Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Summers, a prisoner at HMP Gartree, on 25 April 2020

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*

Summary

1. 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.

2. 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.

3. Mr Robert Summers died of COVID-19 pneumonia on 25 April 2020 in Leicester Royal Infirmary. He had been taken there from HMP Gartree the previous evening. He was 72 years old. I offer my condolences to Mr Summers' family and friends.

4. Mr Summers had been in prison for a number of years. He had a number of chronic health conditions, including possible moderate dementia.

5. On 31 March 2020, prison healthcare sent Mr Summers a letter advising him to self-isolate as his health conditions put him at risk if he contracted COVID-19. Mr Summers did not respond and no one checked whether he understood the risk.

6. On 23 April, he was unwell and was assessed by a prison-based paramedic. His medical observations were all within the normal range. The next morning, a nurse was concerned about Mr Summers, but no medical observations were taken, despite healthcare staff seeing him several times that day. By the evening his condition had deteriorated, and he was taken to hospital. He was subject to physical restraints. Mr Summers died the next morning.

7. We shared the clinical reviewer's concerns about poor communication among healthcare staff the day before Mr Summers died. The clinical reviewer has made several other recommendations, which we do not repeat in this report but which the Head of Healthcare will need to address.

Recommendations

- The Head of Healthcare should ensure that:
    - nurses take medical observations when they have concerns about a prisoner; and
    - where this is not possible, requests for clinical tasks to be undertaken are properly documented.
- The Head of Healthcare should ensure that prisoners understand the reasons for shielding and have capacity to make an informed choice about whether to do so.
- The Governor should revise the risk assessment form for hospital escorts to make it clear that:
    - healthcare staff must provide information on the prisoner's current state of health and mobility; and

- prison managers must confirm that they have read and taken into account the healthcare information about the prisoner's current state of health and mobility in determining the level of security needed.

- The Prison Group Director for the East Midlands should assure the Ombudsman that managers 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 ensure that a debrief for staff is held after a death in custody.

The Investigation Process

8. NHS England commissioned an independent clinical reviewer to review Mr Summers' clinical care at the prison.

9. The PPO investigator has investigated non-clinical issues, including the prison's response to COVID-19 and shielding prisoners, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered. The investigator interviewed two members of staff at Gartree. The interviews were conducted by telephone because of the restrictions in place during the COVID-19 pandemic.

10. We informed HM Coroner for Leicester City and South Leicestershire of the investigation. She confirmed the cause of death. We have sent the Coroner a copy of this report.

11. One of the Ombudsman's family liaison officers contacted Mr Summers' sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Summers' sister did not have any specific questions.

Background Information

HMP Gartree

12. HMP Gartree, which is near Market Harborough in Leicestershire, holds up to 700 men sentenced to indeterminate or long-term sentences. Nottinghamshire Healthcare Foundation Trust provide healthcare services. Nurses are available 24 hours a day.

Previous deaths at HMP Gartree

13. Mr Summers was the fifth prisoner at Gartree to die since June 2018. Of the previous deaths, two were from natural causes and two were self-inflicted. There have since been two further deaths, both due to natural causes.

14. We have previously raised the inappropriate use of restraints on prisoners being taken to hospital.

COVID-19 (coronavirus)

15. COVID-19 is an infectious disease that affects the lungs and airways. It is mainly spread through droplets when an infected person coughs, or sneezes. The first reported case of COVID-19 in the UK was in February 2020. On 11 March, the World Health Organisation (WHO) declared COVID-19 as a worldwide pandemic.

16. COVID-19 can make anyone seriously ill, but the risk is higher for some people. There are two levels of higher risk: high-risk (clinically extremely vulnerable); and moderate risk (clinically vulnerable). People at high risk include those who have had an organ transplant; have a severe lung condition; or are having certain types of treatment for cancer; or have a condition with a very high risk of getting infections. Those at moderate risk include people over 70; people with a lung condition; or a chronic medical condition, such as diabetes, heart, liver, lung, or chronic kidney disease; or those who are very obese (this list is not exhaustive).

