

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Colin Adlard, a prisoner at HMP Gartree, on 20 June 2022**

**A report by the Prisons and Probation Ombudsman**



## Our vision

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



## Our values

We are:

**Impartial:** we do not take sides

**Respectful:** we are considerate and courteous

**Inclusive:** we value diversity

**Dedicated:** we are determined and focused

**Fair:** we are honest and act with integrity



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## 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. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Colin Adlard died of heart failure in hospital on 20 June 2022 while a prisoner at HMP Gartree. He was 72 years old. We offer our condolences to Mr Adlard's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Adlard received at Gartree was equivalent to that which he could have expected to receive in the community. The clinical reviewer made no recommendations.
5. We are concerned that when Mr Adlard was taken to hospital on 12 April, staff used an escort chain to restrain him. Given his age, poor mobility and health, we consider the use of an escort chain was not proportionate to his risk.
6. Gartree has also been unable to locate several bedwatch logs, which we requested as part of our investigation.

## Recommendations

- The Governor should ensure that authorising managers 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 all evidence relevant to a death in custody is retained and that evidence is made available to the PPO, in line with PSI 58/2010.

## The Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Adlard's clinical care at Gartree.
8. The PPO investigator investigated the non-clinical issues relating to Mr Adlard's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
9. The investigator and clinical reviewer interviewed one member of staff at Gartree on 18 July. This was completed by video conference.
10. The PPO family liaison officer wrote to Mr Adlard's next of kin, his friend, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not have any questions but requested a copy of our report.
11. We shared our initial report with HM Prison and Probation Service (HMPPS). They said that the statement on the escort risk assessment that Mr Adlard was a permanent wheelchair user was incorrect. We have added a sentence to this report to reflect that, though it does not affect our finding. They provided an action plan which is annexed to this report.
12. We sent a copy of our initial report to Mr Adlard's next of kin. She did not notify us of any factual inaccuracies.

## Previous deaths at HMP Gartree

13. Mr Adlard was the eleventh prisoner to die at Gartree since June 2020. Of the previous deaths, eight were from natural causes and two were self-inflicted. We have previously raised concerns about the use of restraints on prisoners with poor health.

## Key Events

14. On 28 September 2011, Mr Colin Adlard was convicted of murder and sentenced to life imprisonment. On 27 March 2012, Mr Adlard was moved to HMP Gartree.
15. Mr Adlard was in poor health and had several long-term health conditions including heart failure, heart disease, kidney disease and anaemia. In February 2019, staff provided Mr Adlard with a wheelchair as his mobility worsened.
16. On 11 April 2022, a prison nurse saw Mr Adlard after he reported shortness of breath. The nurse arranged an urgent blood test for Mr Adlard.
17. On 12 April, a prison nurse reviewed Mr Adlard. He continued to complain of shortness of breath. She also reviewed Mr Adlard's blood test results and found them to be abnormal. She assessed that Mr Adlard should go to hospital for further investigations. The prison authorised Mr Adlard to be taken to hospital restrained by an escort chain (a long chain with a handcuff at each end, one attached to a prisoner and the other to an officer.) He was taken to Leicester Royal Infirmary Hospital later that day where he was admitted.
18. On 3 May, Mr Adlard's bedwatch risk assessment was reviewed. Due to his deteriorating health, a prison manager authorised removal of the escort chain.
19. On 6 May, a prison nurse called the hospital for an update. A hospital nurse told her Mr Adlard was now being treated for heart failure.
20. On 16 May, Mr Adlard said he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect.
21. On 26 May, Mr Adlard was moved to Glenfield Hospital for treatment at their heart failure suite.
22. Mr Adlard's condition continued to deteriorate while in hospital. On 17 June, a prison nurse called the hospital for an update. A hospital nurse told her Mr Adlard was now being treated under a palliative care pathway.
23. Mr Adlard died at 12.55am on 20 June.

## Cause of death

24. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Adlard's cause of death as congestive cardiac (heart) failure, caused by severe left ventricle impairment (muscular chamber that pumps blood out of the heart) and ischaemic heart disease.

## Non-Clinical Findings

### Restraints, security and escorts

25. 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.
26. 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. It 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.
27. The escort risk assessment said that Mr Adlard was in poor health and was a permanent wheelchair user. (During the consultation period, the prison told us that this was incorrect as Mr Adlard used a walking stick.) Mr Adlard was also assessed as a low risk to staff and a low risk of escape. We consider that the use of an escort chain on Mr Adlard when he was taken to hospital was not proportionate to the risk he posed. We recommend:

**The Governor should ensure that authorising managers 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.**

### Missing bedwatch logs

28. Prison Service Instruction (PSI) 58/2010, *The Prisons and Probation Ombudsman*, says that Governors must ensure that when the PPO is carrying out investigations or enquiries, staff comply with requests for information and assistance.
29. At the start of this investigation, the PPO requested all relevant documents required for their investigation from Gartree, including copies of bedwatch logs. When the documents were reviewed, it was found that bedwatch logs covering the period from Mr Adlard's admission on 12 April to 25 April were missing. After several weeks of chasing by the PPO investigator, prison staff told him that the logs could not be located.

30. We are concerned the prison was unable to provide the PPO with these logs. Such documents can provide crucial evidence for investigations, and we would expect the prison to ensure that evidence is preserved following a death in custody to enable appropriate scrutiny and accountability. We recommend:

**The Governor should ensure that all evidence relevant to a death in custody is retained and that evidence is made available to the PPO, in line with PSI 58/2010.**

**Louise Richards  
Assistant Ombudsman**

**January 2023**

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