Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Peter Gill a prisoner at HMP Wymott on 1 March 2017

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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*

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.

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

Mr Gill died on 1 March 2017 in hospital of fluid on the lungs related to an infection and end stage Chronic Obstructive Pulmonary Disease. He was 73 years old. I offer my condolences to Mr Gill's family and friends.

Mr Gill's clinical care was good but it is disappointing that there was confusion between Preston and Wymott around his restraint arrangements. An escort chain was initially removed due to the rapid decline in Mr Gill's health, but it was unnecessarily reapplied a few days later despite there being no improvement in his condition.

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 **October 2017**

Contents

Summary

Events

1. On 10 May 2013, Mr Peter Gill was sentenced to nine years and eight months in prison for sexual offences and was sent to HMP Preston. He was transferred to Wymott on 4 March 2016. He was transferred back to Preston on 6 January 2017.

2. In 1998, Mr Gill had a stroke, which left him with severe left-hand sided weakness and affected his mobility. He had Chronic Obstructive Pulmonary Disease (COPD) and in July 2015 was diagnosed with prostate cancer for which he received regular injections to shrink the tumour.

3. From April 2016, Mr Gill experienced numerous exacerbations of his COPD and was frequently admitted to hospital. When he was discharged from hospital, he was sent to either Wymott or Preston, depending on the level of care he required, as Preston had 24-hour inpatient facilities. Wymott retained overall responsibility for Mr Gill when he was located in Preston's inpatient unit.

4. On 12 February 2017, Mr Gill was admitted to hospital for the last time. He had abdominal pain, a rapid pulse, high temperature and high blood pressure. Managers at Wymott instructed that Mr Gill be restrained by an escort chain and that it be removed on 15 February when his condition deteriorated. Escort staff did not receive any formal paperwork authorising these decisions and, on 20 February, managers at Preston decided that the escort chain should be reapplied, even though his condition had not improved. On 23 February, Mr Gill became incontinent and was put on an antibiotic drip. Staff removed the escort chain and did not use restraints on Mr Gill again.

5. Mr Gill died on 1 March in the early hours of the morning of fluid on the lungs and end stage Chronic Obstructive Pulmonary Disease.

Findings

6. The clinical reviewer found that the care Mr Gill received in prison was equivalent to that which he could have expected to receive in the community.

7. No formal arrangement about decisions on the use of restraints existed between Preston and Wymott even though Preston frequently cared for Wymott prisoners on a temporary basis. Mr Gill was a very ill man with impaired mobility. He was restrained by an escort chain when he went to hospital on 12 February.

8. A Wymott manager authorised the escort chain to be removed on 15 February but Preston managers authorised the restraint be re-applied on 20 February, despite there having been no improvement in Mr Gill's condition.

Recommendations

- **The Governors of HMP Wymott and HMP Preston should ensure 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 Governors of HMP Wymott and HMP Preston should ensure that there is a formal protocol between them regarding escort risk assessments for prisoners who remain the responsibility of Wymott while located at Preston.**

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Wymott informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

10. The investigator obtained copies of relevant extracts from Mr Gill's prison and medical records.

11. NHS England commissioned a clinical reviewer to review Mr Gill's clinical care at the prison.

12. We informed HM Coroner for Milton Keynes of the investigation who gave us the cause of death details. We have sent the coroner a copy of this report.

13. The investigator contacted Mr Gill's son to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not raise any concerns.

14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Wymott

15. HMP Wymott is a medium secure prison holding over 1,100 adult men. Lancashire Care NHS Foundation Trust provides the healthcare services and Indigo Locum Agency, provides GP services and out of hours medical cover. There are no inpatient beds but there is 24-hour nursing cover.

HMP Preston

16. HMP Preston is a local prison holding up to 842 men. Lancashire Care Foundation Trust provides the healthcare services. There is an inpatient unit for up to 30 prisoners, which is used as a regional facility, including provision for end of life care.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Wymott was in October 2016. Inspectors reported that Wymott remained a reasonably safe prison, staff-prisoner relationships were generally respectful but healthcare provision was weak and in some areas potentially unsafe. They felt that the care of prisoners with chronic conditions was not good enough.

18. The last inspection at HMP Preston was in April 2014. Inspectors reported that, overall, healthcare was safe and decent. Staff in the inpatient unit gave good support to patients with complex needs. However, some aspects of the environment and regime needed improvement.

Independent Monitoring Board

19. 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 regarding Wymott, for the year to May 2016, the IMB reported that although there had been some improvement in health services since 2015, there were still serious problems with providing medication. This was exacerbated by staff shortages, although the report noted that staffing levels had also improved.

