Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jason Tremayne a prisoner at HMP Featherstone on 17 August 2017

A report by the Prisons and Probation Ombudsman

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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 Jason Tremayne died in hospital on 17 August 2017 as a result of aspiration of gastric contents (food or drink entering the respiratory tract) while a prisoner at HMP Featherstone. Mr Tremayne had peritoneal sarcoma (a rare cancer that develops in a thin layer of tissue lining the abdomen) which was not diagnosed until after his death. He was 47 years old. We offer our condolences to his family and friends.

The clinical care Mr Tremayne received at Featherstone was equivalent to that which he could have expected to receive in the community. However, we are not satisfied that prison managers who authorised and reviewed the use of restraints properly considered the impact of Mr Tremayne's health on his risk.

Mr Tremayne was so weak that he needed a wheelchair when he was first sent to hospital in June 2017. It is, therefore, hard to see that the use of restraints was justified at that point. We feel it was inappropriate that he continued to be restrained after he was subsequently re-categorised to D, the lowest security category, in July and that he was not considered for release on licence.

On the day he died, Mr Tremayne collapsed after moving a few metres from his bed and although the escorting staff removed the restraints to allow emergency medical care, they inappropriately reapplied them once he was returned to bed. He remained in restraints until he suffered a cardiac arrest about an hour and a half before he died. Featherstone should have acted long before to recognise that restraints were not necessary for Mr Tremayne. It is unacceptable that they did not.

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 **June 2018**

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Summary

Events

1. On 15 January 2016, Mr Jason Tremayne was sentenced to seven years in prison for conspiracy to evade a prohibition on the import of class A drugs. On 11 July, he was transferred to HMP Featherstone.

2. On 30 April 2017, Mr Tremayne told a nurse that he had abdominal pain and had been vomiting. The nurse requested blood tests and booked a GP appointment. On 8 May, Mr Tremayne told the GP that his stomach had been swollen for a month, he was eating less and being sick. The GP prescribed medication to reduce stomach acid and relieve constipation. He asked for a routine ultrasound scan, which was booked for 7 June.

3. Mr Tremayne struggled to attend work or eat. An officer telephoned the healthcare team a few times towards the end of May to tell them about her concerns. This was not acted on. Mr Tremayne did not, though, raise concerns about his health with nurses himself, nor did he make a GP appointment.

4. On 1 June, Mr Tremayne was taken to the healthcare department in a wheelchair because he was too unwell to walk. An ambulance was called and Mr Tremayne was admitted to hospital where he remained until his death.

5. Two officers escorted Mr Tremayne and an escort chain (a long chain with a handcuff at each end, one of which is attached to a prison officer) was used for most of his stay in hospital. Mr Tremayne had investigations for cancer, tuberculosis and infective diarrhoea, but the medical team were unable to determine what was making Mr Tremayne unwell.

6. On 10 July, Mr Tremayne was given category D status (the lowest security category for prisoners). The bedwatch risk assessment reviews continued to maintain the escort at two officers and an escort chain.

7. During August, Mr Tremayne's condition deteriorated and he developed intestinal failure and pneumonia. On 17 August, he collapsed in the bathroom. The restraints were removed and nursing staff moved Mr Tremayne back to his bed. The restraints were then reapplied. At 5.15pm Mr Tremayne, went into cardiac arrest. The restraints were removed (and not reapplied after this time) and the hospital team resuscitated Mr Tremayne. They felt he was too weak to be resuscitated again. He stopped breathing at 6.40pm and died.

Findings

8. The clinical reviewer was satisfied that Mr Tremayne's care at Featherstone was equivalent to that which he could have expected to receive in the community. It is unclear to what extent Mr Tremayne's continuing problems with vomiting and feeling unwell during May were known to nursing staff. Mr Tremayne did not raise concerns himself with nurses giving out medication. Officers' telephone calls to the healthcare team were not recorded and we do not know who they spoke to.

9. The Prison Service has a duty to protect the public when escorting prisoners outside of prison. The level of restraints used should be appropriate to the circumstances and based on a risk assessment. Given Mr Tremayne's medical condition when he went to hospital, we do not consider that he was capable of escape. He did not need to be restrained.

