Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Delroy Brown, a prisoner at HMP Swaleside, on 3 March 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*

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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 Delroy Brown died on 3 March 2019 of an abnormally fast heartbeat caused by heart disease, while a prisoner at HMP Swaleside. He was 50 years old. I offer my condolences to Mr Brown's family and friends.

I am satisfied that, overall, Mr Brown received appropriate clinical care while at Swaleside, which was equivalent to that which he could have expected to receive in the community.

However, I am concerned that when a prison GP asked for Mr Brown to be escorted to hospital in January 2019, he was not transferred because healthcare staff did not explain the urgency to prison staff. Five days later, Mr Brown collapsed and was taken to hospital as an emergency and he remained there for three weeks for treatment. Although the clinical reviewer is satisfied that this delay did not contribute to Mr Brown's death, this fell below the level of clinical care Mr Brown could have expected to receive in the community.

When Mr Brown was taken to hospital for the final time on 1 March 2019, healthcare staff did not provide information about his state of health to enable prison staff to make an informed decision about whether it was necessary to restrain Mr Brown. I am also concerned that the prison could not provide the escort risk assessments for six previous hospital admissions. We have previously drawn our concerns about the inappropriate use of restraints at Swaleside to the attention of the Executive Director for the Long-Term and High Security Estate, and I have done so again

It is disappointing that the prison did not provide all relevant documentation during the investigation. The Governor should ensure effective action is taken to ensure this does not happen again.

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 **November 2019**

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Summary

Events

1. Mr Delroy Brown was serving a life sentence for murder and had been in prison since 2008. He had been at HMP Swaleside since 2009.

2. Mr Brown had a complex cardiac history, including an enlarged heart, a leaking heart valve and heart failure. Between 2016 and 2019, he had numerous admissions to hospital for chest pain and breathlessness and had three pulmonary embolisms (blood clots in the lungs). Mr Brown declined to have a pacemaker implanted and his heart function steadily deteriorated.

3. Mr Brown did not take his medications, despite hospital and prison healthcare staff explaining the serious implications of not taking them.

4. On 11 January 2019, a prison GP spoke to a doctor at the local hospital because Mr Brown was vomiting, had chest pain and was breathless. The doctor told the GP to send Mr Brown to hospital for review. A member of healthcare staff asked the prison's duty manager to authorise an escort to accompany Mr Brown to hospital. The duty manager refused their request because he was told that an ambulance had not been called and that transfer to hospital was not an emergency.

5. Five days later, Mr Brown collapsed and was taken to hospital as an emergency. He spent three weeks in hospital. A hospital doctor told Mr Brown he had deteriorating heart failure and told him not to return to Accident and Emergency (A&E) unless he was being fully compliant with his medications.

6. Mr Brown continued to refuse his medications and blood tests.

7. On 1 March, Mr Brown was admitted to hospital with vomiting, swollen legs and breathlessness. He was restrained until the following evening.

8. On 2 March, a hospital doctor told Mr Brown his heart was beating out of rhythm which could cause significant complications. Mr Brown refused to have the medication to help regulate his heartbeat and said he understood this could have fatal consequences. However, he accepted the medication later that evening and his symptoms improved.

9. At 4.55am on 3 March, Mr Brown went into cardiac arrest. Hospital staff started cardiopulmonary resuscitation (CPR) immediately, but were unsuccessful. At 5.20am, a hospital doctor confirmed that Mr Brown had died.

Findings

10. The clinical reviewer concluded that the overall clinical care Mr Brown received while at Swaleside was equivalent to that which he could have expected to receive in the community. Despite Mr Brown's regular and persistent refusal to take appropriate prescribed medications and attend for blood test monitoring, prison healthcare staff provided a good level of care. There was also good communication between prison healthcare staff and hospital staff.

11. On 11 January, healthcare staff did not share crucial information with the prison's duty manager that a hospital doctor had advised the prison GP that Mr Brown should go to hospital for clinical assessment. As a result, the duty manager refused Mr Brown's hospital escort. Healthcare staff should have made it clear to prison staff that Mr Brown's transfer was a clinical necessity and custodial staff should in turn have respected a clinical decision and facilitated the transfer as a matter of urgency.

