

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Sean Roddy, a prisoner at HMP Altcourse, on 24 November 2020

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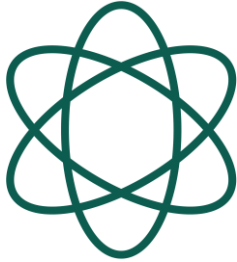
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Our vision

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

OGI

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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 Sean Roddy died in hospital on 24 November 2020 from multi-organ failure caused by cirrhosis of the liver, while a prisoner at HMP Altcourse. Mr Roddy was 54 years old. I offer my condolences to Mr Roddy's family and friends.

Mr Roddy had serious, long-term health issues and a history of drug and alcohol misuse. He had only been at Altcourse for five days when he became seriously ill and was taken to hospital as an emergency. He died a week later.

We found that there were a number of failings in the healthcare he received. The clinical reviewer concluded that the healthcare Mr Roddy received at Altcourse was not of the required standard and not equivalent to that which he could have expected to receive in the community.

The clinical reviewer was concerned, among other things, that there were delays in prescribing medication for Mr Roddy's complex health issues, and that his alcohol detoxification and methadone treatment were not adequately monitored and recorded. In addition, Mr Roddy was prescribed alcohol detoxification medication when he had a known medical condition which was on the medication's exclusion list.

I am concerned that when Mr Roddy was taken to hospital on 17 November, a manager authorised that he should be double-cuffed despite his poor health. I am also concerned that, although we were told this decision was later changed, there is no record of this. There was also a delay of over 18 hours in notifying Mr Roddy's family that he was seriously ill and had been admitted to hospital.

I am concerned that I am repeating recommendations in this report that I have made before, and that recommendations made by HM Inspectorate of Prisons in 2018 appear not to have been implemented consistently. The Director of Altcourse and the Head of Healthcare will need to ensure that these issues are now addressed.

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 2023

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Summary

Events

1. On 13 November 2020, Mr Sean Roddy was sentenced to four and a half years imprisonment for drug offences. He was sent to HMP Altcourse.
2. On arrival at Altcourse, Mr Roddy saw a nurse for an initial health screen. He disclosed a number of serious medical conditions, including alcoholism and heroin addiction, and had a large bag of medication with him. Mr Roddy then saw a prison GP, who prescribed some but not all of his prescription medication, as well as alcohol detoxification medication and methadone (a heroin substitute). Mr Roddy was located in the prison's detoxification unit.
3. On 15 November, a nurse saw Mr Roddy after he complained of chest pains. He was taken to the prison healthcare unit for further tests. He was seen by a senior nurse who did not consider it necessary for him to be admitted to the healthcare unit.
4. On the morning of 17 November, Mr Roddy was noted to be drowsy and was seen by a nurse. The medical records indicated that he had been unwell for three days with shortness of breath. Healthcare staff agreed he needed an urgent GP appointment.
5. That afternoon, before he had been seen by the GP, prison staff found Mr Roddy in his cell struggling to breathe and called a medical emergency code. Nurses arrived and gave him oxygen and medication to aid his breathing.
6. Mr Roddy was taken to hospital by emergency ambulance, where he was diagnosed with pneumonia. He was also treated with naloxone for opioid toxicity. He remained in hospital where his condition continued to deteriorate.
7. On 21 November, Mr Roddy was placed into an induced coma. On 23 November, he suffered an upper gastrointestinal bleed. The hospital contacted Mr Roddy's family, who arrived later that night. Mr Roddy's life support was turned off 10 minutes later and just after midnight on 24 November, it was confirmed that he had died.

Findings

8. The clinical reviewer concluded that the care Mr Roddy received at Altcourse was not equivalent to that which he could have expected to receive in the community.

She identified a number of concerns, including delays in the prescribing of medication for Mr Roddy's complex health issues, and the lack of monitoring and documenting of his alcohol detoxification and methadone treatment. In addition, he was prescribed alcohol detoxification medication when he had a known medical condition which was on the medication's exclusion list.

9. We are concerned that when Mr Roddy was taken to hospital on 17 November, the Duty Director authorised double-cuffing, although he was a Category C prisoner in

very poor health. We are also concerned that, although the Duty Director told us that he later authorised that Mr Roddy could be taken to hospital restrained by an escort chain (and not by double cuffs), there is no record of this or that the double cuffs were removed.

