Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Daniel Wilson a prisoner at HMP Humber on 27 September 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*

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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Daniel Wilson died in hospital of pneumonia on 27 September 2017 while a prisoner at HMP Humber. He was 40 years old. We offer our condolences to his family and friends.

We agree with the clinical reviewer that Mr Wilson received a good standard of care for his lung condition. Staff could not have anticipated or prevented his sudden death. However, we are concerned about the timing of his prison transfer from HMP Lincoln to Humber and the circumstances of his appointment at Lincoln County Hospital.

We are also concerned that HMP Lincoln was unable to provide us with relevant risk assessments or bedwatch logs for the time Mr Wilson was in hospital.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Elizabeth Moody
Acting Prisons and Probation Ombudsman **April 2018**

Contents

Summary 1
The Investigation Process 3
Background 4
Key Events 6
Findings 12

Summary

Events

1. Mr Daniel Wilson was sentenced to 10 months in prison for drug offences and breaching bail conditions. On 14 July 2017, he was sent to HMP Lincoln.

2. At his reception health screen, Mr Wilson told healthcare staff that he was unwell and had breathing problems. Healthcare staff arranged for him to go to hospital, where he had a chest drain for a collapsed lung. No one recorded what happened or any contact with the escorting staff.

3. Mr Wilson returned to Lincoln on 20 July. The hospital discharge letter said that he should have a follow-up chest x-ray. The GP completed the hospital form for this on 28 July and the appointment was booked for 3 August.

4. Due to prison population pressures, staff at Lincoln arranged for Mr Wilson to transfer to HMP Humber on 2 August. Staff at Humber took Mr Wilson to hospital for his appointment the next day but the hospital had no record of it.

5. Shortly after arriving at HMP Humber, Mr Wilson had trouble breathing. Staff arranged for him to go to hospital. He had a chest drain and remained in hospital for 19 days, before being discharged back to Humber. Two weeks later Mr Wilson became unwell and was diagnosed with a chest infection. He was taken to hospital by emergency ambulance where he was treated in the intensive care unit. His condition did not improve and he died in hospital on 27 September from pneumonia, with his family present.

Findings

6. The clinical reviewer found that the overall care that Mr Wilson received in prison was equivalent to that which he could have expected to receive in the community. We do, however, have some concerns.

7. When Lincoln sent Mr Wilson to hospital in July 2017, control room staff should have recorded what happened and any contact with the escorting staff.

8. Although the initial decision to transfer Mr Wilson to Humber was reasonable, staff at Lincoln failed to check his medical condition when completing the transfer application and there was poor coordination in arranging the transfer.

9. We experienced significant difficulties in carrying out our investigation at Lincoln, which were only resolved after escalating our concerns to the Governor.

Recommendations

- The Head of Healthcare at HMP Lincoln should ensure that medical records are fully checked and kept updated before prisoners are transferred and any issues or appointments are accurately recorded.

- The Governor and Head of Healthcare of HMP Lincoln should review the decision-making procedures for the routine transfer of prisoners and ensure that the transfer process includes input from healthcare staff and that the consideration of decisions is recorded.
- The Governor of HMP Lincoln should review control room procedures and ensure that control room staff keep a log during medical emergencies and hospital admissions.
- The Governor of HMP Lincoln should ensure that, in line with PSI 58/2010, the Prison and Probation Ombudsman is promptly provided with all requested documents after a death in custody.

The Investigation Process

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

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

12. The investigator interviewed four members of staff by telephone on 21, 22 and 23 November 2017.

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

14. We informed HM Coroner for East Riding and Kingston upon Hull of the investigation who gave us the cause of death. We have sent the Coroner a copy of this report.

15. The investigator contacted Mr Wilson's mother to explain the investigation and to ask if she had any matters they wanted the investigation to consider. She asked for information about Mr Wilson's discharge from hospital to HMP Lincoln and if staff had delayed issuing his medication. She was concerned that this might have caused his health to decline. She said that HMP Lincoln had cancelled Mr Wilson's follow-up appointments but had failed to notify staff at Humber about this. She said that she had nothing but praise for the way that staff at Humber had treated Mr Wilson.

