

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Aubrey Mitchell a prisoner at HMP Woodhill on 16 February 2017

**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.

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 Aubrey Mitchell, a prisoner at HMP Woodhill, died in hospital on 16 February 2017 of a heart attack. Mr Mitchell was 83 years old. We offer our condolences to those who knew him.

We are satisfied that Mr Mitchell received a good standard of clinical care at Woodhill, equivalent to that which he could have expected to receive in the community.

We are concerned that managers authorised the inappropriate use of restraints when Mr Mitchell was taken to hospital. Mr Mitchell was an elderly and frail man with very limited mobility, who was in poor health. We have raised the issue of restraints with Woodhill before and are disappointed that staff continue to apply restraints when their use is clearly disproportionate. Record keeping was also inadequate.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman

September 2017

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Summary

Events

1. Mr Aubrey Mitchell arrived at HMP Woodhill in February 2014. He was 80 years old and this was his first time in prison. He had a number of long term medical conditions and very poor mobility, so he was admitted to the healthcare unit as an inpatient. Healthcare staff provided Mr Mitchell with daily assistance in accordance with his care plans.
2. Mr Mitchell suffered from chest and urinary tract infections which resulted in his admission to hospital for intravenous antibiotic treatment. In November 2016, he fell out of bed and suffered a broken right arm.
3. On 15 February 2017, Mr Mitchell complained of nausea and abdominal pain. A full set of blood tests and liver function tests revealed abnormal results and a prison GP arranged his transfer to hospital. Two prison officers went with Mr Mitchell to hospital and restrained him with an escort chain.
4. Hospital doctors treated Mr Mitchell with intravenous antibiotics but his condition deteriorated. He died on 16 February after suffering a heart attack.

Findings

5. The clinical reviewer considered that the care Mr Mitchell received at Woodhill was equivalent to that which he could have expected to receive in the community. We are satisfied that Mr Mitchell received good clinical care at the prison.
6. We are concerned that managers authorised the use of restraints when Mr Mitchell was taken to hospital in November 2016. Although he had demonstrated challenging behaviour, Mr Mitchell was an elderly, frail man with a broken arm and very poor mobility. The use of restraints was disproportionate.
7. The prison was unable to provide risk assessments to explain the decision to use restraints during Mr Mitchell's previous hospital visits. We are concerned that this documentation was not available.

Recommendations

- 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 Governor should ensure that, in line with PSI 58/2010, the Prison and Probation Ombudsman is promptly provided with all requested documents following a death in custody.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Woodhill informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
9. The investigator obtained copies of relevant extracts from Mr Mitchell's prison and medical records.
10. NHS England commissioned a clinical reviewer to review Mr Mitchell's clinical care at the prison.
11. We informed HM Coroner for Milton Keynes of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
12. The investigator wrote to Mr Mitchell's son to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond to our letter.
13. 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. The action plan has been annexed to this report.

Background Information

HMP Woodhill

14. 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

15. 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 focused. Clinical records were of a high standard and included effective care planning for those with complex health needs.

Independent Monitoring Board

16. 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

17. Mr Mitchell was the fifth man to die of natural causes at HMP Woodhill since January 2016. There has been one death since. We have raised the need for properly considered risk assessments to justify the use of restraints in three other investigations.

Key Events

18. On 7 February 2014, Mr Aubrey Mitchell was remanded in custody charged with sexual offences and sent to HMP Woodhill. On 10 March, he was sentenced to 20 years in prison.
19. Mr Mitchell was 80 years old and this was his first time in prison. He had a number of long term medical conditions including type two diabetes, osteoarthritis, depression, and leg ulcers. Mr Mitchell had poor mobility and used two walking sticks.
20. Prison GPs admitted Mr Mitchell to the healthcare unit as an inpatient. He had daily healthcare assistance to manage his personal hygiene, nutrition and prescribed medication. Nurses created care plans to manage Mr Mitchell's medical conditions and completed a social care needs assessment. Mr Mitchell settled well on the inpatient unit and there was nothing of significance in his medical record until September 2015.
21. On 11 September 2015, a prison GP assessed Mr Mitchell because his breathing was noisy and he felt weak. The GP diagnosed a chest infection and he arranged for Mr Mitchell's transfer to Milton Keynes General Hospital. He was accompanied by two prison officers who did not use restraints. Hospital doctors diagnosed a lower respiratory chest infection and treated Mr Mitchell with intravenous antibiotics.
22. On 21 September, a prison manager authorised the escort officers to apply 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) to Mr Mitchell after he became abusive and threatening towards escort officers. Mr Mitchell remained on an escort chain until his return to Woodhill on 23 September.
23. Healthcare staff saw Mr Mitchell daily and managed his care in accordance with his care plans.
24. On 23 November 2016, Mr Mitchell fell out of his bed during the night. A prison GP examined Mr Mitchell who complained of pain in his right arm. The GP prescribed pain relief medication and Mr Mitchell said his arm felt more comfortable. Later that day, a nurse saw Mr Mitchell in his cell who complained of increased pain in his arm. When the nurse started to examine him, Mr Mitchell became abusive, spitting and attempting to hit her. The GP arranged for Mr Mitchell's transfer to Milton Keynes General Hospital where a doctor admitted him. A prison manager authorised two prison officers to go with Mr Mitchell and to use an escort chain to restrain him, which they attached to his left arm. Hospital doctors diagnosed a fractured upper right arm and Mr Mitchell returned to Woodhill the same day.
25. On 25 November, Mr Mitchell refused to eat, drink or take his prescribed medication. A prison GP arranged for Mr Mitchell's transfer to Milton Keynes General Hospital. A prison manager authorised two prison officers to go with Mr Mitchell and to use an escort chain to restrain him. Hospital doctors treated Mr Mitchell with intravenous fluids for dehydration and intravenous antibiotics for a

chest and urinary tract infection. Mr Mitchell was returned to Woodhill on 6 December.