10. Mr Tremayne was given category D status on 10 July and his condition deteriorated at the beginning of August. Reviews of his bedwatch arrangements during this period did not seem to take his security status or state of health sufficiently into consideration. Restraints were inappropriately reapplied after Mr Tremayne collapsed on the day he died. We note that the prison had previously accepted a recommendation about the inappropriate use of restraints and agreed to resolve the issues. It is clear this has not been actioned.

11. When Mr Tremayne was first admitted to hospital he was well enough to be able to decide whether to contact his next of kin to let them know he was in hospital. Featherstone told us that the escorting officers encouraged Mr Tremayne to make contact with his family and tell them they could visit him in hospital. Mr Tremayne used a mobile phone that prison staff gave him access to, to contact his family in July and members of his family visited in July and August.

12. Prisoners can be given temporary release before their sentence has expired for certain reasons, including medical reasons. Featherstone did not consider temporary release for Mr Tremayne.

Recommendations

- The Governor and Head of Healthcare should ensure that when staff raise medical concerns about prisoners with nursing staff, they should record this in the wing observation book and the prisoner's case notes. Nursing staff should act on concerns and make entries in a prisoner's SystmOne record.
- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital or on a bedwatch understand the legal position 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 release on temporary licence is considered without delay for seriously ill prisoners in hospital who meet the criteria.

The Investigation Process

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

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

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

16. A second investigator took over the investigation after the first investigator left the office. She obtained further information from members of staff at HMP Featherstone in November 2017.

17. We informed HM Coroner for South Staffordshire District of the investigation who sent us the results of the post-mortem examination. We have given the Coroner a copy of this report.

18. The first investigator contacted Mr Tremayne's sister-in-law by letter to explain the investigation and to ask if she had any matters that she wanted the investigation to consider. The second investigator also wrote to Mr Tremayne's sister-in-law.

19. One of our family liaison officers subsequently spoke to Mr Tremayne's sister-in-law. The family wanted to know why the prison had not told them Mr Tremayne was unwell and in hospital. They were upset about the use of restraints and wanted to know why they were needed. The family wanted to know who Mr Tremayne had listed as his next of kin and when the hospital diagnosed his cancer.

20. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and provided additional information not known at the time of writing the report. We have amended this report accordingly. The action plan has been annexed to this report.

21. The initial report was shared with Mr Tremayne's family. They had no further comments or questions about the report.

Background Information

HMP Featherstone

22. HMP Featherstone is a medium security, Category C prison, holding around 650 convicted men. Healthcare services are provided by Care UK.

HM Inspectorate of Prisons

23. The most recent inspection of Featherstone was in November 2016. Inspectors reported "a shocking worsening of standards" since the last inspection in 2013 and, in particular, a sharp decline in safety, which they assessed as poor. They noted that levels of violence and intimidation were very high. Inspectors felt the decline was caused by poor industrial relations, staff shortages and significant prisoner unrest. The inspectors noted that, unusually, staff and prisoners spoke openly about what they perceived to be a lack of leadership and direction in the prison. Inspectors judged that primary healthcare services were reasonably good.

Independent Monitoring Board

24. 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 October 2016, the IMB said the healthcare department had a new management team but some nurse vacancies were proving difficult to fill.

Previous deaths at HMP Featherstone

25. Mr Tremayne's death was the third natural cause death at Featherstone since the start of 2016. In a previous investigation into the death of a prisoner in 2016, Featherstone accepted our recommendation about their inappropriate use of restraints and agreed to improve their decision-making. Since Mr Tremayne's death, there have been two more deaths and investigations into those deaths are ongoing.

Key Events

26. On 29 September 2015, Mr Jason Tremayne was remanded into custody for conspiracy to evade a prohibition on the import of class A drugs. He was taken to HMP Birmingham but was bailed the next day. On 7 October, Mr Tremayne was convicted and remanded to Birmingham. On 15 January 2016, he was sentenced to seven years in prison. On 11 July 2016, Mr Tremayne was transferred to HMP Featherstone.

27. On 30 December 2016, a prison GP saw Mr Tremayne. The GP noted he had depression and prescribed sertraline (an antidepressant) and promethazine (a sleeping aid). He was reviewed by another GP on 19 January 2017 and was prescribed amitriptyline (an antidepressant) in addition to the sertraline. Mr Tremayne went to the medication hatch each day to take the tablets in front of nursing staff.

