Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Waring a prisoner at HMP Forest Bank on 16 January 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 David Waring died on 16 January 2018 of pneumonia while a prisoner at HMP Forest Bank. He was 79 years old. I offer my condolences to Mr Waring's family and friends.

I am satisfied that, overall, Mr Waring received a good standard of care and support at Forest Bank, equivalent to that which he could have expected to receive in the community. However, I consider it unacceptable that an elderly man with reduced mobility and a longstanding illness, which had left him in a very weak condition, was double handcuffed during his journey to hospital and while receiving continuous invasive treatment.

I am also concerned that prison staff failed to notify Mr Waring's next of kin of his admission to hospital, which denied them the opportunity to visit in the days before he became unconscious.

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 **October 2018**

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Summary

Events

1. Mr David Waring was sentenced to eight years in prison on 19 November 2015 and arrived at HMP Forest Bank the same day. Healthcare staff monitored and treated his existing medical conditions and he received regular social care.

2. In October 2016, healthcare staff became concerned that Mr Waring was losing weight and began to monitor him more closely. A prison GP suspected his weight loss might be due to cancer and referred him to a specialist. Over several months, Mr Waring was seen by hospital specialists in several departments, including gastroenterology, urology, respiratory and haematology. They found a tumour in his kidney, but decided against surgery due to his age and frailty.

3. On 8 January 2018, Mr Waring was admitted to hospital after collapsing in his cell. Two prison officers escorted him, using double handcuffs (restraints were finally removed on 11 January). Doctors diagnosed pneumonia and treated him intravenously. Mr Waring did not respond to treatment and died on 16 January.

Findings

4. The clinical review found that Mr Waring received a good standard of healthcare and social care at Forest Bank. When his health deteriorated, prison GPs referred him promptly to secondary care and continued to monitor him. We agree with the clinical reviewer's conclusion that Mr Waring's care was equivalent to that which he could have expected to receive in the community.

5. We consider that the security risk assessment carried out for his hospital admission did not address the requirements of caselaw and, specifically, did not reflect the impact of Mr Waring's condition on his risk of escape. We consider the use of double handcuffs for the journey to hospital and during intravenous treatment inappropriate. The decision to use them was made without explanation or justification and against medical advice that he should not be handcuffed and was unable to escape unaided.

6. The investigation also found that prison staff did not adhere to Prison Rules and the national policy on contacting and supporting the families of seriously ill prisoners. At the request of the hospital, the police notified Mr Waring's brother of his admission, on 14 January. By then, Mr Waring was unconscious.

Recommendations

- The Director and Head of Healthcare should ensure that all staff completing and authorising risk assessments justifying the use of restraints on prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner, are regularly reviewed and are based on the actual risk the prisoner presents at the time.

- 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.
- The Director should write to Mr Waring's brother to apologise for the prison's failure to inform him that Mr Waring was seriously ill and had been taken to hospital.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Forest Bank informing them of the investigation and asking anyone with relevant information to contact her. Two prisoners wrote to the investigator.

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

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

10. We informed HM Coroner for Greater Manchester West District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

11. One of the Ombudsman's family liaison officers contacted Mr Waring's brother, his next of kin, to explain the investigation and to ask if there were any matters he wanted the investigation to consider. Mr Waring's brother was concerned about Mr Waring's weight loss in the months before his death and felt that it was obvious he was deteriorating. He wondered if more should have been done to address this and whether admitting him to hospital during this time might have prevented him developing pneumonia.

12. Mr Waring's brother was also concerned that although the prison had his contact details and he had been Mr Waring's only visitor, he was not told of his admission to hospital on 8 January until he received a call from the police on 14 January. He also mentioned that he had spoken to a family liaison officer about Mr Waring's health in March and July 2017. He was upset that Mr Waring was unconscious by the time he saw him.

13. Mr Waring's brother said that the prison's family liaison officer had been helpful and supportive after Mr Waring's death.

14. Mr Waring's brother received a copy of the initial report. He had concerns about the scope of the recommendations and we have responded to him directly.

15. The initial report was shared with HM Prison and Probation Service (HMPPS). They pointed out some factual inaccuracies and this report has been amended accordingly. The HMPPS action plan has been annexed to this report.

