Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Roberts a prisoner at HMP High Down on 22 April 2018

A report by the Prisons and Probation Ombudsman

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Our Vision

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

Our Values

We are:

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

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

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

Mr Anthony Roberts died on 22 April 2018, of cardiorespiratory arrest, caused by asthma, chronic obstructive pulmonary disease (COPD) and heart disease, while a prisoner at HMP High Down. He was 55 years old. I offer my condolences to Mr Roberts' family and friends.

Mr Roberts had only arrived at High Down on remand the day before his death. He had severe COPD and relied on medication to manage his symptoms. Healthcare staff at High Down did not verify the severity of his condition or his medication. The care he received for the management of his chronic condition was poor and was not equivalent to that which he could have expected to receive in the community.

I am concerned that, although Mr Roberts needed to go to hospital as an emergency, there was an unnecessary delay in the ambulance leaving the prison. I am also concerned that staff made an inappropriate decision on the use of restraints when sending Mr Roberts to hospital.

This is the ninth occasion since January 2013 when we have expressed concern about the inappropriate use of restraints at High Down. In a previous report in March 2018, we drew this unsatisfactory state of affairs to the attention of the Prison Group Director, as well as making a recommendation to the Governor. Although the prison accepted our recommendation, it is clear that effective action has not yet taken place. I have, therefore, recommended that the Prison Group Director for Surrey and Sussex should assure himself that the Governor takes effective action to address the inappropriate use of restraints.

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 **March 2019**

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Summary

Events

1. On 21 April 2018, Mr Roberts was remanded to HMP High Down after being arrested for theft and threatening behaviour.

2. During the prison reception health screen Mr Roberts told a nurse that he was a long-term opiate user and was taking methadone. He also said he had chronic obstructive pulmonary disease (COPD) and asthma for which he used inhalers, but only had one of his inhalers with him.

3. Mr Roberts was moved to the substance misuse houseblock. When he arrived, he saw a substance misuse GP and a nurse. Mr Roberts reiterated that he had COPD and took methadone. The nurse confirmed Mr Roberts' methadone prescription with his community pharmacy but the GP told Mr Roberts he would have to wait until the next weekday (23 April) to confirm his inhaler prescriptions. His basic observations were checked and were normal. A substance misuse nurse observed Mr Roberts twice through the night and noted that he did not have any signs of withdrawal or intoxication.

4. On 22 April, at 9.30am, a healthcare assistant took Mr Roberts' basic observations, which were normal. At 11.00am, Mr Roberts told a prison officer that he was short of breath and his inhaler was not working. Mr Roberts was seen by a nurse at the request of staff. The nurse noted that he was alert and able to speak in sentences but had a wheeze. His basic observations were normal but his oxygen saturations were low. The nurse treated Mr Roberts with a nebuliser and his condition improved. The nurse told Mr Roberts that if his condition worsened, he should let staff know and he would be sent to hospital.

5. At about 2.10pm, Mr Roberts told prison officers that his condition was getting worse. An officer radioed a code blue emergency. A nurse responded, and gave Mr Roberts oxygen until paramedics arrived at 2.36pm. The paramedics put Mr Roberts on a nebuliser but his oxygen saturation levels did not improve and they decided that he needed to go to hospital as a priority.

6. There was a 10-15 minute delay in the ambulance leaving the prison because of an administrative error with the escort risk assessment paperwork. Prison managers did not keep up to date with Mr Roberts' condition during this time, so they did not know that his condition had deteriorated in the ambulance. Two officers escorted Mr Roberts to hospital and applied double cuffs and an escort chain.

7. The ambulance left the prison at 3.36pm, and arrived at the hospital 10 minutes later. The double cuffs were removed but the escort chain remained on and became tangled in Mr Roberts' legs when staff moved him to the hospital bed. Shortly afterwards, Mr Roberts started to hallucinate and then went into cardiac arrest. The escort chain was removed and hospital staff tried to resuscitate him.

8. Mr Roberts' condition did not improve and at 4.55pm, a hospital doctor confirmed that Mr Roberts had died.

Findings

9. We agree with the clinical reviewer that Mr Roberts received a variable level of care while at High Down. Although interaction and observation from the substance misuse team was good, the response to Mr Roberts' COPD and asthma was not equivalent to that he could have expected to receive in the community.

