

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Aldo Tartaglia a prisoner at HMP Woodhill on 6 October 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Aldo Tartaglia, a prisoner at HMP Woodhill, died in hospital on 6 October of pneumonia. Mr Tartaglia was 92 years old. I offer my condolences to Mr Tartaglia's family and friends.

I am satisfied that Mr Tartaglia received a good standard of care at Woodhill, equivalent to that he could have expected to receive in the community.

However, I am concerned that staff did not tell Mr Tartaglia's family for 10 days that he had been admitted to hospital and that the prison informed his family of his death by telephone rather than in person. I am also concerned by the inappropriate use of restraints which managers authorised when Mr Tartaglia went to hospital. It is evident that Mr Tartaglia was elderly, frail, seriously ill and largely immobile. He was also assessed as low risk and there were medical objections to the use of restraints. It is therefore hard to understand why staff at Woodhill did not manage the issue with the degree of humanity and common sense that the law requires. This is a matter that I have raised before with Woodhill and the Governor needs to take active steps to ensure staff understand their responsibilities.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

March 2017

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Summary

Events

1. On 22 August 2016, Mr Aldo Tartaglia was remanded in custody, charged with sexual offences and sent to HMP Woodhill. On arrival, staff immediately put him on constant watch following a recent suicide attempt. Observations were later reduced, as his risk of suicide and self-harm decreased.
2. Mr Tartaglia was 92 years old and this was his first time in prison. He had a number of long term medical conditions but, following an initial health screen, he was moved to a cell on a standard wing. Healthcare staff visited him regularly to administer medication and attend to his care.
3. On 2 September, Mr Tartaglia was convicted of indecent assault and sentenced to 7 years in prison. He remained at Woodhill but could no longer look after himself on a standard wing. On 9 September, following an assessment, he was moved to the healthcare unit as an in patient. He had daily healthcare assistance and staff completed a social care needs assessment and implemented appropriate care plans.
4. On 12 September, a prison GP examined Mr Tartaglia and arranged a blood test. Results indicated possible renal dysfunction (kidney disease). On 15 September, Mr Tartaglia told a nurse he had diarrhoea and the nurse arranged a GP appointment. After examining him later that day, the GP noted that Mr Tartaglia's blood pressure was low. The GP stopped his blood pressure medication, advised him to drink more fluids and arranged further blood tests to check his liver and kidney function.
5. Mr Tartaglia continued to have diarrhoea and, when the GP examined him the next day, he appeared weak and dehydrated. The GP prescribed intravenous medication but, as the result of recent blood tests again indicated renal dysfunction, the GP arranged his transfer to hospital. Two prison officers went with Mr Tartaglia to hospital and restrained him in handcuffs. These were removed the next day. His family were informed that he was in hospital on 25 September.
6. Mr Tartaglia spent three weeks in hospital where his condition gradually deteriorated. He died on 6 October, of hospital acquired pneumonia but he also had acute renal failure due to diarrhoea, chronic obstructive pulmonary disease (a collection of lung diseases) and ischaemic heart disease.

Findings

7. The clinical reviewer considered that the care Mr Tartaglia received at Woodhill was equivalent to that he could have expected to receive in the community. We are satisfied that Mr Tartaglia received good care at the prison.
8. However, we are concerned that staff did not tell Mr Tartaglia's family that he was in hospital until ten days after his admission. We are also concerned that the prison family liaison officer informed Mr Tartaglia's family of his death by telephone rather than in person.

9. We are also concerned that managers authorised the use of restraints when Mr Tartaglia went to hospital without taking into account his condition at the time and its impact on his risk of escape.

Recommendations

- The Governor should ensure that the next of kin of seriously ill prisoners are informed as soon as possible.
- The Governor should ensure that a member of Prison Service staff informs a prisoner's family in person of their death, in line with national guidance.
- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints 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.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Woodhill informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
11. The investigator obtained copies of relevant extracts from Mr Tartaglia's prison and medical records.
12. NHS England commissioned a clinical reviewer to review Mr Tartaglia's clinical care at the prison.
13. We informed HM Coroner for Milton Keynes of the investigation who confirmed the cause of death. We have sent the coroner a copy of this report.
14. The investigator wrote to Mr Tartaglia's daughter to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. She did not respond to our letter.
15. We shared the initial report with the Prison Service. There were no factual inaccuracies.

Background Information

HMP Woodhill

16. HMP Woodhill has a dual role of a local prison and a high security prison and can hold 727 men. Central and North West London NHS Foundation Trust provides health services at the prison. There is an inpatient unit with 12 beds, which provides physical and mental healthcare for prisoners. End of life palliative care is also provided.