26. On 13 February 2017, Mr Mitchell complained of nausea and abdominal pain. A urine test revealed a urinary tract infection. A prison GP prescribed antibiotics and arranged a full set of blood tests.
27. On 15 February, a prison GP assessed Mr Mitchell and noted that he looked well and did not complain of any pain or respiratory difficulty. Mr Mitchell was eating and drinking normally. The GP noted that Mr Mitchell's blood and liver function tests revealed abnormal results. After seeking advice from hospital doctors, the GP arranged Mr Mitchell's transfer to Milton Keynes General Hospital at 10.30pm. A prison manager authorised two prison officers to go with Mr Mitchell and to use an escort chain to restrain him.
28. Hospital doctors treated Mr Mitchell with intravenous antibiotics. At 12pm, his condition deteriorated and he suffered a heart attack. Mr Mitchell died in hospital on 16 February at 2.25pm.

Contact with Mr Mitchell's family

29. At 8am on 16 February, the prison appointed a custodial manager and prison officer as family liaison officers. One of the family liaison officers telephoned Mr Mitchell's son, his nominated next of kin, to introduce herself and told him that Mr Mitchell was in hospital.
30. Mr Mitchell's son did not wish to visit his father in hospital and asked the family liaison officer to keep in contact with him by telephone. Shortly after Mr Mitchell died, the family liaison officer telephoned his son and told him that his father had died. She offered condolences and support.
31. On 17 February, both family liaison officers visited Mr Mitchell's son at home. They remained in contact with him until Mr Mitchell's funeral on 16 March. The prison contributed towards the cost in line with national prison service instructions.

Support for prisoners and staff

32. The prison posted notices informing other prisoners of Mr Mitchell'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 Mitchell's death.

Post-mortem report

33. The post-mortem report indicated that Mr Mitchell had died from an acute myocardial infarction (heart attack). He also suffered from heart disease.

Findings

Clinical care

34. Mr Mitchell entered prison aged 80, in poor health with a number of pre-existing long term medical conditions. He was admitted to the healthcare unit where staff put in place appropriate care plans. When Mr Mitchell's condition deteriorated, healthcare staff quickly arranged his transfer to hospital.
35. The clinical reviewer considered that Mr Mitchell received good and compassionate care from the healthcare team at Woodhill. We agree with the clinical reviewer that the care Mr Mitchell received at Woodhill was equivalent to that which he could have expected to receive in the community.

Restraints, security and escorts

36. 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.
37. On 25 November 2016, Mr Mitchell was taken 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 no medical objections to the use of restraints.
38. Mr Mitchell was 83 years old, frail, in poor health and had limited mobility. He had no previous convictions and a Senior Officer (SO) assessed him as low risk to the public, low risk of escape and a medium risk to females and hospital staff. The SO recommended the use of an escort chain and a prison manager agreed and authorised its use. There is no indication that the SO or manager considered Mr Mitchell's age, poor health and mobility in terms of how these factors would affect his ability to escape and his risk to the public. A custodial manager briefed the escort staff and discharged Mr Mitchell to outside hospital.
39. The custodial manager told the investigator that a two officer escort is usually the minimum requirement for any escort departing from Woodhill. She believed that the HCC staff, in completing the front page of the risk assessment, had already considered the prisoner's age or medical history. She was aware that Mr Mitchell had an injury to his right arm and asked escort officers to apply the escort chain to his non-injured arm. She said that Mr Mitchell had a history of threatening and abusive behaviour towards prison and healthcare staff and could be unpredictable. We have not seen any evidence which suggests that two escorting officers would not have been able to manage any such behaviour without needing to resort to chains and handcuffs.

40. Despite our requests, Woodhill failed to provide us with the risk assessments to cover Mr Mitchell's admission to hospital on three occasions between September 2015 and February 2017. However, the prison provided security information reports and bed watch documents which confirmed that escort officers restrained Mr Mitchell with an escort chain on each occasion.

41. While the Prison Service has a fundamental responsibility to protect the public, security must be balanced with humanity and be legally justified. We are concerned that managers authorised the use of restraints without fully considering Mr Mitchell's advanced age and poor health, and how this impacted on his risk of escape, as required by the High Court judgment. We consider that the use of restraints on Mr Mitchell was disproportionate given his age, frailty and poor mobility. There have been other recent cases at Woodhill where the evidence did not justify the use of restraints. As in previous reports, we found that staff and managers at Woodhill still appear not to understand (or choose not to address) the tests which are set out in the High Court judgement. 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.

42. Prison Service Instruction (PSI) 58/2010 contains a mandatory instruction that "when the PPO is carrying out investigations or enquiries that staff comply with requests for information and assistance". Throughout our investigation, the investigator asked for copies of the risk assessment documents justifying the use of restraints on Mr Mitchell. However, the prison was unable or unwilling to provide all but one of the risk assessments. We make the following recommendation:

The Governor should ensure that, in line with PSI 58/2010, the Prison and Probation Ombudsman is promptly provided with all requested documents following a death in custody.

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