20. In its latest annual report regarding Preston, for the year to March 2016, the IMB reported that the prison seemed to be 'settling down' after a period of management changes but there were still major concerns with the healthcare service which was not adequately staffed.

Previous deaths at HMP Wymott

21. Mr Gill was the tenth prisoner to die of natural causes at HMP Wymott since January 2015. We have made recommendations about restraints before.

Key Events

22. On 10 May 2013, Mr Peter Gill was sentenced to nine years and eight months in prison for sexual offences and was sent to HMP Preston. He was transferred to HMP Wymott on 4 March 2016. He was moved back to Preston on 6 January 2017.

23. Mr Gill's medical history included mobility issues related to a stroke in 1998, which had left him with severe left-hand sided weakness, COPD and prostate cancer, for which he received regular injections to shrink the tumour.

24. On 4 March 2016, at an initial health screen, a nurse at Wymott confirmed that Mr Gill had complex care needs including poor mobility (to the extent he could not walk up stairs or long distances) and needed assistance with hygiene and meals.

25. Mr Gill experienced numerous exacerbations of his COPD. He was either treated by Wymott or Preston healthcare teams or admitted to hospital. Emergency codes were called on 14 April, 30 April, 12 June and 4 July 2016.

26. On 6 July 2016, the hospital admitted Mr Gill until 15 July. They discharged him to Preston's 24-hour healthcare facility so he could receive continuous after care. By 9 September, he had recovered sufficiently to return to Wymott. On 17 November, Mr Gill experienced another episode of COPD exacerbation and was readmitted to hospital until 30 November 2016, and was again discharged to Wymott.

27. On 14 December 2016, Mr Gill was admitted to hospital with pneumonia. He spent three weeks in hospital and was discharged to Preston on 6 January.

28. On 13 January 2017, Mr Gill was admitted to hospital with a further episode of COPD exacerbation until 17 January. Hospital staff treated with him with antibiotics, a nebuliser (a device to aid breathing) and steroids to reduce the inflammation in his lungs. They also noted that he was bed bound and unable to mobilise. Mr Gill was discharged to Preston's 24-hour healthcare facility where his needs were better catered for.

29. On the evening of 11 February 2017, Mr Gill became very ill. A nurse at HMP Preston was concerned that he had lower abdominal pain and his stomach was distended. He had an elevated temperature, rapid pulse and high blood pressure. She called the out-of-hours doctor, who advised her that she should call paramedics to provide an assessment. At 11.10pm, she called the paramedics and, on arrival, they assessed Mr Gill and suspected he had urinary retention. He was taken to hospital on 12 February at 00:40am. An emergency risk assessment on restraints was carried out and it was decided that Mr Gill should be restrained by an escort chain, accompanied by two officers.

30. On 14 February, Mr Gill was incontinent and had a gall bladder drain fitted. On 15 February, a Custodial Manager (CM) (HMP Wymott) authorised an officer to remove the escort chain. The escorting officers did not receive a risk assessment document confirming that they should remove the restraints. The

officers described Mr Gill as being mostly asleep, refusing food, not drinking, on an intravenous drip, fitted to a nebuliser and struggling to breathe.

31. On 17 February, a nurse from HMP Preston visited Mr Gill in hospital. She felt he had improved and noted that hospital staff were discussing his possible discharge for a few days hence.

32. On 20 February, the officer queried the lack of risk assessment paperwork with Preston prison managers. They instructed him to replace the escort chain in line with the risk assessment document that they would send to him later that day.

33. On 22 February, physiotherapists visited Mr Gill to help him with his mobility, to help him get to his feet. They were unsuccessful and they used a hoist to transfer him from his bed to a chair. In the early hours of 23 February, Mr Gill was incontinent again and they placed him on a new antibiotic drip.

34. On 23 February, a CM (HMP Preston) reviewed the restraints risk assessment and assessed Mr Gill's risk of escape as extremely low given that his mobility was very limited. He authorised for the restraints to be removed. Escorting staff received the risk assessment at 4.55pm and removed the restraints, which were not applied again.

Contact with Mr Gill's family

35. On 25 February 2017, Mr Gill's health took a significant turn for the worse. Wymott appointed a chaplain as the family liaison officer. He telephoned Mr Gill's son and advised him of his father's condition and that he might like to visit. He made follow up phone calls and Mr Gill's son said that he would like to be informed of his father's death by telephone when it happened.

36. Mr Gill died on 1 March at 2.15am. The chaplain called Mr Gill's son to tell him his father had died. He stayed in touch and offered support.

