Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Thomas Mitchell a prisoner at HMP Bullingdon on 8 April 2019

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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

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 Thomas Mitchell died of pneumonia caused by a stroke in hospital on 8 April 2019, while a prisoner at HMP Bullingdon. He was 64 years old. I offer my condolences to Mr Mitchell's family and friends.

Mr Mitchell was a frail man, with poor health and reduced mobility. Healthcare staff appropriately managed his many chronic conditions.

I am concerned that when Mr Mitchell became unwell in his cell at Bullingdon, staff were confused about how to deal with a medical emergency.

I am also concerned that, despite Mr Mitchell's very poor health and mobility and the fact that he was considered to pose a low risk, he was restrained with double hand cuffs on his way to hospital and with an escort chain at hospital, including when he was unconscious after an operation.

In March 2019, Bullingdon told us they were taking action in response to a previous recommendation we had made about the inappropriate use of restraints. It is, therefore, very disappointing that Mr Mitchell was also inappropriately restrained and I am escalating this issue to the Prison Group Director for Central South Prisons to ensure that meaningful action is taken to address this unsatisfactory state of affairs.

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 **October 2019**

Contents

Summary

Events

1. On 10 February 2012, Mr Thomas Mitchell received an indeterminate sentence for public protection. He spent time in a number of prisons and was transferred to HMP Bullingdon on 22 February 2019.

2. Mr Mitchell had a complex medical history: he had Type 2 diabetes, Bowen's disease (an early form of skin cancer), pancreatitis, thrombosis, gallstones, and bone disease in his right leg. He used a walking stick and needed a lot of medication to manage his conditions.

3. Healthcare staff developed care plans to manage his conditions. They reviewed him frequently and adjusted his medication, as necessary.

4. On 21 March, Mr Mitchell became unwell in his cell. He was coughing up blood. Prison staff escorted him to hospital in a taxi.

5. Mr Mitchell's condition did not improve and he remained in hospital, where he died on 8 April.

Findings

6. The clinical reviewer concluded that the care that Mr Mitchell received was equivalent to that which he could have expected to receive in the community.

7. Healthcare staff provided a good standard of support and prompt and responsive primary care.

8. We share the clinical reviewer's commendation of the Head of Healthcare for intervening and preventing Mr Mitchell from returning to Bullingdon when he was unresponsive and needed palliative care.

9. However, when Mr Mitchell became unwell in his cell on the night of 21/22 March, staff did not follow prison procedures for transferring a prisoner to hospital. Although an emergency radio code was appropriately called, the control room did not call for an ambulance. Due to poor record keeping, there are conflicting accounts about what happened from the time Mr Mitchell was found unwell in his cell until he was transferred to hospital.

10. We are concerned that prison staff only notified Mr Mitchell's family of his condition after he had been seriously ill in hospital for eight days.

11. When Mr Mitchell was taken to hospital, he was restrained with double handcuffs and then with an escort chain in hospital, including when he was unconscious after an operation. Mr Mitchell was a Category C prisoner, considered to be a low risk of escape and to others, in very poor health and with poor mobility. We are not satisfied that prison staff took Mr Mitchell's medical condition and his lack of mobility into account when they assessed his risk and concluded he needed to be restrained.

12. We are particularly concerned that we had identified the same issue in a previous investigation into a death at Bullingdon and had been told that relevant staff would be reminded of the legal position in March 2019. It is clear from our interviews with staff in May 2019 that these reminders had not been effective.

13. We consider that it is important for staff who were involved in Mr Mitchell's care to see the findings of and learn lessons from our investigation.

