Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gary Hart a prisoner at HMP Wormwood Scrubs on 15 February 2017

A report by the Prisons and Probation Ombudsman

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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 Gary Hart died on 15 February 2017 of an acute stroke while in the custody of HMP Wormwood Scrubs. Mr Hart was 65 years old. We offer our condolences to Mr Hart's family and friends.

Mr Hart had hypertension (high blood pressure) and had had two previous strokes, but throughout his time in custody he refused to take medication for his condition. We are satisfied that prison healthcare staff encouraged Mr Hart to accept treatment for his hypertension and that they regularly checked that he had the mental capacity to make this decision.

Mr Hart was a challenging patient who was sometimes aggressive and violent and frequently covered himself and his cell with faeces and urine. We are satisfied that prison healthcare staff provided him with a good standard of care and helped him with his personal care needs, and that the care provided to Mr Hart was equivalent to that which he could have expected to receive in the community.

Mr Hart's placement in the prison's healthcare unit for the 15 months he spent at Wormwood Scrubs was the most appropriate location for him in the prison. From November 2015, healthcare staff made repeated attempts to find Mr Hart a more suitable placement in the community, without success. The clinical reviewer found that the delay in finding an appropriate placement was due in part to difficulties in deciding which NHS body was responsible for paying for Mr Hart's care. This is outside our remit, but we note that the clinical reviewer has made a recommendation to NHS England (London) to provide clarification about who pays in complex care cases.

We are concerned that a nurse did not call an emergency code when Mr Hart had difficulty breathing, although this did not affect the outcome for Mr Hart.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman December 2017

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Summary

Events

1. On 25 September 2015, Mr Gary Hart was sentenced to three years imprisonment for drug offences and was sent to HMP Wormwood Scrubs.

2. Mr Hart had a history of chronic alcoholism and hypertension (high blood pressure) and had suffered two strokes in 2011. He also had a history of poor mobility, urinary incontinence and self-neglect. Shortly before his imprisonment he had spent two months in hospital with a diagnosis of Korsakoff's syndrome (an alcohol-related brain disorder). He was assessed as lacking mental capacity while in hospital, although he later regained capacity following treatment.

3. When Mr Hart arrived at Wormwood Scrubs, prison healthcare staff prescribed medication to treat his high blood pressure and to prevent a recurrence of Korsakoff's syndrome, but he refused to take it.

4. On 30 September, he was moved to the prison's healthcare unit and remained there throughout his time in prison.

5. On 9 October, a prison GP checked Mr Hart's mental capacity, as he continued to refuse his medication. The GP explained the risks, which Mr Hart understood. Five days later, a psychiatrist reviewed Mr Hart and considered that he had the capacity to refuse his medication. Other healthcare staff reviewed Mr Hart during his time in custody and found that he had capacity to refuse his medication.

6. Mr Hart continued to refuse his medication, saying it was "poison", although healthcare staff continued to offer it and explain the risks of not taking it. Mr Hart occasionally allowed healthcare staff to check his blood pressure, which remained very high. Healthcare staff also helped Mr Hart with his personal care needs, as he was incontinent of urine and frequently covered himself and his cell with faeces and urine. Mr Hart's response to staff was erratic and he was sometimes aggressive and violent.

7. In November 2015, healthcare staff at the prison tried to arrange a transfer for Mr Hart to the older persons' unit at HMP Norwich but that unit was full.

8. From March 2016, a psychiatrist tried to arrange for Mr Hart's admission to the older adult inpatient service at a local hospital, but they refused to accept him due to concerns about his and other patients' safety.

9. On 21 June 2016, the psychiatrist reviewed Mr Hart. Mr Hart told the psychiatrist that his medication was "rubbish", but could not explain why he thought this. The psychiatrist decided that Mr Hart did not have the capacity to refuse his medication. A week later, a multidisciplinary meeting decided that it was inappropriate to medicate him covertly. On 18 August, a prison GP decided that Mr Hart's capacity had returned.

10. Healthcare staff continued to try to arrange for Mr Hart to be transferred to a more appropriate location, but the local Clinical Commissioning Group and NHS

England could not determine who was responsible for funding a placement for him.

11. In December 2016, Mr Hart was taken to hospital with a broken arm and returned to prison with his arm in a plaster cast. A few days later he removed the cast himself. Staff at the hospital considered he had the capacity to refuse care and said they were therefore unable to treat him.