17. To reduce the spread of the virus, the Government introduced voluntary and mandatory actions, such as ‘social distancing’ and ‘lockdown’ (on 16 and 23 March, respectively). Public Health England (PHE), HM Prison & Probation Service (HMPPS) and NHS England worked together to devise measures to contain the outbreak, achieve social distancing, reduce the risk to the most vulnerable in prisons in England and protect the NHS (by reducing the number of people requiring specialist care in community-based hospitals).

Key Events

18. Mr Robert Summers was sentenced to life imprisonment for murder on 2 October 1974. He was released on licence in 2008 but in 2012 he was convicted of wounding and sentenced to four years imprisonment. His licence was revoked.

19. Mr Summers transferred to HMP Gartree on 7 February 2017. His medical record noted a history of ischaemic heart disease and angina. In May 2017, Mr Summers apparently had a stroke, although he refused to stay in hospital for further investigations.

20. In 2018, he was referred to the mental health team when staff became concerned about changes in his demeanour and symptoms of dementia, but he refused to engage with them. A cognition test in April 2019 suggested moderate dementia, although he was never formally diagnosed.

21. During his time in Gartree, Mr Summers sometimes suffered from chest pains. He often refused his medication, and on occasions when taken to hospital, refused treatment. He was prescribed medication for his angina. In January 2019, Mr Summers' medical record notes that he had emphysema (a lung condition causing shortness of breath). He sometimes coughed up blood, and in March 2019, a care plan was created for Chronic Obstructive Pulmonary Disease (COPD).

22. After a fall that required hospitalisation in early 2019, Mr Summers needed support equipment including an armchair in his cell, a Zimmer frame, a shower chair, and a grab rail in his cell toilet.

23. On 19 April 2020, Mr Summers complained of abdominal pain and was examined by a nurse. He told her that he had not eaten or drunk anything that day. His medical observations were all within the normal range. The nurse gave him paracetamol for his pain and encouraged him to drink fluids. Later, he told officers that he had vomited blood. He had not eaten his meal, but there was no evidence of blood in his cell. Officers reported this to the healthcare department. The night duty nurse telephoned the wing, and officers told her that Mr Summers had not made any further complaint. She asked them to monitor him and inform the healthcare team if there were any concerns.

23 to 24 April 2020

24. On the afternoon of 23 April, prison officers asked the prison paramedic to see Mr Summers. It was not an emergency, but they wanted her to check him as he looked unwell and said that he had not eaten that day. She went to his cell, but Mr Summers refused to let her assess him. At about 5.00pm, officers rang her again and asked her to see him, but said it was not an emergency.

25. When the prison paramedic got to Mr Summers' cell, Mr Summers was on his bed and had been incontinent. He told her that he could not get up but did not want her help. His meal was on the cabinet beside him, and he said that he had not eaten all day. Prison officers helped Mr Summers change his clothing and bedding, and they sat him in a chair. The prison paramedic took Mr Summers' medical observations, including his pulse, blood pressure, temperature, blood

oxygen levels and respiratory rate. They were all within normal limits. The prison paramedic said in interview that Mr Summers had no symptoms of COVID-19 at that time.

26. At 8.20am on 24 April, an officer unlocked Mr Summers' cell to allow a nurse to give him his medication. Mr Summers was lying on his bed and had been incontinent. The nurse gave Mr Summers his medication and contacted the prison paramedic to say he was concerned about Mr Summers. He was unable to walk about his cell as he usually did and appeared unwell. The nurse said that he asked the prison paramedic to take Mr Summers' medical observations, as he was making a medical round and did not have the necessary equipment to do so. He thought she spoke to the GP over the phone to prescribe antibiotics.