28. On 30 April 2017, Mr Tremayne went to the medication hatch and spoke to a nurse. He said he had abdominal pain and had been vomiting. The nurse thought Mr Tremayne looked generally unwell, slightly jaundiced and his stomach was soft but very distended (swollen). She requested blood tests and booked an appointment for him to see the GP on 8 May.

29. On 4 May, a GP reviewed his blood test results and found they were satisfactory, apart from a slightly elevated potassium level. He saw Mr Tremayne on 8 May and Mr Tremayne told him his stomach had been swollen for the past month, his appetite was reduced and he was sick after eating. The GP examined Mr Tremayne and found his abdomen was swollen but not tender and his observations were within normal range. The GP prescribed lansoprazole (to reduce stomach acid) and macrogol (to relieve constipation). He requested a routine ultrasound scan to be taken in the healthcare department.

30. In May, Mr Tremayne continued to collect his medication but began to struggle to attend work in the kitchens. He missed three sessions the first week, two the following week, four the third week and did not go to work on 30 or 31 May. The catering manager said the team were aware he was ill, but were not aware how unwell he was. He said the catering team tried to support Mr Tremayne and said that he did not think Mr Tremayne wanted to stay in his cell and liked to go to work if he felt able.

31. When Mr Tremayne became more unwell, an officer said staff would offer to take him a meal but he did not eat it. The officer said she told Mr Tremayne to see the doctor and he would say he had been or was going.

32. The officer told us she rang the healthcare department about three times towards the end of May but could not remember who she spoke to. She was told that the healthcare team were already aware of Mr Tremayne. The officer said she also told the wing nurses a few times that Mr Tremayne was unwell and suggested that someone should check on him. She did not think that anyone did.

33. On 1 June, the officer said she took a nurse to Mr Tremayne's cell door and the nurse said they would make an emergency appointment for him in the healthcare department. The Head of Safer Custody and Equalities spoke to the Deputy

Head of Healthcare to arrange for Mr Tremayne to be seen. The officer spoke to a supervising officer and a prisoner took Mr Tremayne to the healthcare department in a wheelchair. On their way there, Mr Tremayne was sick.

34. A nurse saw Mr Tremayne and noted that he looked gaunt, malnourished and had lost a lot of weight. His stomach was hard and swollen. An ultrasound scan was booked for 7 June. An urgent appointment was made for Mr Tremayne to see the GP and he saw him that afternoon. Mr Tremayne said he was not keeping any food or drink down, was vomiting bile and had diarrhoea. The GP decided that Mr Tremayne should be admitted to hospital as an emergency. An ambulance was called.

35. An undated and unsigned form, titled Paramedic/ A& E Transfer Form, was completed. It noted that Mr Tremayne had had three weeks of abdominal pain and vomiting, had spent the last three days "off his legs" and that he had lost 8kg in three weeks.

36. At 5.40pm, paramedics took Mr Tremayne to New Cross Hospital in Wolverhampton. Two officers escorted him using handcuffs. This was later changed to an escort chain. (An escort chain is a long chain with a handcuff at each end, one of which is attached to a prison officer.) Hospital staff admitted Mr Tremayne and gave a provisional diagnosis, querying cancer, tuberculosis (TB) or infective diarrhoea.

37. The distension of Mr Tremayne's stomach was due to ascites (an accumulation of fluid that is usually found in the abdominal cavity which surrounds the abdominal organs. When this fluid builds up, it is commonly due to liver disease, cancer, congestive heart failure or kidney disease). Testing for TB can take up to 10 weeks. Mr Tremayne also tested positive for clostridium difficile (a bacterium that can infect the bowel) and was nursed in a separate room to prevent infection of other patients.

38. The Head of Business Assurance completed a risk assessment on 2 June and decided that the bedwatch staff should sit outside the room where Mr Tremayne was being looked after because of infection control. He also decided, after talking to the Governor, that Mr Tremayne should continue to be restrained by an escort chain (or two escort chains attached to each other). The risk assessment refers to Mr Tremayne's physical health being poor, that he was transported to hospital in a wheelchair and that it was considered that he would not be strong enough to escape.

39. Hospital staff referred Mr Tremayne to the gastroenterology team (who specialise in stomach and intestinal conditions). The microbiology department thought his vomiting might be due to his previously high level of alcohol consumption. The gastroenterologist arranged for further tests and for Mr Tremayne's ascetic fluid to be drained from his stomach. He thought Mr Tremayne might have cancer, cirrhosis (damaged liver tissue) or TB.

