Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Boot a prisoner at HMP Littlehey on 30 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 I oversee can improve their work in the future.

Mr Paul Boot died on 30 June 2018 of heart disease while a prisoner at HMP Littlehey. He was 62 years old. I offer my condolences to Mr Boot's family and friends.

I am satisfied that Mr Boot received a good standard of healthcare at Littlehey, equivalent to that he could have expected in the community.

However, I am concerned that the prison did not use clinical information to inform its decisions about the use of restraints when Mr Boot was taken to hospital.

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 **December 2018**

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Summary

Events

1. In December 2015, Mr Paul Boot transferred to HMP Littlehey. He was several months into a nine-year sentence for sexual offences. He had a pre-existing heart condition and took medication for this and for symptoms of anxiety.

2. During 2016 and 2017, Mr Boot refused hospital investigation for an injured ankle as well as for signs of blood in his urine. He developed symptoms of breathlessness but investigative tests conducted in February 2018 did not reveal any cause for concern.

3. On 8 May 2018, Mr Boot collapsed in the shower and was taken to hospital with a suspected stroke. In hospital Mr Boot was found to have a left-sided weakness as a result of the stroke which caused him problems with eating, drinking and his vision. Tests also revealed severe damage to his heart.

4. Mr Boot remained in hospital, where he received rehabilitation from occupational therapists, until 6 June. When he returned to Littlehey, he was given a ground floor cell and was considered to be capable of caring for himself.

5. On 29 June, Mr Boot was taken to hospital as an emergency due to shortness of breath and being pale and weak. His family were informed that he was very unwell and visited him in hospital. He died the next day at 8.55pm.

Findings

6. We agree with the clinical reviewer that the care Mr Boot received was equivalent to that which he could have expected to receive in the community.

7. We are concerned that the risk assessments undertaken by the prison when Mr Boot went to hospital were not informed by medical information.

Recommendations

- The Governor and Head of Healthcare should ensure that:
    - all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints;
    - risk assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time; and
    - the risk assessment form includes a section for medical information.

The Investigation Process

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

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

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

11. We informed HM Coroner for Cambridgeshire and Peterborough of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.

12. The investigator wrote to Mr Boot's brother to explain the investigation and to ask whether he had any matters he wanted the investigation to consider. He did not respond to our letter.

13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

HMP Littlehey

14. HMP Littlehey in Cambridgeshire is a medium security prison holding approximately 1,200 men. A large proportion of the prison's population have been convicted of sexual offences.

15. Northamptonshire Healthcare NHS Foundation Trust provides healthcare services at Littlehey. The prison healthcare centre is open from 7.30am to 7.30pm, Monday to Friday, and from 8.00am to 5.30pm at weekends. A local practice provides GP services, and there is a range of nurse-led clinics. There are no inpatient beds at the prison.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Littlehey was conducted in March 2015. Inspectors reported that a small group of GPs who regularly attended the prison had significantly improved patient care. Lifelong conditions were effectively identified and there was an appropriate range of clinics, led by specialist nurses. Inspectors found that hospital appointments for prisoners were rarely cancelled but that risk assessments for keeping medications in-possession were not always reviewed and recorded correctly.

Independent Monitoring Board

17. 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 January 2018, the IMB reported that an ageing population continued to make significant demands on healthcare services. They found areas of good practice including installation of four hospital beds and improved access to social care. They were disappointed that an end of life care suite completed in 2013 continued to be unused due to a lack of funding and that repairs to healthcare services were not completed due to difficulties with the maintenance contractor, Carillion, in 2017.

Previous deaths at HMP Littlehey

18. Mr Boot was the seventeenth prisoner to die of natural causes at Littlehey since June 2016. There are no similarities to these previous deaths.

Key Events

19. Mr Paul Boot was serving a nine-year sentence for sexual offences. He had been at HMP Littlehey since December 2015. He was happy to have been transferred to Littlehey as it was his first time in prison and he had felt very anxious on entry to prison at HMP Pentonville. Mr Boot had entered custody with a diagnosed heart condition and was prescribed medications for this and to relieve his anxiety.

20. On 2 February 2016, Mr Boot had a fall and hurt his ankle. He subsequently found it difficult to put any weight on this. A nurse assessed Mr Boot and, as he refused to go to hospital for an x-ray, she requested that he be reviewed by a doctor the next day. A prison GP reviewed Mr Boot on 3 February. He said that he had experienced heart attacks in 2010 and 2013. He also said he had stopped taking his heart medication because he did not care anymore, but agreed to restart taking it after discussion with the GP.

21. On 11 March 2016, Mr Boot first reported having blood in his urine. He was offered a hospital referral to investigate these symptoms on 22 March, as the symptoms persisted. Despite understanding that this could be a symptom of bladder cancer, he refused an appointment. He said it was degrading to be handcuffed during a hospital appointment. Mr Boot refused further investigation for this problem again in January 2017.

22. On 6 November 2017, a nurse reviewed Mr Boot's reported breathlessness. He felt that this had got worse since he stopped smoking and he also had occasional swelling in his foot, so she referred him for a doctor's appointment. On 8 November, a prison GP recommended that Mr Boot had a breathing test and prescribed an inhaler for him to try. He reviewed Mr Boot again in February 2018 and confirmed that his breathing test and blood tests were normal. His folic acid levels were low and he was given a prescription for this.

