

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Gary Bootle a prisoner at HMP Isle of Wight on 1 December 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*

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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 Gary Bootle died on 1 December 2017 of a heart attack at HMP Isle of Wight. He was 60 years old. I offer my condolences to Mr Bootle's family and friends.

Healthcare staff managed Mr Bootle's complex conditions appropriately and communicated well with secondary services. We are satisfied that Mr Bootle's care while at Isle of Wight was equivalent to that which he could have expected to receive in the community.

We are, though, very concerned to see that a very ill, frail man with very limited mobility, who posed minimal risk, was restrained when he was taken to hospital, and was kept in restraints even when hospital staff said he was having a heart attack. Prison managers should properly address the legal requirements of the risk assessment process when considering the use of restraints.

We have made recommendations to Isle of Wight about the use of restraints on nine previous occasions since January 2013. On each occasion, Isle of Wight have accepted our recommendations and committed to act on them. Effective action must now be taken to implement our recommendation and we draw this unsatisfactory state of affairs to the attention of the Prison Group Director as well as the Governor.

**Elizabeth Moody**  
**Acting Prisons and Probation Ombudsman**

**June 2018**

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# Summary

## Events

1. Mr Gary Bootle was serving an 18 year sentence for sexual offences and had been at HMP Isle of Wight since 15 March 2017. He had complex health conditions including diabetes and heart failure. He was frail and used a walking stick to mobilise.
2. Mr Bootle was admitted to hospital on two occasions, 5 June and 22 June, for symptoms relating to heart failure. While in hospital, Mr Bootle had investigations and medical intervention and a hospital doctor noted the damage to his heart was serious.
3. At about 1.10 pm on 1 December, Mr Bootle told an officer he had chest pain. He was pale and clammy. The officer called an emergency code and the prison control room called an ambulance. A nurse went straight to Mr Bootle's cell and asked if he had any pain. He said he did not but when he sat up, he vomited.
4. Paramedics took Mr Bootle to hospital at 1.49pm. A prison manager authorised the use of an escort chain.
5. When Mr Bootle arrived at the hospital, he had an ECG. A hospital doctor advised he needed to be transferred to another hospital via air ambulance. At 2.30pm, the hospital doctor told escort staff that Mr Bootle was still having a heart attack and hospital staff were administering treatment.
6. At 2.50pm, twenty minutes after escort staff were told Mr Bootle was still having a heart attack, a prison manager authorised the escort officers to remove the escort chain.
7. Mr Bootle's condition continued to deteriorate and a hospital doctor pronounced him dead at 4.03pm.

## Findings

8. Healthcare staff appropriately reviewed and monitored Mr Bootle for his complex medical conditions. He received a good standard of care, which was equivalent to that which he could have expected to receive in the community.
9. Mr Bootle was restrained when taken to hospital after suffering from a heart attack. Although he was conscious, he was frail, chronically unwell and experiencing a medical crisis. The use of an escort chain was not clearly justified and it is a matter of particular concern that the escort chain was not removed for the ECG, or even when he was having a heart attack.

## Recommendations

- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that risk assessments show clear justification for the use of restraints.

- The Executive Director of the long term and high security estate should assure himself that the Governor takes effective action to address the continuing inappropriate use of restraints at HMP Isle of Wight.

## The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Isle of Wight informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
11. The investigator obtained copies of relevant extracts from Mr Bootle's prison and medical records.
12. NHS England commissioned a clinical reviewer to review Mr Bootle's clinical care at the prison.
13. We informed HM Coroner for Isle of Wight of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
14. The investigator wrote to Mr Bootle's next of kin to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.
15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

## Background Information

### HMP Isle of Wight

16. HMP Isle of Wight is an amalgamation of two prisons, Parkhurst and Albany, and holds approximately 1,100 men, mostly convicted of sex offences. Care UK provides healthcare services at the prison. There is a healthcare inpatient unit at the Albany site, providing 24-hour care for prisoners with a wide range of health needs. The inpatient unit includes special facilities for end of life care.

### HM Inspectorate of Prisons

17. The most recent inspection of HMP Isle of Wight was in June 2015. Inspectors reported that health services were good, the inpatient unit provided compassionate care to men with complex needs and prisoners with palliative and end of life needs received excellent care.