12. At 10.15pm on 17 January 2017, a nurse heard abnormal breathing sounds coming from Mr Hart's cell. She entered and found him on the floor, confused and with right-sided weakness. The nurse asked for an ambulance and, at 11.43pm, Mr Hart was taken to hospital. The following day, hospital doctors diagnosed that Mr Hart had had a stroke.

13. Mr Hart's condition continued to deteriorate and, on 10 February, hospital doctors placed Mr Hart on the end of life pathway. A week later, Mr Hart died.

Findings

14. We agree with the clinical reviewer that Mr Hart received care equivalent to that which he could have expected to receive in the community. Although Mr Hart could be very challenging, medical and nursing staff continued to engage with him throughout his time in prison, the mental health team played an active part in his care, and he received good support with personal care and all activities of living. While it is expected that staff should do this, as the clinical reviewer noted, services in the community had previously withdrawn support from Mr Hart but the prison healthcare service persisted in engaging with him.

15. Mr Hart's high blood pressure and previous history of strokes meant that he was at very high risk of further strokes. We are satisfied that healthcare staff made regular attempts to treat and manage Mr Hart's hypertension but he consistently rejected treatment (as he had done before entering prison). Healthcare staff also repeatedly checked Mr Hart's mental capacity and concluded that he had the capacity to refuse his medication and understood the possible consequences. The clinical reviewer said, however, that it was not clear if healthcare staff had a full and shared understanding of the Mental Capacity Act and how this is applied to a prisoner.

16. The prison should also have considered involving Mr Hart's family, with his consent, when he refused treatment.

17. Mr Hart's placement in the healthcare unit from 30 September 2015 was the most appropriate place for him in the prison. From November 2015 onwards, staff at the prison appropriately attempted to find a more suitable environment for him. There were, however, delays in communication between the Clinical Commissioning Group (CCG) commissioners and the prison, and debate about which NHS body should fund his placement, which lasted several months and had not been resolved by the time Mr Hart died.

18. We are concerned that when a nurse found Mr Hart unresponsive in his cell on 17 January, she did not call a code blue emergency (which indicates that a

prisoner is unconscious or having difficulties breathing), despite him suffering with breathing difficulties, and did not record any structured clinical observations.

19. Although the hospital informed Mr Hart's son of his death directly, the prison's family liaison officer should still have considered visiting Mr Hart's son in person to offer her condolences and support, particularly as he lived only around half an hour from the prison.

Recommendations

- The Head of Healthcare, Lead GP and Mental Health provider should establish clear guidelines for all healthcare staff in the prison to ensure that the principles and requirements of the Mental Capacity Act are followed. This should be underpinned by training for all healthcare staff. If such training is already mandatory, the Head of Healthcare should ensure that it is as detailed as is required.
- The Governor and Head of Healthcare should ensure that, when a prisoner refuses treatment, consideration is given to involving his family (in line with Prison Service Instruction (PSI) 64/2011).
- The Head of Healthcare should ensure that all healthcare staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including using the appropriate emergency code to effectively communicate the nature of a medical emergency.

The Investigation Process

20. The investigator issued notices to staff and prisoners at HMP Wormwood Scrubs informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

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

22. NHS England commissioned clinical reviewers to review Mr Hart's clinical care at the prison.

23. We informed HM Coroner for West London of the investigation. Our investigation was suspended for nearly three months until we received cause of death from the coroner. We have sent the coroner a copy of this report.

24. The investigator wrote to Mr Hart's son to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr Hart's son questioned whether Mr Hart should have been sent to prison. He said that when he visited Mr Hart in hospital, he was visibly underweight and unkempt, and that he felt that the prison's care led to his premature death.

25. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

26. Mr Hart's son received a copy of the initial report. He did not make any comments.

Background Information

HMP Wormwood Scrubs

27. HMP Wormwood Scrubs is a local prison in west London, holding over 1,200 men, either convicted or remanded by courts in the local area. It is also a designated resettlement prison for London prisoners. On 1 April 2016, Care UK took over the healthcare contract for primary care and several other health services. Mental health services are subcontracted to Barnet, Enfield and Haringey Mental Health Trust. There is 24-hour healthcare cover and an inpatient unit with 17 beds.