10. There was a delay of over 18 hours in notifying Mr Roddy's family that he had been taken to hospital and was seriously unwell.

Recommendations

- The Head of Healthcare should ensure that the summary care record (SCR) is accessed immediately for newly arrived prisoners, and any problems in accessing the record are escalated to senior staff.
- The Head of Healthcare should ensure that a contingency plan is in place for medical prescribing for prisoners entering Altcourse over a weekend.
- The Head of Healthcare should ensure that there is comprehensive drug and alcohol scoring and monitoring, and this is recorded in the SystemOne records in line with Drug misuse and dependence: UK guidelines on clinical management (published by the Department of Health and Social Care).
- The Head of Healthcare should ensure that prisoners who are prescribed chlordiazepoxide are monitored in accordance with the standard operating procedure and in accordance with the NICE pathway on assisted alcohol withdrawal.
- The Head of Healthcare should ensure that all staff are trained and competent in the use of NEWS-2 scoring and that this is documented accurately.
- The Head of Healthcare should ensure that all staff maintain accurate and contemporaneous records in SystemOne.
- The Director and Head of Healthcare should ensure that all staff 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 Director should revise the prison's escort risk assessment form to ensure that it requires:
 - healthcare staff to say whether the prisoner's current state of health has an impact on his mobility; and
 - prison staff to show that they have taken this information into account in assessing the prisoner's current level of risk; and
 - prison security staff to show sufficient detail on any security warning marker (including dates and content).

- The Director should ensure that any changes to the level of restraints are recorded accurately and promptly.
- The Director should ensure that staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill.
- The Director and Head of Healthcare should ensure that after incidents where staff are exposed to trauma:
 - post incident care and support is provided to all staff involved in the incident in line with PSI 02/2018; and
 - consideration is given to whether any staff not directly involved in the incident, but who provided care, may need support and care
- The Director should share the report with the duty Director and discuss the Ombudsman's findings with him.
- The Head of Healthcare should ensure that this report is shared with the healthcare staff named in it, including the GPs, to ensure they are aware of the Ombudsman's findings.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Altcourse informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
12. The investigator wrote to Altcourse on 24 November 2020. He obtained a range of documents including copies of relevant extracts from Mr Roddy's prison and medical records.
13. NHS England commissioned a clinical reviewer to review Mr Roddy's clinical care at the prison.
14. The investigator and clinical reviewer interviewed seven members of staff on 7 and 8 January 2021. All the interviews were conducted by telephone because of the restrictions imposed in response to the COVID-19 pandemic. A statement was requested from one further member of staff. Unfortunately, the audio quality of one of the interviews was so poor that it was not useable. This interview was replaced with a statement.
15. We informed HM Coroner for Liverpool and the Wirral of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
16. The Ombudsman's family liaison officer contacted Mr Roddy's next of kin to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.
17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not identify any factual inaccuracies, but we agreed to amend the wording of one recommendation.

Background Information

HMP Altcourse

18. Altcourse is a local prison holding around 1,033 men, including around 100 young adults, run by G4S. As a local prison one of its primary functions is to serve the courts of Merseyside, Cheshire and North Wales.
19. Altcourse has a twelve-bed inpatient healthcare unit and 24-hour nursing provision run by G4S Health Services.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Altcourse was in November 2021. Inspectors reported that staffing vacancies within the healthcare department, in particular primary care, mental health and the pharmacy were a considerable concern and were negatively affecting key areas of delivery. However, inspectors noted that efforts were being made to reduce those vacancies by the use of bank and agency clinicians to cover shortfalls. Inspectors were concerned that clinical supervision did not regularly take place within the healthcare department.
21. They were also concerned that over half of healthcare staff had not had an annual appraisal with their manager in the previous twelve months. They felt this had a negative effect on the delivery and safety of care. Despite their concerns, they considered that health services were well-led and that clinical leaders had an awareness and oversight of key risk areas.

Independent Monitoring Board

22. 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 report for the year to June 2021, the IMB considered that the health and wellbeing needs of prisoners were being met. However, they were concerned at the length of waiting times for GP and dentist consultations. In addition, the Board were also concerned that the specific needs of older prisoners, those requiring social care and prisoners with serious mental health needs were not being fully met.
23. The Board noted they had met with the Head of Healthcare and had discussed the action plans which are made following recommendations made in our previous reports. They were reassured that the Ombudsman's recommendations were being addressed systematically and effectively.