Background Information

HMP Forest Bank

16. Forest Bank is a local prison in Salford, serving courts in the North West. It holds 1,460 remanded and sentenced men. The prison is managed by Sodexo Justice Services. Sodexo provides primary health care services. There is a 19-bed inpatient unit with 24-hour nursing cover. An agency provides GP services with doctors available from 9.00am to 9.00pm Monday to Friday, 1.00pm to 5.00pm Saturday and 9.00am to 12.00pm Sunday. There is out of hours cover at other times.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Forest Bank was in February 2016. Inspectors reported that most areas of health provision were reasonable, but some required considerable improvement. Prisoners had access to an appropriate range of primary care services and visiting specialist services. Urgent same-day appointments were available, but waiting times for routine appointments were slightly long. Long-term conditions were well managed.

Independent Monitoring Board

18. 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 31 October 2017, the IMB were satisfied with the overall quality of healthcare provision. They reported that there was a wide range of services, reasonable access to GPs and emergency appointments were dealt with in line with NHS standards.

Previous deaths at HMP Forest Bank

19. Mr Waring was the third prisoner to die of natural causes at HMP Forest Bank since January 2016. There were no significant similarities between the circumstances of Mr Waring’s death and those previously investigated.

Key Events

20. On 19 November 2015, Mr David Waring was sentenced to eight years imprisonment, for sexual offences. He arrived at HMP Forest Bank later that day. It was his first time in prison.

21. The prison nurse who conducted Mr Waring's initial health screen had no immediate concerns about his health, but noted that he had been diagnosed with anaemia. A prison GP then assessed Mr Waring and noted raised blood pressure. The doctor requested a full blood count before re-prescribing iron tablets and listed him for the blood pressure clinic.

22. Over the following months, healthcare staff reviewed Mr Waring and treated minor conditions. Healthcare support workers visited him most days to assist with social care.

23. During a health review on 20 July 2016, a prison GP noted no recent change in Mr Waring's weight, and requested monthly weight checks. In October, a nurse recorded that he appeared underweight and nutritional supplements were prescribed. Healthcare staff continued to monitor his weight weekly, but found no cause for his weight loss.

24. Throughout 2017, there were several references to deterioration in Mr Waring's health and his inability to walk more than a few steps. Prison healthcare assistants continued to see him almost daily, closely monitoring his health and weight.

25. On 12 January 2017, prison officers reported to healthcare staff that Mr Waring had fallen in his cell and that they were generally concerned about his reduced mobility and unsteadiness on his feet. A nurse examined him in his cell and treated his injuries. A wheelchair was provided on the wing to help prevent further accidents.

26. On 14 January, a prison GP noted Mr Waring had lost 8kg in weight since November 2016 and suspected this might be due to underlying cancer. The GP referred him urgently to the Gastroenterology Department at Salford Royal Hospital, under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.

27. A consultant gastroenterologist began investigation of Mr Waring's symptoms on 27 January. She requested a CT scan of his chest, abdomen and pelvis, a gastroscopy and blood tests. She also referred him to the Urology Department at the same hospital.

28. On 3 March, a urologist wrote to say that abnormalities in Mr Waring's left kidney suggested possible cancer. However, he felt that this was unlikely to account for the weight loss and doubted he would be fit enough to undergo surgery. On 8 March, a specialist registrar in urology confirmed that the CT scan had found a tumour in his kidney and some secondary cancer deposits in his bones but the origin was unknown. He considered it unwise to remove Mr Waring's kidney, as it would almost certainly result in the need for dialysis and he planned to refer him to a respiratory specialist for further investigation of his weight loss.

29. In March, a prison officer noted that Mr Waring was getting weaker and finding it increasingly difficult to manage on the residential houseblock. He had bouts of dizziness and potential falls had been prevented by the assistance of his cellmate. (A subsequent physiotherapy assessment found he was generally steady for around five metres and he declined a walking aid.)

30. The specialist registrar in urology discharged Mr Waring from his care on 12 April, as the source of the cancer deposits did not appear to be urology related. In view of Mr Waring's health and poor renal function, he advised against active intervention and thought it best for healthcare staff to monitor him. He referred him to the haematology team to investigate other possible causes of his weight loss.

31. On 4 May, a consultant respiratory physician discharged Mr Waring and suggested a further referral for a repeat CT scan if the results of the haematologist's investigations were normal. In June, the consultant gastroenterologist also discharged Mr Waring as his weight had stabilised and she had found no gastroenterology link to his weight loss.