### 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 their latest annual report, for the year to 31 December 2016, the IMB said that it continued to be impressed by the standard of healthcare provided by Care UK. However, they were concerned about prisoners blocking beds in the inpatient healthcare unit, as cell doors were not wide enough for wheelchair users.

### Previous deaths at HMP Isle of Wight

19. Mr Bootle is the fifth prisoner to die of natural causes at Isle of Wight since January 2017. This is the ninth time we have made a recommendation about unjustified use of restraints since January 2013.

## Key Events

20. On 1 July 2016, Mr Gary Bootle received an 18 year sentence for sexual offences and was sent to HMP Norwich.
21. Mr Bootle was diabetic and had heart failure. Prior to going into prison, Mr Bootle was admitted to hospital for treatment for diabetic ketoacidosis (too much acid in the blood stream). A letter from the hospital stated that his prognosis was poor due to severe heart failure and he was at increased risk of a heart attack. The letter also noted he had an acute kidney and liver injury.
22. Mr Bootle saw healthcare staff daily for medications and they reviewed him regularly for his diabetes and his blood pressure. Healthcare staff noted in his medical record that he struggled to maintain a healthy diet and would eat sugary snacks. Healthcare staff warned Mr Bootle of the risks of not eating a balanced diet but he ignored their advice.
23. On 15 August, a prison GP reviewed Mr Bootle. The prison GP noted he was in the end stages of heart failure and advised Mr Bootle to take two puffs of glycerol trinitrate (GTN) spray if he had chest pain (GTN spray is used to relieve the symptoms of angina/chest pain). If that did not resolve the pain, then he would need to go to hospital.
24. On 16 August, a prison GP had a frank discussion with Mr Bootle about his condition and whether resuscitation would be appropriate. Mr Bootle said he would have a discussion with his family. On 18 August, he signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order (which means that, in the event of cardiac or respiratory arrest, no attempt at resuscitation will be made. All other appropriate treatment and care would continue to be provided).
25. Mr Bootle did not have any significant interactions with healthcare staff from August to March 2017.
26. On 15 March 2017, Mr Bootle was moved to HMP Isle of Wight and was located in the inpatient healthcare unit (IHU). When he arrived, a nurse reviewed him and noted that he had poor mobility and struggled to manage his own insulin. She told Mr Bootle that healthcare staff would see him daily to administer his insulin and to advise him on his diet. On 18 April, a nurse noted that Mr Bootle was coping with his diabetes better with the support of healthcare staff. He was taking ownership of testing his blood sugar levels and administering his insulin. Mr Bootle was also mobilising around the ward better.
27. On 5 June, Mr Bootle complained of chest pain. A nurse gave Mr Bootle his GTN spray and aspirin and requested an emergency ambulance. Mr Bootle was admitted to hospital, where he had an angioplasty (a balloon is inserted into the artery and inflated to improve blood flow). The hospital doctor noted that the damage to his heart was serious. Mr Bootle was discharged from hospital and was sent back to the prison's IHU the following day.
28. On 22 June, Mr Bootle experienced chest pain again and was admitted to hospital. He had another angioplasty and a blood test indicated he had raised troponin levels (troponins are released into the blood when the heart is damaged).

A hospital doctor diagnosed that Mr Bootle had had a heart attack. Mr Bootle was discharged from hospital and was returned to the IHU on 1 July.

29. At about 1.10 pm on 1 December, Mr Bootle pressed his cell bell. An officer went to his cell and Mr Bootle said he had chest pain. He was pale and clammy. The officer immediately called a code blue (indicating that a prisoner is unconscious, not breathing or is having breathing problems), and the prison control room requested an ambulance. A nurse went straight to Mr Bootle's cell and asked if he had any pain. He said he did not. A nurse assisted him to sit up and he vomited.
30. An ambulance arrived at 1.20pm and paramedics took Mr Bootle to hospital, at 1.49pm. A prison manager authorised the use of an escort chain.
31. Mr Bootle arrived at the hospital at 2.05pm and he had an ECG. About ten minutes later, the hospital doctor advised he needed to be transferred to another hospital via air ambulance but he was too ill to travel. At 2.30pm, the hospital doctor informed escort staff that Mr Bootle was still having a heart attack and hospital staff were administering treatment
32. At 2.50pm, twenty minutes after escort staff were told Mr Bootle was having a heart attack, a prison manager authorised the escort officers to remove the escort chain.
33. Mr Bootle's condition continued to deteriorate and a hospital doctor pronounced him dead at 4.03pm.