Previous deaths at HMP Altcourse

24. Mr Roddy was the 14th prisoner to die at Altcourse since November 2018. Eleven of the previous deaths were from natural causes, one was a self-inflicted death and in one case the cause of death was "unascertained".

25. In a previous investigation we recommended that all healthcare staff should be trained to complete NEWS-2 assessments. In another investigation we made recommendations about the use of restraints and the completion of escort risk assessments. The prison accepted these recommendations, and it is, therefore, disappointing to have found the same issues in this investigation.

Key Events

26. On 13 November 2020, Mr Sean Roddy was sentenced to four and a half years imprisonment for drug offences. He was sent to HMP Altcourse.
27. On arrival at Altcourse, he was seen for his initial health screening by a nurse. Mr Roddy had a large carrier bag full of medication with him. The nurse recorded that he had heart failure, liver failure and COPD (Chronic Obstructive Pulmonary Disease). Following the screening the nurse handed Mr Roddy's medication to the on-duty substance misuse GP.
28. The GP recorded that Mr Roddy reported his current drinking as around 175 units of alcohol per week. He carried out an alcohol assessment known as AUDIT PC. Mr Roddy scored 40 indicating dependant drinking. The GP carried out an alcohol withdrawal assessment known as CIWA. Mr Roddy scored 18, indicating mild to moderate alcohol withdrawal. The GP prescribed chlordiazepoxide, a tranquiliser, for alcohol detoxification.
29. The GP also prescribed several of Mr Roddy's community prescription medications and a 40ml daily dose of methadone. Mr Roddy was located in the prison detoxification unit and placed into isolation in line with prison and Public Health England COVID-19 guidance.
30. On 14 November, Mr Roddy saw a prison GP. The GP was unable to view Mr Roddy's Summary Care Record (SCR) on SystmOne (the electronic record system for prisoners' medical records). It is unclear why. This meant that the GP could not see Mr Roddy's full prescription list and, as a result, some was not prescribed until the following day.
31. On 15 November, a nurse saw Mr Roddy, after Mr Roddy complained of chest pains. The nurse was sufficiently concerned that he took Mr Roddy to the prison healthcare unit for further tests. He took a sputum sample. The results did not come back until 20 November, by which time Mr Roddy was in hospital.
32. The nurse alerted a senior nurse to Mr Roddy's condition. The senior nurse did not consider that Mr Roddy needed admission to the prison's healthcare unit, and he returned to the detoxification unit.
33. On 16 November, Mr Roddy was seen by a Healthcare Assistant, who took his physical observations and completed a National Early Warning Score (NEWS-2) assessment (a tool to measure clinical deterioration). She scored Mr Roddy incorrectly at 4.
34. On 17 November, Mr Roddy was noted to be drowsy. At 11.45am he was seen by a nurse. The medical records showed that he had been unwell for three days with shortness of breath. The nurse completed a NEWS-2 assessment. Mr Roddy's score was 3 (indicating a low risk but requiring prompt assessment by a senior nurse). The nurse spoke to two senior nurses. They said that Mr Roddy needed an urgent GP appointment.
35. Before he could be seen by the prison GP, prison staff found Mr Roddy in his cell struggling to breathe and, at 3.31pm, they called a code blue (a medical emergency)

code used when a prisoner is unconscious or having breathing difficulties). The control room called an ambulance, and prison healthcare staff attended Mr Roddy's cell. A prison paramedic assessed Mr Roddy. She noted he was struggling to breathe, with body swelling and reduced consciousness. She completed a NEWS-2 assessment which scored Mr Roddy at 16, indicating he was very unwell and needed to be seen urgently in hospital. Mr Roddy was given oxygen and medication to aid his breathing.

