

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Christopher Carroll a prisoner at HMP Preston on 21 November 2018

**A report by the Prisons and Probation Ombudsman**

## 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 Christopher Carroll died in hospital on 21 November of a heart attack, probably due to gastrointestinal bleeding, while a prisoner at HMP Preston. He was 55 years old. I offer my condolences to Mr Carroll's family and friends.

Mr Carroll had a number of pre-existing health conditions when he arrived at Preston two weeks before his death. I am satisfied that, overall, the care he received at Preston was equivalent to that which he could have expected to receive in the community.

However, I am concerned that when Mr Carroll was taken to hospital, the healthcare input into the escort risk assessment was inadequate and that there is no evidence that the authorising manager took into account Mr Carroll's health and mobility at the time.

I am also concerned that the prison did not contact Mr Carroll's family when his condition deteriorated in hospital. The prison did not contact his family until after Mr Carroll had died, which was unacceptable.

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**

**July 2019**

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# Summary

## Events

1. On 8 November 2018, Mr Christopher Carroll was remanded in custody charged with having a bladed article and attempted grievous bodily harm. He was sent to HMP Preston. Mr Carroll had several long-term health conditions and was also a heavy drinker.
2. On 19 November, a healthcare support worker went to see Mr Carroll. She noted a strong smell of urine and was concerned that he was struggling to maintain his personal hygiene. Later that day, staff decided to admit Mr Carroll to the healthcare inpatient unit for a period of assessment and observation.
3. On 20 November, a member of healthcare staff went to see Mr Carroll, who showed her a blood-stained incontinence pad. Healthcare staff requested a non-urgent ambulance and at 9.30am, Mr Carroll was taken to hospital. Two prison officers accompanied him and he was restrained using double cuffs.
4. After arriving at hospital, Mr Carroll's condition deteriorated rapidly. At 8.05pm, hospital doctors had to resuscitate Mr Carroll after his heart stopped. He was moved to the Intensive Care Unit and put into an induced coma. At 9.40pm, a hospital nurse contacted Mr Carroll's next of kin. On 21 November, Mr Carroll's life support was turned off and at 12.30am, he was pronounced dead.

## Findings

5. The clinical reviewer found that overall, Mr Carroll's care was of a good standard and was equivalent to that which he could have expected to receive in the community.
6. However, she found that on Mr Carroll's admission to the inpatient unit at Preston, staff did not take his clinical observations or complete a National Early Warning System score (NEWS – a tool used to identify clinical deterioration in adult patients) as they should have done.
7. The clinical reviewer also identified that Mr Carroll did not have any blood tests taken on his second day in prison, contrary to the prison's guidelines on the clinical management of prisoners with alcohol dependence.
8. We are concerned that when Mr Carroll was taken to hospital, healthcare input to the escort risk assessment was inadequate and there is no evidence that the authorising manager took Mr Carroll's health into account when deciding the cuffing arrangement.
9. We are also concerned that the prison did not contact Mr Carroll's family when his health deteriorated significantly after his arrival at hospital.

## Recommendations

- The Head of Healthcare should ensure that all healthcare staff are aware of and follow the admissions policy to the prison's inpatient unit, including the need for

clinical observations to be taken and a NEWS score to be completed on admission

- The Head of Healthcare should ensure that clinical staff follow the internal guidelines for the clinical management of adult alcohol dependence, including carrying out blood tests as specified.
- 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 Governor should revise the prison's escort risk assessment form to ensure that it requires:
  - healthcare staff to say whether the prisoner's current state of health has an impact on his mobility; and
  - prison staff to show that they have taken this information into account in assessing the prisoner's current level of risk.
- The Governor should ensure that staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill.

## The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Preston informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
11. The investigator interviewed two members of staff by telephone on 10 January 2019.
12. NHS England commissioned a clinical reviewer to review Mr Carroll's clinical care at the prison.
13. We informed HM Coroner for Preston of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
14. Ms Portlock contacted Mr Carroll's daughter to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Carroll's daughter asked:
  - whether anything could have been done to prevent Mr Carroll's death; and
  - what clinical protocols and procedures are in place for prisoners with medical problems?

We have addressed these questions in this report.

15. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.
16. The initial report was shared with Mr Carroll's family. The family reported one minor factual inaccuracy which has now been corrected.

# Background Information

## HMP Preston

17. HMP Preston is a Category B local prison serving the courts in Lancashire and Cumbria. It holds up to 811 adult male prisoners.
18. Lancashire Care NHS Foundation Trust provides primary healthcare services 24 hours a day, seven days a week. GPs provide daytime cover between 8.00am and 9.00pm Monday to Friday and 3.00pm to 5.30pm on Saturdays. Outside of these hours a Registered General Nurse is on duty. An out of hours service is provided by GTD Healthcare.
19. Preston is a regional healthcare facility taking patients from other prisons. The facility has a ten-bed physical care inpatient unit with two three-bed dormitories and four single cells. Palliative care is provided within that setting.