12. There is no evidence that healthcare staff monitored Mr Brown when he was not sent to hospital. Mr Brown collapsed with the same symptoms five days later and spent three weeks in hospital. This fell below the standard of care Mr Brown could have expected to receive in the community.

13. Given the nature of Mr Brown's illness, the delay in taking him to hospital is unlikely to have affected the outcome for him. However, in a future case, an immediate transfer to hospital might have a direct effect on the outcome.

14. We are concerned that healthcare staff did not provide information about Mr Brown's current state of health when Mr Brown went to hospital on 1 March. As a result, we cannot say whether the use of restraints was justified. We consider that the restraints should have been removed for the ECG procedure and MRI scan.

15. Despite numerous requests by the investigator, the prison failed to provide six risk assessments for Mr Brown's hospital escorts and the prison family liaison log. Swaleside also failed to explain the reason for the missing risk assessments. This is not in line with the mandatory requirement set out in Prison Service Instruction 64/2011.

Recommendations

- The Governor and Head of Healthcare should ensure that:
    - there is a clear process, including effective communication between staff, for transferring prisoners to hospital urgently, where there is a medical need;
    - there is a clear escalation and clinical care review process for clinical staff to follow if there is a delay in prisoners being transferred to hospital; and
    - detailed notes are made in the medical record.

- The Head of Healthcare should ensure that all healthcare staff understand the legal position on the use of restraints and that it is their responsibility to provide information about the prisoner's current state of health (to enable prison managers to make decisions based on the actual risk the prisoner presents at the time).

- The Executive Director for the Long-Term and High Security Estate should personally provide the Ombudsman with an update on the progress in addressing the prison's continuing failure to comply with case law on the use of restraints.

- The Governor should ensure that all staff are aware of their responsibilities under PSI 64/2011, specifically:
    - staff must co-operate fully with the Prisons and Probation Ombudsman following a death; and
    - staff must retain, and securely store in a locked cabinet with signed access only, all documentation (except for the clinical records) relating to the deceased prisoner for investigation by the PPO
- The Governor and Head of Healthcare should ensure that a copy of this report is shared with the following members of staff so that they are aware of the Ombudsman's findings: the prison GP; the Custodial Manager who was duty manager on 11 January 2019; the nurse who completed the healthcare section of the escort risk assessment on 1 March 2019; and the prison manager who authorised the use of restraints on 1 March 2019.

The Investigation Process

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

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

18. NHS England commissioned an independent clinical reviewer to review Mr Brown's clinical care at the prison.

19. We informed HM Coroner for Mid-Kent and Medway of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

20. We shared our initial report with HM Prison and Probation Service (HMPPS). They did not identify any factual inaccuracies. HMPPS provided an action plan which is annexed to this report.

21. Solicitors responded to our initial report on behalf of Mr Brown's sister. She did not identify any factual inaccuracies but expressed continued concern about Mr Brown's medication and treatment. We addressed her concerns in separate correspondence.

Background Information

HMP Swaleside

22. HMP Swaleside, which is on the Isle of Sheppey, is part of the Long-Term and High Security estate. It houses up to 1,112 men. IC24 Integrated Care provides primary healthcare at Swaleside. There is 24-hour nursing cover, which includes a qualified nurse and a healthcare assistant at night. Minster Medical Group provides GP cover on weekdays from 9.00am to 5.00pm, and Medoc provides an out of hours GP service.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Swaleside was conducted in December 2018. Inspectors found that health services had improved and were reasonably good but a few areas were still causing concern. The chronic healthcare staffing shortages had started to reduce, although there were still some vacancies. The management of patients with long-term conditions had improved considerably with the introduction of an advanced nurse practitioner who ran clinics and implemented care plans. Healthcare assistants were being trained to undertake regular reviews of patients with long-term conditions. In the previous four months, one-third of external hospital appointments had been cancelled because of prison staffing issues. The monitoring of relevant PPO recommendations by the healthcare department had improved.

Independent Monitoring Board

24. 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 30 April 2018, the IMB reported that although the prison was fully staffed, many staff members were young and inexperienced which caused issues with the control and discipline of prisoners. The IMB continued to receive complaints about the quality of the healthcare treatment and waiting times for healthcare services.