16. Mr Wilson's family received a copy of the initial report. The solicitor representing them wrote to us pointing out some factual inaccuracies and/or omissions. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Lincoln

18. HMP Lincoln houses up to 729 prisoners, both those on remand and convicted. It serves the courts of Lincolnshire, Nottinghamshire and Humberside. It has four residential wings, including a Vulnerable Prisoners' Unit. Nottingham Healthcare NHS Trust provides health services and there is 24-hour nursing cover.

HMP Humber

19. HMP Humber is made up of two former prisons, HMP The Wolds and HMP Everthorpe. The formal merger of the two prisons took place in April 2014. The prison holds up to 1,062 prisoners. City Health Care Partnership provides healthcare services. Onsite healthcare cover is available 24 hours a day, seven days a week

HM Inspectorate of Prisons

HMP Lincoln

20. The most recent inspection of HMP Lincoln was in January and February 2017. Inspectors reported that although some of the progress identified at the last inspection had been maintained, there had also been some deterioration.

21. Prisoners were mostly positive about the quality of care they received from healthcare staff. Inspectors found that waiting times to see GPs were good at just over one week and 'on the day' urgent appointments were available if necessary. However, there was no cover at the weekends or in the evenings, which contributed to delays in giving new arrivals their medication.

HMP Humber

22. The most recent inspection of HMP Humber was in July 2015. Inspectors reported that the new health provider had begun to make positive changes and services were generally safe and responsive. The report noted that there was good prioritisation of urgent cases. However, care for prisoners with long-term conditions was developing, and it required a more formal and systematic process in line with community procedures.

Independent Monitoring Board

23. 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.

HMP Lincoln

24. In its latest annual report, for the year to January 2017, the IMB at Lincoln reported that it had been a challenging year due to prison officer vacancies and sickness, which resulted in wing lock-downs and restricted regimes.

HMP Humber

25. In the latest annual report for Humber for the year to December 2016, the IMB noted that there had been a shortage of staff which affected the running of the prison. They noted that because staff were not always rostered to work on the same wings, relationships between staff and prisoners suffered. They said that City Health Care Partnership delivered a good service and complaints had decreased. They said that the focus on health education, wellbeing clinics and well man sessions were positive steps to offering a comparable service to that offered in the community.

Previous deaths at HMP Lincoln and Humber

26. While we recognise that Mr Wilson did not die at Lincoln, we note that two prisoners have died from natural causes at HMP Lincoln since January 2015. We recently made a recommendation about the need for the control room to keep an accurate log as we found that the initial call for an ambulance and the subsequent five calls from the emergency services to the prison were not recorded.

27. Mr Wilson was the fourth prisoner to die from natural causes at HMP Humber since January 2015. There are no similarities with the circumstances of the other deaths.

Key Events

HMP Lincoln

28. On 14 July 2017, Mr Wilson was sentenced to 10 months in prison for drug offences and breaching bail conditions and sent to HMP Lincoln.

29. During his initial health screen, Mr Wilson said that he had alcohol problems and had previously completed detoxification. He also said he had a chest infection. A substance misuse nurse, made an appointment for him to see a prison GP.

30. A completed a secondary reception screen. Mr Wilson said he was a moderate smoker, had had a recent chest infection and collapsed right lung. The nurse noted that there was a "rasp" sound on Mr Wilson's right side, which was painful and left him breathless. He asked staff to arrange to take Mr Wilson to Lincoln County Hospital. Staff escorted him by taxi at 7.33pm.

31. A prison GP, saw Mr Wilson to discuss plans for alcohol detoxification. She prescribed librium so that he could start his detoxification.

32. In hospital, Mr Wilson had a chest drain for his collapsed lung. On 15 July, a member of the prison chaplaincy team visited him and told him that a member of the team would visit him daily.

33. On 16 July, a Reverend visited Mr Wilson in hospital. That day an offender supervisor, visited Mr Wilson in hospital to complete the basic custody screening. He noted that Mr Wilson was receiving treatment for a collapsed lung and alcohol detoxification. The escorting staff obtained permission from managers for Mr Wilson to contact his mother.

34. Mr Wilson remained in hospital until 20 July. The hospital discharge letter said that he had had a pneumothorax (a collapsed lung) and should have a repeat hospital chest x-ray in two weeks.