27. The prison paramedic, however, told the police that she remembered having a general conversation in the office, that included a prison doctor. The prison paramedic did not recall being asked to take Mr Summers' observations again. The prison paramedic told the doctor that Mr Summers had been unwell the previous night, but his medical observations were all within normal limits. The doctor prescribed antibiotics for a suspected urinary infection. The doctor did not see Mr Summers.

28. Two officers helped Mr Summers change and get comfortable on his bed. One of the officers told the police that he had no concerns about Mr Summers' welfare at that stage and was aware that healthcare staff would return to check him later that morning. The officer returned to the cell shortly afterwards, and again made Mr Summers comfortable on his bed.

29. The prison paramedic spoke to a healthcare assistant who knew Mr Summers from having provided social care. She asked the healthcare assistant to check if Mr Summers' health had deteriorated since she saw him the previous day. The healthcare assistant and a colleague went to see him sometime between 10.00am and 11.00am. While he looked unwell, she did not think he needed immediate medical assistance. He had been incontinent, but when they began to start helping him to change, he became abusive. They laid him back on the bed and left the cell.

30. At approximately 11.30am, an officer took Mr Summers' meal to him. Mr Summers was struggling to eat, so the officer peeled a banana for him and gave him some water. Mr Summers had difficulty drinking.

31. At 12.00pm, a nurse took Mr Summers' medication to him. He took the medication but seemed unwell and confused. He had been incontinent again. The nurse asked the prison officers on duty what he had eaten, and they said he had not eaten properly "for a few days". Prison staff should begin to record prisoners refusing food after they have done so for 72 hours. However, as Mr Summers had not refused all food as a form of protest, this mechanism had not been triggered.

32. At approximately 1.30pm, an officer checked Mr Summers. He brought a chair into Mr Summers' cell and helped him into it. He left the cell door open to allow fresh air to circulate. On two further occasions, as he passed Mr Summers' cell, he went in and helped make him comfortable again.

33. Shortly before 4.00pm, a nurse and a healthcare assistant went to see Mr Summers. His condition had deteriorated, and he had difficulty taking his medication. The nurse checked Mr Summers' medical observations, which were within normal parameters, except his blood oxygen levels which were low. He gave Mr Summers oxygen, and the levels went back up.

34. Prisoners were being let out of their cells to collect their meals. Some approached an officer and told him that they had passed Mr Summers' open door and seen him slumped in his chair. The officer explained that healthcare staff had just seen him. At approximately 5.00pm, just before finishing his shift, the officer checked Mr Summers again. He confirmed that he was okay and locked the cell door.

35. Shortly before 6.30pm, a nurse returned to check Mr Summers, and he was clearly unwell. The nurse found Mr Summers' blood oxygen levels were again low and his condition was not improving. Staff called an ambulance, and Mr Summers was taken to hospital.

36. A Custodial Manager (CM) completed an escort risk assessment and concluded that Mr Summers should be escorted by two officers, using the double cuffing method. (Double cuffing is when the prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs.) In this instance, the CM indicated that the additional set of cuffs would be what is known as an escort chain (which has a chain six feet long between the cuffs). The risk assessment was countersigned by another CM. Both managers were aware of Mr Summers' history of poor behaviour towards staff, including while attending hospital. Neither manager saw Mr Summers or sought input from the healthcare team before signing the risk assessment.

37. Mr Summers' condition did not improve. At 11.20pm he was moved to a different ward of the hospital, and his double cuffs were removed. He remained on an escort chain. The following morning, at 7.15am, Mr Summers died.

38. One of the prison's managers spoke to the staff who were on bed watch duty with Mr Summers when he died to discuss any issues arising, and to offer support. The prison Family Liaison Officer contacted Mr Summers' sister to inform her of her brother's death. In line with national guidance, the prison offered a financial contribution to the costs of Mr Summers' funeral.

Cause of death

39. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Summers' cause of death as COVID-19 pneumonia, with COPD and ischaemic heart disease as underlying conditions that contributed to but did not cause his death.