Previous deaths at HMP Swaleside

25. Mr Brown was the fourteenth prisoner to die at Swaleside in the last two years, and the ninth from natural causes.

26. We have previously made recommendations about the inappropriate use of restraints at Swaleside and have twice drawn our concerns about this serious and continuing failure to the attention of the Executive Director for Long-Term and High Security prisons.

Key Events

27. Mr Delroy Brown was serving a life sentence for murder and had been in prison since 2008. He had been at HMP Swaleside since 2009.

28. Mr Brown had a complex cardiac history. In 2016, he had a pulmonary embolism (blood clot on the lung) and was also diagnosed with an enlarged heart, a leaking heart valve and heart failure. A hospital doctor prescribed medication to treat water retention (a side effect of heart failure) and an ACE inhibitor (medication to help improve cardiac function).

29. In 2017, Mr Brown had another pulmonary embolism and a blood clot in his heart. He refused to have an intracardiac defibrillator implanted (a kind of pacemaker placed under the skin, which constantly monitors the heart and can deliver electric shocks to restore normal heart rhythm). A hospital doctor prescribed warfarin (a blood thinning drug). Warfarin needs regular blood tests to ensure the patient is on the correct dosage. This initially starts as daily blood tests, but once the patient is stable, the monitoring is reduced.

30. Between 2017 and 2019, Mr Brown had numerous admissions to hospital for chest pain and breathlessness. His heart function steadily deteriorated and hospital doctors changed his medications according to his condition.

31. Mr Brown did not take his medications. Hospital doctors and prison healthcare staff regularly explained the importance of his medications and the implications of not taking them. Despite this, Mr Brown did not to take his medications or attend his blood testing (INR testing) appointments for his warfarin. When asked why he was not taking his medications, Mr Brown either said, “They are not required” or gave no reason. Healthcare staff were satisfied that Mr Brown had the mental capacity to make these decisions.

32. On 21 January 2018, Mr Brown was admitted to hospital with another pulmonary embolism. He was sent back to Swaleside five days later and healthcare staff reiterated the importance of taking his medications. Mr Brown did not accept the advice and on 29 January, his medications were changed to ‘supervised’. This meant Mr Brown had to attend the medications hatch each day to collect his medications and take them in the presence of the dispensing nurse.

33. On 27 March, 6 April and 22 May, Mr Brown was admitted to hospital with chest pain and breathlessness. On all three occasions he was discharged from hospital after a medication review and no significant changes were made.

34. On 18 June, Mr Brown was admitted to hospital with breathlessness and chest pain. He was discharged the following day, with a referral to Kings College Hospital cardiology department for a second opinion.

35. On 31 August, Mr Brown attended Kings College Hospital for review with a cardiologist. The cardiologist said that Mr Brown had severely reduced ventricular function and dilation, and non-ischaemic cardiomyopathy (a condition which affects the hearts ability to pump blood around the body). The cardiologist amended Mr Brown’s medications.

36. Mr Brown continued to refuse his medications or to attend his INR tests. He told nursing staff that he had the capacity to make such a decision.

37. On 15 October, Mr Brown went to hospital with chest pain and breathlessness. He spent a month in hospital after being diagnosed with septicaemia (blood poisoning). On 17 November, he was discharged from hospital and was returned to Swaleside.

38. In December, Mr Brown went to hospital on two occasions with chest pain and breathlessness. On both occasions hospital doctors diagnosed a worsening of his heart failure and his medications were amended.

39. On 3 January 2019, a prison manager recorded that she had spoken to Mr Brown and that he seemed to be in denial about the state of his health, his prognosis and the need to take his medications. She also recorded that he told her that he had not seen a cardiologist in London, although she knew he had. A note in the wing log said that if Mr Brown refused to attend the healthcare unit to collect his medications, prison staff should inform healthcare staff.

40. On 11 January, a prison GP examined Mr Brown because he was complaining of breathlessness, central chest pain, vomiting and reduced appetite. The GP noted that Mr Brown was alert, active and talking in full sentences. The GP telephoned the on-call doctor at Kings College Hospital, who said that Mr Brown should go to hospital for further assessment.