35. As a local prison, Lincoln receives prisoners after their court appearances before they progress into the prison estate. Overall decisions about the management of the prison population are made centrally in the Prison Population Management Unit (PMU) in HM Prisons and Probation Service. PMU notified staff in Lincoln Offender Management Unit that there were five places available at HMP Humber and that a prison van was booked for transport. The Observation, Classification and Allocation Unit (OCA) within the Offender Management Unit (OMU) at Lincoln began the paperwork process for transfer. They added Mr Wilson's name to the transfer list.

36. On 18 July, a case administrator completed an initial categorisation and allocation form. This is a standard form for all newly sentenced prisoners to assign a security category and to recommend subsequent suitable prisons to best meet the prisoner's needs. This should be based on all relevant documents about the prisoner's offence. She noted Mr Wilson's offence details and sentence length. She indicated that she had referred to prison records for information about conviction, previous offence record and current custodial record. She completed the form algorithm, which indicated that Mr Wilson was

suitable for categorisation as a category C prisoner at Humber. The healthcare section asked if there were any specific healthcare issues to record. This was left blank.

37. A prison administrator told the investigator that the healthcare section could not be completed due to data protection issues. She said that she could not remember what information she had checked when completing the form and that Mr Wilson's health would not influence categorisation decisions.

38. The offender supervisor countersigned the form. He said that he checked the information on the form and signed it off.

39. On 20 July, hospital staff discharged Mr Wilson and prison escorts returned to Lincoln with him by taxi at 5.58pm. A nurse completed his health screen. He noted that the hospital had discharged Mr Wilson with his medication of ibuprofen, paracetamol and vitamins. However, this was passed to the pharmacy for a prison GP to check and reissue. His blood pressure was noted as a little high (at 158/88mmHg). His pulse was regular (at 59bpm).

40. The next day, a member of the substance misuse team assessed Mr Wilson. Mr Wilson told him that he had completed his alcohol detoxification in hospital. A prison GP, reissued the hospital medication. On 23 July, a nurse issued more ibroprofen and paracetamol. On 26 July, another nurse also issued more paracetamol.

41. On 28 July, Mr Wilson began a programme to stop smoking. That day, the administrative team in the healthcare department arranged for a prison GP to complete the x-ray referral form and booked a hospital appointment for this for 3 August.

42. On 1 August, a prison GP examined Mr Wilson as he said he felt breathless and was concerned that he had another pneumothorax. The GP concluded that Mr Wilson was stable and needed a follow up chest x-ray (which had already been booked).

43. In the early hours of 2 August, a nurse noted in Mr Wilson's medical record that she had reviewed his notes as he was scheduled for transfer to HMP Humber. She noted his recent condition, treatment and medication. She also noted that the prison GP had asked for his oxygen saturation levels to be monitored daily. She said there were no medical risks to prevent the use of restraints and he was medically fit for transfer. She did not record whether she had seen Mr Wilson.

44. A nurse also reviewed Mr Wilson's medical record before his transfer. She noted that his chest x-ray appointment was outstanding and she asked for staff at Humber to arrange it. She said that Mr Wilson was leaving Lincoln with a supply of medication and was fit for transfer. She did not record whether she had seen Mr Wilson when she made this assessment.

HMP Humber

45. On 2 August, when he arrived at Humber, Mr Wilson told reception staff that he had concerns about his health. He was breathless and was described as looking "generally unwell". A nurse noted Mr Wilson was in possession of his prescribed medication and he recorded clinical details about Mr Wilson's health condition and checked his baseline observations. He noted that the hospital chest x-ray referral was scheduled for 3 August at Lincoln General Hospital.

46. Later that afternoon, wing staff asked a healthcare assistant, to see Mr Wilson in his cell. She noted that he was breathless when he tried to speak. He told her that he had a pain in the top right side of his shoulder blade and felt like he had an air bubble in his chest. She asked a nurse to review him. Shortly afterwards, the nurse checked his observations again which she noted were in the normal range and his breathing pattern was smooth and not laboured. She booked a GP appointment for the next day and told Mr Wilson that if there were any changes, healthcare staff should be contacted.