23. On 8 May 2018, Mr Boot collapsed in the shower and was taken to hospital at 9.15pm with a suspected stroke. He was restrained with an escort chain. (This is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.) On 11 May, the escort chain was removed after review by a prison manager.

24. A heart scan revealed Mr Boot had significant damage to his heart. On 18 May, the nurse manager visited Mr Boot in hospital. He had a severe left-sided facial weakness which caused him problems with eating, drinking and vision. Mr Boot received support from occupational therapists in hospital to help improve his mobility.

25. The nurse manager visited Mr Boot in hospital several times before his discharge back to prison. She liaised with hospital occupational therapists on what aids Mr Boot required on his return to prison. On 6 June, Mr Boot returned to Littlehey, to a ground floor cell, and healthcare were informed that he was self-caring in every way. Mr Boot said he did not want further physiotherapy at the hospital and was discharged from their service.

26. On 26 June, a prison GP saw Mr Boot on his wing at the request of an officer who was concerned about him. Mr Boot said he had problems with his balance and would like physiotherapy. The GP made a referral to the hospital for physiotherapy and also discussed end of life care with Mr Boot who said he did not want anyone to resuscitate him if his heart or breathing stopped. He signed an order to that effect.

27. On 27 June, the nurse manager received a call from the hospital's rehabilitation services who said that Mr Boot did not want their support on discharge because he did not want to be restrained at hospital. The occupational therapist said that a prison governor had told her that healthcare staff could advise against cuffing Mr Boot but the nurse manager said that it was not their decision.

28. On 29 June, Mr Boot was seen by a nurse at 3pm at the request of staff. She recorded that he was pale and breathing rapidly. At 4pm Mr Boot was seen by a prison GP, who recorded that he had been unwell for two days, looked grey, was short of breath and had a fast pulse. She arranged for him to be taken to hospital as an emergency. He was initially restrained with an escort chain which was removed permanently at 11.10pm. Mr Boot died the next day at 8.55pm.

Contact with Mr Boot's family

29. On 29 June 2018, a Supervising Officer (SO) acting as a family liaison officer, was advised that Mr Boot was very unwell in hospital. During the morning of 30 June, the SO, together with a nurse visited Mr Boot in hospital. They discussed his next of kin details as he had told escort staff that he did not want his family to know he was in hospital. Mr Boot told the SO that he would like his brother to be informed that he was in hospital and he would be happy for him to visit.

30. The SO contacted Mr Boot's brother immediately and arranged to meet him at the hospital at 2pm. They were joined by two members of staff, who took over the family liaison (FLO) role. After visiting Mr Boot, his brother decided to go home and return the next day.

31. One of the FLOs contacted Mr Boot's brother later that evening to tell him that Mr Boot's condition was deteriorating. She arranged to meet him and another brother at the hospital. Both FLOs met them at the hospital at 10.30pm and broke the news of Mr Boot's death. They arranged for them to see Mr Boot's body in the mortuary as his brothers were upset not to have arrived before he died.

32. The prison contributed to the funeral costs in line with national policy.

Support for prisoners and staff

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

Post-mortem report

34. The post-mortem report gave Mr Boot's cause of death as: 1a) decompensation congestive heart failure (the sudden worsening of the signs and symptoms of heart failure); 1b) ischaemic heart disease (a narrowing of the arteries to the heart); and 2) heart failure paroxysmal atrial fibrillation (heart failure caused by the heart being overworked).

Findings

Clinical care

35. We agree with the clinical reviewer that the care that Mr Boot received at Littlehey was equivalent to that he could have expected to receive in the community.

36. The clinical reviewer commends the nursing team for visiting Mr Boot in hospital and planning with the occupational therapists for his transfer back to prison. The clinical reviewer makes one recommendation that the Head of Healthcare will want to consider.

Use of restraints

37. 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.

38. Mr Boot went to hospital twice during his time at Littlehey and on each occasion an escort chain was used to restrain him. The risk assessments were provided to the investigator and neither contained any medical information to inform the assessment. Mr Boot was assessed as being a medium risk to the public and a low risk of escape. There was no section on the risk assessment form for medical information to be included.

39. The safer custody Custodial Manage (CM), agreed to discuss the escort risk assessments with the investigator. He explained the first escort on 8 May took place at night and there were no medical staff in the prison available to provide an input to the risk assessment. He said the escort on 29 June was an emergency and there was no time to seek medical input. We note, however, that Mr Boot was taken to hospital on this occasion on the advice of a GP, who could have been asked to what extent his medical condition affected his risk.

40. The nurse manager told the investigator that healthcare staff usually filled out medical information for escort risk assessments and that the document was sent to healthcare. She said that she kept a copy of the document for audit purposes. For the escort on 29 June, when healthcare staff were working in the prison, she said that healthcare were not asked to input to the risk assessment as she had no record of any information being provided.

41. We are concerned that on the two occasions Mr Boot went to hospital, medical information was not used to inform the risk assessment. He was very frail and unwell on each transfer and we consider the use of restraints on each occasion

to be unjustified considering he was accompanied by two prison officers. This view is reinforced by the fact that his restraints were removed shortly after his arrival at hospital on each occasion. The risk assessment document should include a medical section as this information is important when assessing the level of risk a prisoner presents at the time. We make the following recommendation:

The Governor and Head of Healthcare should ensure that:

- **all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints;**
- **risk assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time; and**
- **the risk assessment form includes a section for medical information.**

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