Recommendations

- The Governor should ensure that control room staff call an ambulance as soon as an emergency code is called.
- The Governor and Head of Healthcare should ensure that during an emergency response, all staff maintain accurate and contemporaneous records of events, issues, concerns and action taken.
- 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 and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.
- The Head of Healthcare should ensure that all relevant healthcare staff receive training in how to complete escort risk assessments for patients going to hospital.
- The Prison Group Director for South Central Prisons should satisfy himself that effective measures have been taken to address Bullingdon's continuing failure to comply with case law on the use of restraints.
- The Governor should ensure that:
  - a prisoner's next of kin is informed when a prisoner is admitted to hospital seriously ill; and
  - a family liaison officer is appointed promptly in these circumstances.
- The Governor and Head of Healthcare should ensure that any staff named in this report are given the opportunity to read the report at the draft stage in line with paragraph 1.11 of PSI 58/2010.

The Investigation Process

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

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

16. The investigator interviewed six members of staff at Bullingdon on 14 and 15 May 2019. NHS England commissioned a clinical reviewer to review Mr Mitchell's clinical care at the prison. The investigator and clinical reviewer jointly interviewed staff.

17. We informed HM Coroner for Oxfordshire of the investigation. He gave us the cause of death. We have sent the Coroner a copy of this report.

18. One of the Ombudsman's family liaison officers contacted Mr Mitchell's son, to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond.

19. 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 Bullingdon

20. HMP Bullingdon is a training and local prison, serving the courts of Oxfordshire and Berkshire. It holds approximately 1,100 prisoners. Care UK provides healthcare services and Cotswold Medicare Ltd provides general practitioner services. There is an inpatient healthcare unit, with 24-hour nursing care.

HM Inspectorate of Prisons

21. The most recent inspection of Bullingdon was conducted in May 2017. Inspectors found that the management of prisoners with long-term conditions had deteriorated since the previous inspection. They noted that nurse-led clinics were limited to a diabetic clinic, triage and discharge clinics, and that not all nurses were adequately trained in nurse triage. The assistant practitioner held a phlebotomy clinic and undertook regular observations for prisoners with long-term conditions. However, inspectors noted that there was good attendance at primary care clinics, and waiting lists were in line with those in the community. They found that GP provision was appropriate and waiting times for routine appointments were acceptable. They noted that allocated daily slots ensured that emergency appointments were available. Inspectors found that while a 24-hour nursing service was provided, the NHS 111 telephone line was accessed appropriately for medical support.

Independent Monitoring Board

22. 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 most recent annual report for the year to 30 June 2018, the IMB noted that improved facilities in the prison had reduced the need for prisoners to receive treatment outside the prison. They noted that this meant that prisoners were treated more quickly, and that officers did not have to leave the prison on escort duty. They reported that staff levels had also been increased but the IMB noted that it would take time to build up the experience and knowledge lost as a result of previous staff cuts.

Previous deaths at HMP Bullingdon

23. Mr Mitchell was the ninth prisoner to die at HMP Bullingdon since April 2017, and there has been one death at the prison since Mr Mitchell's. Four of these deaths were from natural causes, and five were self-inflicted. One prisoner took his life two days before Mr Mitchell died and another died from natural causes after Mr Mitchell's death. Both deaths remain under investigation.

24. In an investigation into the death of a prisoner in September 2018, we found that restraints were used inappropriately when he was taken to hospital. We recommended that 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 and that assessments take the prisoner's health into account and are based on the actual risk the prisoner presents at the time. We also recommended that the Governor should revise the prison's escort

risk assessment form to make it clearer to prison and healthcare staff what is required. The prison accepted these recommendations and told us that all relevant staff would be reminded of the legal position on the use of restraints in March 2019, that healthcare staff would receive training in May 2019 on how to complete risk assessments, and that the risk assessment form would be revised by the end of April.

Key Events

25. On 10 February 2012, Mr Thomas Mitchell was convicted of sexual offences and received an indeterminate sentence of Imprisonment for Public Protection (IPP) with a minimum term of 10 years before parole could be considered. He spent time in a number of prisons. On 11 January 2018, he was transferred to HMP Bullingdon, and was then transferred to HMP Grendon on 27 September 2018, before he returned to Bullingdon on 22 February 2019.