40. Mr Tremayne's test results were reviewed on 13 June. A CT scan had not identified any cause for the ascites. Mr Tremayne continued to lose weight and vomit. The consultant thought he might have cancer or alcoholic liver disease but noted there was no evidence of cancer from the tests and scans. Further

tests and biopsies were taken but none showed signs of cancer or TB. Mr Tremayne remained in hospital with a two-officer escort, restrained with an escort chain.

41. On 2 July 2017, Mr Tremayne had a Peripherally Inserted Central Catheter (PICC) line fitted (which enables nutrition to be administered directly into the body). It remained in place for the rest of Mr Tremayne's stay in hospital.

42. On the same day, the Offender Management Unit recommended that Mr Tremayne's security category be changed from C to D. Category D is for prisoners who "present a low risk; can reasonably be trusted in open conditions and for whom open conditions are appropriate". The Head of Residence approved the recommendation on 10 July. He made an entry in Mr Tremayne's case notes to indicate this and said he should be moved to an open prison in due course.

43. Between 1 June and 10 July, Mr Tremayne's bedwatch risk assessment was reviewed twice – on 11 June and 17 June. The risk assessment form states reviews must be completed every 72 hours or if there has been a relevant change in circumstances. The reviews indicate that Mr Tremayne's behaviour had been "excellent", "compliant" and "respectful". The form did not have a specific section for medical professionals to advise on Mr Tremayne's ability to escape.

44. On 11 July, Mr Tremayne's bedwatch risk assessment was reviewed by the Head of Reducing Reoffending who made no changes to Mr Tremayne's escort arrangements or his restraints. No one considered the fact that Mr Tremayne had just been given Category D status. He countersigned another review three days later in which the person completing the review had written, "No further recommendations. Escort chain and two staff on duty at all times!"

45. Mr Tremayne's bedwatch arrangements were reviewed on 23 July, 29 July and 1 August with no change to staffing or restraint arrangements. The review on 1 August referred to Mr Tremayne's health deteriorating very rapidly and said that the healthcare team should be consulted about his health changes. There is no entry in Mr Tremayne's medical record to show that this took place.

46. The hospital records from 1 August describe Mr Tremayne's condition as intestinal failure (a condition where the intestines cannot digest food or absorb fluids, electrolytes and nutrients essential to life). On 3 August, prison healthcare staff were updated that a referral had been made to transfer Mr Tremayne to the Queen Elizabeth Hospital, part of the University Hospitals Birmingham Foundation Trust. (This transfer did not take place and it was subsequently decided to refer Mr Tremayne to a specialist Intestinal Failure Centre at St Mark's Hospital in London.)

47. On 4 August, the Head of Reducing Reoffending reviewed Mr Tremayne's bedwatch arrangements but made no changes and did not refer to his deteriorating health. A multidisciplinary hospital team meeting on 8 August discussed Mr Tremayne but there was no consensus on a diagnosis or the way forward with his treatment.

48. The last security review of Mr Tremayne's bedwatch arrangements was on 9 August and noted, "To continue as it is currently, review on 13/8/17 or before if any significant changes." On 11 August, a nurse contacted the ward for an update and was told Mr Tremayne had developed pneumonia.

49. Mr Tremayne's physical condition continued to deteriorate. On 15 August, he was given a blood transfusion because his haemoglobin was very low (the part of the red blood cells that carry oxygen to the body's tissues). A consultant noted on 16 August that the plan was to ensure Mr Tremayne was well enough for the journey to London.

50. Hospital records show that Mr Tremayne's sister-in-law and two brothers were in contact with the ward and that his sister-in-law visited on 15 August. Mr Tremayne's sister-in-law said she could not remember the exact date, but told us Mr Tremayne had telephoned her after borrowing a prison mobile phone from one of the bedwatch officers (Featherstone told us they had been encouraging Mr Tremayne to contact his family).

51. On 17 August, one of the escorting officers noted that Mr Tremayne remained "in pain but polite and fully compliant". The other escorting officer said in his police statement that in the morning, Mr Tremayne was disorientated and vomiting what appeared to be a brown liquid. At 2.20pm, Mr Tremayne went to the toilet, about three metres from his bed. He asked for assistance to get back to his bed but collapsed and fell off the toilet. The escorting officers immediately alerted the nursing staff and removed the escort chain because of the medical emergency. A prison manager was told retrospectively that this had happened. Mr Tremayne was returned to his bed. One of the escorting officers re-applied the restraints at 3.50pm and told the duty governor.