HM Inspectorate of Prisons

17. The most recent inspection of Woodhill was in September 2015. Inspectors reported that primary health services were good, although a high non-attendance rate meant prisoners waited too long for some services. The inpatient unit continued to provide good care, but the regime still needed to be more recovery focussed. Clinical records were of a high standard and included effective care planning for those with complex health needs.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to May 2016, the IMB reported that healthcare and mental health services continued to improve during the last year, as did the relationship between the provider and the prison. The healthcare provider had worked to keep medical and dental waiting times to a minimum, which were comparable to the community. This was achieved despite a number of vacancies and problems recruiting healthcare staff.

Previous deaths at HMP Woodhill

19. Mr Tartaglia was the fourth man to die of natural causes at HMP Woodhill since January 2015. We have raised the need for properly considered risk assessments to justify the use of restraints in other investigations.

Key Events

20. On 22 August 2016, Mr Aldo Tartaglia was remanded in custody charged with sexual offences and sent to HMP Woodhill. This followed his discharge from hospital after shooting himself twice with an airgun, in an attempt to take his own life.
21. On his arrival at Woodhill, staff immediately put Mr Tartaglia on an ACCT (Assessment, Care in Custody and Teamwork - the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm). Initially staff kept him under constant watch but, during the first week, reduced this to two visits every hour. Checks gradually reduced further as the risk of suicide or self harm lessened.
22. Mr Tartaglia was 92 years old and this was his first time in prison. He had a number of long term medical conditions including incontinence, high blood pressure, angina and asthma. He took medication which the prison GP's continued to prescribe. He had previously been diagnosed with prostate cancer and needed monthly injections which he continued to have in prison. He had mobility issues and walked with the aid of a stick.
23. Following an initial and secondary physical and mental health screen, Mr Tartaglia moved to a cell on a standard wing. Healthcare staff visited him regularly to administer medication and attend to his care.
24. On 2 September, Mr Tartaglia was convicted of indecent assault and sentenced to 7 years in prison. He remained at Woodhill.
25. Mr Tartaglia struggled to cope on a standard wing and staff raised concerns about his ability to look after himself. On 6 September, a nurse saw him in his cell to give him his morning medication and noted he looked frail. Mr Tartaglia told her that he felt he should be in the healthcare unit but she recorded that in her opinion he could look after himself.
26. However, Mr Tartaglia's condition continued to deteriorate and, on 9 September, after a further assessment he returned to the healthcare unit as an in patient. He had daily healthcare assistance and staff completed a social care needs assessment and implemented appropriate care plans.
27. A prison GP examined Mr Tartaglia on 12 September, and requested a blood test. Staff took a sample of blood for examination the next day and results later indicated renal dysfunction.
28. On 15 September, a nurse saw Mr Tartaglia to assist with his morning routine. He told her he had diarrhoea and she arranged a GP appointment. A prison GP examined Mr Tartaglia later the same day. He recorded his blood pressure as low, stopped his blood pressure medication and advised him to drink more. He arranged further blood tests in relation to liver and kidney function. A nurse checked Mr Tartaglia twice more that evening, he told her he was comfortable and felt ok.

29. On 16 September, Mr Tartaglia continued to have diarrhoea and, when a prison GP examined him, he appeared weak and dehydrated. The GP arranged intravenous medication. The result of the recent blood tests again indicated renal dysfunction and the GP diagnosed acute renal failure. He arranged for Mr Tartaglia's transfer to hospital, where a doctor admitted him. A senior prison manager authorised two prison officers to go with Mr Tartaglia to hospital and to restrain him in handcuffs. These were removed the next day.
30. Mr Tartaglia's condition gradually deteriorated and he died in hospital on 6 October 2016.

Contact with Tartaglia's family

31. On 25 September, ten days after Mr Tartaglia's hospital admission the prison appointed an officer as the family liaison officer. She telephoned Mr Tartaglia's daughter, his nominated next of kin, to introduce herself and they arranged to meet at the hospital that afternoon.
32. The officer met the family at the hospital as arranged. They discussed and arranged family visits, the return of property and arrangements in the event of Mr Tartaglia's death.
33. The officer kept in regular contact with the family over the following days. On 6 October, she telephoned Mr Tartaglia's daughter and told her that her father had died. She offered her condolences.
34. A custodial manager took over as the prison family liaison officer when the officer went off duty after her night shift. She contacted the family and arranged to meet them at the mortuary that afternoon to view the body.
35. She stayed in contact with Mr Tartaglia's family. They discussed funeral arrangements and the return of his property. Mr Tartaglia's funeral was held on 19 October and the prison contributed towards the cost in line with prison service instructions.

Post-mortem report

36. The immediate cause of Mr Tartaglia's death was from hospital acquired pneumonia. He also had acute renal failure due to diarrhoea, chronic obstructive pulmonary disease (a collection of lung diseases) and ischaemic heart disease.