36. An ambulance arrived at the prison at 3.39pm. Paramedics took Mr Roddy to Aintree Hospital, arriving there at 4.37pm. Hospital staff diagnosed Community Acquired Pneumonia (CAP), a type of pneumonia that is contracted outside the healthcare system. This was later confirmed as pseudomonas, a bacterial infection that can cause pneumonia and mainly affects people who already have a lung condition. He was admitted to the Critical Care Unit.
37. On 18 November, the hospital contacted Altcourse because hospital staff were concerned with Mr Roddy's level of sedation and wanted to know if this might be due to his medication. Concerns were raised that he might have had an opioid overdose, and he was given naloxone to reverse the opioid toxicity.
38. On 21 November, Mr Roddy's health continued to deteriorate, and he was placed in an induced coma. On 23 November, he suffered an upper gastrointestinal bleed (which is common in patients, like Mr Roddy, with chronic liver disease).
39. Later that day, hospital staff rang Mr Roddy's next of kin. Mr Roddy's family arrived at the hospital at about 11.40pm, and after discussions with his family, his life support was turned off.
40. On 24 November, at 12.01am Mr Roddy died.

Contact with Mr Roddy's family

41. On 18 November, the prison appointed a Family Liaison Officer (FLO), who made contact with Mr Roddy's next of kin shortly after 11.00am and told her that he was in hospital. In the days following Mr Roddy's death the FLO offered support and advice to the family.
42. Mr Roddy's funeral was held on 21 December 2020. In line with prison policy, Altcourse contributed to the costs of Mr Roddy's funeral.

Support for prisoners and staff

43. The prison posted notices informing other prisoners of Mr Roddy'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 Mr Roddy's death.

Cause of death

The Coroner held an inquest on 11 December 2020 and concluded that Mr Roddy died from multi-organ failure caused by cirrhosis of the liver.

Findings

Clinical Care

44. The clinical reviewer concluded that the care Mr Roddy's received at Altcourse was not equivalent to that which he could have expected to receive in the community. She raised a number of concerns about his prescribed medication, detoxification regime, the use of the NEWS-2 tool and record keeping.

Prescribing of Mr Roddy's medication

45. When Mr Roddy arrived at Altcourse on 13 November, his medications were not prescribed in a timely manner due to issues with accessing his community summary care record. As a result, there were delays in the prescribing him essential medication.
46. Some of Mr Roddy's medications were prescribed on 13 November, some on 14 November and some on 15 November. Some of these medications were critical medications, including digoxin (taken for atrial fibrillation – an abnormal beating of the heart) and nebivolol (taken for high blood pressure).
47. The clinical reviewer acknowledged that due to the strength of Mr Roddy's digoxin prescription, it was appropriate for healthcare staff at Altcourse to be cautious about prescribing it until they had seen the summary care record because the drug slows the heart rate down.
48. We make the following recommendations:

The Head of Healthcare should ensure that the summary care record (SCR) is accessed immediately for newly arrived prisoners, and any problems in accessing the record are escalated to senior staff.

The Head of Healthcare should ensure that a contingency plan is in place for medical prescribing for prisoners entering Altcourse over the weekend.

Alcohol and drug treatment

49. When Mr Roddy arrived at Altcourse on 13 November, the substance misuse GP used appropriate tools to assess his level of alcohol dependency and his withdrawal symptoms, and prescribed chlordiazepoxide (a tranquiliser) for alcohol detoxification. The clinical reviewer was concerned that Mr Roddy's test scores were not checked again after 13 November although he continued to be prescribed chlordiazepoxide. This was not in line with NICE guidelines on assisted alcohol withdrawal.
50. In addition, the G4S Patient Group Directions says that chlordiazepoxide should not be prescribed for more than 72 hours and should not be prescribed to patients with COPD. There are no entries in Mr Roddy's medical records to explain the reasons for prescribing chlordiazepoxide to Mr Roddy when he had a medical condition on the exclusion criteria list.

51. Mr Roddy was also prescribed methadone as he had been prescribed it in the community. However, he said at his reception screen that he had not been taking his medication for months. The clinical reviewer said that to avoid the risk of overdose, Mr Roddy should have been started on a low dose of methadone which could be slowly increased. Instead, he was prescribed 40mls from the outset.
52. The clinical reviewer also noted that chlordiazepoxide is a benzodiazepine drug and that when benzodiazepines are taken together with methadone (as in Mr Roddy's case) they can cause central nervous system depression and affect breathing. She said that the British National Formulary (BNF) states that if methadone is co-prescribed with a benzodiazepine, patients should be monitored for at least two weeks and should be advised to seek urgent medical attention if they experience symptoms of respiratory depression and sedation.
53. The clinical reviewer noted that there was only one substance misuse monitoring entry, at about 4.00am on 14 November, in Mr Roddy's medical records. She could not find any further evidence of substance misuse monitoring.
54. She also noted that on 17 November, Mr Roddy was noted as being "drowsy". She said that because there were no entries in his medical records monitoring his consciousness (as required by the BNF), it is unclear whether the drowsiness was related to the fact that he was taking chlordiazepoxide in conjunction with methadone or to his generally failing health.
55. She also noted that when Mr Roddy was admitted to hospital on 17 November, hospital staff were concerned about his level of sedation and administered naloxone (an opiate antidote) as they considered he may be suffering from an opiate overdose. This may have been caused by the dose of methadone he had been prescribed.
56. We make the following recommendations:

The Head of Healthcare should ensure that there is comprehensive drug and alcohol scoring and monitoring, and that this is recorded in SystmOne in line with Drug misuse and dependence: UK guidelines on clinical management (published by the Department of Health and Social Care).

The Head of Healthcare should ensure that prisoners who are prescribed chlordiazepoxide are monitored in accordance with the standard operating procedure at HMP Altcourse and in accordance with the NICE pathway on assisted alcohol withdrawal.

Use of the National Early Warning Score (NEWS-2)

57. The clinical reviewer found that there were three occasions between 13 and 17 November when NEWS-2 assessments were not carried out as they should have been or were completed incorrectly. The NEWS-2 assessment is a tool to measure clinical deterioration and an important tool to improve patient outcomes. Absent and/or incorrect scores can impact negatively on clinical decision-making, including the monitoring of prisoners and knowing when intervention is needed. We make the following recommendation:

The Head of Healthcare should ensure that all staff are trained and competent in the use of NEWS-2 scoring and that this is documented accurately.

Record Keeping

58. The clinical reviewer was concerned that, although Mr Roddy arrived at Altcourse with a large carrier bag full of medications, these medications were not documented on SystmOne either by the nurse who did his reception screen or by the substance misuse GP.
59. The clinical reviewer also noted that when Mr Roddy was seen by the substance misuse GP, this assessment was brief, and the planning lacked content and essential details. The entry on SystmOne does not indicate the dose of chlordiazepoxide that had been prescribed, how often it should be taken, or the alcohol detoxification monitoring that should have taken place.
60. In addition, Mr Roddy's long-term conditions were not documented correctly in his SystmOne records, which resulted in staff members not knowing Mr Roddy's past medical history.
61. The clinical reviewer also found that there were several occasions between 13 and 17 November where observations and clinical decision-making were not recorded on Mr Roddy's SystmOne. She noted in particular that there was an absence of records about Mr Roddy's alcohol detoxification or his methadone treatment programme which is contrary to NICE guidelines and is not in accordance with the BNF. There was no record to explain why Mr Roddy was not admitted to the prison's healthcare unit on 15 November.
62. More detailed records would have shown clearly the decision-making processes and action staff took to provide care for Mr Roddy and provided critical information for other clinicians treating him. We make the following recommendation:

The Head of Healthcare should ensure that all staff maintain accurate and contemporaneous records in SystmOne.

The Head of Healthcare should ensure that this report is shared with the healthcare staff named in it, including the GPs, to ensure they are aware of the Ombudsman's findings.

Restraints, security and escorts

63. 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 a prisoner's health and mobility.
64. 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.