41. A healthcare member of staff (whose name was not recorded) tried to arrange a hospital escort for Mr Brown and asked a Custodial Manager (CM), the prison's duty manager, to authorise an escort. The healthcare member of staff told the CM that an ambulance had not been called as it was not an emergency and that there were contingency plans in place for Mr Brown to be moved to the prison's inpatient unit if necessary. As a result, the CM considered Mr Brown's condition was not life threatening and did not authorise an escort. Mr Brown did not go to hospital.

42. On 16 January, Mr Brown collapsed and was taken to hospital as an emergency. He spent three weeks in hospital for treatment of his symptoms. A hospital doctor told Mr Brown that he had decompensated (deteriorating) heart failure and should not return to A&E unless he was being fully compliant with his medications.

43. Despite the advice of the hospital doctor and prison nursing staff, Mr Brown continued to refuse his medications and INR tests.

Events of 1-3 March

44. On 1 March, a nurse examined Mr Brown because he had been vomiting, had leg swelling and breathlessness. The nurse discussed his symptoms with the prison GP, who decided Mr Brown should go to A&E.

45. The risk assessment for the escort showed Mr Brown as a medium risk to the public, but a low risk of escape or hostage taking. In the medical section of the form, a nurse from the prison's healthcare team indicated that she had no medical objections to the use of restraints but did not provide any information

about Mr Brown's state of health. A prison manager authorised the use of a single cuff and escort chain.

46. At 10.30pm, Mr Brown had an electrocardiogram (ECG) and blood test in hospital. There is no evidence that the escort officers removed the single cuff for these procedures.

47. At 3.30am on 2 March, Mr Brown had a computerised tomography scan (CT). The cuffs were removed for the scan and then reapplied. Mr Brown was admitted to a ward and the restraints were reduced to an escort chain.

48. At 9.45am, a hospital doctor told Mr Brown his heart was beating out of rhythm, which could cause significant complications. The doctor prescribed water tablets and medication to help regulate his heart rate.

49. At 2.45pm, a hospital doctor said Mr Brown needed a tube inserted into a vein in his neck to administer the medication to regulate his heartbeat. Mr Brown refused to have the line put in because he said the medication made him feel unwell. The doctor told Mr Brown that if he did not have the medication, he could die. Mr Brown said that he understood the implications and said that he did not want the line to be put in.

50. At about 6.30pm, the CM authorised the removal of the escort chain following consultation with medical staff. The CM also noted that Mr Brown did not have restraints applied during previous hospital admissions.

51. Mr Brown's heart rate continued to be dangerously irregular and he was encouraged by hospital staff to have a line inserted for the medication. Mr Brown accepted the medication at 10.45pm, and his heart rate improved.

52. At 4.25am on 3 March, Mr Brown was given fluids through a drip. He had not been able to pass urine for some hours, despite having a catheter, and his blood pressure was low.

53. At 4.55am, Mr Brown went into cardiac arrest. Hospital staff started CPR immediately, but at 5.20am, a hospital doctor confirmed that Mr Brown had died.

Contact with Mr Brown's family

54. The prison kept Mr Brown's mother and sister informed when he went out to hospital for treatment and they visited him in line with normal prison visiting guidelines.

55. The prison failed to provide the investigator with the family liaison log and therefore, we are unable to say who was appointed as the family liaison officer, when they were appointed or what level of support they offered to Mr Brown's family.

56. On 8 May, Mr Brown's body was repatriated to Jamaica. The prison offered a financial contribution towards the cost of the funeral in line with national guidance.

Support for prisoners and staff

57. After Mr Brown's death, the CM debriefed the staff on the bedwatch to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

58. The prison posted notices informing other prisoners of Mr Brown'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 Brown's death.

Post-mortem report

59. The post-mortem report gave Mr Brown's cause of death as ventricular tachycardia, caused by cardiomegaly with biventricular hypertrophy and dilation. This means Mr Brown had a fast heart rate, caused by an abnormally enlarged heart and thickened heart walls, which meant the heart could not pump blood sufficiently.

60. Also noted as significant, but not directly linked to Mr Brown's death, was a build-up of plaque (cholesterol deposits) in the arteries and haemorrhagic gastritis (inflammation of the stomach lining).

Findings

Clinical care

61. Mr Brown had complex heart issues and his heart function was gradually declining. Despite his refusal to take appropriate prescribed medications and attend for blood test monitoring, prison healthcare staff provided a good level of care. Healthcare staff communicated appropriately with hospital staff.