## HM Inspectorate of Prisons

20. The most recent inspection of HMP Preston was in March 2017. Inspectors noted that healthcare provision had deteriorated. Care for prisoners with long term conditions was inconsistent and care plans were inadequate. Inspectors found that the standard of care in the inpatient unit was generally good.

## Independent Monitoring Board

21. 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.
22. In its latest annual report for HMP Preston, for the year to 31 March 2018, the IMB reported that healthcare provision had significantly improved since the current provider assumed responsibility in April 2017. Healthcare services were accessible to prisoners, with all initial healthcare needs being assessed within twenty-four hours of reception. The average waiting time to see a GP was four days. The Board welcomed the improvements but were disappointed to see an increase in applications about healthcare, which raised some concerns.

## Previous deaths at HMP Preston

23. Mr Carroll was the 10th prisoner to die at Preston since March 2015. Of the previous deaths, eight were from natural causes and one prisoner took his own life. There were no similarities between Mr Carroll's death and previous deaths at Preston.

## Key Events

24. On 8 November 2018, Mr Christopher Carroll was remanded in custody charged with having a bladed article and attempted grievous bodily harm. He was sent to HMP Preston.
25. A nurse completed the reception health screen. She noted that Mr Carroll had a number of chronic health conditions, including heart disease, diabetes and arthritis. He also had poor mobility due to arthritis and an old ankle injury. She noted that Mr Carroll had recently had a colonoscopy and polyp removal (a colonoscope is a thin, flexible tube with a camera at the end that is used to look inside the bowel and remove small growths called polyps), which had resulted in considerable blood loss and a blood transfusion. She also noted that he had outstanding hospital appointments to treat haemorrhages from his rectum (back passage). Mr Carroll told the nurse that he was a heavy drinker and drank more than ten units of alcohol a day.
26. On the same day, Mr Carroll was seen by a prison GP. He prescribed Mr Carroll with medication for his health conditions. At the time of the assessment Mr Carroll was not showing any signs of alcohol withdrawal but, because of his history of alcohol abuse, the prison GP decided that he should undergo an alcohol detoxification programme. This programme started on 8 November and included a short course of medicine called chlordiazepoxide (a sedative used to help ease withdrawal symptoms and anxiety).
27. On 9 November, a nurse completed Mr Carroll's secondary health screen. The nurse noted that he was showing some signs of alcohol withdrawal for which he was given diazepam (used to treat alcohol withdrawal and anxiety).
28. Over the next week, healthcare staff monitored and reviewed Mr Carroll frequently. A referral was sent to the community drug and alcohol service, and the admin team arranged an outpatient follow up appointment for Mr Carroll at a hospital to monitor previous haemorrhages from his back passage.
29. On 16 November, a prison officer told a healthcare support worker, that Mr Carroll was struggling to meet his personal hygiene needs. She made a social care referral to Lancashire County Council and an interim plan was agreed of two half hour visits twice a week starting on 19 November.
30. On 19 November, a healthcare support worker went to see Mr Carroll for his first social care session. On arrival, she noted a strong smell of urine. Mr Carroll said that he did not want a shower but would have a wash instead.
31. Later that day, the healthcare support worker, discussed Mr Carroll with a prison GP, and a clinical manager. They decided that he should be admitted to the prison's healthcare unit for a period of assessment and observation. Mr Carroll did not meet the normal criteria for admission to the inpatient unit but, as he was waiting for a bowel operation, they decided it was appropriate.
32. On 20 November, at 8.50am, the healthcare support worker, saw Mr Carroll for a review and he showed her a blood-stained incontinence pad. This was the first time Mr Carroll had reported any bleeding. She took his observations. His pulse

was slightly raised at 101bpm (a normal resting heart rate for adults ranges from 60 to 100 beats per minute) and he had a National Early Warning System (NEWS) score of 4. (NEWS is a tool used to assess clinical deterioration in adult patients – a score of 4 indicates medium clinical risk.)

33. The healthcare support worker, reported her findings to the clinical manager who then requested a non-urgent ambulance. Paramedics arrived at 9.30am and took Mr Carroll to hospital. Two prison officers went with him and restrained him using double handcuffs (where the prisoner's hands are cuffed together in front of him and a second set of handcuffs is used to cuff one of the prisoner's wrists to the wrist of a prison officer).
34. On arrival at the hospital, Mr Carroll was given an electrocardiogram (ECG – to monitor the electrical rhythms of the heart) and had a series of blood tests. At 11.10am, his condition deteriorated. A prison manager agreed to the removal of double cuffs and authorised the use of an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to a prison officer). At 8.05pm, Mr Carroll's heart stopped. Prison staff removed the escort chain and doctors performed cardiopulmonary resuscitation (CPR). They managed to resuscitate Mr Carroll and he was moved to the Intensive Care Unit where he was placed on a ventilator and put into an induced coma. A hospital nurse contacted Mr Carroll's next of kin at 9.40pm.
35. On 21 November, Mr Carroll's life support was turned off and at 12.30am, he was pronounced dead. His son and daughter were at his bedside.