HM Inspectorate of Prisons

28. The most recent inspection of Wormwood Scrubs was in December 2015. Inspectors had a number of concerns about the prison, but found that the quality of health services was reasonable with an adequate range of primary care services. The management of long-term conditions was mostly reasonable but few prisoners with long-term or complex conditions had care plans. The healthcare unit was a good environment. Most inpatients had severe mental health problems or other complex needs but there were often too few beds available to meet demand. The prison cancelled too many external hospital appointments due to a shortage of prison staff to take prisoners to hospital and this had a detrimental effect on prisoners' health.

Independent Monitoring Board

29. 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 was concerned with the considerable number of prisoners with mental health issues and that the age profile of the prison population continued to increase, bringing an increased demand on healthcare services. The Board noted that there were four daily slots for prisoners who needed to be escorted to treatment outside the prison but they continued to find cases where staff shortages meant that prisoners were not taken to hospital appointments. The Board was also concerned by the number of dirty protests in the healthcare unit and the apparent delay in cleaning the affected cells

Previous deaths at HMP Wormwood Scrubs

30. Mr Hart was the fourth prisoner to die at Wormwood Scrubs from natural causes since January 2016. There were no similarities between the circumstances of Mr Hart's death and previous deaths at the prison.

Key Events

31. On 25 September 2015, Mr Gary Hart was sentenced to three years imprisonment for drug offences and was sent to HMP Wormwood Scrubs.

32. Mr Hart had a history of alcohol dependence, hypertension (high blood pressure), pulmonary oedema (the collection of fluid around the lungs) and ischaemic cardiomyopathy (where the walls of the heart become stretched and thickened so it cannot pump properly). He had suffered two strokes in 2011.

33. Between 23 July 2015 and 23 September 2015, Mr Hart had been an inpatient at the hospital, suffering with acute confusion, double incontinence, poor mobility and recurring falls, together with considerable self-neglect and poor personal hygiene. While in hospital, doctors diagnosed Mr Hart with Korsakoff's syndrome (an alcohol-related brain disorder caused by a lack of vitamin B1). Initially, hospital doctors decided that he did not have the mental capacity to make decisions about his treatment, though his capacity returned after being treated with vitamin B1. During his hospital stay Mr Hart was agitated and at times violent. When he was discharged, it was noted that he was refusing to take his medication. No follow up care package was arranged.

34. On arrival at Wormwood Scrubs, Mr Hart was given a shower by officers in reception as he was 'unkempt'. A nurse performed an initial health screen, took Mr Hart's observations and found his blood pressure was very high. The nurse also decided that Mr Hart needed full personal care as he suffered from occasional urinary incontinence.

35. Mr Hart was seen by a prison GP the following day. He was using a wheelchair, although he said he normally walked with a stick. He refused medication for his hypertension, saying pills were "all rubbish". It was decided that he would remain in the prison's First Night Centre until there was space for him in the healthcare unit.

36. On 29 September, after receiving information from Mr Hart's community GP, a pharmacist prescribed him various medications, including a vitamin B supplement, amlodipine (to treat angina) and Bendroflumethiazide, Doxazosin and Ramipril (all to treat high blood pressure). However, Mr Hart refused to take his medication and continued to refuse throughout his time in prison.

37. On 30 September, healthcare staff moved Mr Hart to the healthcare dormitory to give him personal care. On 1 October, he was relocated to a single cell in the healthcare unit, following an incident in which he had smeared faeces all over himself and the toilet area. Staff helped him to shower and provided incontinence pads. He was hostile and aggressive and threw his glasses at staff.

38. On 3 October, a nurse created a care plan to support Mr Hart's personal care needs. The plan instructed that staff should offer him a shower, clean clothes, incontinence pads and other personal care on a daily basis. Staff ensured he was able to leave his cell and take part in association with other prisoners. He continued to refuse all medication, and also refused to use the incontinence pads.

39. On 9 October, a prison GP reviewed Mr Hart to check his mental capacity, as he continued to refuse his medication. He explained to Mr Hart the risks of not taking his medication. He then performed a GPCOG (a test to determine cognition) and gave Mr Hart a score of seven out of 15 (a score of seven or lower indicates cognitive impairment). He asked for a second opinion from the mental health in-reach team.

40. Five days later, a psychiatrist reviewed Mr Hart and found that while he was confused about what year it was, he was able to explain the reasons for and potential consequences of not taking his medication. He considered that Mr Hart had the capacity to refuse his medication.

