Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Richard Miles a prisoner at HMP Oakwood on 18 June 2018

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*

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

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

Mr Richard Miles died in hospital on 18 June of septicaemia (blood poisoning), while a prisoner at HMP Oakwood. He was 41 years old. I offer my condolences to Mr Miles' family and friends.

Mr Miles received timely and appropriate healthcare in prison, equivalent to that which he could have expected in the community. However, our investigation found several irregularities in the management of the security and escort arrangements during Mr Miles' admission to hospital.

Mr Miles was admitted to hospital, with suspected sepsis, on 31 May. Although he was incapacitated by his medical condition, receiving invasive treatment, assessed as a low risk of escape, and escorted by two prison officers, he was held in restraints until the day before his death. The security risk assessment was poorly managed and documented by the prison managers who conducted daily checks, with no recorded justification for the continued use of restraints. The restraints remained in place for over 30 hours after a doctor asked for them to be removed. By then, Mr Miles had been in a medically induced coma for around three hours.

This is the fifth time we have made had to make recommendations to Oakwood about the inappropriate use of restraints on seriously ill and dying prisoners. On each occasion, our recommendations have been accepted and the prison has committed to act on them, but it seems that lessons are not being learned. The two most recent recommendations on this subject were made in April 2018, before Mr Miles was admitted to hospital. We also recommended in April 2018 that the Head of Operational Contracts at Her Majesty's Prison and Probation Service (HMPPS) should satisfy himself that effective action was being taken.

I am very disappointed to have to repeat previous concerns about the management of risk assessments and restraints by Oakwood, and to have to draw our concerns to the attention of HMPPS's Head of Operational Contracts once more. I hope that action will now be taken urgently by the Director of Oakwood and by HMPPS to ensure that our recommendations are implemented.

I am also concerned that the prison did not inform Mr Miles' family that he was in hospital with a life-threatening condition and that they were subjected to insensitive treatment by escort staff when they visited him. I have recommended that the Director write to Mr Miles' family to apologise.

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

Sue McAllister CB
Prisons and Probation Ombudsman **April 2019**

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Summary

Events

1. Mr Richard Miles was remanded to HMP Hewell on 1 September 2017. He was subsequently convicted of drug offences and sentenced to four years in prison. At his initial health screen, healthcare staff noted his history of substance misuse and placed him on methadone stabilisation therapy. Mr Miles declined a general health assessment and signed a disclaimer to confirm that he understood the possible consequences.

2. On 28 February 2018, Mr Miles was transferred to HMP Oakwood. Healthcare staff created a methadone reduction care plan and continued to dispense his methadone daily. There were no concerns about his general health.

3. On 31 May, while waiting at the medication hatch for his methadone, a prison officer and a nurse noticed that Mr Miles seemed unwell and jaundiced. The nurse asked wing staff to monitor him until she was available to assess him. On examination, she found symptoms of possible sepsis and sent Mr Miles to hospital as an emergency.

4. Mr Miles was admitted as an inpatient and doctors diagnosed several conditions, including liver and kidney failure, cancer and sepsis.

5. On 5 June, the prison authorised a telephone call. Mr Miles contacted his partner, who then informed his parents that he was in hospital.

6. Mr Miles' health deteriorated and he was placed on life support. He died at 2.45pm on 18 June.

Findings

7. We agree with the clinical reviewer that Mr Miles received timely and appropriate care in prison, equivalent to that which he could have expected in the community.

8. The investigation found several irregularities in the management of the security and escort arrangements during Mr Miles' admission to hospital. The risk assessment was incomplete, with no medical input; managers did not conduct proper reviews of Mr Miles' risk; restraints were in place almost continuously for 18 days while he was receiving intravenous treatment and there was a significant delay when doctors asked for them to be removed. As a result, Mr Miles was restrained while in a medically induced coma. We consider that the actions and inaction of some staff during his stay in hospital showed a lack of concern about dignity and decency and fell below acceptable standards.