47. On 3 August, prison staff at Humber arranged for Mr Wilson to attend his chest x-ray appointment at hospital. A nurse issued the discharge letter. However, staff returned to the prison with Mr Wilson and noted that the hospital appointment had not taken place as hospital staff had no record of the referral. The nurse arranged a GP appointment for the next morning.

48. A nurse created a care plan for Mr Wilson, which said that there should be daily respiratory observations to check for signs of complications after his pneumothorax. It said that if there were complications, specialist services should be contacted and arrangements made for a follow-up chest x-ray to assess the resolving collapsed lung.

49. On 4 August, a prison GP, examined Mr Wilson as he had complained of a sudden onset of breathlessness and discomfort. He diagnosed a suspected collapsed lung and arranged for Mr Wilson to go to hospital.

50. That day, a modern matron, told the Deputy Governor of Humber, that Mr Wilson had complained of shortness of breath when he arrived. She said that hospital staff had said that Mr Wilson had recently been in hospital for the same condition when he was at Lincoln and was waiting for a chest x-ray.

51. The Deputy Governor contacted the Governor of Lincoln, saying:

"We received Mr Wilson this week from HMP Lincoln and it looks like he had a punctured lung prior to the escort and he was still "fitted" [for transfer]. He is now in Hospital in their Resuscitation Unit and is likely to be out for the next four days. I have asked my Head of Healthcare at Humber to look into the appropriateness of this transfer."

52. The Governor asked staff at Lincoln to explain. The Head of Residence and Services, said:

"It would appear that there is nothing underlying and that Mr Wilson was added to the transfer list due to him fitting the criteria. Reception staff cannot recall

anything untoward on that day. Mal cannot recall any reasons other than normal transfer for the move.

"A member of staff was supposed to go on a hospital escort on Wednesday of last week – taking Mr Wilson for an x-ray – but Mr Wilson had been transferred the day prior."

53. The Head of Healthcare at Lincoln, said:

"I have looked at the case notes for Mr Wilson and nothing to suggest medical hold at time of transfer:

- Mr Wilson had history of pneumothorax.
- Seen by GP on the 28th July 2017 with concerns of shortness of breath on exertion, all base line observations in normal rage including oxygen saturation of 99%, referred for chest x-ray within two weeks, due to past medical history.
- Follow up appointments with Nurse practitioner in place but not attended by patient, refusal.
- Seen again by GP on the 1st August 2017, again due to shortness of breath over exertion, again all base line observations within normal range oxygen saturations 98%. No shortness of breath at rest.
- Reception screen raised no issues for transfer, documentation of hospital appointment and medications sent with patient."

54. In hospital, Mr Wilson had another chest drain and was in a lot of pain. He was on the maximum dose of pain killers. On 14 August, hospital staff told a nurse that another CT scan was needed so that the surgeons could complete their assessment. On 23 August, hospital staff discharged Mr Wilson to Humber after draining his collapsed lung. They scheduled an appointment on 27 August to remove his stitches.

55. On 24 August, a prison GP, completed a prescription for pain relief. A nurse examined Mr Wilson and noted his observations were in the normal range. Mr Wilson told her that he was gradually regaining his appetite, was passing urine, had opened his bowels and needed his stitches removed in a few days. She booked an appointment for the nurses' clinic for this.

56. Healthcare staff completed daily checks with Mr Wilson. They found his wound was healing and he was taking his antibiotics and pain relief. On 29 August, a nurse removed his stitches and created a care plan for the daily cleaning of his chest wound.

57. At 9.41am on 5 September, Mr Wilson was walking to collect his medication but became unwell. A nurse noted he was visibly short of breath, clammy and had trouble walking. She noted that a prison GP (whose name is not recorded) examined him, diagnosed a chest infection and said that he should go to hospital. A nurse asked the control room to call for an emergency ambulance. The ambulance arrived at 9.45am and paramedics took Mr Wilson to hospital. Two officers escorted him and he was restrained.

58. In hospital, Mr Wilson was in the intensive care unit and was sedated on a ventilator. He was in a critical condition. On 19 September, prison healthcare staff were told that he had had a tracheotomy to allow air to enter his lungs.