41. Mr Hart continued to refuse his medication, saying he believed it was ”poison”, although healthcare staff continued to offer it and explain the risks of not taking it. Mr Hart occasionally allowed healthcare staff to check his blood pressure, which remained very high. Healthcare staff also continued to help Mr Hart with his personal care needs, though he was threatening and abusive, hit an officer with his walking stick, threw a cup of tea at staff and acted in a threatening and racist manner. He was eating and drinking well.

42. During a meeting between a prison GP and a nurse practitioner on 16 October, they decided to assess Mr Hart’s mental capacity regularly. On 27 October and 24 November, the GP decided Mr Hart had mental capacity.

43. Mr Hart’s medical conditions and behaviour remained unchanged. Support was offered with his personal hygiene, and was sometimes accepted and sometimes not. Mr Hart was regularly incontinent and refused to use any incontinence aids. His cell was cleaned regularly by the bio-hazard cleaning team. His eating and drinking was good and his weight remained unchanged.

44. On 28 November, a locum prison GP reviewed Mr Hart, who continued to refuse his medication. He considered that Mr Hart had a significant cognitive deficiency and asked a prison GP to consider this. On 7 December, a prison GP reviewed Mr Hart and noted that his blood pressure was high, though Mr Hart denied suffering from headaches or blurred vision. Mr Hart became agitated when discussing why he had refused his medication and the GP reiterated to him that he could suffer another stroke or die. The GP added Mr Hart to a virtual ward round to allow medical professionals to assess his mental capacity.

45. On 18 December, Mr Hart collapsed in his cell and a nurse found that his blood pressure was lower than normal. An hour later, another GP reviewed Mr Hart, who denied feeling unwell. The GP requested an electrocardiogram (a test that checks the heart’s rhythm and electrical activity), a urine test and blood tests. Mr Hart refused these tests.

46. During a virtual ward round on 29 December, a prison GP and a nurse requested that staff check Mr Hart’s blood pressure twice a week. The following day, a nurse created a tachycardia care plan to monitor Mr Hart’s blood pressure on a daily basis, though he often refused to allow healthcare staff to do this. When healthcare staff were able to check his blood pressure, it remained high.

47. During a virtual ward round on 8 January 2016, two prison GPs and a nurse decided to refer Mr Hart to a hypertension clinic. Three days later, a GP completed the referral and the clinic arranged an appointment for 8 April.

48. On 14 January, a prison GP reviewed Mr Hart, who said that he did not want to take his medication because he had had a stroke despite taking it. He decided that Mr Hart did not show any signs of cognitive impairment, as he appropriately requested food. Six days later, a locum GP assessed that Mr Hart had the mental capacity to refuse his medication.

49. On 12 February, a psychiatrist saw Mr Hart and undertook an Addenbrooks Cognitive Assessment test (a test to assess cognitive performance, often used in the diagnosis of dementia). She determined that Mr Hart had the capacity to refuse his medication, as he was aware of the consequences of not doing so. She considered that Mr Hart's responses were highly suggestive of dementia so decided to refer him for a memory clinic assessment and requested blood tests, which Mr Hart refused. Six days later, a prison GP completed the referral, though there is no record that the assessment took place.

50. Mr Hart remained incontinent of urine and also began to soil himself more frequently. It appears that this was part of Mr Hart's behaviour and self-neglect. He remained unkempt and was sometimes aggressive with staff.

51. On 26 March, a prison GP reviewed Mr Hart, who had blurred vision, and decided that his hypertension meant retinal haemorrhages were possible. He referred Mr Hart to an optician and encouraged him to take his medication, but Mr Hart rejected this advice. On 5 April, Mr Hart refused to see the optician.

52. On 8 April, the prison was unable to take Mr Hart to his hypertension clinic appointment due to problems transporting him by wheelchair. The clinic rearranged the appointment for 1 July.

53. On 14 June, a prison GP attempted to assess Mr Hart's capacity, but this had to be abandoned as Mr Hart became agitated and began to throw things.

54. On 21 June, a prison GP reviewed Mr Hart, who said that his medication was "rubbish" but could not explain why he thought this. She decided that Mr Hart did not have the capacity to refuse his medication, though she noted that this might fluctuate. A week later, at a meeting involving her and a psychiatrist, they decided that despite Mr Hart's failing capacity, it was not appropriate to medicate him covertly.

55. On 1 July, Mr Hart attended his hypertension clinic appointment at hospital and told the cardiology specialist that he had no intention of taking medication. As a result, the specialist discharged him from the clinic.