10. Mr Roberts' COPD was severe and he relied on medication to manage his condition. Healthcare staff did not attempt to obtain Mr Roberts' medical history or prescriptions and did not take his baseline oxygen saturation levels, which would have assessed the severity of his condition.

11. Prison and healthcare staff responded promptly to Mr Roberts' presenting symptoms, and healthcare staff called an ambulance when they realised they could not manage his symptoms in the prison.

12. Completion of the escort risk assessment paperwork caused a significant delay in the ambulance leaving the prison. Prison managers did not obtain up-to-date information about Mr Roberts' condition. If they had been aware that his condition was deteriorating, the ambulance could have left the prison immediately without the risk assessment documentation.

13. We are concerned that the prison did not take account of Mr Roberts' poor health when considering the use of restraints. We do not consider that it was appropriate or proportionate to use double cuffs and an escort chain given that he was being taken to hospital as an emergency, was in very poor health and was assessed as presenting a low risk.

Recommendations

- The Head of Healthcare should review the reception screen process for patients with chronic diseases, including COPD and asthma, and should put in place a robust system to ensure healthcare staff appropriately assess disease severity and record baseline observations.

- The Head of Healthcare should ensure a robust system is put in place within three months of the date of this report to obtain information from a prisoner's GP or other sources during the reception screen. This should cover when it may be appropriate to access information urgently and when it may be appropriate to access information if a prisoner enters custody at a weekend or other times when community services may not be open.

- The Governor should ensure that all staff are aware of their responsibilities during a medical emergency and prison managers stay up-to-date on a prisoner's condition to ensure the ambulance can leave the prison without delay.

- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that risk assessments show clear justification for the use of restraints.

- The Prison Group Director, Surrey and Sussex, should assure himself that the Governor takes effective action to address the inappropriate use of restraints at HMP High Down.

The Investigation Process

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

15. The investigator visited High Down on 1 May 2018. She obtained copies of relevant extracts from Mr Roberts' prison and medical records.

16. The investigator interviewed seven members of staff at High Down on 11 and 26 June. She interviewed two members of staff by telephone on 12 and 20 June.

17. NHS England commissioned a clinical reviewer to review Mr Roberts' clinical care at the prison.

18. We informed HM Coroner for Surrey of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

19. The investigator contacted Mr Roberts' partner and sons to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Roberts' partner wanted to know the details of what happened to Mr Roberts when he became unwell, including who attended to him and the timings.

20. Mr Roberts' partner received a copy of the initial report. The solicitor representing Mr Roberts' partner raised an issue that did not impact on the factual accuracy of the report.

21. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP High Down

22. HMP High Down is a local prison in Surrey, which at the time of Mr Roberts' death, held up to 1,130 men. Central and North-West London NHS Foundation Trust provides primary health services and in-reach mental health care. The healthcare unit has inpatient facilities with 24-hour nursing cover. The Forward Trust provides both clinical and psychosocial drug and alcohol services.

HM Inspectorate of Prisons

23. The most recent inspection of High Down was in May 2018. Inspectors reported that reception was busy and the processes were disorganised and slow. Staff dealt with prisoners sympathetically and the system to identify risk factors on arrival was adequate. Delays in carrying out healthcare assessments kept prisoners in reception for too long. Reception health screening was thorough and identified health concerns, but prisoners waited too long to be assessed and transferred to first night accommodation, which carried a potential risk, particularly for prisoners who needed help with detoxification and ongoing treatment.

24. The Forward Trust teams were well managed and staff with appropriate skills and expertise offered integrated and effective care. The clinical team was based on houseblock 4, six days a week. Long delays in the reception process resulted in some prisoners not reaching their first night accommodation or receiving their first dose of methadone until the early hours of the morning., Houseblock 4 provided a safe environment and 24-hour nursing cover to monitor prisoners during stabilisation or detoxification. Prisoners receiving opiate substitute treatment were appropriately located and the supervision of controlled drugs administration on houseblock 4 was prioritised.

Independent Monitoring Board

25. 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 December 2017, the IMB said that GPs were planning to increase their sessions and provide additional clinics with support in reception from nurse practitioners. The range of outpatient clinics had been extended to include consultants coming in from local hospitals to provide orthopaedic advice and further clinics were being arranged in 2018. Where risks were identified, prisoners were managed under supervised medication. There were 250 prisoners on supervised medication including over 100 on houseblock 4, where Methadone and Subutex treatment programmes was provided.