26. Mr Mitchell had a complex medical history, including Type 2 diabetes, Bowen's disease (an early form of skin cancer), pancreatitis, thrombosis, gallstones, bone disease in his right leg. He used a walking stick and later a wheeled Zimmer frame as well.

27. At an initial health screen, a nurse noted that Mr Mitchell needed several medications to manage his conditions. She arranged for him to see a GP. A prison GP prescribed his medication.

28. Throughout his time in prison, doctors prescribed medications for pain relief, to prevent infections and to control his illnesses. Healthcare staff monitored Mr Mitchell and checked on him frequently.

Events from 21 March 2019

29. At approximately 11.10pm on 21 March, an Operational Support Grade (OSG) noted that Mr Mitchell had pressed his cell bell. When she opened the cell door observation panel, she saw that Mr Mitchell was standing in his cell and had vomited blood clots. Mr Mitchell said that he needed to see the healthcare team. She immediately radioed a medical emergency code red, which indicates that a prisoner has lost blood. She said that duty managers and officers arrived and entered the cell while she remained outside.

30. A Custodial Manager (CM), the night duty manager, heard the OSG's emergency radio call. On the way to Mr Mitchell's cell, he met a nurse and together they went to Mr Mitchell's cell. He opened the door (as he was the first person on scene with a key). He told the investigator that Mr Mitchell looked pale and he saw small pools of blood on the floor. He said that as Mr Mitchell "wasn't any kind of physical threat to anyone" he let the nurse examine Mr Mitchell in the cell while he and the other staff waited outside the cell.

31. The nurse said she heard the emergency radio call and waited for the CM to collect her and escort her to Mr Mitchell's cell. She took the emergency medical bag. She saw Mr Mitchell was moving around in his cell using his Zimmer frame. There was blood on the floor – at interview she said there was a lot of blood which had clotted and looked like diced liver - and Mr Mitchell told her that he had diarrhoea and had vomited blood. He was alert and mobile and said that he felt "ok". He also said that this had happened to him before and that on that occasion he had been taken to hospital for a blood transfusion. She said that he needed to go to hospital in an ambulance and asked someone to get a wheelchair.

32. The nurse said that she wheeled Mr Mitchell to the healthcare inpatient unit. She checked his observations which were all within normal range, and told him that she was going to complete the paperwork for him to go to hospital. She left him in the treatment room with officers as she did so, and estimated that they took him to reception in a wheelchair approximately 45 minutes later.

33. The nurse said that an ambulance was not called after the code red call. She said that an ambulance would be called automatically for a code blue, but in the case of a code red, officers often waited until the duty nurse had completed an assessment before calling for an ambulance because a code red normally meant that a prisoner had self-harmed. (The Head of Healthcare also confirmed that this was the practice at the prison.)

34. The nurse said on this occasion, the duty manager called for the ambulance after she had assessed Mr Mitchell and concluded that he needed to go to hospital. She recorded in Mr Mitchell's medical notes that he had been taken to A&E by ambulance.

35. The CM said that he did not ask for an ambulance when the code red was called as he wanted the nurse to assess the situation and advise if an ambulance or taxi was necessary. He said that although the control room should call an ambulance automatically in the case of a code blue, this was not the case with a code red. He could not remember if he called an ambulance or a taxi, but said he would have acted on the nurse's advice. He said that they took Mr Mitchell to reception in a wheelchair as "he looked … a fairly immobile chap".

36. The Ambulance Service confirmed they were not contacted by the prison.

37. An officer told the investigator that she heard the emergency code red call and went to Mr Mitchell's cell. She said that the nurse was already there and had said that Mr Mitchell needed to go to hospital. She did not know who made the decision to call a taxi or who contacted the taxi company but thought it would have been the CM.

Risk assessment

38. The nurse said that she completed the medical section of the escort risk assessment. She indicated that there were no medical objections to the use of restraints for Mr Mitchell, that his medical condition did not restrict his ability to escape unaided and it was an essential appointment. She also noted that Mr Mitchell had reduced mobility and used a Zimmer frame or walking stick.

