Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alan Wilson, a prisoner at HMP Doncaster, on 22 December 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*

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 Alan Wilson died in hospital on 22 December, while a prisoner at HMP Doncaster. He was 63 years old. The cause of his death was a viral infection and he had several chronic underlying conditions. I offer my condolences to Mr Wilson's family and friends.

Mr Wilson had several chronic medical conditions but was non-compliant with all aspects of his care. I am satisfied that healthcare staff tried hard to offer appropriate support throughout his time at Doncaster and that his care was equivalent to that he could have expected to receive in the community.

Mr Wilson was a wheelchair user. I am concerned that prison staff who authorised the use of restraints for his final journey to hospital did not take sufficient account of his reduced mobility, as well as the additional incapacity caused by breathing difficulties. The inappropriate use of restraints is a matter I have previously raised with Doncaster and with the Executive Director for Custodial Contracts in HMPPS.

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 **February 2022**

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Summary

Events

1. Mr Alan Wilson had been at HMP Doncaster since 11 July 2012. He had been sentenced to 25 years imprisonment for sexual offences.

2. Mr Wilson had several long-term medical conditions, including high blood pressure, ischaemic heart disease and chronic obstructive pulmonary disease (COPD). He was a wheelchair user and lived in the prison's social care unit. Mr Wilson persistently refused to engage with health services, declining reviews, clinical observations, tests and referrals to specialists.

3. On 11 December 2020, Mr Wilson felt weak and short of breath. At that time, he was in protective isolation, having had contact with a prisoner who had tested positive for COVID-19. A swab was taken for testing, but the prison did not receive the results. On 18 December, Mr Wilson's condition worsened and he was admitted to hospital. He did not respond to treatment and died on 22 December.

Findings

4. The clinical reviewer found that Mr Wilson received a good standard of clinical care, equivalent to that he could have expected to receive in the community. Despite his attitude towards health services, healthcare staff continued to offer support and monitored him under the multidisciplinary complex case arrangements. When Mr Wilson became acutely unwell, he was promptly referred to secondary care. The clinical reviewer made no recommendations.

5. Mr Wilson was handcuffed with an escort chain for his journey to hospital and during the first day of his hospital admission. We consider that the security risk assessment did not fully consider his circumstances as a wheelchair user with limited mobility, or his physical condition at the time and that he was inappropriately restrained.

Recommendation

- The Director should ensure that all staff undertaking and reviewing risk assessments for prisoners admitted to hospital understand the legal position on the use of restraints, that assessments fully take into account the prisoner's health and are based on the actual risk he presents at the time.

The Investigation Process

6. The investigator issued notices to staff and prisoners at HMP Doncaster informing them of the investigation and asking anyone with relevant information to contact her.

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

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

9. We informed HM Coroner for Yorkshire South East of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

10. One of the Ombudsman's family liaison officers contacted Mr Wilson's next of kin, his son, to explain the investigation and to ask if he had any matters they wanted the investigation to consider. He did not reply.

11. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies. They provided an action plan which is annexed to this report.

Background Information

HMP Doncaster

12. HMP Doncaster is a local prison, operated by Serco. It holds up to 1,145 prisoners who have been remanded in custody or sentenced. Care UK provides clinical services. The healthcare team has qualified paramedics, who respond to emergency calls in the prison.

HM Inspectorate of Prisons

13. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Doncaster in September 2019. Inspectors reported an improvement in health services since the previous inspection and found that healthcare and operational staff worked well together at management and operational levels. Prisoners had good access to services and waiting times were the same as in the community. Inspectors observed staff caring for the men appropriately, despite the highly challenging environment and population.

Independent Monitoring Board

14. 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 most recent annual report, for the year to 30 September 2019, the IMB reported that they had observed a high standard of professionalism and care, but they were concerned that 20% of complaints to the Board were about healthcare.

Previous deaths at HMP Doncaster

15. Mr Wilson was the 21st prisoner at Doncaster to die, since December 2018. Nine of the previous deaths were self-inflicted, nine were from natural causes and two were drug-related. There have been six further deaths: three from natural causes, two self-inflicted and one drug-related. Three of the deaths were due to COVID-19. We have previously raised the issue of inappropriate use of restraints.

Key Events

16. Mr Alan Wilson was remanded to HMP Doncaster on 11 July 2012. He was later convicted of sexual offences and sentenced to 25 years imprisonment.

17. At an initial health screen, a nurse noted that Mr Wilson had high blood pressure, ischaemic heart disease, a previous heart attack and mental health problems. He was later diagnosed with COPD. Mr Wilson had reduced mobility and became a wheelchair user. He received social care and for the last five years of his life he lived in the prison's social care unit.