9. Prison staff did not comply with the requirement in the Prison Rules to notify Mr Miles' next of kin (his mother) that he was seriously ill and had been admitted to hospital. Neither did they follow the national policy to promptly assign a specific member of staff to communicate with and support his family. By the time they were able to arrange a visit, Mr Miles was critically ill on life support and he died a day later. When his family questioned the lack of contact, they were told that it was Mr Miles' responsibility to inform them.

10. In spite of Mr Miles' low security risk and poor condition, escort officers were heavy-handed in their approach to his family. The officers searched them in a public hospital ward and would not permit Mr Miles to have food bought from the hospital shop.

Recommendations

- The Director should investigate the actions of all the staff and managers responsible for completing and reviewing risk assessments and the use of restraints, during Mr Miles' stay in hospital and inform the PPO of the outcome within three months.

- The Director 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 escort arrangements are proportionate to risk, notably:

  - Staff should fully complete all relevant sections of the risk assessment, including a medical assessment.
  - Managers should review risk assessments within 24 hours if a prisoner is admitted to hospital as an inpatient; when there is a significant change in circumstances; and during the daily management visits. They should take full account of the prisoner's medical condition in decisions on the continuing use of restraints.
  - Restraints should not be used during serious or invasive treatment, unless there are exceptional reasons for doing so.
  - Escort staff should understand the importance of informing the prison immediately when a health professional asks for a prisoner's restraints to be removed. Decisions by managers should be taken quickly and documented.

- The Head of Operational Contracts at Her Majesty's Prison and Probation Service should satisfy himself that the PPO's recommendations on restraints have been properly implemented at HMP Oakwood.

- The Director should ensure, in line with Prison Rule 22 and PSI 64/2011, that prison staff inform the next of kin of seriously ill prisoners immediately of their admission to hospital, to allow the opportunity to visit if they wish to do so and that staff comply with Prison Service guidance about engaging with prisoners' families, including providing timely and accurate information.

- The Director should write to Mr Miles' family to apologise for the prison's failure to inform them that he was seriously ill and had been taken to hospital.

- The Director should ensure that escort staff are sensitive and considerate in their contact with prisoners' families; searches are conducted privately; and decisions are consistent with the assessed risk.

The Investigation Process

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

12. The investigator obtained copies of relevant extracts from Mr Miles' prison and medical records.

13. NHS England commissioned a clinical reviewer to review Mr Miles' clinical care at the prison

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

15. The investigator spoke to Mr Miles' sister and mother, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They had several concerns, including:

    - The prison did not inform them that Mr Miles had been admitted to hospital, or update them on the seriousness of his condition. A member of prison staff subsequently gave inaccurate information, which had caused additional distress.
    - Prison staff responsible for booking visits were unhelpful and this had caused delays in arranging to visit Mr Miles.
    - Escort officers had searched Mr Miles' family, including his elderly parents, in a hospital ward, in full view of other members of the public and would not allow them to purchase food and drink for him.
    - Mr Miles' handcuff was placed on his severely swollen arm and escort officers refused to move the cuff to his other arm.

16. Mr Miles' mother received a copy of our initial report. She provided additional information regarding family contact and we have amended the report to reflect this.

17. The initial report was shared with HM Prison and Probation Service (HMPPS). They accepted our recommendations and their action plan has been annexed to this report.

Background Information

HMP Oakwood

18. HMP Oakwood is managed by G4S and is one of the largest prisons in England and Wales, providing places for around 2,100 male prisoners. Care UK provides healthcare services, which include a daily GP clinic, some specialist services and out-of-hours GPs.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Oakwood was conducted in January and February 2018. Inspectors reported that health services had improved considerably since their last inspection and, overall, were reasonably good. The range of services was appropriate and the management of prisoners with lifelong or complex health needs was very good, although staff shortages had led to a backlog of nurse reviews. Inspectors found that the healthcare rooms were well equipped and staff created appropriate care plans.

Independent Monitoring Board

20. 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 March 2018, the IMB reported that a Learning from Experience Group had been set up to review recommendations from clinical reviews, PPO investigations and Coroners. The group highlights themes and shares learning. The Board had some concerns about the number of staff vacancies in the healthcare department.