62. The clinical reviewer concluded that the overall clinical care Mr Brown received while at Swaleside was equivalent to that which he could have expected in the community. We agree.

Mental capacity

63. Mr Brown regularly and persistently refused to take his medications and attend for blood monitoring. There is evidence that staff regularly encouraged him to take his medications and explained the implications of refusing his medication.

64. Healthcare staff clearly recorded that Mr Brown had the mental capacity to decide not to take his medications. There is no evidence that healthcare staff completed a formal mental capacity assessment, but the clinical reviewer is satisfied that this is not a concern as Mr Brown did not have a history of mental health issues and healthcare staff adhered to the National Institute for Clinical Excellence (NICE) guidelines.

Transferring Mr Brown to hospital and staff communication

65. The clinical reviewer concluded that the CM's refusal to provide an escort to take Mr Brown to hospital on 11 January 2019 did not contribute to his death.

66. However, we are concerned that healthcare staff did not give the CM sufficient information about Mr Brown's condition to be able to make an informed decision about whether an escort should be authorised.

67. It is not clear who the CM spoke to but he said that healthcare staff told him that an emergency ambulance had not been called, that it was not a medical emergency and that a contingency plan was in place to move Mr Brown to the prison's inpatient unit if necessary. Healthcare staff did not tell the CM that the prison GP had been advised by the on-call hospital doctor that Mr Brown needed to attend hospital for review. In the absence of this information, the CM said he did not think Mr Brown needed immediate medical attention. He also said that the prison was in partial shutdown and providing an escort would have caused staff shortages.

68. The CM interpreted the fact that an emergency ambulance had not been called as meaning that Mr Brown did not need to be taken to hospital urgently. This is a misunderstanding. An emergency ambulance is required when a prisoner is likely to require paramedical intervention such as cardiopulmonary resuscitation or assistance with breathing on the journey to hospital. A prisoner may, however, have a condition which requires him to be seen by doctors in an emergency department as soon as possible but which does not require an emergency

ambulance. In Mr Brown's case, healthcare staff could have requested a non-emergency ambulance, but had not done so.

69. If a GP asks for a prisoner to be taken to hospital, we do not think it is appropriate for prison and healthcare staff to decide it is not necessary. The CM was not qualified to decide if Mr Brown needed to go to hospital urgently or not. We consider that the member of healthcare staff should have sought further advice when the escort was refused. There is, however, no evidence that healthcare staff told the prison GP that Mr Brown was not being taken to hospital as he had asked, or that the issue was escalated to the Head of Healthcare for advice.

70. We are also concerned that there is no evidence that healthcare staff asked for Mr Brown to be taken to hospital the following day or that they made any alternative arrangements for Mr Brown's care in the prison. There are no significant clinical entries in Mr Brown's medical record to suggest that healthcare staff reviewed or monitored Mr Brown's symptoms over the next five days and there is no evidence that Mr Brown was moved to the prison's inpatients unit for monitoring. Mr Brown collapsed five days later and spent three weeks in hospital.

71. This level of care was not equivalent to the care Mr Brown could have expected to receive in the community. We make the following recommendation:

The Governor and Head of Healthcare should ensure that:

- **there is a clear process, including effective communication between staff, for transferring prisoners to hospital urgently, where there is a medical need;**
- **there is a clear escalation and clinical care review process for clinical staff to follow if there is a delay in prisoners being transferred to hospital; and**
- **detailed notes should be made in the medical record.**

Restraints

72. When prisoners have to travel outside 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. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility.

73. A High Court judgment in 2007, highlighted a number of factors that prisons should consider when deciding on the use of restraints. These included addressing the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit, and those risks posed by the same prisoner when suffering from a serious medical condition.

74. Mr Brown was escorted to hospital on seven occasions between January 2018 and January 2019. The prison failed to provide us with the risk assessments for

these hospital escorts. Without seeing these assessments, we cannot say whether restraints were used and, if they were, whether they were justified.

75. When Mr Brown was taken to hospital for the final time on 1 March 2019, the risk assessment for the escort showed him as a medium risk to the public, but a low risk of escape or hostage taking. A nurse noted she had no medical objections to the use of restraints but did not include any medical information relating to Mr Brown's current medical condition to help inform the security department's decision. A prison manager authorised the use of a single cuff and escort chain.