Findings

Clinical care

37. The clinical reviewer was satisfied that the care Mr Tartaglia received at Woodhill was equivalent to that he could have expected to receive in the community.
38. Mr Tartaglia entered Woodhill aged 92, in poor health with a number of pre-existing long term medical conditions. Healthcare staff saw him regularly and he had appropriate care plans in place. When he could no longer cope on a standard prison wing, staff moved him to the healthcare unit, where he received good compassionate care
39. Prison doctors saw Mr Tartaglia regularly and prescribed or omitted medication as appropriate, depending on his presentation. A prison GP arranged for his transfer to hospital, as appropriate, where he spent the last three weeks of his life.

Contact with Tartaglia's family

40. Mr Tartaglia went to hospital by ambulance on 16 September. He was weak and dehydrated. Recent blood tests indicated renal dysfunction and a prison GP had diagnosed acute renal failure. However, no one from the prison informed Mr Tartaglia's family of his admission to hospital until 25 September, ten days later.
41. Prison Rule 22 requires that when a prisoner is seriously ill, the governor should tell the prisoner's spouse or next of kin "at once". Woodhill should have contacted his next of kin as soon as he was taken to hospital. We make the following recommendation:

The Governor should ensure that the next of kin of seriously ill prisoners are informed as soon as possible.

42. Prison Rule 22 also requires that the Governor should inform families at once when a prisoner dies. Prison Service Instruction (PSI) 64/2011 requires that wherever possible, the family liaison officer and another member of staff visit the next of kin or nominated person to break the news of the death. It notes that time will be of the essence in order to try to ensure that the family do not find out about the death from another source. If the next of kin live a long distance away, consideration must be given to requesting the assistance of a family liaison officer from the nearest prison.
43. Mr Tartaglia's next of kin lived approximately 36 miles from the prison. At the time of Mr Tartaglia's death an officer was due to go off duty. She had been at work for ten hours and was expected back at the prison that night. She and a senior manager discussed who should inform Mr Tartaglia's next of kin and, following their discussion, she telephoned his daughter.
44. We accept that it was unreasonable to expect the officer to tell the family of the death in person but Woodhill should have delegated this to another officer or used a family liaison officer from another prison. We make the following recommendation:

The Governor should ensure that a member of Prison Service staff informs a prisoner's family in person of their death, in line with national guidance.

Restraints, security and escorts

45. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. 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 takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.
46. On 16 September 2016, Mr Tartaglia went to hospital, accompanied by two prison officers. Staff completed a risk assessment and a member of the healthcare team, who did not sign the entry, recorded that there were medical objections to the use of restraints. Unfortunately, the unnamed member of staff did not record what the objections were.
47. Mr Tartaglia was 92 years old, frail, in poor health and with mobility issues. He had no previous convictions and a Senior Officer (SO) assessed him as low risk to the public and low risk of escape. None the less, she recommended the use of handcuffs and a senior prison manager agreed and authorised their use. There is no indication that she or the senior prison manager considered Mr Tartaglia's medical condition or how it might affect the risk he presented or his ability to escape.
48. The SO told the investigator that a two officer escort is the minimum requirement for any escort departing from Woodhill, irrespective of the prisoner's age or, medical history. She said she had no access to medical information as this was held 'in confidence' and she did not know the reason why Mr Tartaglia needed to go to hospital.
49. However, she explained that this lack of knowledge had no impact on her assessment or recommendations regarding the use of restraints, single handcuffing (where the prisoner has their wrists handcuffed to each other) being minimum requirement for Category C prisoners (Category C prisoners cannot be trusted in open conditions but are considered to be prisoners who are unlikely to make a determined escape attempt). She said she would only consider the lack of suitability of restraints if Mr Tartaglia had an injury to his arm, for example. She would then restrain him using the non-injured arm.
50. The SO said she would not be comfortable to make a recommendation not to use restraints. The senior prison manager confirmed that he supported her decision. However, for treatment at hospital he authorised the use of an escort chain (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).

51. Mr Tartaglia remained on an escort chain until 4.15pm the following day when another senior prison manager conducted a review and authorised removal. Staff did not restrain him again.
52. While the Prison Service has a fundamental responsibility to protect the public, security must be balanced with humanity and be legally justified. We are pleased to note that officers removed the restraints the day after Mr Tartaglia's hospital admission but we are not satisfied that staff could justify the earlier use of handcuffs.
53. We are concerned that managers authorised the use of restraints without enough information about Mr Tartaglia's health condition at the time or how this impacted on his risk of escape, as required by the High Court judgment. A serious medical condition is not just a physical injury, but any condition that affects a prisoner's risk or ability to escape. There have been other recent cases at Woodhill where there was little evidence to justify the use of restraints. As in previous reports, we consider that staff and managers at Woodhill do not understand the tests they should apply when deciding whether the use of restraints is justified when seriously ill prisoners are taken to hospital. We repeat our previous recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints 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.

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