56. During a virtual ward round on 5 August, a prison GP and a nurse noted that Mr Hart acted aggressively when being assessed or discussing his medication.

57. On 18 August, Mr Hart's capacity was assessed to have returned because he told a prison GP about the risks of not taking his medication.

58. On 22 November, a prison GP queried whether Mr Hart was prepared to accept medication in liquid form, though there is no record that Mr Hart was asked about this. She noted that Mr Hart may have lost weight and a nurse was asked to try to check his weight.

59. On 9 December 2016, staff noticed that Mr Hart's arm was swollen. He could not account for the injury and did not recall falling. He was seen by a prison GP and his arm was put in a sling. On 16 December, the prison GP reviewed him and Mr Hart attended accident and emergency at hospital. He returned to prison with his arm in a plaster cast. A few days later, Mr Hart removed the cast himself. He was seen in the facture clinic at hospital on 23 December, where x-rays confirmed he had broken his arm. Hospital staff said they were unable to provide treatment due to Mr Hart's refusal to engage with them and his high level of aggression. They concluded that he had the capacity to refuse care and informed the prison that they were unable to treat him. He was seen by the prison doctor but declined pain relief or treatment for his broken arm and said he did not want to take any medications because they were "poisons".

60. Mr Hart's blood pressure was taken on 1, 8 and 14 January 2017, and remained very high. On 8 January 2017, Mr Hart agreed to be weighed. His weight was 57kg. Although his Body Mass Index was still within the normal range, he weighed 12kg less than when he had arrived in prison 15 months earlier.

61. At 10.15pm on 17 January, a nurse heard abnormal breathing sounds coming from Mr Hart's cell and found him on the floor, distressed and confused, with right-sided stiffness and not responding to staff. At 11.00pm, she requested an ambulance.

62. The first responder and ambulance crew arrived at the prison by 11.15pm. The first responder noted that Mr Hart's blood pressure was 240/140 (extremely high) and that he had a Glasgow coma score (a method of determining the level of consciousness) of 8. (The maximum score is 15 – fully alert and conscious – and the lowest possible score is 3.) Paramedics administered oxygen. At 11.43pm, an ambulance took Mr Hart to hospital, where he was admitted. In the early hours of 18 January, hospital doctors diagnosed that Mr Hart had had a stroke.

63. After Mr Hart's admission, the prison healthcare team made regular contact with the hospital staff caring for Mr Hart. On 25 January, a hospital doctor told the prison that Mr Hart had been moved to the hyper acute stroke unit. His Glasgow coma score remained between 8 and 9 and he had profound right-sided weakness.

64. A week later, the Modern Matron from the prison attended a case conference at the hospital, which confirmed that Mr Hart had not progressed since his stroke two weeks previously: he had significant neurological damage, was unable to speak and had not regained full consciousness.

65. On 10 February, hospital doctors placed Mr Hart on the end of life pathway. His condition continued to deteriorate and he died on 17 February. A hospital doctor found that Mr Hart died from an acute stroke, contributed to by hypertension, ischaemic heart disease and vascular dementia.

66. Mr Hart's high blood pressure and previous history of strokes meant that he was at high risk of further strokes. We are satisfied that healthcare staff made regular attempts to treat and manage Mr Hart's hypertension but he refused these attempts both before entering custody and once at Wormwood Scrubs. We are also satisfied that healthcare staff supported Mr Hart with all aspects of his day-to-day living. We agree with the clinical reviewer that Mr Hart received care equivalent to that which he could have expected to receive in the community.

67. Healthcare staff took repeated steps to test Mr Hart's mental capacity and generally found that he had the capacity to refuse his medical treatment, although there was a two month period between June and August 2016 when doctors deemed that he did not.

68. Although Mr Hart's mental capacity was assessed regularly and assessments were in line with those in the community, the clinical reviewer said that it was not clear if healthcare staff had a full and shared understanding of the Mental Capacity Act and how this is applied to a prisoner. We make the following recommendation:

The Head of Healthcare, Lead GP and Mental Health provider should establish clear guidelines for all healthcare staff in the prison to ensure that the principles and requirements of the Mental Capacity Act are followed. This should be underpinned by training for all healthcare staff. If such training is already mandatory, the Head of Healthcare should ensure that it is as detailed as is required.