39. The investigator asked why she had indicated that Mr Mitchell's medical condition did not restrict his ability to escape when she had also said that he had reduced mobility. She said that her understanding of the escort risk assessment procedure was that every prisoner left the prison handcuffed unless there was some physical reason why this was not possible (such as a fractured hand). (The Head of Healthcare said this was also her understanding.)

40. The CM completed the rest of the risk assessment. He concluded that Mr Mitchell's risk to the public, to hospital staff, of hostage taking, and escape potential were low. He authorised officers to double cuff Mr Mitchell. (This means that a prisoner's hands are handcuffed in front of him and one wrist is attached to

a prison officer by an additional set of handcuffs.) He said as Bullingdon is a Category B prison, this is the default position for prisoners leaving the prison, irrespective of the prisoner's security category. Mr Mitchell's Category C status was, therefore, "pretty irrelevant". He said that he also took into account that a nurse had said there was no medical objection to the use of cuffs. He said that, although he had described Mr Mitchell as "fairly immobile" on the basis of what he had seen of him that night, he did not know Mr Mitchell and "ultimately, the security of the escort is paramount".

41. The Head of Residence said that he was not involved in the risk assessment when Mr Mitchell was taken to hospital. However, he described "the standard cuffing arrangements" at Bullingdon as double cuffs, which he said would be removed and replaced with an escort chain once the prisoner was secure in a hospital side room. (An escort chain is a long length of chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.)

42. The officer said that she was one of the two escorting officers. She collected the escort bag and handcuffs for Mr Mitchell for the journey. Mr Mitchell was in his cell and they took him to reception when the taxi arrived. She thought this was perhaps 20-25 minutes after she responded to the code red. She said that Mr Mitchell used a walking stick and the two officers escorted him, double cuffed, in the taxi to hospital.

43. When they arrived at the A&E department of the hospital, they took Mr Mitchell to reception in a wheelchair and explained that he had had diarrhoea and had had quite a severe loss of blood. They sat in the waiting area for about 45 minutes. They were then taken through to see a nurse and then waited in the waiting room again. Mr Mitchell continued to have diarrhoea and had to use the toilet a lot. He remained in double cuffs, although an escort chain was used when he used the toilet.

44. When hospital staff admitted Mr Mitchell to hospital some time before 8.00am on 22 March, the escort staff replaced the double handcuffs with an escort chain.

Events in hospital

45. Hospital doctors diagnosed an upper gastro-intestinal bleed. Mr Mitchell remained in hospital and his condition deteriorated over the next two weeks.

46. On 23 March, the bedwatch log recorded that he "visited the toilet with nurse assistance" and then walked slowly back to his bed. On 26 March, the log recorded that Mr Mitchell was "being violently sick in bed" and had been given an intravenous painkiller and morphine injection.

47. On 27 March, the escort officer noted in the bedwatch log that Mr Mitchell had vomited approximately five litres of blood and had had an operation. The escorts obtained permission from a prison manager and the restraints were removed for the operation and then reapplied "in the recovery room before waking from anaesthetic".

48. On 29 March, the bedwatch log recorded that Mr Mitchell was "rude to hospital staff when trying to help him" and that he "has displayed a poor attitude, woke up

confused, was very unsteady on his feet and was unable to wash himself". (Earlier escort records had described him as "polite and respectful".)

49. On 30 March, the escorts recorded that the Head of Residence had authorised the removal of the restraints "due to [Mr Mitchell's] condition". On 31 March, at the start of a new bedwatch shift at 7.00am, the new escorts noted in the bedwatch log that "no name of Governor asked why he has no restraints on. Comms spoken to Oscar 1 CM who has told the escort to apply an escort chain." At 8.15am, the Head of Residence told the escorts the handcuffs could be removed after he was told that Mr Mitchell had had some kind of stroke and was critically ill. The restraints were never reapplied.