37. Mr Gill's funeral was held on 21 March. The chaplain and a manager attended. Wymott contributed to the funeral costs in line with national policy.

Support for prisoners and staff

38. After Mr Gill's death, a CM debriefed the escorting staff and offered support.

39. Wymott posted notices informing other prisoners of Mr Gill's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Gill's death.

Post-mortem report

40. A post-mortem was not carried out. However, a doctor's report prepared for the coroner confirmed that the expected cause of death was 1a) Acute Respiratory Distress Syndrome (ARDS) 1b) Biliary Sepsis 1c) Cholecystitis and 2) End Stage Chronic Obstructive Pulmonary Disorder. (ARDS is fluid on the lungs arising from the sepsis and Cholecystitis, which are infections.)

Findings

Clinical care

41. The clinical reviewer found that Mr Gill's care was equivalent to that which he could have expected to receive in the community. Staff at Wymott and Preston addressed his multiple care needs to a good standard and maintained contact with hospital staff during his frequent hospital admissions.

Restraints

42. 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.

43. In Mr Gill's case, the risk assessment process appeared to have been slow and confusing. Escort officers were left without the formal paperwork that explained the restraint instructions and the reasons why restraints should to be applied or removed.

44. When Mr Gill was taken to hospital on 12 February 2017, an emergency risk assessment was carried out by staff at Preston, which concluded that he should be restrained by an escort chain accompanied by two officers. Staff sought medical input from a nurse, who did not object to the officers using restraints. A cursory security check was completed and a Preston manager authorised the use of an escort chain only.

45. On 14 February, escorting officers described Mr Gill as incontinent and having had a gall bladder drain inserted. One of the officers noted in the bedwatch log that a new restraints risk assessment was needed and that he had spoken to a Senior Officer (HMP Wymott) about it. The risk assessment paperwork was started that day by a security collator at Preston, but took six days to be fully completed.

46. At 6.30pm on 15 February, one escorting officer noted that a CM from Wymott had spoken to him and authorised Mr Gill's cuffs to be removed and said he would arrange for a risk assessment confirming the decision to be sent to the hospital the next day. The escorting officers removed the escort chain. On 17 February at 1.30pm, a Senior Officer noted in the bedwatch notes that a risk assessment was still required.

47. On 20 February, the escorting officer noted that an up to date risk assessment was still required. Later that day, at 3.47pm, an officer noted that he had spoken to a prison manager and a CM at Preston, who advised that an escort chain

should be ‘reapplied’ as per their risk assessment that was being delivered by another Preston manager. The officer applied the escort chain and the CM arrived at 4.20pm with the risk assessment. A nurse completed the medical section of the risk assessment. She said that Mr Gill had the ability to escape even though he used a wheelchair and she did not object to the use of restraints. The CM assessed all Mr Gill’s risks as ‘normal’ and the prison manager authorised the escort chain to be replaced.

48. We do not believe that the decisions to use of restraints were appropriate. Mr Gill was in very poor health, had very poor mobility, had quickly deteriorated and his risks were low.

49. The decision making processes and accountabilities between the two prisons were confused, delayed and poorly communicated. Mr Gill went from a position of having restraints removed in acknowledgement of deterioration in his condition to having them replaced a few days later. Once the escort chain was replaced, it was on for three days even though Mr Gill became so immobile that a hoist was needed to transfer him from the bed to his chair.

50. We asked Preston why it had taken so long to get the risk assessment paperwork to the escorting officers and on what basis it was decided to reapply Mr Gill’s restraints when his condition had not improved and he had not presented any problems. They said the decision was based on the nurse’s medical assessment, carried out 3 days previously. Preston could not account for the delays in providing the escort assessment paperwork and said they were unaware of the CM’s earlier decision to remove restraints.

51. A security governor at Wymott told the investigator that no formal protocol existed between Preston and Wymott to deal with risk assessment and restraint issues for prisoners such as Mr Gill. Mr Gill’s security file was transferred to Preston with him and only Preston had access to the intelligence information that was essential in assessing risk. The CM from Wymott made a decision to remove Mr Gill’s restraints, but seemingly without the intelligence information to inform his decision.

52. There was a lack of communication and co-ordination between Wymott and Preston in making decisions about escort risk assessments and use of restraints. We make the following recommendations:

The Governors of HMP Wymott and HMP Preston should ensure 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 Governors of HMP Wymott and HMP Preston should ensure that there is a formal protocol between them regarding escort risk assessments for prisoners who remain the responsibility of Wymott while located at Preston.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141