Previous deaths at HMP Oakwood

21. Mr Miles was the 21st prisoner to die at Oakwood since January 2016, the 18th from natural causes. There has since been a further death. We have previously made recommendations about risk assessments, the use of restraints and contacting prisoners’ families.

Key Events

22. On 1 September 2017, Mr Richard Miles was remanded to prison for drug offences (possession of a class A controlled drug with intent to supply) and sent to HMP Hewell. It was his first time in prison.

23. At Mr Miles' initial health screen, a prison nurse recorded a history of substance misuse. He was otherwise fit and well and had not seen a doctor in the previous few months. On 2 September, a locum prison GP noted that Mr Miles used heroin, crack cocaine, cannabis and diazepam. The doctor placed him on methadone stabilisation therapy, managed and reviewed by the substance misuse team. Mr Miles was also a heavy smoker. (He later requested a referral to the smoking cessation service and stopped smoking for some time.)

24. On 8 November, Mr Miles declined a secondary health assessment. Healthcare staff explained the possible consequences to his health and he signed a disclaimer to confirm that he understood.

25. The medical records showed that on 16 February 2018, Mr Miles went to hospital for a gastroscopy (where a thin, flexible tube and camera are used to examine the inside of the stomach). However, due to low blood pressure he was only lightly sedated and he was unable to tolerate the procedure due to pain. There was no record of the reason for the gastroscopy.

26. Mr Miles was convicted on 21 February and sentenced to four years in prison. A week later, on 28 February, he was transferred from Hewell to HMP Oakwood. After a health screen, his methadone prescription was continued, under daily supervision. Healthcare staff later created a methadone reduction care plan. Mr Miles declined the psychosocial service offered by the mental health team, but said he would self-refer closer to his release date. He settled well and staff had no concerns about him.

27. In April, Mr Miles complained of back pain and was prescribed naproxen, an anti-inflammatory painkiller. (It was subsequently discovered that he had stopped taking this medication.) On 26 May, it was noted in the medical record that Mr Miles had tested positive for hepatitis C.

28. At around 9.00am on 31 May 2018, Mr Miles went to the medication hatch for his dose of methadone. While speaking to him, a prison officer noticed that he did not look very well, his complexion was yellow and he was sweating heavily. Mr Miles told him that he felt all right and the same thing had happened a few weeks before.

29. While dispensing his medication, the nurse also thought that Mr Miles appeared jaundiced and invited him for a full assessment a little later. The officer escorted Mr Miles back to his cell and told two wing officers to check on him every ten minutes.

30. Just after 11.00am, the nurse examined Mr Miles and found that the whites of his eyes were tinged yellow, he was sweaty and his tongue was dry. Mr Miles said he felt continually thirsty and completely drained and this had worsened over the last few days. As well as jaundice, the nurse noted possible signs of sepsis -

high pulse and respiratory rates, fever and low blood pressure. (Sepsis is a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs.) She arranged for an emergency ambulance to take him to New Cross Hospital, Wolverhampton and they left the prison at 12.21pm.

31. The next day, 1 June, the prison's healthcare manager called the hospital for an update. Hospital staff said that they were treating Mr Miles with intravenous antibiotics and there were no plans to discharge him. Prison managers visited daily. On each visit, they completed and signed a detailed checklist covering actions and issues such as equipment, security and visits.

32. On 7 June, the prison was informed that Mr Miles was expected to remain in hospital for at least another month. The same day, he received some money from his prison account. Healthcare staff kept in touch with the hospital and were told that Mr Miles was receiving kidney dialysis and had multiple problems, including liver and kidney failure, cancer and sepsis.

33. On 15 and 16 June, the escort officers informed the prison that Mr Miles' condition was worsening and noted that he was unsteady on his feet.

34. Just after midnight on 16 June, a doctor instructed Mr Miles not to leave his bed and a catheter was fitted. At 3.40am, a doctor asked for the handcuffs to be removed, explaining that Mr Miles might be transferred to the critical care unit for specialist care. The escort officers passed the request to the prison. At 3.45pm, Mr Miles was moved to the critical care unit. Multiple tubes were inserted in his arms and neck. During the evening, he became confused and tried to remove the tubes.