50. On 2 April, it was recorded that Mr Mitchell remained unresponsive and that only palliative care would be provided.

51. On 4 April, hospital staff considered sending Mr Mitchell back to Bullingdon for palliative care. However, after representations from the Head of Healthcare that his transfer would be undignified, it was agreed he should remain in hospital. Mr Mitchell died at 6.35am on 8 April.

Contact with Mr Mitchell's family

52. On 30 March, hospital staff contacted Mr Mitchell's son and discussed him visiting his father. On 31 March, the prison appointed a case administrator in the Offender Management Unit, as the family liaison officer. She contacted Mr Mitchell's sons on 1 April to tell them their father had had a stroke and met them at the hospital to offer support.

53. When Mr Mitchell died, the prison family liaison officer telephoned his son to break the news and offer her condolences and support by telephone, as previously agreed. Bullingdon arranged and paid for Mr Mitchell's funeral, which was held on 24 April 2019.

Support for prisoners and staff

54. After Mr Mitchell's death, a prison manager debriefed the escorting officers to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

55. The prison posted notices informing other prisoners of Mr Mitchell'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 Mitchell's death.

Cause of death

56. The Coroner established that Mr Mitchell had died of bronchopneumonia caused by a cerebrovascular infarction (a stroke). Mr Mitchell also had chronic pancreatitis and a variceal haemorrhage (bleeding from abnormal blood vessels in the oesophagus) which contributed to but did not cause his death.

Findings

Clinical care

57. The clinical reviewer said that the care that Mr Mitchell received at Bullingdon was of a standard equivalent to that which he could have expected to receive in the community.

58. The clinical reviewer commended the Head of Healthcare at the prison for intervening and preventing Mr Mitchell from returning to Bullingdon when he was unresponsive and needed palliative care. We agree.

59. However, the clinical reviewer identified two concerns, which we share:

- the slow response in transferring Mr Mitchell to hospital; and
- the lack of records to explain the decisions to take Mr Mitchell to hospital in a taxi and to use double handcuffs.

Emergency response

60. PSI 03/2013 on medical emergency response codes requires governors to have a medical emergency response code protocol (normally red for bleeding and burns, and blue for breathing difficulties and collapses) to ensure that prisons call an ambulance immediately in a life-threatening medical emergency. The PSI explicitly states that control room staff should automatically call an ambulance whenever an emergency code is called and that it is not necessary for a member of the prison healthcare team or a duty manager to attend the scene before emergency services are called.

61. When an OSG called an emergency code red, the control room should have called for an ambulance immediately. This did not happen and the Ambulance Service confirmed that an ambulance was never called. Instead, Mr Mitchell was taken to hospital in a taxi about 45 minutes after the code red was called.

62. We are concerned that both prison and healthcare staff at Bullingdon believe that it is not necessary for an ambulance to be called automatically in response to a code red. This is not in line with Prison Service policy set out in the PSI.

63. The clinical reviewer said that although Mr Mitchell appeared stable at the time, given the amount of blood that was described by a nurse and prison staff, she considered that the situation required a faster response and that an ambulance should have been called to transfer Mr Mitchell to hospital as soon as possible.

64. While the failure to call an ambulance immediately is unlikely to have affected the outcome for Mr Mitchell, a delay of this kind could be critical in other emergencies.

65. We make the following recommendation:

The Governor should ensure that control room staff call an ambulance as soon as an emergency code is called.

66. Despite checking the records and interviewing staff, we cannot confirm the sequence of events after staff responded to the code red and arrived at Mr Mitchell's cell. A CM and an officer said that Mr Mitchell left his cell, went to reception and then left for the hospital. He could not recall if he went in a taxi or an ambulance. A nurse said that she took Mr Mitchell to the healthcare unit in a wheelchair to check his observations and that he left the prison in an ambulance after approximately 45 minutes.

67. It appears that the night orderly officer, a CM, made the decision to call a taxi rather than an ambulance, although he said he would have made this decision on the basis of advice from the nurse. However, the nurse told us that she asked for Mr Mitchell to be taken to hospital by ambulance and she recorded in his medical notes at the time that this is what had happened.