52. One of the escorting officers said that for the remainder of the afternoon, Mr Tremayne was weak and unable to co-ordinate his movements when trying to drink a glass of water. At about 5.00pm, Mr Tremayne seemed delirious and talked to himself.

53. At 5.15pm, Mr Tremayne went into cardiac arrest. The restraints were removed (and not reapplied after this time). The hospital team were able to resuscitate Mr Tremayne after about 20 minutes, but he remained in a poor state. The medical team completed a Do Not Attempt Resuscitation (DNAR) as they considered the prognosis of a further successful resuscitation to be very low. Mr Tremayne stopped breathing at 6.40pm and died.

Contact with Mr Tremayne's family

54. The hospital contacted Mr Tremayne's next of kin when he went into cardiac arrest at 5.15pm. The family arrived at 8.15pm. One of the escorting officers told them a prison family liaison officer would be in touch the next day.

55. The family liaison officer who had been appointed by the prison after Mr Tremayne's death, spoke to Mr Tremayne's sister-in-law on 19 August and offered her condolences and support. The family liaison officer asked whether the family would like to visit Featherstone and meet the Governor, but it was decided that the Head of Safer Custody and Equalities and the family liaison

officer would visit Mr Tremayne's family at their home instead. Mr Tremayne's funeral took place on 11 September. The prison contributed towards the costs of the funeral in line with national policy.

Support for prisoners and staff

56. The bedwatch staff were debriefed by the duty governor on the day Mr Tremayne died.

57. The Deputy Governor posted notices informing other prisoners of Mr Tremayne's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Tremayne's death.

Post-mortem report

58. A post-mortem examination found that Mr Tremayne died from aspiration of gastric contents (entry of stomach contents into the respiratory system) and peritoneal sarcoma. The clinical reviewer explained that sarcoma is a term used to describe a cancer of bone or tissue and is one of the less common forms of cancer. Peritoneal sarcoma describes the location of the cancer – a cancer which develops between the thin layer of tissue lining the abdomen and covering the abdominal organs.

Findings

Clinical care

59. The clinical reviewer was satisfied that overall, Mr Tremayne's care at Featherstone was equivalent to that which he could have expected to receive in the community.

60. When a prison GP saw Mr Tremayne on 8 May he asked the prison healthcare department to conduct a routine ultrasound scan of Mr Tremayne's abdomen. The appointment for the scan was made for 7 June (four weeks after the request). The scan was later cancelled as Mr Tremayne was already in hospital. The clinical reviewer said a wait of four weeks for a routine test was within the expected standards of NHS practice. The clinical reviewer considered that a routine request was appropriate because it was the first time the GP had seen Mr Tremayne and his vital signs were not of concern.

61. It is unclear to what extent healthcare staff knew of Mr Tremayne's continuing problems with vomiting and feeling unwell during May. He saw nurses when he collected his medication daily from the treatment hatch when he would have been able to raise medical issues or request an appointment to see the GP. The wing officer thought she had contacted the healthcare team about three times at the end of May and also raised her concerns with the nurses at the house block treatment area. There are no records in Mr Tremayne's medical records, the wing observation book or Mr Tremayne's case notes of any conversations between the house block and the healthcare team. While we acknowledge that Mr Tremayne could have been more proactive in asking to see a GP sooner, we recommend that:

    The Governor and Head of Healthcare should ensure that when staff raise medical concerns about prisoners with nursing staff, they should record this in the wing observation book and the prisoner's case notes. Nursing staff should act on concerns and make entries in a prisoner's SystmOne record.

62. Throughout Mr Tremayne's hospital stay, his diagnosis remained unconfirmed and it was not known that he had cancer until after he died. Updates from the hospital about Mr Tremayne's condition were not always clear from the SystmOne records. The clinical reviewer felt that communication between the prison and the hospital could have been more comprehensive and made a recommendation about this which the Head of Healthcare will need to address.

Restraints

63. 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. Using restraints when they are not justified amounted to a breach of Article 3 of the European Convention on Human Rights (inhuman and degrading treatment).