35. Early the next morning, 17 June, the hospital sedated Mr Miles due to aggression (arising from his medical condition). At 9.50am, an escort officer told prison healthcare staff that Mr Miles was thought to have sepsis, kidney and liver failure and a mass on his lungs.

36. At 10.10am, a doctor passing with another patient commented on Mr Miles being handcuffed despite his critical condition. An escort officer replied that this was the procedure and the cuffs would remain in place until they knew "the exact issues" and were able to relay this to a senior manager. The doctor read Mr Miles' notes and confirmed that his liver and kidneys were failing and his brain was not functioning. She told the officer the restraints were "uncalled for and inappropriate" and that she and the nurses felt upset about it. The officer reiterated that this was the procedure.

37. A few minutes later, Mr Miles' own doctor confirmed the diagnosis to the officer, stating that Mr Miles was on full life support, would be sedated for another 24 hours and was unlikely to recover. He added that if he deteriorated further, they would stop treatment. At 10.45am, the officer spoke to a prison manager, who authorised the removal of Mr Miles' handcuffs. The officer removed the handcuffs five minutes later and noted in the records that they would need to be bio cleaned due to skin/dirt.

38. On 18 June, the nurse manager and the Head of Safer Custody visited the hospital and spoke to Mr Miles' named nurse and consultant. They were told that doctors planned to reduce sedation and ventilation and allow Mr Miles to die peacefully. The escort staff were then authorised to remain in the staff area to allow his family privacy and, shortly afterwards, managers sent them back to the prison.

39. Mr Miles' family were with him when he died at 2.45pm that day.

Contact with Mr Miles' family

40. Escort staff made detailed entries in the escort log. During the morning of 5 June, Mr Miles asked the escort officers to seek management approval for a telephone call to his partner. The prison manager who visited that afternoon said that they would arrange this when they returned to the prison. He asked again at around 8.00pm. The escort officers obtained his authorised telephone numbers from the prison and he called his partner an hour later. His partner then informed his family that he was in hospital. On 9 June, a visiting prison manager authorised a five-minute call to Mr Miles' partner as there had been problems with his hospital phone. Twenty minutes later, the prison telephoned the escort officers to reverse this decision.

41. On 12 June, Mr Miles' partner made a call to his hospital phone to arrange a visit for 16 June. The escort officers told Mr Miles that he was not allowed to have incoming calls. On 13 June, Mr Miles' mother telephoned the hospital ward to arrange a visit and was advised that she had to do this through the prison. Later that day, Mr Miles rang his mother and said that he had to arrange visits himself. On 14 June, one of the escort officers tried three times to arrange a visit for Mr Miles' family, but they could not get through to the visits booking staff. Mr Miles' partner visited that day and contacted his family afterwards, as she realised that he was seriously ill. On 15 June, the escort officers confirmed the family visit with the prison's visits manager.

42. At 8.35am on 17 June, one of the escort officers telephoned Mr Miles' family to inform them of his deteriorating condition. Mr Miles' parents visited at 2.00pm and his consultant discussed the details of his condition and critical state. They asked the escort officers if Mr Miles' partner and other relatives could attend and this was approved. During the afternoon, the prison appointed a family liaison officer (FLO) and she went to the hospital. Mr Miles' mother mentioned her concern that it had been five days before she found out that Mr Miles was in hospital. The FLO told her that Mr Miles could have made telephone calls after 36 hours and booked visits after 72 hours.

43. At 7.30am on 18 June, the FLO contacted Mr Miles' family to say that Mr Miles' life support would shortly be withdrawn. (She had been given this information by a prison manager.) His family asked if this could be delayed until they arrived at the hospital. The FLO also passed this information to the escort officers, who informed her that this was incorrect and that Mr Miles' consultant was due to review him at 8.00am, before deciding what action should be taken. The FLO assisted Mr Miles' family by picking up one of his sisters from the airport and took her to the hospital to join the rest of his family.

44. In line with Prison Service guidance, the prison contributed to the costs of Mr Miles' funeral, which was held on 13 July.