Previous deaths at HMP High Down

26. Mr Roberts was the eighth prisoner to die of natural causes at HMP High Down since January 2016. This is the ninth time we have made a recommendation about the unjustified use of restraints at High Down since 2013.

Key Events

27. On 20 April 2018, Mr Anthony Roberts (known as Terry Roberts to his family) was arrested for theft and threatening behaviour and was taken into police custody.

28. Mr Roberts told a police healthcare professional that he had asthma, chronic obstructive pulmonary disease (COPD, a group of lung conditions that cause breathing difficulties), had smoked heroin for over 20 years and had last smoked two days before. He said he had been coughing up green phlegm for a couple of weeks but had not seen his community GP, and was taking 30ml of methadone. A medical officer gave Mr Roberts his methadone medication at 11.10pm that evening and diazepam (a type of benzodiazepine, a sedative) to help him sleep. He had used his salbutamol inhaler three times between 6.30pm and 11.10pm. Mr Roberts was checked every half an hour and did not show any signs of withdrawal or being acutely unwell.

29. On 21 April, Mr Roberts was remanded to HMP High Down and arrived in reception at about 2.00pm. a nurse completed Mr Roberts' initial health screen at 2.42pm. She noted he was an opiate user but was not showing any signs of withdrawal. A urine test showed a positive result for methadone and benzodiazepines. No other drugs were detected. Mr Roberts said he had asthma and COPD and had a salbutamol inhaler with him. She said that he should tell healthcare staff if his inhaler ran out. She referred Mr Roberts to the substance misuse services and he was moved to houseblock 4, the substance misuse wing.

30. At 5.00pm, Mr Roberts saw the substance misuse GP and a nurse on houseblock 4. Mr Roberts said that he had COPD for which he had several inhalers. He said one of the inhalers was called Symbicort but he could not remember the dosage. As it was a Saturday, the substance misuse GP said Mr Roberts' community GP service could not confirm his inhaler prescriptions until Monday. However, Mr Roberts said he had his salbutamol inhaler with him, which was the most important one. The nurse contacted Mr Roberts' local pharmacy to confirm his methadone prescription. The substance misuse GP said Mr Roberts did not complain of any respiratory distress or mention a cough or green phlegm. Mr Roberts' blood pressure and pulse were checked and were normal.

31. A substance misuse nurse observed Mr Roberts through his cell observation hatch twice through the night. The nurse noted that Mr Roberts had no signs of withdrawal or intoxication.

Events of 22 April

32. At 9.30am, a healthcare assistant took Mr Roberts' basic observations including his blood pressure and pulse. His observations were normal.

33. At 11.00am, Mr Roberts came out of his cell and told an officer that he was short of breath. He was holding his inhaler and said it was not working and had run out. The officer walked up the stairs to the medication hatch to ask a nurse to see Mr Roberts. The nurse asked her to bring him up to the hatch, but when she

went to get Mr Roberts he said he could not walk up the stairs. An officer stayed with Mr Roberts while the other officer asked the nurse to come to his cell. She went straight away and helped the officers walk Mr Roberts back to his cell and onto his bed. It was 11.15am.

34. Mr Roberts told the nurse he had COPD and asthma, and was short of breath. She noted he was alert but was struggling to speak in sentences and was using his chest muscles to breathe. She listened to his chest and noted a wheeze when he breathed out. Mr Roberts said he had recently had a chest infection that was treated with antibiotics. She found no signs of infection remaining. She took his observations, which were normal, but his oxygen saturations were low at 88% and his respirations were high. She asked an officer to call a code blue emergency over the radio (indicating that a prisoner is unconscious, not breathing or is having breathing problems) and for a nebuliser to be brought. She gave the instruction that no ambulance was needed at present because she intended to treat him with the nebuliser medications first. The officer called a code blue over the radio at 11.21am.

35. A nurse was on houseblock 2 and responded to the code blue call. He made his way to the healthcare centre to get the nebuliser but it was not there. He then made his way straight to houseblock 4 to help the other nurse. On the way, he radioed to find the nebuliser, which was on another houseblock, and another nurse brought it straight to houseblock 4. It took him about 10 minutes to get to the cell after responding to the code blue. The other nurse said Mr Roberts' condition did not deteriorate during this time.