59. Mr Wilson's condition deteriorated. A nurse visited him in hospital and met his family on 25 September. On 26 September, the escorting staff did not remain in the room to allow Mr Wilson's family some privacy. On 27 September, Mr Wilson died, with his family present.

Letter found in Mr Wilson's property

60. After Mr Wilson died, prison staff found an undated letter that he had written to his former partner. It said that he had been very ill and was taking all sorts of antibiotics that made him feel worse. He said that the side effects were killing him. He said that he had been in the hospital resuscitation unit twice but would continue with his medication. He complained that he always had two prison officers with him when he was admitted to hospital and was handcuffed. He said that over the last month, he had been in three hospitals. Mr Wilson said that he had been moved to a better wing and a single cell but remained locked in his cell for up to 22 hours a day as he was unfit to work. He said this was better than being in hospital.

Contact with Mr Wilson's family

61. On 16 July, when he was in hospital, staff at Lincoln arranged for Mr Wilson to ring his mother to tell her that he was in hospital. She visited him with other family members.

62. At Humber on 7 September, the prison appointed a prison manager, as the family liaison officer after Mr Wilson's health deteriorated in hospital. He contacted Mr Wilson's mother to inform her but she was already aware as she had visited him daily in hospital. He went to the hospital, met the family and explained his role.

63. On 26 September, the family liaison officer spoke to Mr Wilson's mother at the hospital after hospital staff had told her it was unlikely that Mr Wilson would survive. She asked for privacy for Mr Wilson's final hours. The family liaison officer arranged for the prison escorts to be in a room near Mr Wilson.

64. When Mr Wilson died, the family liaison officer visited Mr Wilson's mother to offer advice and support. Mr Wilson's funeral was held on 17 October 2017. The prison contributed to the funeral costs in line with national policy.

Support for prisoners and staff

65. After Mr Wilson's death the prison duty manager, debriefed the staff who monitored Mr Wilson in hospital to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

66. The prison posted notices informing other prisoners of Mr Wilson'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 his death.

Cause of death

67. The Coroner gave the cause of death as bilateral pneumonia.

Findings

Clinical care

68. The clinical reviewer said that the care that Mr Wilson received was largely of a good standard and was equivalent to that which he could have expected to receive in the community.

69. Prison Service Order (PSO) 3050 on the continuity of healthcare, emphasises the importance of continuity in the success of clinical interventions and treatment. Mr Wilson complained in a letter to his former partner, and his mother was concerned that he had missed several hospital appointments. Mr Wilson's medical records show that he attended all of his scheduled medical appointments and was taken to hospital when prison doctors were concerned about his condition.

70. A nurse and a colleague at Lincoln noted in Mr Wilson's medical record that there were no concerns about his transfer.

71. There is confusion about the arrangements for Mr Wilson's hospital appointment for a chest x-ray. A nurse noted that the hospital x-ray appointment would need to be arranged from Humber. However, his medical record already noted that Mr Wilson's hospital appointment had been arranged and a nurse (also at Lincoln) said that staff at Lincoln were aware of the 3 August appointment as they had arranged the escort for the journey. However, when staff at Humber took Mr Wilson for the appointment, hospital staff had no record of it. This suggests that staff at Lincoln may have cancelled it in light of the transfer, although there is no evidence of this. We therefore recommend that:

    The Head of Healthcare of HMP Lincoln should ensure that medical records are fully checked and kept updated before prisoners are transferred and any issues or appointments are accurately recorded.

Transfer from Lincoln to Humber

72. Because of population pressures, Mr Wilson was identified as one of a small number of prisoners suitable for transfer to Humber. Staff complete an Initial Categorisation of Adult Male Prisoners (ICA) form for all prisoners who are being transferred. This provides a summary of their risks, including a summary of any healthcare issues.

73. Decisions about Mr Wilson's transfer from Lincoln appear uncoordinated. No one in the Offender Management Unit (OMU) checked his prison record to note that he was in hospital at the time. The countersigning officer, was aware that Mr Wilson was in hospital as he had visited him in hospital two days before he signed the transfer form on 18 July.

74. The healthcare section of the initial categorisation and allocation form asks for healthcare to provide input. However, OMU staff at Lincoln incorrectly told the investigator that the healthcare section could not be completed due to data protection issues and that Mr Wilson's health would not influence categorisation decisions.