#### **Contact with Mr Bootle's family**

34. The prison appointed an officer as the family liaison officer. She telephoned Mr Bootle's next of kin, his daughter, at about 3.20pm on 1 December. The officer explained that Mr Bootle was very unwell in hospital after having had a heart attack. The officer gave Mr Bootle's daughter the hospital telephone number so that she could get regular updates on Mr Bootle's condition.
35. The officer telephoned Mr Bootle's daughter to inform her of Mr Bootle's death. The officer offered Mr Bootle's daughter support and said she would ring again in a couple of days to discuss what happened next. The prison manager telephoned Mr Bootle's daughter that evening to offer his condolences and support. The officer offered on-going support.
36. Mr Bootle's funeral was held on 21 December. The prison contributed to the cost of the funeral in line with Prison Service policy.

#### **Support for prisoners and staff**

37. After Mr Bootle's death, the prison manager debriefed the staff involved in the bedwatch to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
38. The prison posted notices informing other prisoners of Mr Bootle'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 Bootle's death.

## Post-mortem report

39. The post-mortem report showed that Mr Bootle died from a cardiac arrest (heart attack) and ischaemic heart disease.

# Findings

## Clinical care

40. Mr Bootle was in poor health. He had diabetes, kidney and liver injury and end stage heart failure. He took various medications, for which healthcare provided support and reviewed him regularly. Mr Bootle's condition steadily deteriorated and he had two admissions to hospital for chest pain before having a heart attack on 1 December 2017.
41. We are satisfied that the clinical care Mr Bootle received while at Isle of Wight was equivalent to that which he could have expected to receive in the community. On arrival at Isle of Wight, healthcare staff completed a comprehensive assessment and made appropriate referrals to secondary services. Staff reviewed Mr Bootle regularly to provide comprehensive medical care of his chronic and complex conditions.

## Restraints

42. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. 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.
43. When Mr Bootle was taken to hospital as an emergency on 1 December, the risk assessment showed he was considered a normal level of risk of escape, hostage taking and to hospital staff. The prison considered him a high risk to prison staff and the general public. The medical section of the report was blank. Mr Bootle was an enhanced prisoner and there was no intelligence to suggest his behaviour was poor or aggressive. The prison manager authorised an escort chain to be used and if Mr Bootle's condition improved, double cuffs were to be applied.
44. Mr Bootle was in the final stages of heart failure and his condition was poor. He used a walking stick to mobilise. The risk assessment did not show clear justification for the use of restraints, given Mr Bootle's condition. It is difficult to understand how the decision was made to use restraints on a frail, unwell man, but it is simply unacceptable that the restraints were not removed for another twenty minutes after escort staff were told that he was still having a heart attack, and 35 minutes after being told he needed to be airlifted to another hospital. There could not have been a clearer indication to escorting staff that he was critically unwell and any risk he might have conceivably posed of escape or to the public was at an absolutely residual and manageable level.
45. The Prison Service has a responsibility to protect the public, but security must be balanced with humanity and measures must be proportionate to a prisoner's

individual circumstances. The High Court judgement set out very clearly the conditions, which need to be met to justify the use of restraints and it is hard to see that they were appropriately considered.

46. It is the Governor's responsibility to ensure that the process is managed properly, and all prison managers need to show a clear justification for any use of restraints when carrying out the risk assessment. We are troubled that this is the ninth time since 2013 that we have expressed concern about the inappropriate use of restraints on prisoners at Isle of Wight. Given the prison's failure to introduce effective measures to address our concerns, we make the following recommendations:

**The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that risk assessments show clear justification for the use of restraints.**

**The Executive Director of the long-term and high security estate, should assure himself that the Governor takes effective action to address the inappropriate use of restraints at HMP Isle of Wight.**

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