18. Due to his chronic health conditions, Mr Wilson was assigned a healthcare case manager and case coordinator. However, his medical records noted a longstanding and persistent failure to cooperate with healthcare staff. He missed medical appointments and refused observations, medication and tests. Disclaimers were signed each time. He also declined referrals to cardiology and neurology specialists for potentially serious conditions. Nevertheless, he was discussed at fortnightly multidisciplinary complex case team meetings.

19. Healthcare staff frequently noted that Mr Wilson had the mental capacity to make his own decisions, but he declined to engage with formal capacity assessments.

20. In May 2020, Mr Wilson was identified as at moderate risk of complications from COVID-19 (clinically vulnerable).

21. On 6 December 2020, Mr Wilson was placed in isolation due to contact with another prisoner who had tested positive for COVID-19. A swab was taken on 7 December and the result was negative.

22. On 11 December, Mr Wilson became unwell and was noted to have symptoms of COVID-19. Another swab was taken, but no results were returned. Over the next few days, he ate very little but drank fluids. On 16 December, he refused to allow clinical observations to be taken.

23. During a social care visit on the morning of 18 December, a healthcare assistant found that Mr Wilson was weak, tired and short of breath. He asked a nurse to examine Mr Wilson and clinical observations revealed low oxygen saturation levels. An ambulance was requested and Mr Wilson was monitored and given oxygen until the paramedics arrived.

24. The paramedics took Mr Wilson to hospital at 12.20pm. Two prison officers escorted him, using an escort chain. Mr Wilson moved to the Acute Medical Unit at 6.20pm and the prison was informed. At 9.18am on 19 December, a prison manager authorised removal of the escort chain.

25. Prison healthcare staff obtained regular updates from the hospital. On 20 December, they were told that he had tested positive for COVID-19.

26. On 21 December, Mr Wilson was placed on end of life care as he had not responded to treatment. He died at 12.55pm on 22 December.

Contact with Mr Wilson's family

27. Mr Wilson was estranged from his family and had listed his offender manager as his next of kin. A few hours before his death, the prison assigned a family liaison officer who immediately began to collate details of Mr Wilson's children. The family liaison officer asked for information through the escort officers, as well as contacting the police and social services to try to trace them.

28. On 29 December, the police informed Mr Wilson's children of his death. The family liaison officer contacted them soon afterwards to offer support.

29. In line with national policy, the prison met the costs of Mr Wilson's funeral, which was held on 3 February 2021.

Support for prisoners and staff

30. After Mr Wilson's death, a prison manager debriefed the escort staff and offered support. A member of the staff care team attended the debrief.

31. The prison posted notices informing other staff and prisoners of Mr Wilson's death and offering support.

Post-mortem report

32. The post-mortem report concluded that the cause of Mr Wilson's death was a viral infection. He also had underlying chronic obstructive pulmonary disease, obstructive sleep apnoea, raised body mass index, liver cirrhosis, ischaemic heart disease and cerebrovascular disease. These conditions did not directly cause but contributed to Mr Wilson's death.

33. The pathologist noted that Mr Wilson had several significant health issues which would have all put him at particular risk with any chest infection.

Findings

Clinical care

34. The clinical reviewer concluded that Mr Wilson's clinical care was good and equivalent to that he could have expected to receive in the community. Care plans were in place and reviews were timely. Despite his non-compliance with health services, medical staff made every effort to support Mr Wilson and continued to offer services and monitor him through the complex case arrangements. When his condition significantly deteriorated, healthcare staff sent him to hospital promptly. The clinical reviewer made no recommendations.

Security risk assessments and the use of restraints

35. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.

36. 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.

37. Doncaster's security risk assessment form has a prompt to indicate that illness/infirmity of a prisoner should be considered in determining whether restraints should be used. The box for single cuff/escort chain was circled and the form was annotated that Mr Wilson should be single cuffed to the arm not injured. (It seems that an escort chain was used and not standard handcuffs.) At the hospital, a doctor asked the escort staff to move the cuff to his other arm. The Person Escort Record (PER) noted that Mr Wilson had left sided weakness and a section was circled 'yes' to requiring support with mobility.

38. We are concerned that the prison considered it appropriate, without justification, to use restraints on a man with limited mobility, who was further incapacitated by breathing difficulties and located in the acute medical unit. When a prison manager authorised removal of the escort chain, the reason given was that Mr Wilson was a wheelchair user. We consider this rationale should have been applied at the outset when the risk assessment was completed, unless there was a clear reason why restraints were necessary. We repeat a previous recommendation:

    The Director should ensure that all staff undertaking and reviewing risk assessments for prisoners admitted to hospital understand the legal position on the use of restraints, that assessments fully take into account the prisoner's health and are based on the actual risk he presents at the time.

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