Support for prisoners and staff

45. After Mr Miles' death, a prison manager and the staff care team debriefed the escort staff to discuss any issues arising and to offer support.

46. The prison posted notices informing other prisoners of Mr Miles' 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 Miles' death.

Post-mortem report

47. The report of the post-mortem examination concluded that the cause of Mr Miles' death was:

    1a septicaemia with massive hepatic and splenic abscesses/necrosis

    1b Hodgkin's lymphoma.

    (That is, a bacterial infection of the blood with massive liver and spleen abscesses and tissue death, caused by cancer of the lymphatic system.)

Findings

Clinical care

48. Mr Miles received timely and appropriate initial health assessments when he went into prison and on transfer to Oakwood, followed by supervised methadone treatment for his opiate addiction. Healthcare staff created and reviewed a care plan to manage his treatment.

49. When Mr Miles appeared unwell on 31 May, a nurse quickly conducted a thorough assessment and sent him to hospital as an emergency. During his admission, healthcare staff contacted the hospital for updates on his condition.

50. We agree with the clinical reviewer that Mr Miles' clinical care at Oakwood was equivalent to that he could have expected to receive in the community.

Security risk assessments and restraints

51. 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.

52. Mr Miles was a category C prisoner, who received intravenous treatment throughout his time in hospital. Although he was initially mobile, after his condition deteriorated he was confined to bed. Daily tests, scans and personal care were performed at his bedside on the ward.

53. The emergency escort risk assessment for Mr Miles' journey to hospital stated that he was a medium risk to the public (curiously, due to being in possession of fermenting liquid in October 2017) and a low risk on all the other security factors, including the risk of escape and likelihood of outside assistance. The medical section was not completed. The risk assessment concluded that he should be escorted by two prison officers and restrained using single handcuffs. The cuffs were not to be removed for medical treatment without prior approval by the duty director, but they could be removed at the request of a senior medical practitioner in a life-saving emergency.

54. No further risk assessments were completed. The prison said in explanation that when the initial risk assessment was completed, staff knew that Mr Miles would be admitted as an inpatient. However, this was not reflected in the relevant section of the form.

55. Oakwood's local instructions require managers to complete a 24-hour risk assessment when a prisoner is admitted to hospital as an inpatient, which should

be reviewed during the daily management visits and/or in the event of a change of medical circumstances. The 24-hour risk assessment form was not completed, yet for two and a half weeks, successive managers ticked and signed to confirm that they had reviewed its contents. There is no documentary evidence that the visiting managers considered the propriety of restraints. During the investigation, Oakwood acknowledged that managers had signed to confirm they had reviewed the non-existent 24-hour risk assessment.

56. The escort logs were detailed. The section to record the time and reason for the removal of restraints was blank each day, except for 11 June, when they were briefly removed for a CT scan. This suggests that they were not removed at any other time until 10.50am on 17 June, over 30 hours after a doctor had requested their removal. By then, Mr Miles had been in a medically-induced coma for around three hours.

57. Mr Miles' family said the restraints had been uncomfortable on Mr Miles' swollen arm. While there was no documentary evidence of this, escort officers found pieces of his skin stuck to the restraints after his death, which suggests that they were applied inappropriately.

58. We acknowledge that Oakwood has taken steps to ensure that managers comply with the requirement to complete and review 24-hour risk assessments. However, we cannot ignore that their actions and attitudes and those of some escort staff fell below acceptable standards. They failed to comply with policies and showed a lack of concern about dignity and decency. We are not satisfied that staff fully understand the rationale for completing such reviews. In particular, a significant deterioration in a prisoner's condition, or a request from doctors for removal of restraints should prompt an urgent review of their use and prisoners should not be restrained during invasive or life-saving treatment, unless there are exceptional reasons for doing so.

59. We are concerned that despite repeated recommendations to Oakwood on the issue of restraints, as well as one to the Prison Service's Head of Operational Contracts to ensure proper implementation of our recommendations, such serious shortcomings persist. We therefore make the following recommendations:

The Director should investigate the actions of all the staff and managers responsible for completing and reviewing risk assessments and the use of restraints, during Mr Miles' stay in hospital and inform the PPO of the outcome within three months.