75. There is no evidence that healthcare staff were consulted for an update on Mr Wilson's healthcare needs. There is no evidence that staff took into account Mr Wilson's needs or, troublingly, that they believed this was appropriate to consider.

76. In his letter, Mr Wilson complained about the transfer from Lincoln. The clinical reviewer said that although there was no acute medical reason for him to remain at Lincoln on medical hold, transfer with an imminently pending hospital appointment seemed inappropriate, particularly as the hospital was very close to the prison, compared to the two and a half hour journey from HMP Humber.

77. On arrival at Humber, Mr Wilson was recovering from major surgery and staff had concerns. The medical records show that the healthcare staff at Humber had no prior knowledge of the scheduled x-ray appointment. Despite this, prison staff at Humber managed to arrange for Mr Wilson to attend the appointment, only to find that the hospital could not find any record of the referral. The Deputy Governor of Humber asked managers at Lincoln to explain why Mr Wilson had been transferred. Lincoln appear to stand by their decision.

78. The clinical reviewer said that Mr Wilson's transfer may have contributed to the confusion about the follow-up chest x-ray and the wasted journey to hospital. While the clinical reviewer said that this had no effect on the eventual outcome, this could be significant in other circumstances. We make the following recommendation:

The Governor and Head of Healthcare of HMP Lincoln should review the decision-making procedures for the routine transfer of prisoners and ensure that the transfer process includes input from healthcare staff and that the consideration of decisions is recorded.

Restraints, security and escorts

79. 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 treat prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when he has 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.

80. At Lincoln, when a nurse said that Mr Wilson should be transferred to hospital, there is no evidence to confirm what happened. There is no record of any escort risk assessment or the security arrangements. The investigator asked for a manager who may have completed an escort risk assessment to be interviewed but no one responded.

81. At Humber, the escort risk assessment for his admission to hospital noted that he had a history of collapsed lung and he could struggle to breathe. Security staff assessed Mr Wilson's level of risk to the public, hostage taking, escape potential,

likelihood of outside assistance, risk to females and risk to hospital staff as low. Based on this information a prison manager, authorised the use of a single handcuff and two officers during the escort.

82. After he was admitted to hospital, there were daily reviews of the assessments, a new assessment was completed, and an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer) was used. From 7 September, the handcuffs were removed and were never reapplied.

83. We consider that the initial decision to restrain Mr Wilson when he was sent to hospital from Humber was reasonable given his age and index offence. We are satisfied that the decision was reviewed on a daily basis and that appropriate changes were made as Mr Wilson's medical condition changed.

Record management and support to our investigation

84. We are concerned that Lincoln could not produce any documentation about Mr Wilson's admission to hospital in July 2017. There is no evidence to justify the decision to use handcuffs and no bedwatch logs could be located. Lincoln staff said that all documentation should have been transferred with Mr Wilson to Humber. Staff at Humber said that none of the escort risk assessments or bedwatch logs from Lincoln had been included in the paperwork. We accept that whatever documentation there was has been lost. While this is a highly unsatisfactory position, we are unable to draw any conclusions.

85. The investigator asked staff at Lincoln for the control room log when Mr Wilson was taken to hospital. They were unable to provide it. There was no control room log to record when the taxi arrived or left with Mr Wilson. There was no record of the escorting staff contacting the prison with updates and no record of managers conducting any hospital reviews. We found in a recent investigation that Lincoln's control room log did not record its initial call for an ambulance or the subsequent five calls from the emergency services to the prison. We therefore make the following recommendation:

The Governor of HMP Lincoln should review control room procedures and ensure that control room staff keep a log during medical emergencies and hospital admissions.

86. PSI 58/2010 requires staff to comply with requests for information and assist with enquiries from our investigators. During the investigation, Lincoln did not provide documentation fully or promptly and interviews with staff at Lincoln were not adequately facilitated. These issues were not resolved until the investigator contacted the Governor directly. Although communication subsequently improved, we make the following recommendation:

The Governor of HMP Lincoln should ensure that, in line with PSI 58/2010, the Prisons and Probation Ombudsman is promptly provided with all requested documents after a death in custody.

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Independent Investigations

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