32. On 20 July, a haematology consultant confirmed that blood tests had revealed no reason for Mr Waring's weight loss or tumour. In September, he discharged him as a bone marrow test performed on 15 August had shown no evidence of a blood disorder.

33. On 28 November, two healthcare support workers referred Mr Waring to the nurse as his legs were red and inflamed. On 29 November, a nurse examined him. She noted his recent hospital investigations and that he had fluid in his legs. She arranged an urgent GP appointment.

34. The next day, a prison GP checked Mr Waring's general health. They discussed the outcome of his hospital tests to determine the cause of his weight loss. The GP explained that they were monitoring a tumour on his kidney which might possibly be cancer. However, in view of his age and frailty, they did not intend to remove the kidney or carry out any other major treatment. The GP noted that healthcare staff should continue to provide dietary supplements and monitor Mr Waring's social support.

35. Between September and November, Mr Waring's weight increased from 56kg to 59kg. He was not weighed after 18 December, as the scales had been sent away for servicing. Staff noted that he still appeared to be losing weight and planned to weigh him on 8 January when the scales were delivered.

36. At lunchtime on 8 January 2018, Mr Waring fell in his cell. On examination, a nurse found him alert and oriented with no injuries. He had been walking in his socks and she advised him to walk only in trainers, for safety. Mr Waring's cellmate said that he had falls several times a day. A healthcare support worker visited him in the afternoon and he still felt unwell after his earlier fall.

37. At approximately 7.40pm, wing staff called a nurse to Mr Waring's cell as he had collapsed and appeared to be confused. Two prison officers were supporting him in a chair. The nurse assessed Mr Waring using the National Early Warning Score (NEWS - an assessment tool to determine the severity of acute illnesses

and the risk of deterioration) which indicated that he was at high risk of deteriorating.

38. A prison GP arrived at around 8.00pm. She found his blood pressure was low and his pulse erratic. The GP and a nurse gave him oxygen and treated him intravenously for dehydration. The GP asked prison staff to call an emergency ambulance. While waiting for the paramedics to arrive, she tried to speak directly to a medical registrar at Salford Royal Hospital, but there was no response. The nurse and two colleagues monitored him closely and placed him on his bed to try and increase his blood pressure. They also telephoned to check the progress of the ambulance, which had been delayed. The paramedics arrived at 9.38pm and took Mr Waring to Salford Royal Hospital.

39. Two prison officers escorted Mr Waring, using double handcuffs (when the prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs). Shortly after they arrived at the hospital, the escort officers sought permission from the prison to temporarily remove the handcuffs to allow a change of clothing. A little later, they asked to briefly use an escort chain while the doctor was examining Mr Waring. (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.)

40. Hospital doctors diagnosed pneumonia and gave Mr Waring fluids and antibiotics, both intravenously. On 10 January, the escort officers noted that he could not stand unaided and that a new cannula had been fitted to his other arm. At 3.10pm on 11 January, the hospital asked for the handcuffing arrangements to be reviewed as they were concerned that the restraints would cause injury due to Mr Waring's age. The officers passed the request to prison managers, who agreed at 4.55pm that the escort chain should be removed pending a full management assessment the following day (it is not clear when the escort chain had replaced the handcuffs). The restraints were not reapplied.

41. Healthcare staff kept in touch with the hospital and were informed that his prognosis was very poor. On 13 January, Mr Waring was transferred to the high dependency unit. On the morning of 16 January, hospital staff informed the prison that they planned to start the end of life pathway. Mr Waring died at 3.03pm that day.

Contact with Mr Waring's family

42. On 14 January, at the request of a hospital doctor, one of the escort officers telephoned the prison to obtain the contact details of Mr Waring's next of kin and was given the details of his son. A nurse tried the telephone number given, but it was not working. The manager in charge of the prison at the time said they could not provide another family member or an alternative number as "security are not in" and advised the officers to ask a nurse to pursue this. Just after 10.40pm, a nurse asked the police for help to trace his family and they immediately telephoned Mr Waring's brother. Two hours later, in the early hours of 15 January, Mr Waring's brother attended the hospital. Mr Waring's son and daughters also visited him later that morning. Hospital staff telephoned Mr Waring's brother to inform him of Mr Waring's death.