69. Prison Service Instruction (PSI) 64/2011 'Management of prisoners at risk of harm to self, to others and from others' contains guidance on how to manage prisoners who refuse medical treatment, which includes considering involving the prisoner's family (with the prisoner's consent) to provide ongoing support. While we accept that Mr Hart's refusal of treatment did not change and that it is likely that his family would have been mindful of these consistent refusals, we are concerned that there was no evidence that healthcare staff had considered this option. We make the following recommendation:

The Governor and Head of Healthcare should ensure that, when a prisoner refuses treatment, consideration is given to involving his family (in line with Prison Service Instruction (PSI) 64/2011).

Emergency response

70. When a nurse found Mr Hart on 17 January, he was unresponsive and experiencing breathing difficulties. However, we note that she did not call a code blue emergency or perform a structured clinical assessment. PSI 03/2013 'Medical Emergency Response Codes', contains a mandatory instruction that staff should use a code blue (or code one) for any emergency where a prisoner is unresponsive or has symptoms including chest pain and difficulty in breathing. While we note that not using an emergency code did not impact on the outcome for Mr Hart, it could be crucial in other circumstances. We make the following recommendation:

The Head of Healthcare should ensure that all healthcare staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including using the appropriate emergency code to effectively communicate the nature of a medical emergency.

Mr Hart's location

71. After he arrived at Wormwood Scrubs on the night of 25 September 2015, Mr Hart was located in the First Night Centre while he waited for a place to become available in the prison's inpatient unit. On 30 September he was moved to a dormitory bed in the healthcare unit and on 1 October he was relocated to a single cell in the unit. He remained in the unit for the remainder of his time in prison. We are satisfied this was the most appropriate location for him in the prison. Healthcare staff appropriately began trying to find an alternative location for him shortly after this.

72. On 13 November 2015, the Modern Matron spoke to a Matron at HMP Norwich to seek a transfer for Mr Hart to their older persons' unit. She was told that Norwich had a waiting list, though a place may open up in three to six months. The unit at Norwich specialises in providing end of life care and it was unlikely that Mr Hart would be considered suitable.

73. On 18 March 2016, a prison GP decided that Mr Hart's needs may be better met in hospital so made a referral for a gate keeping assessment to assess Mr Hart's suitability to be admitted to a secure older persons' unit.

74. On 4 April, the clinical lead in the West London Mental Health NHS Trust concluded that Mr Hart warranted assessment and that, as this could not be done in prison due to his lack of engagement, he required a hospital admission to investigate the possibility that he had dementia. He said that he had spoken to a charity hospital, independent of the NHS, providing specialist mental healthcare for patients with some of the most complex, challenging mental health needs in the UK, and that they had indicated Mr Hart would be suitable for their locked rehabilitation service for the elderly.

75. On 6 April, a prison GP wrote to the hospital (the Trust that provides mental health services close to Mr Hart's home) asking for a gate keeping assessment to assess Mr Hart's suitability to be admitted to their older adult inpatient service. The specialist registrar in mental services from the hospital assessed Mr Hart on 28 April. In a letter dated 4 May, she recognised that Mr Hart required ongoing long-term mental health care but said that it could not be provided by the hospital's ward, as it was an open ward and that the presence of other patients with dementia could put them and Mr Hart at risk. She concluded that Mr Hart needed long-term care from a locked specialist rehabilitation unit.

76. On 20 May, the prison GP wrote to the Clinical Commissioning Group (CCG) Commissioner, requesting support to find an appropriate placement for Mr Hart. She chased for a response on 27 May. On 1 June, the Commissioner replied she was trying to find the best pathway for Mr Hart.

77. The prison healthcare team were very limited in what they could do at this point. A need for a hospital place had been identified, but no suitable place could be

found in the local area, and, although a possible placement at the charity hospital had been identified, it required the commissioners at the CCG to agree and fund it.

78. On 21 June, the prison GP chased the Commissioner for a response again. She was told the CCG considered that Mr Hart should be reassessed by the Woodlands Centre (part of the hospital). This was the service that had reviewed Mr Hart in April and concluded he was not suitable for them.

79. On 2 July, the prison healthcare team sent a further chasing email to the CCG as no response had been received from Woodlands.

80. On 7 July a Continuing Care Assessment was carried out on behalf of the CCG to establish if Mr Hart's care costs should be met solely by the NHS. This was a separate process from the proposed reassessment by the Woodlands Centre. No report on this was ever received by the prison.