36. When a nurse arrived at the cell, the other nurse went to the pharmacy to collect the nebuliser medications. As it was a Sunday, the pharmacy was locked so she had to go to the prison gate to get the keys. She said it took her 10-15 minutes to get back to the cell. She said Mr Roberts' condition did not change in that time.

37. Mr Roberts was given two doses of 2.5ml salbutamol and one dose of 1ml of a steroid in the nebuliser. He appeared to improve after treatment. His oxygen saturations were 90-93%. A nurse told Mr Roberts to press his cell bell if he felt worse and that he would be sent to hospital.

38. At about 2.05pm, an officer was in the wing office when she saw Mr Roberts' cell bell light on. She went to his cell with another officer. They opened his cell door and Mr Roberts walked out and leaned over the pool table. He was short of breath. The other officer called a code blue over the radio and went to the wing office and telephoned the control room to give additional information. The communications log showed the radio call was made at 2.13pm, and an ambulance was called immediately.

39. One officer stayed with Mr Roberts and talked to him to keep him calm. She said he was talking back to her. A nurse arrived within five minutes and had brought the emergency bag. She told the investigator that Mr Roberts' condition was no worse than the morning and his observations were not critical for someone with COPD. His oxygen saturations were under 91% and his respirations were over 25. She put Mr Roberts on oxygen while they waited for the paramedics. She said that she was unsure if Mr Roberts could have more nebuliser medications.

40. Paramedics arrived at 2.36pm, and put Mr Roberts on the nebuliser with salbutamol and Atrovent. His blood pressure was initially high, but settled, and his skin colour was good. The last dose of salbutamol was administered at 3.00pm. Mr Roberts' symptoms did not improve and the paramedics decided he needed to be transferred to hospital as a priority. The paramedics radioed the Hospital to inform them they were on the way.

41. Two officers were assigned to escort Mr Roberts to hospital. Mr Roberts was talking and alert and he made his way into the ambulance without assistance. The paramedics put him on oxygen and one officer double-cuffed Mr Roberts to the other officer and applied an escort chain. (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. An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.)

42. The escort risk assessment paperwork was completed for another prisoner with the same name by mistake and had to be re-written, which caused a delay in the ambulance leaving the prison. A prison manager radioed for the paperwork to be completed and taken straight to reception where the duty manager would sign the risk assessment. The paramedics drove round to the front of the prison and waited for the paperwork. While they were waiting, Mr Roberts was unable to maintain his oxygen saturation levels and his condition was deteriorating. An officer told the investigator Mr Roberts was obviously uncomfortable and in distress.

43. The paramedics asked an Operational Support Grade who was waiting with the ambulance what the delay was and said they needed to leave the prison as a priority because Mr Roberts' condition was deteriorating. He said he was waiting for the escort paperwork and had radioed the communications room for an update but they did not have any information. The paramedics said they waited for about 10-15 minutes before they were given permission to leave the prison to go to hospital. The communications log showed the ambulance left the prison at 3.36pm.

44. The ambulance arrived at the hospital at 3.46pm. Mr Roberts was taken straight into the resuscitation area of the Accident and Emergency department. Mr Roberts was uncomfortable and would not lie down on the stretcher to be moved to the hospital bed as he said he could not breathe lying down. At 4.10pm, an officer removed the double cuffs.

45. An officer and hospital staff helped Mr Roberts move to the hospital bed but his legs became tangled in the escort chain. Shortly after, Mr Roberts' eyes rolled back and he started to hallucinate. At 4.15pm, while the officer was on the telephone to the prison, Mr Roberts went into cardiac arrest and the nurses shouted for the restraints to be removed immediately. One of the officers shouted for the other officer to take the escort chain off, which he did immediately.

46. Hospital staff began cardiopulmonary resuscitation (CPR) but Mr Roberts did not regain consciousness. At 4.55pm, a hospital doctor confirmed that Mr Roberts had died.

Contact with Mr Roberts' family

A prison officer was appointed as the prison family liaison officer. The officer and the Duty manager visited Mr Roberts' partner's home at 7.00pm to inform her that Mr Roberts had died in hospital. They explained what would happen next and the officer left her contact details. The officer and the duty manager stayed with Mr Roberts' partner until her pastor arrived to provide support. The officer provided on-going support to Mr Roberts' partner.