64. Featherstone's Local Security Strategy (LSS) requires that a risk assessment is completed to determine the level of escort and restraints required, including taking account of the following:

- The prisoner's medical condition. Where there is doubt, the prison medical officer must be asked to advise on any medical objections to the use of restraints, and assess the prisoner's ability to escape unaided.
- The prisoner's category.
- The nature of the offences, the risk to the public and hospital staff, including the risk of hostage taking.
- The prisoner's motivation to escape, likelihood of external assistance and conduct while in custody.

Escort to hospital and bedwatch arrangements from 1 June to 10 July 2017

65. Mr Tremayne was handcuffed to an officer when he went to hospital by ambulance on 1 June. For his entire stay in hospital, prison managers authorised the use of an escort chain and two officers, and the escort chain was only removed when Mr Tremayne suffered a cardiac arrest about an hour and a half before he died.

66. The wing officer told us that, on 1 June, Mr Tremayne, "Needed to be in a wheelchair because he was quite unsteady on his feet and whenever he tried to walk he would either throw up or soil himself." The assessment form completed by healthcare staff before the escort leaving the prison referred to Mr Tremayne being "off his legs" (as he was in a wheelchair) for the past three days and vomiting persistently.

67. The review the next day by the Head of Business Assurance said, "It is considered [Mr Tremayne] would not be strong enough to physically complete an escape", and yet the decision was made, apparently after consulting the Governor, to continue using an escort chain. It is hard to see the justification for this decision.

68. The 2007 High Court judgement makes it clear that a medical opinion about the prisoner's ability to escape must be considered as part of the risk assessment process. The risk assessment review forms do not include the opinion of the hospital medical team (as to the impact of the patient's condition on their ability to escape).

69. Mr Tremayne's risk should have been reviewed every 72 hours. Only two reviews were conducted between 1 June and 10 July and neither addressed the key considerations of risk in any meaningful way, or were clear about Mr Tremayne's mobility level or condition.

Bedwatch arrangements from 10 July 2017

70. On 10 July, Mr Tremayne was given Category D status in the course of a scheduled categorisation review (not connected to his health). Prison Service Instruction (PSI) 40/2011 (Categorisation and Recategorisation) says that Category D is for prisoners who "present a low risk; can reasonably be trusted in open conditions and for whom open conditions are appropriate".

71. We note two entries in Mr Tremayne's prison records about the Category D decision and that his prison records showed him as a Category D prisoner. However, the manager who reviewed (or countersigned) Mr Tremayne's bedwatch risk assessment on 11, 14 and 23 July, said he was not aware that Mr Tremayne had been re-categorised to Category D and did not take therefore this into account when reviewing Mr Tremayne's bedwatch risk assessment.

72. The review on 1 August referred to Mr Tremayne's health "deteriorating very rapidly" and that the healthcare team should be spoken to. It is not clear who was meant to take this action but there is no evidence this was followed up. The subsequent review on 4 August repeats a standard line previously used, "To continue as it is currently. Review if any significant changes".

73. We feel that the continuing use of restraints by Featherstone, reviewed and endorsed on several occasions was unreasonable and failed to take into account his lower security category, deteriorating health or comply with legal precedent. It is particularly troubling that restraints were reapplied after Mr Tremayne had collapsed in the toilet area on the day he died.

74. The Governor of Featherstone accepted a recommendation about the inappropriate use of restraints in August 2016, and agreed to implement a detailed action plan. It is clear from this case that the prison did not do this effectively. We make the following recommendation:

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

Release on temporary licence

75. Prisoners can be given temporary release before their sentence has expired for certain reasons, including medical reasons. Prison Service Order (PSO) 6300 sets out the criteria for early release for determinate sentenced prisoners. It says that a special purpose licence can be given, often at short notice, to allow eligible prisoners to attend medical outpatient appointments or inpatient treatment. There is no maximum duration of a licence for inpatient treatment. A risk assessment should decide whether release is appropriate. It says that the Governor may grant the temporary licence and will decide whether staff should accompany the prisoner.

76. Featherstone did not start an application for temporary release for Mr Tremayne, even after he was given category D status in July 2017. We were told that it was not considered because "at no point were we informed his condition was terminal". Release on temporary licence is not dependent on a prisoner having a terminal medical condition.

77. We are not satisfied that the prison appropriately considered release on temporary licence for Mr Tremayne as an alternative to the escort arrangements they had in place. We make the following recommendation:

The Governor should ensure that release on temporary licence is considered without delay for seriously ill prisoners in hospital who meet the criteria.

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