78. On 27 October, the prison GP noted that a response had not been received from the Woodlands Centre and that as Mr Hart was due to be released in March 2017, the prison needed to pursue a suitable placement for his release. The following day, the Woodlands Centre told the prison healthcare team that they would not be offering another assessment or placement for Mr Hart.

79. The healthcare team then contacted the CCG mental health commissioner who said that the hospital would be told that a further assessment was needed. On 15 and 27 November, healthcare staff chased for updates on the reassessment. On 28 November they learnt that the hospital had said that Mr Hart was not suitable for their service. The healthcare team asked the CCG commissioner for an update. On 30 November they sent the commissioner a report requesting a place in the private sector for Mr Hart.

80. On 28 December, the commissioner told healthcare that the referral needed to be sent to NHS England. They sent the information later that day. The following day, a commissioner from NHS England agreed to look into Mr Hart's case, though there was no record that this happened before his death.

81. Despite the efforts of the prison healthcare team to find a more appropriate location for Mr Hart, he remained at Wormwood Scrubs until shortly before his death. The clinical reviewer concluded that the delay in finding an appropriate placement was due in part to difficulties in deciding which body was responsible for paying for his care, with the decision not having been made prior to his death.

82. Although these issues are beyond the remit of this investigation, we note that there are structural issues which need to be addressed and also note that the clinical reviewer has made a recommendation to NHS England (London) to provide clarification about who pays for complex care cases.

Restraints, security and escorts

83. 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.

84. When Mr Hart was taken to hospital on the night of 17 January, two officers accompanied him and restrained him with 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). At 3.40pm the following day, a senior prison manager authorised officers to remove the escort chain, due to Mr Hart's medical condition. Officers did not reapply the restraints at any time.

85. PSI 23/2015 'External Prisoner Movement' sets out Prison Service policy on the use of restraints during medical emergencies. The PSI states "In an emergency situation, an escort of at least two officers must be supplied and restraints must be used unless there are medical objections to their use". There was no evidence that a nurse or the paramedics objected to the use of restraints on Mr Hart on 17 January. Although Mr Hart had limited mobility, we note that this had not prevented him from attempting to assault staff at the prison with walking aids or hot drinks. We, therefore, consider that the prison acted appropriately in restraining Mr Hart and that the nurse quickly authorised officers to remove the restraints once the deterioration in his condition became clear.

Liaison with Mr Hart's family

86. On 18 January 2017, the prison appointed a prison manager as the family liaison officer. That day she contacted one of Mr Hart's sons, his listed next of kin, and told him that his father had been taken to hospital.

87. On 15 February, hospital staff contacted Mr Hart's sons to break the news of his death. Later that day, the prison manager telephoned Mr Hart's son to offer her condolences and support.

88. Mr Hart's funeral was held on 6 March and the prison contributed to the costs of the funeral in line with national instructions.

89. PSI 64/2011 sets out the processes that prisons should follow for informing families when a prisoner is seriously ill and after a death in custody. This includes that prisons must promptly notify the prisoner's next of kin about their death and that, where possible, contact should be made in person.

90. We are satisfied that after Mr Hart was taken to hospital, the prison promptly informed his son. When Mr Hart later died in hospital, the hospital informed his sons directly. Nevertheless, the prison's family liaison officer should still have considered visiting Mr Hart's son in person to offer her condolences and support, particularly as he lived only around half an hour from the prison.

Compassionate release

91. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.

92. Release on temporary licence (ROTL) can be granted for precisely defined and specific activities which cannot be provided in the prison. A risk assessment is completed to ensure that the prisoner's temporary release does not present unacceptable risks. The governor of the prison is able to grant the temporary licence and will decide whether the prisoner is to be accompanied by staff.

93. From 7.30am on 19 January, the prison released Mr Hart on temporary licence to obtain medical treatment from the hospital, though a member of staff accompanied him for support.

94. On 3 February, a prison GP completed the medical report for an application to release Mr Hart on compassionate grounds. She recorded that Mr Hart was in a critical and terminal condition, though he did not provide a definitive prognosis. Five days later, Mr Hart's probation officer and the deputy Governor supported releasing Mr Hart on compassionate grounds. However, the application for compassionate release was not completed before Mr Hart's death.

95. We are satisfied that the prison quickly released Mr Hart on temporary licence when it became clear that he required a lengthy hospital admission. We are also satisfied that the prison appropriately prioritised an application for compassionate release when his condition deteriorated significantly.

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