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

36. On 21 November, a prison manager was appointed as family liaison officer (FLO). At 1.30pm, the FLO contacted the family by phone to offer support and to discuss the funeral arrangements.
37. The FLO provided ongoing support to Mr Carroll's family. The funeral took place on 12 December. No representative from the prison attended at the request of Mr Carroll's family. The prison contributed to the cost of the funeral, in line with national instructions.

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

38. After Mr Carroll's death, a prison manager debriefed the staff who had been at the hospital when Mr Carroll died to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
39. The prison posted notices informing other prisoners of Mr Carroll's death, and offered support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Carroll's death.

## Post-mortem report

40. The post-mortem report concluded that Mr Carroll died of acute myocardial ischaemia (insufficient blood flow to the heart), caused by coronary artery atheroma (narrowing of the arteries which restricts the flow of blood to the heart). Gastrointestinal haemorrhage (internal bleeding) and cirrhosis of the liver (poor liver function) were given as contributory factors.
41. The pathologist concluded that the gastrointestinal haemorrhage, which was possibly linked to the liver damage, was likely to have caused inadequate blood supply to the heart, which ultimately caused Mr Carroll's death.

# Findings

## Clinical Care

42. The clinical reviewer considered that Mr Carroll received good clinical care while at Preston, equivalent to that which he could have expected to receive in the community. She noted that staff put in place appropriate plans to support Mr Carroll's medical needs and that healthcare staff responded promptly and appropriately when there was a deterioration in his health.
43. When it was evident that he was experiencing incontinence, extra support was quickly put in place. In spite of this additional support, Mr Carroll still struggled to maintain his independence so he was admitted to the healthcare inpatient unit for further monitoring and support. This was agreed even though he did not meet the criteria for healthcare admission. This is an example of the good clinical care that Mr Carroll received.
44. However, when Mr Carroll was admitted to the healthcare inpatient unit two days before his death, a set of clinical observations and a NEWS score should have been completed in line with the admissions policy. We are concerned that neither was completed. Although it is not clear if this would have made any difference in Mr Carroll's case, Preston should ensure that all healthcare staff follow their admissions policy. We therefore make the following recommendation:

**The Head of Healthcare should ensure that all healthcare staff are aware of and follow the admissions policy to the prison's inpatient unit, including the need for clinical observations to be taken and a NEWS score to be completed on admission.**

45. The clinical reviewer also identified that the guidelines for the clinical management of adult drug and alcohol dependence at Preston says that blood tests should be taken on the day following admission to the detoxification unit, to screen for any underlying physical health issues. These blood results should be reviewed by a doctor. Records show that Mr Carroll did not have these blood tests. We therefore make the following recommendation:

**The Head of Healthcare should ensure that clinical staff follow the internal guidelines for the clinical management of adult alcohol dependence, including carrying out blood tests as specified.**

## Restraints, security and escorts

46. 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 considers 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 said 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.

47. When Mr Carroll was taken to hospital the day before his death he was restrained using the double cuffing method. (Mr Carroll was a category B prisoner and double cuffing is the standard level of restraint for this category of prisoner.) The risk assessment does not demonstrate that the authorising manager, took into account Mr Carroll's health or mobility at the time. He did not consider whether other options might have been more appropriate given Mr Carroll's state of health. There was also little input from healthcare staff who had simply ticked a box to say that they had no objection to the use of restraints.
48. When the authorising manager was interviewed he said that he did not go to see Mr Carroll to assess him, but completed the risk assessment based on the information that he had been given. He said that this was the normal procedure. We therefore 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 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 Governor should revise the prison's escort risk assessment form to ensure that it requires:**

- **healthcare staff to say whether the prisoner's current state of health has an impact on his mobility; and**
- **prison staff to show that they have taken this information into account in when assessing prisoners.**

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

49. Prison Rule 22 states that prisons should inform the next of kin immediately if a prisoner becomes seriously ill. Prison Service Instruction 64/2011, about safer custody, says 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. If a prisoner's health deteriorates a family liaison officer should be appointed immediately and next of kin should be contacted.
50. On 20 November, Mr Carroll was taken to hospital for further tests after he was found to be bleeding from his back passage. We accept that at that stage, prison staff did not know the seriousness of his condition and we consider it reasonable that they did not contact his family. However, after Mr Carroll's arrival at hospital, his health deteriorated rapidly. We are concerned that despite Mr Carroll being moved to the Intensive Care Unit, the prison did not appoint a family liaison officer and no contact was made with Mr Carroll's next of kin until after Mr Carroll had died. Although hospital staff contacted Mr Carroll's son and he was able to be with his father when he died, there is still a duty on the prison to liaise with the family when a prisoner becomes seriously ill. We therefore make the following recommendation:

**The Governor should ensure that staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill.**

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