Information received after Mr Summers' death

40. After Mr Summers had died, a relative of a fellow prisoner contacted the Coroner's office saying that staff had not responded quickly to Mr Summers' deteriorating health on 24 April. The Coroner's office referred the matter to the police. The police investigated the matter and interviewed relevant staff. They took no further action.

Findings

Clinical Findings

41. The clinical reviewer considered the standard of care provided to Mr Summers up to 24 April 2020 was equivalent to that he could have expected to receive in the community. The care on the day of his hospitalisation, however, was not.

42. Mr Summers had several health conditions including COPD, a previous stroke, and ischaemic heart disease. He was prescribed appropriate medication, and when he complained of pain, including chest pain, the healthcare team responded appropriately. Care plans were in place, although none specifically focusing on his cardiac or stroke issues.

43. No one assessed Mr Summers' condition after he had reportedly vomited blood in his cell on the evening of 19 April, and officers were simply asked to monitor him.

44. The nurse told the police that on 24 April 2020, he did not call an ambulance for Mr Summers earlier in the day as, despite thinking he was unwell, he did not feel that he required urgent medical assistance.

45. There was some critical miscommunication within the healthcare team and poor recording that day. The nurse was concerned at Mr Summers' presentation but did not feel that it was his role to take clinical observations. In interview, the nurse said that he believed it was the responsibility of the emergency responder (known as Hotel One), the prison paramedic. The prison paramedic said that she did not recall being asked to take Mr Summers' observations, and that the nurse should have taken them himself. Guidance on the role of Hotel One does not clarify the issue. There is no note in Mr Summers' medical record to show that such a request was made. The result was a delay in taking Mr Summers' observations.

46. The clinical reviewer considers that this lack of effective communication must be addressed. We agree, and make the following recommendation:

    The Head of Healthcare should ensure that:

    - **nurses take medical observations when they have concerns about a prisoner; and**
    - **where this is not possible, requests for clinical tasks to be undertaken are properly documented.**

47. The clinical reviewer made some further recommendations that the Head of Healthcare will need to address.

Management of Mr Summers' risk of catching Covid-19

48. On 13 March, the National Health and Justice team issued an interim notice providing advice on preventing and controlling outbreaks of COVID-19 in prisons. HMPPS issued further instructions over the following weeks with guidance on the appropriate use of personal protective equipment (PPE), hygiene, cleaning

schedules and stock checks. The guidance outlined the importance of effective preventative measures and that methodical cleaning would help prevent infection spread. On 24 March, HMPPS issued an instruction, in line with Government advice, to all prisons to introduce social distancing and to implement a restricted regime and supported enforcement of social distancing of two metres for staff and prisoners wherever possible. The most vulnerable prisoners were identified and put into protective isolation.

49. On 31 March HMPPS, in consultation with Public Health England (PHE), issued an order to significantly reduce transfers between prisons and to implement 'compartmentalisation' measures were implemented. These measures were designed to be implemented at local level, depending on the needs of each individual establishment and included:

- Protective Isolation Units (PIUs): to accommodate known or probable COVID-19 cases, ideally in single-cell accommodation.
- Shielding Units (SUs): to protect the most vulnerable identified through collaboration with NHS England, with enhanced levels of bio-security including dedicated staff;
- Reverse Cohorting Units (RCUs): to accommodate new receptions or transfers in for a period of 14 days to detect any emergent infectious cases before entering general population. These units could also accommodate any one returning from hospital.

50. Gartree's healthcare department followed the published advice from NHS England. They wrote letters to all prisoners who had chronic conditions, were on certain medications, or were over 70 years old. The letters explained the situation and offered the prisoners the opportunity to isolate in their cells. Information about coronavirus published by the prison, and specifically by the healthcare department, was posted on all wings.

51. The healthcare department sent a letter to Mr Summers on 31 March. He did not respond. There was no system in place to follow up any non-responses, and, given Mr Summers' limited mobility, he may not have seen the information posted around the wing. Moreover, there is no evidence that staff took steps to ensure that Mr Summers had read or understood the situation. Given his medical record documented possible moderate dementia, we consider that this was a concerning omission.

