned to him, in the light of this and his condition, we do not think the use of an escort chain was necessary or justified particularly when he was receiving medical treatment.
40. Later that afternoon, after receipt of information from the hospital, a SO reviewed the risk assessment and recommended no restraints and reduction of the escort to one officer. She took into account the man's behaviour while at the hospital and his medical condition. We consider this was an appropriate assessment. However, we are concerned that the earlier assessment did not make the same conclusion and that it then took until the next afternoon before his restraints were removed.
41. When people go into prison, they are given a security category to reflect their risk to the public in the event of an escape. The prison carried out the man's initial categorisation as a priority the next day, 3 October, and assigned him category D status (the lowest security category). The SO explained that this information was taken into account by the Governor when authorising her risk assessment the following morning. We do not consider it was necessary to wait for a decision

about security categorisation to be made before making a decision about his risk of escape from the hospital.

42. The man's restraints were not removed until 2.45pm that afternoon when another SO went to the hospital to complete the daily management check. This was a further delay of around 24 hours after the initial recommendation for removal of restraints was made.

The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances, are based on the actual risk the prisoner presents and are authorised and actioned without delay.

Funeral expenses

43. The family liaison officer told the investigator that he did not offer a contribution towards funeral expenses when he visited the man's family since it seemed inappropriate so soon after his death and with the number of family members present. The family did not contact the officer after this date. If they had done, he said he would have offered them a contribution towards the funeral expenses. It is hard to understand this reasoning, as a part of the family liaison officer role at that stage is to assuage any concerns families might have about the cost of a funeral. The officer did not contact the family again himself.

44. The investigator queried why the man's family were not offered assistance with funeral expenses as directed in Prison Service Instruction (PSI) 64/2011, Safer Custody which states that:

"Prisons must offer to pay a contribution towards reasonable funeral expenses of up to £3,000. The only exceptions [are] where the family has a pre-paid funeral plan or is entitled to claim a grant from other government departments e.g. Department of Work and Pensions."

45. The Governor indicated that it was a difficult decision which had been based on the fact that the man never entered Chelmsford Prison. He wrote to the investigator explaining that:

"It was felt at the time that if money were granted to the family to pay for the funeral and this information was brought into the public forum it could be presented in a very negative light for the Service. We can easily imagine a comparison where a person is admitted to hospital from court at the same time as the prisoner and dies, and that person's family are not given a public grant to pay for a funeral. On that level it would be impossible to defend awarding the grant to the prisoner's family when there is nothing comparable for a member of the public in exactly the same set of circumstances.

In this case, although there is an option to provide financial assistance I made the decision to make no offer of assistance, but I would respond to a request from the family to receive assistance. I believe this remains a fair and balanced point of view given the circumstances."

46. It therefore appears that the decision not to offer a contribution towards funeral expenses was a policy decision by the Governor – not because it appeared to be

too soon after his death as the family liaison officer suggested. We do not agree that the examples cited by the Governor are directly comparable circumstances. It also seems a little disingenuous that the prison would respond to a request for assistance when the possibility was never put to the family. Nor does the relevant Prison Service Instruction give “an option” as the Governor suggests. PSI 64/2011 indicates that prisons “*must offer*” to contribute to reasonable funeral expenses after a death in custody.

47. Nevertheless, we accept that these were unusual circumstances in which the man had never physically entered the prison. Such a situation was unlikely to have been envisaged when the instruction was drafted. His connection with the prison was technical and essentially all the prison did was to take on responsibility for his security arrangements at the hospital. We understand that the requirement for prisons to offer a contribution towards funeral costs reflects their full duty of care towards the prisoner, which in his case never really fully began. On balance, we are satisfied that a reasonable case could be made that it should not be a requirement to offer help with funeral expenses in these circumstances.

RECOMMENDATION

1. The Head of Custody Services for Serco should ensure that decisions and authorisations regarding the level of restraint of a prisoner do not affect or cause any delay to the prisoner's treatment and transfer in a medical emergency

Accepted

Serco accept this recommendation and have drafted an update to the Standard Operating Procedure (SOP) – Medical.

The revised text will advise that "A request to release from handcuffs should normally be required by Duty Director or a Senior Manager however in an emergency situation the OIC may take this decision to ensure that the escort is not delayed."

A Directors Instruction will follow to contract staff regarding this matter and the formal SOP update process followed.

2. The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances, are based on the actual risk the prisoner presents and are authorised and actioned without delay.

Accepted

We accept this recommendation and are working to the guidance issued by the PPO's office on 27 March 2013.