76. Given Mr Brown's poor health, we query whether restraints were necessary and proportionate over and above the control already available through the escorting officers. However, Mr Brown was a relatively young man and without information about how his medical condition affected his mobility on 1 March we cannot say whether restraints were justified or not. We are concerned that the nurse did not provide this essential information to enable the prison manager to make an informed decision.

77. We are also concerned that there is no evidence that the escort chain was removed for investigative tests such as the MRI scan and ECG procedure. We consider that the restraints should have been removed for these tests.

78. The restraints were removed on the evening of 2 March after a risk assessment review and consultation with hospital staff.

79. It is the Governor's responsibility to ensure that the risk assessment process is managed properly and that there is a clear justification for any use of restraints. However, it is also important that healthcare staff understand their responsibility to provide information about the extent to which the prisoner's current state of health impacts on their risk. We make the following recommendation:

    The Head of Healthcare should ensure that all healthcare staff understand the legal position on the use of restraints and that it is their responsibility to provide information about the prisoner's current state of health (to enable prison managers to make decisions based on the actual risk the prisoner presents at the time).

80. We have previously made recommendations about the inappropriate use of restraints at Swaleside. In June 2017, we raised the inappropriate use of restraints again and we drew this serious and continuing failure to the attention of the Executive Director for Long-Term and High Security prisons. In October 2018, we raised the inappropriate use of restraints again, and asked the Executive Director to provide an update on what had been done to address the prison's continuing failure to comply with case law on the use of restraints.

81. The Executive Director told us that he has a Group Safety Team who liaise with Swaleside (and the other prisons he is responsible for) regularly and test the prison's compliance with PPO recommendations. The team provides assurance to the Executive Director and Deputy Director who address failures to comply with the Governor.

82. Because we raised the inappropriate use of restraints again in a recent investigation, we asked the Executive Director to provide us with an account of the progress of the Group Safety Team in addressing the prison's continuing failure to comply with case law on the use of restraints.

83. The Group Safety Team responded on his behalf and said that there have been ongoing discussions with the Head of Healthcare and prison management in the review of the existing guidance and forms on risk assessments for the use of restraints. The last review was undertaken in April and June 2019, and the Team were satisfied that guidance and forms used by staff complied with the legal judgement. Where the guidance and forms had not been followed, staff were being taken through the guidance and their understanding was being checked by managers. The Team said that they continued to liaise with the prison regularly to ensure that any continuing failure to comply with case law was addressed promptly and appropriately.

84. We are concerned that the work that has been done so far does not appear to have made any difference in Mr Brown's case in that the prison cannot show that the use of restraints was justified. We make the following recommendation:

The Executive Director for the Long-Term and High Security Estate should personally provide the Ombudsman with an update on the progress in addressing the prison's continuing failure to comply with case law on the use of restraints.

Prison liaison

85. Prison Service Instruction (PSI) 64/2011 sets out the mandatory actions a prison needs to take following a death in custody. These includes effective communication with the PPO and retaining all documentation relating to the deceased prisoner.

86. Despite numerous attempts by the investigator, the prison's PPO liaison officer failed to obtain seven escort risk assessments for January 2018 to January 2019 and the prison's family liaison log. The lack of effective communication and missing documentation has had a negative impact on the investigation. This is unacceptable. We therefore recommend:

The Governor should ensure that all staff are aware of their responsibilities under PSI 64/2011, specifically:

- **staff must co-operate fully with the Prisons and Probation Ombudsman following a death; and**
- **staff must retain, and securely store in a locked cabinet with signed access only, all documentation (except for the clinical records) relating to the deceased prisoner for investigation by the PPO.**

Other matters

87. We consider that it is important for staff who were involved in Mr Brown's care to see the findings of our investigation and we therefore make the following recommendation:

    The Governor and Head of Healthcare should ensure that a copy of this report is shared with the following members of staff so that they are aware of the Ombudsman's findings: the prison GP; the Custodial Manager who was duty manager on 11 January 2019; the nurse who completed the healthcare section of the escort risk assessment on 1 March 2019; and the prison manager who authorised the use of restraints on 1 March 2019.

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