68. We found that there were no entries in the control room log to confirm who was contacted and how transport was arranged. These events highlight the importance of accurate record keeping. We therefore recommend:

The Governor and Head of Healthcare should ensure that during an emergency response, all staff maintain accurate and contemporaneous records of events, issues, concerns and action taken.

Restraints, security and escorts

69. 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.

70. 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.

71. We are concerned that staff did not conduct a proper assessment of Mr Mitchell's risk, taking his medical condition into account, as required by the High Court judgement. Too much weight was given to Mr Mitchell's original offences rather than his actual risk at the time.

72. We do not consider that it was appropriate to use double handcuffs on Mr Mitchell when he was taken to hospital. It appears that staff mistakenly believe that any prisoner leaving Bullingdon to go to hospital must be double cuffed, regardless of their security category or the state of their health. Double cuffing is usually required for moving Category A or Category B prisoners in good health. Mr Mitchell was a seriously ill Category C prisoner, with very poor mobility, assessed as a low risk of escape and a low risk of harm to others. It is difficult to see how the escort risk assessment could conclude that he had the ability to escape unaided from two escort officers.

73. We are also concerned that when Mr Mitchell was in hospital, he was restrained using an escort chain for more than a week although he was seriously ill and his mobility was very poor. We are particularly concerned that although the escort chain was removed when he had an operation, it was reapplied while he was unconscious in the recovery room. It is very difficult to understand why prison staff thought this was justified for a seriously ill and immobile category C prisoner.

74. What makes this particularly worrying is that we had found the same issue in a previous investigation and that Bullingdon had told us in response that all relevant staff would be reminded of the legal position on the use of restraints in March 2019. Despite this, Mr Mitchell was inappropriately restrained in late March 2019, and it is clear from our interviews with the CM and the Head of Residence in May 2019 that they still thought that the use of double cuffs was "standard". The reminders that were apparently issued in March about the inappropriate use of restraints do not appear to have been effective.

75. We had also been told that healthcare staff would receive training on escort risk assessments in May 2019. However, when we interviewed a nurse and the Head of Healthcare in May, this training had not taken place and there were no immediate plans for it.

76. We, therefore, make the following recommendations in the hope that meaningful action will now be taken to address this issue at Bullingdon:

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 and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Head of Healthcare should ensure that all relevant healthcare staff receive training in how to complete escort risk assessments for patients going to hospital.

The Prison Group Director for South Central Prisons should satisfy himself that effective measures have been taken to address Bullingdon's continuing failure to comply with case law on the use of restraints.

Liaison with Mr Mitchell's family

77. Prison Rule 22 says that if a prisoner dies or becomes seriously ill, the governor shall inform the prisoner's spouse or next of kin at once. PSI 64/2011 on safer custody says that prisons must ensure that arrangements are in place for an appropriate member of staff to engage with the next of kin of prisoners who are terminally or seriously ill.

78. When Mr Mitchell was taken to hospital on 22 March, he was seriously ill and his condition deteriorated over the following days. We consider that the prison should have informed his family that he had been admitted to hospital and was seriously ill on 22 March - or at the very latest on 27 March when he needed an operation. We also consider that the prison should have appointed a family liaison officer at this point.

79. Mr Mitchell's family were not told that he was in hospital until 30 March, when hospital staff contacted his son. The bedwatch log recorded that the duty governor had given permission for the family visit. By this time Mr Mitchell was very seriously ill. We make the following recommendation:

The Governor should ensure that:

- **a prisoner's next of kin is informed when a prisoner is admitted to hospital seriously ill; and**
- **a family liaison officer is appointed promptly in these circumstances.**

Sharing of PPO reports

80. We consider that it is important for staff who were involved in Mr Mitchell's care to see the findings of and learn lessons from our investigation. We make the following recommendation:

The Governor and Head of Healthcare should ensure that any staff named in this report are given the opportunity to read the report at the draft stage in line with paragraph 1.11 of PSI 58/2010.

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