52. Medical observations taken on 23 and 24 April were stable, and Mr Summers did not display symptoms of COVID-19 until an ambulance was called shortly before he was taken to hospital. Nevertheless, the clinical reviewer noted that Mr Summers was at risk from the virus because of his age and his medical condition. It was the prison's responsibility to ensure he understood the importance of shielding.

53. The Prison Service must be confident that prisoners understand the reasons for shielding and have capacity to decide whether to shield or not. We make the following recommendation:

The Head of Healthcare should ensure that prisoners understand the reasons for shielding and have capacity to make an informed choice about whether to do so.

Non-clinical Findings

Restraints, security and escorts

54. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this must 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 considering factors such as 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.

55. Prison Service Instruction (PSI) 33/2015 says:

> "Normal practice is for male Category B and Escape-List prisoners to be double cuffed while on escort. All other prisoners will be single cuffed unless the individual risk assessment indicates that double cuffing is required and is proportionate."

The PSI goes on to say:

> "Handcuffs will not normally be used … if "the prisoner's medical condition or advanced age or physical impairment renders restraints inappropriate. Restraints will not normally be necessary for example, when the prisoner's mobility is severely limited, e.g. due to advanced age or disability unless there are grounds for believing that an escape attempt may be made with external assistance.".

56. When he was taken to hospital on 24 April, Mr Summers was restrained using double cuffs. Mr Summers had a history of being difficult during hospital visits. We note, though, that the CM who completed the escort risk assessment did not see Mr Summers before signing it, and the CM who countersigned it only saw him being taken into the ambulance as he left the prison. They did not seek views from their healthcare colleagues about the impact of his medical condition on his level of risk. While Mr Summers' record clearly suggested he might present a security risk while on escort, we are not satisfied that the authorising managers took into account his physical health and mobility when deciding that it was necessary for him to be restrained.

57. At 11.20pm, Mr Summers was moved to a hospital ward and at that point the double cuffs were removed. Mr Summers remained on an escort chain. Records indicate that he did at times get agitated during the night.

58. In March 2018, in response to similar concerns about the inappropriate risk assessment of prisoners before escort, the prison told us that escort risk assessments did take account of the prisoner's health and mobility. We raised further concerns in another report in April 2019. The recommendations were accepted, and the prison undertook to ensure that managers must confirm that they had read and taken into account the healthcare information about a prisoner's current state of health and mobility in determining the level of security needed.

59. Although the prison's action plan was not scheduled to be completed before Mr Summers was taken to hospital, we are very concerned to be raising this issue again. In interview, both authorising managers said that they did not consider Mr Summers' current mobility when making their decisions and there is no evidence that they sought input from healthcare colleagues. Both managers indicated that Mr Summers should be subject to double cuffing and an escort chain. These are separate levels of restraint, but in this instance seem to have been combined.

60. As the prison has not addressed this issue, we escalate this matter to the attention of the Prison Group Director and make the following recommendations:

The Governor should revise the risk assessment form for hospital escorts to make it clear that:

- **healthcare staff must provide information on the prisoner's current state of health and mobility; and**
- **prison managers must confirm that they have read and taken into account the healthcare information about the prisoner's current state of health and mobility in determining the level of security needed.**

The Prison Group Director for the East Midlands should write to the Ombudsman setting out what he is doing to satisfy himself that managers at Gartree 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.

Debrief

61. When Mr Summers died, the duty governor spoke to the staff who were on bed watch duty with Mr Summers when he died to discuss any issues arising, and to offer support. There should have been a debrief for all staff involved in the emergency response, as set out in PSI 09/2014, *Incident Management Manual*. We make the following recommendation:

The Governor should ensure that a debrief for staff is held after a death in custody.

Sue McAllister CB **December 2020**
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