47. Mr Roberts' funeral was held on 10 May. The prison made a financial contribution towards the cost the funeral in line with national guidance.

Support for prisoners and staff

48. After Mr Roberts' death, the Duty manager debriefed the staff involved in the hospital escort to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

49. The prison posted notices informing other prisoners of Mr Roberts' 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 Roberts' death.

Post-mortem report

50. The toxicology report indicated the presence of cocaine, benzodiazepine, methadone, morphine and codeine in Mr Roberts' system when he died. The toxicologist noted that the risk of respiratory depression (a life-threatening condition where the lungs cannot provide the body's vital organs with enough oxygen) is increased by the use of methadone and diazepam (a type of benzodiazepine), particularly in an individual like Mr Roberts with underlying respiratory issues. The toxicologist also noted that cardiotoxicity (damage to the heart muscle) from previous use of cocaine might have played a part in Mr Roberts' death.

51. The post-mortem report gave Mr Roberts' cause of death as cardiorespiratory arrest caused by asthma, COPD and myocardial fibrosis (scarring of the heart muscle), with cocaine use as a contributory factor.

Findings

Clinical care

52. Mr Roberts had COPD and asthma. His community GP records (which were not available to healthcare staff) showed that he had very severe COPD and was at high risk of associated symptoms. He was reliant on high levels of medication to manage his condition. While in the community, Mr Roberts had had exacerbations of his symptoms leading to admission to hospital, and on one occasion to the intensive care unit where he was placed on a ventilator. Mr Roberts' condition while at High Down initially remained stable until he had sudden onset exacerbation of his symptoms.

53. The clinical reviewer found that Mr Roberts' COPD was very severe and was probably nearing the end stages of the condition. Due to his lifestyle and chronic condition, he was underweight (which indicates a poorer outcome for those with COPD). The community GP had referred Mr Roberts to a specialist chest clinic for advice and rehabilitation treatment, but he had not attended those appointments.

54. The clinical reviewer concluded that overall, the standard level of clinical care that Mr Roberts received while at High Down was variable. The management and monitoring of Mr Roberts' heroin withdrawal symptoms was good and equivalent to the care he could have expected to receive in the community. However, there is no recorded evidence that healthcare staff took his baseline oxygen saturation levels during his reception screen, which would have highlighted the severity of his COPD and asthma, and they did not request additional information or ask for advice from a senior clinician. This was below the equivalent care he could have expected to receive in the community.

55. We are concerned that there is no system in place at High Down for healthcare staff to record and monitor the severity of prisoners' long-term medical conditions. We make the following recommendation:

    The Head of Healthcare should review the reception screen process for patients with chronic diseases, including COPD and asthma, and put in place a robust system to ensure healthcare staff appropriately assess disease severity and record baseline observations.

Medication

56. Mr Roberts had a long history of substance misuse and was receiving methadone treatment in the community. A prison nurse promptly confirmed his methadone prescription with the community dispensing pharmacy and Mr Roberts appropriately received his methadone while at High Down.

57. However, healthcare staff did not obtain information about Mr Roberts' COPD medication. He was prescribed various inhalers in the community to help manage his condition. When he arrived at High Down, he only had a salbutamol inhaler. Access to Mr Roberts' community GP records would have provided significant information about the type and dose of his inhaler medications and the severity of his condition.

58. Prison Service Order (PSO) 3050, Continuity of Healthcare for Prisoners, emphasises the importance of continuity in clinical interventions and treatment from community to prison healthcare. When a prisoner has a reception health screen, efforts should be made to retrieve any information required from the prisoner's community GP or other relevant service they have recently been in contact with. There are a number of possible information sources, including the prisoner's community GP, NHS out-of-hours advice service, previous custodial records, police records, the prisoner's dispensing pharmacy and the prisoner's family.

59. The clinical reviewer noted that the only evidence that any attempt was made to obtain Mr Roberts' medical information was a copy of his signed disclosure form. Although it may not have been possible to obtain his records from his GP surgery on a Saturday, there is no evidence that healthcare staff in reception tried to do this, or that they reviewed his police custody records or escort paperwork, or that any effort was made to contact any other source for information. This is concerning, given that Mr Roberts had a chronic disease and was reliant on medication.