65. Prison Service Instruction (PSI) 33/2015, External Escorts, says that normal practice is for male Category B and Escape-List prisoners to be double cuffed while on escort and that “all other prisoners will be single cuffed unless the individual risk assessment indicates that double cuffing is required and is proportionate”.
66. On 17 November, when staff found Mr Roddy struggling to breathe, an emergency ambulance was called, and staff completed a risk assessment for Mr Roddy’s escort to hospital.
67. A senior nurse completed the clinical section of the risk assessment form. She identified that the escort was for essential treatment and that Mr Roddy had mobility issues. However, she gave no information about Mr Roddy’s current state of health at the time. Body-worn camera (BWC) footage shows Mr Roddy receiving oxygen and medication via injection in his cell before he was taken to hospital. He appeared immobile and was pulled from his cell onto the landing by staff so that emergency treatment could be given. At one-point staff ask whether he has a DNACPR (Do Not Attempt Cardio-Pulmonary Resuscitation) form in place. In interview, the senior nurse said that she had not seen Mr Roddy when she completed the form, and that the information she received from staff treating him was that he was very poorly and had collapsed. She did not reflect this on the risk assessment form as she should have done.
68. The duty Director took the decision that Mr Roddy should be ‘double cuffed’ (where a prisoner’s wrists are handcuffed together and then separately handcuffed to a prison officer). In his statement he said that he had limited recollection of the escort. He took this decision based on the information in front of him and the limited time available. He took into account Mr Roddy’s category, escorting history and security warnings. Mr Roddy had only been in prison four days and this was his first prison escort. Mr Roddy had a warning marker for violence which had been flagged by security staff on the escort authorisation form given to the duty Director.
69. The duty Director also said in his statement that although he authorised double cuffing, in fact Mr Roddy did not leave the prison double cuffed. He said that escorting staff were provided with more information and that around 4.20pm they rang him requesting authorisation for the double cuffs to be removed. The ambulance then left the prison around 4.30pm with Mr Roddy restrained only by an escort chain.
70. We are concerned that the duty Director authorised double cuffs for Mr Roddy. We can see no justification for this. Mr Roddy was a Category C prisoner, and the normal practice would therefore have been to use a single handcuff. The risk assessment form says that Mr Roddy a marker for violence. The only record of a violence marker in Mr Roddy’s file was a Police National Computer (PNC) marker from 1998. The security information given to the duty Director did not reflect his current risk.
71. We recognise that the risk assessment form was completed under time pressures during a medical emergency, but we do not consider that double cuffing was

proportionate or justifiable for a seriously ill Category C prisoner, even if the duty Director later changed his mind.

72. We are also concerned that the healthcare section of the risk assessment form did not make clear how ill Mr Roddy was when he was taken to hospital. We are concerned that the security warning information flagged on the escort authorisation form was over 20 years old and his PNC print showed no later violence markers or violent convictions.
73. In addition, we are concerned that there is no record that the double cuffs were removed or that the duty Director had authorised this. The bed watch escort log for 17 November records that an escort chain was applied at 4.25pm. Although we accept that it is possible that the double cuffs were removed at this point, this was not recorded and the 'removal of restraints' section of the log was left blank. We consider that accurate recording of the level of restraints is important, not least because bed watch staff need to be clear exactly what is required.
74. We make the following recommendations:

The Director and Head of Healthcare should ensure that all staff 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 Director should revise the prison's escort risk assessment form to ensure that it requires:

- **healthcare staff to say whether the prisoner's current state of health has an impact on his mobility; and**
- **prison staff to show that they have taken this information into account in assessing the prisoner's current level of risk; and**
- **prison security staff to show sufficient detail on any security warning marker (including dates and content).**

The Director should ensure that any changes to the level of restraints are recorded accurately and promptly.

The Director should share the report with the duty Director and discuss the Ombudsman's findings with him.

Notifying next of kin

75. Prison Rule 22 says that prisons should inform the next of kin immediately if a prisoner becomes seriously ill. PSI 64/2011, about safer custody, says that if a prisoner suffers an unpredicted or rapid deterioration in their physical health, a member of prison staff should contact their next of kin to provide information and support. If a prisoner's health deteriorates a family liaison officer should be appointed immediately and next of kin should be contacted.

76. Mr Roddy's next of kin's details were recorded in his prison records. Mr Roddy's family were not told that he was seriously ill in hospital until 11.00am on 18 November, some 18 hours after he arrived in hospital. It was clear that Mr Roddy was seriously ill, and we consider that there was too long a delay in contacting his family.
77. However, once a FLO was appointed on the morning of 18 November, the FLO provided timely information and support to Mr Roddy's family prior to and after his death.
78. We make the following recommendation:

The Director should ensure that staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill.

Post incident debriefing and staff care

79. During the investigation we asked for records of the hot debrief. We were told that there were no minutes of the debrief, and we were unable to confirm that a hot debrief had taken place in line with PSI 02/2018 on post incident care. In our interviews we were told that there had been no debrief for healthcare staff involved in the emergency response or those involved in Mr Roddy's wider care. We make the following recommendation:

The Director and Head of Healthcare should ensure that after incidents where staff are exposed to trauma:

- **post incident care and support is provided to all staff involved in the incident in line with PSI 02/2018; and**
- **consideration is given to whether any staff not directly involved in the incident, but who provided care, may need support and care.**

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