The Director 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 escort arrangements are proportionate to risk, notably:

- **Staff should fully complete all relevant sections of the risk assessment, including a medical assessment.**
- **Managers should review risk assessments within 24 hours if a prisoner is admitted to hospital as an inpatient; when there is a significant**

change in circumstances; and during the daily management visits. They should take full account of the prisoner's medical condition in decisions on the continuing use of restraints.

- **Restraints should not be used during serious or invasive treatment, unless there are exceptional reasons for doing so.**

- **Escort staff should understand the importance of informing the prison immediately when a health professional asks for a prisoner's restraints to be removed. Decisions by managers should be taken quickly and documented.**

60. We repeat the recommendation previously made to HM Prison and Probation Service:

    The Head of Operational Contracts at Her Majesty's Prison and Probation Service should satisfy himself that the PPO's recommendations on restraints have been properly implemented at HMP Oakwood.

Contact with Mr Miles' family

61. Prison Rule 22 instructs that prisons should inform the next of kin immediately if a prisoner becomes seriously ill. Prison Service Instruction 64/2011, about safer custody, sets out the expectation that if a prisoner suffers an unpredicted or rapid deterioration in their physical health, an appropriate member of prison staff should engage with their next of kin to provide information and support.

62. Mr Miles was sent to hospital on 31 May by emergency ambulance with suspected sepsis, a life-threatening condition. We are concerned that despite Mr Miles' poor and worsening health, the prison made no attempts to inform his family that he was seriously ill. The family liaison records show that his family raised this with prison staff at the hospital and were told, incorrectly, that the onus was on Mr Miles to telephone after 36 hours and to book a visit after 72 hours. A family liaison officer was not appointed until 17 June, the day before his death.

63. When the investigator questioned the failure to notify Mr Miles' family of his admission to hospital, the prison said that when he was first admitted no concerns were raised to indicate his life was in danger and as soon as they were informed of the extent of his illness they appointed a family liaison officer.

64. Although Mr Miles had access to a hospital telephone and money a few days after his arrival, it was the prison's responsibility to notify and support his family sooner. As they failed to do this, his family was unaware of the severity of his condition. After his partner informed them, they unsuccessfully tried to arrange a visit through the visits line. Escort officers experienced similar difficulties when they tried to book the visits on Mr Miles' behalf. By the time his family visited, he was in the critical care unit and they were shocked to find that he was on life support. The next morning, prison staff incorrectly told them that his life support was to be withdrawn imminently.

65. Sepsis is life-threatening condition and therefore clearly falls within the circumstances defined by the Prison Rules. Mr Miles' family should have been

informed of his hospital admission at the outset. They received inadequate information and support until the appointment of a family liaison officer the day before his death. We make the following recommendation:

The Director should ensure, in line with Prison Rule 22 and PSI 64/2011, that prison staff inform the next of kin of seriously ill prisoners immediately of their admission to hospital, to allow the opportunity to visit if they wish to do so and that staff comply with Prison Service guidance about engaging with prisoners' families, including providing timely and accurate information.

The Director should write to Mr Miles' family to apologise for the prison's failure to inform them that he was seriously ill and had been taken to hospital.

66. We are satisfied that after Mr Miles' death, his family received appropriate and sympathetic support from Oakwood's family liaison officer.

Security procedures in hospital

67. Mr Miles' sister said that the escort officers publicly searched his family, including his elderly parents, in the hospital ward. Also, they refused to allow Mr Miles food purchased from a shop on site, on the grounds that the food would not be sealed. The officers declined the suggestion that one of them supervise the purchase and said they would buy the food later for Mr Miles, but this did not happen.

68. Prisons must discharge their duty to protect the public, particularly in open and vulnerable environments, but this should be proportionate to risk. We consider that the searching procedures should have been more discreet and, given Mr Miles' security category, low risk and critical condition, the refusal to allow his family to buy him food seems unreasonable. We make the following recommendation:

The Director should ensure that escort staff are sensitive and considerate in their contact with prisoners' families; searches are conducted privately; and decisions are consistent with the assessed risk.

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