60. Although it is not possible to say whether the absence of his usual medications affected the outcome for him, the clinical reviewer concluded that staff missed steps to ensure the correct medication was available to Mr Roberts. The clinical reviewer found that this was below the equivalent care he could have expected to receive in the community.

61. We make the following recommendation:

The Head of Healthcare should ensure a robust system is put in place within three months of the date of this report to obtain information from a prisoner's GP or other sources. This should cover when it may be appropriate to access information urgently and when it may be appropriate to access information if a prisoner enters custody at a weekend or other times when community services may not be open.

Emergency response

62. Mr Roberts sought help from prison and healthcare staff after feeling short of breath on the morning of 22 April and the responding nurses treated him. Although there was a delay in obtaining the equipment and medication, his condition improved.

When Mr Roberts became breathless again in the afternoon, the officers immediately requested an ambulance, which arrived promptly.

Delay leaving the prison

63. The ambulance was unable to leave the prison immediately because of an administrative error with the escort risk assessment paperwork. The prison manager arranged for new paperwork to be completed and asked for the escort paperwork to be taken to reception to meet the ambulance so it could leave without delay. However, completion of the paperwork caused an unacceptable delay of around 10-15 minutes before the ambulance was given permission to

leave the prison, during which time Mr Roberts' condition was rapidly deteriorating.

64. Paramedics repeatedly asked for updates on what was causing the delay and repeated that Mr Roberts needed to go to hospital as a priority. Mr Roberts' falling oxygen saturation levels indicated a risk of respiratory failure, a medical emergency requiring urgent clinical assessment. As in any acute medical emergency, time is critical, and not just minutes, seconds can determine the difference between life and death.

65. Although an Operational Support Grade radioed the communications room for an update, the officers there said they did not have any information. He told the investigator he was unable to leave the ambulance to ask for information. However, it is unclear why he did not ask the communications room officers to radio the duty prison manager for an update. The prison manager said she was unaware of the urgency of the situation, but none of the on-duty prison managers kept up to date with Mr Roberts' condition while waiting for the paperwork. She said that an ambulance can leave the establishment without the paperwork in an emergency. If communication had been better between prison staff, Mr Roberts could have been taken to hospital straight away.

66. We make the following recommendation:

The Governor should ensure that all staff are aware of their responsibilities during a medical emergency and that prison managers stay up to date on a prisoner's condition to ensure the ambulance can leave the prison without delay.

Restraints, security and escorts

67. 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 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 taking into account factors such as the prisoner's health and mobility.

68. A High Court judgement 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.

69. Mr Roberts was a remand prisoner, who had been at High Down for less than 24 hours. A nurse and a prison manager completed the risk assessment for the hospital escort. The nurse noted there were no medical objections to the use of restraints, which could only be removed in an emergency. The prison manager highlighted that there was not a lot of information about Mr Roberts in his prison electronic record, NOMIS, but he assessed Mr Roberts as low risk to the public, staff and of escape or hostage taking. The duty manager authorised the use of double cuffs and an escort chain.

70. We are concerned that restraints were used, in addition to Mr Roberts being escorted by two officers. We question whether this was appropriate given that his health was clearly deteriorating. We are also unclear why restraints were considered necessary and proportionate to the risks he posed, over and above the control already available through the escorting officers, and we question why the double cuffs were only removed twenty minutes after arriving at hospital, when his condition was clearly poor. The escort chain also became a hindrance because Mr Roberts' legs had become tangled in the chain while he was being moved to the hospital bed and it was not removed immediately to enable hospital staff to treat him without restriction.

71. It is the Governor's responsibility to ensure that the risk assessment process is managed properly, and all prison managers need to show a clear justification for any use of restraints in carrying out the risk assessment. Healthcare staff also need to understand their role in assessing the impact the prisoner's current state of health has on his mobility. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that risk assessments show clear justification for the use of restraints.

72. We are concerned that this is the ninth time we have expressed concern about the inappropriate use of restraints on prisoners at High Down. We have already escalated our concerns to the Prison Group Director. Given the prison's failure to introduce effective measures to address our concerns, we again make the following recommendation:

The Prison Group Director, Surrey and Sussex, should assure himself that the Governor takes effective action to address the inappropriate use of restraints at HMP High Down.

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