43. The prison assigned a prison chaplain as the family liaison officer. He telephoned Mr Waring’s brother during the afternoon to offer condolences and support. He subsequently telephoned and visited other family members. He provided continuing support over the following weeks.

44. The Director of Forest Bank also telephoned Mr Waring’s brother to offer condolences and they discussed the confusion about Mr Waring’s next of kin. In line with national policy, the prison contributed to the costs of Mr Waring’s funeral, which was held on 6 February.

Support for prisoners and staff

45. After Mr Waring’s death, a prison manager debriefed the escort officers to ensure they had the opportunity to discuss any issues arising and to offer support.

46. The prison posted notices informing other prisoners of Mr Waring’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 Waring’s death.

Post-mortem report

47. The report of the post-mortem examination concluded that Mr Waring had died of 1a - pneumonia and 2 - chronic kidney disease and ischaemic heart disease.

Findings

Clinical care

48. The review of Mr Waring's clinical care found that prison healthcare staff managed him appropriately and referrals by prison GPs to hospital specialists were timely. He also received very good social care from healthcare support workers.

49. Mr Waring's next of kin was concerned about his weight loss and asked whether admission to hospital sooner might have prevented the development of pneumonia. The clinical reviewer considered that Mr Waring's condition did not require inpatient secondary care until his deterioration on 8 January and that there had been thorough, ongoing investigations to try and establish the cause of his weight loss. The clinical reviewer concluded that Mr Waring's care at Forest Bank was equivalent to that which he could have expected to receive in the community and we agree.

50. The clinical reviewer made recommendations in the clinical review report on matters not directly related to Mr Waring's cause of death, but which the Head of Healthcare will wish to address.

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 Waring was an elderly and frail category C prisoner, with limited mobility. In 2017, staff had recorded that he was only able to take a few steps and used a wheelchair to get around the prison. The medical report in the security risk assessment for his journey to hospital noted his recent behaviour as quiet and cooperative. It also stated that he would not be able to escape unaided and advised against the use of restraints for the journey and during treatment.

53. In spite of these limitations and the medical advice, a prison manager specified on the risk assessment that Mr Waring should be double cuffed at all times and that escort officers should seek prior approval from the prison's duty manager to remove them for medical treatment or emergencies. No reasons were recorded for either the use or level of restraint. The prison subsequently told the investigator that the prison manager would normally speak to the paramedics about the seriousness of a prisoner's condition before deciding about restraints and she could not remember Mr Waring's case being any different. Prison managers conducted management checks at the hospital each afternoon, but

there is no evidence that they reviewed the need for restraints until the hospital asked them to do so.

54. Mr Waring had a longstanding illness that had left him in a very weakened condition. We are concerned that in spite of his advanced age, compliance, severely reduced mobility and against the advice of healthcare staff, prison managers concluded that he should be restrained, with no justification as to why this was considered necessary. We make the following recommendation:

The Director and Head of Healthcare should ensure that all staff completing and authorising risk assessments justifying the use of restraints on prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner, are regularly reviewed and are based on the actual risk the prisoner presents at the time.

Family liaison

55. 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.

56. Mr Waring's electronic prison record listed his brother as his next of kin and his son as his emergency contact. (In May and August 2017, wing staff had checked that those details were still correct and recorded there had been no change.) The escort risk assessment also showed his brother as his next of kin and part of his address, but no telephone number. The form was ticked to indicate that his next of kin should not be informed that he had been taken to hospital and there is no evidence that this decision was reviewed in the following days.

57. We are concerned that despite Mr Waring's poor and deteriorating condition, the prison made no attempts to inform his family that he was seriously ill. Six days after his admission, hospital staff asked for the next of kin details. The prison gave those of Mr Waring's son, rather than his brother, the primary contact. When the hospital had difficulty with his son's telephone number, the prison was unhelpful and refused to provide an alternative. By the time Mr Waring's brother became aware of the situation, Mr Waring was unconscious and unable to communicate. It is disappointing that staff failed to discharge their responsibility for notifying and supporting Mr Waring's family during his illness. We make the following recommendations:

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.

The Director should write to Mr Waring's brother to apologise for the prison's failure to inform him that Mr Waring was seriously ill and had been taken to hospital.

58. We are satisfied that the prison's family liaison officer provided appropriate and continuing support to Mr Waring's family after his death.

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