

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Tottem, a prisoner at HMP Highpoint, on 13 July 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 Michael Tottem died of lung cancer in hospital on 13 July 2022, while a prisoner at HMP Highpoint. He was 71 years old. We offer our condolences to Mr Tottem's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Tottem received at Highpoint was of a mixed standard and therefore not equivalent to that which he could have expected to receive in the community. She makes recommendations regarding compliance with national health guidelines and escalation of concerns about clinical presentation, which are detailed in the annexed review and should be addressed by the Head of Healthcare.
5. We found that managers at Highpoint did not consult healthcare when they made their decision to restrain Mr Tottem during his escort to hospital on 29 June 2022. The PPO highlighted the same issue in a previous investigation in 2020, and it is concerning that it has been repeated. Since Mr Tottem's death, a new national policy framework has been published which includes a mandatory escort risk assessment form for prisons. The form makes clear the need for a medical opinion. We have seen recent examples of Highpoint's escort risk assessments, which all included healthcare input. We are satisfied that the new national form will help ensure a lasting change in the process and no further omissions.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Tottem's clinical care at Highpoint.
7. The PPO investigator investigated the non-clinical issues relating to Mr Tottem's care, including Mr Tottem's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. The PPO family liaison officer wrote to Mr Tottem's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy in the clinical review and the clinical review has been amended accordingly.

Previous deaths at HMP Highpoint

10. Mr Tottem was the fourth prisoner to die at Highpoint since July 2020. Of the previous deaths, two were from natural causes and one was self-inflicted. We found similarities in our findings on Mr Tottem's death and the previous natural cause death of another prisoner. In the other prisoner's case, Highpoint did not ask for healthcare's opinion on a decision to restrain him on a trip to hospital. The prisoner had terminal cancer, was in pain and struggled to walk. The investigator concluded that the decision to restrain the prisoner was inappropriate, based on his poor health at the time of the escort. The Governor and Head of Healthcare accepted the PPO's recommendation to ensure that all future escort restraint assessments take into account the prisoner's health at the time and include a completed medical section. The prison issued a reminder of the requirement to all staff in February 2022.

Key Events

11. On 27 September 2016, Mr Michael Tottem was given a 13-year prison sentence for attempted murder and grievous bodily harm (GBH) with intent.
12. On 16 December 2020, Mr Tottem transferred to HMP Highpoint. At his initial healthcare screening, healthcare staff recorded that Mr Tottem had suspected heart disease and could manage his own personal care. His weight was 96.3kg.
13. On 10 February 2022, healthcare staff recorded Mr Tottem's weight as 88kg.
14. On 11 March, Healthcare staff diagnosed Mr Tottem with anaemia, although they could not find the cause.
15. On 18 May, a prison nurse recorded that Mr Tottem might have an abdominal aortic aneurysm (a bulge in the aorta, the largest blood vessel running from the heart, chest, and abdomen) and therefore require a referral to a Gastroenterologist (a specialist in digestion).
16. On 8 June, staff moved Mr Tottem to a different unit because he was struggling with his personal care and mobility. The new unit was on the ground floor, and he was given the support of a carer.
17. On 13 June, healthcare staff referred Mr Tottem to a Gastroenterologist for his low anaemia.
18. On 28 June, Mr Tottem's carer reported to officers that he was feeling weak, breathless and spoke of self-harm. They took him to healthcare to be examined. A nurse assessed Mr Tottem and recorded that he was not breathless and had no deliberate thoughts of self-harm but appeared to be low in mood. The nurse referred Mr Tottem to the mental health team. She also noted that he weighed 79.6kg.
19. On 29 June, Mr Tottem reported to healthcare staff that he had pain in his legs and was feeling weak. He then attended hospital for his Gastroenterologist appointment. Two officers escorted Mr Tottem to hospital with an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). The Gastroenterologist sent Mr Tottem to A&E, where he was admitted as an inpatient. He was diagnosed with deep vein thrombosis (a condition in which blood clots form in the veins of the lower limbs).
20. On 1 July, bedwatch officers (staff responsible for ensuring that prisoners are kept in secure and lawful custody) told prison management that Mr Tottem's restraints were obstructing the hospital staff, and that Mr Tottem was struggling to breathe. Prison management authorised bedwatch officers to remove Mr Tottem's restraints.
21. On 2 July, the hospital told prison healthcare staff that Mr Tottem had left leg Ischaemia (where there is an obstruction to the blood supply of the lower limbs which reduces blood flow), Rhabdomyolysis (a condition in which damaged skeletal muscle breaks down) and Abdominal Aortic Aneurysm (a bulge in the aorta, the largest blood vessel running from the heart, chest, and abdomen).

22. On 6 July, the hospital told prison healthcare staff that Mr Tottem had lung cancer, which had spread to the brain. The prison started an application for early release on compassionate grounds.
23. On 13 July, Mr Tottem died.

Post-mortem report

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 Tottem's cause of death as lung cancer which had started to spread to other parts of the body. Acute left lower limb ischaemia (managed conservatively), acute kidney injury secondary to rhabdomyolysis, and a previous stroke were listed as contributory factors.

Non-Clinical Findings

Escort restraints

25. The Prison Service has a duty to protect the public, but this has to be balanced with a responsibility to treat prisoners with humanity. Prison Service Instruction (PSI) 33/2015 *External Prisoner Movement* requires that any restraints are necessary and proportionate. It also requires that decisions are based on the security risk, with consideration for factors such as the prisoner's health and mobility.
26. The 2007 Graham judgment in the High Court 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 a 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. Managers at Highpoint did not consult healthcare when they made their decision to restrain Mr Tottem during his escort to hospital on 29 June 2022. The decision was not informed by an assessment of Mr Tottem's health at the time, and we consider that the use of restraints was inappropriate. We note that they were later removed, when it was clear that Mr Tottem's health was continuing to deteriorate. However, we are concerned that we have already identified this learning at Highpoint, during an investigation into a previous death in 2020. In response, Highpoint issued a reminder to staff of the requirement to seek a medical opinion. It appears that this did enable long term change.
28. During our investigation into Mr Tottem's death, we found that Highpoint's escort risk assessment form did not make clear the need for a medical opinion. Since Mr Tottem's death, a new national escorts policy *Prevention of Escape: External Escorts Policy Framework*, has come into force. The policy annexes an escort risk assessment form which very clearly states that a medical opinion is required and also requires that this form replaces all escort risk assessment forms currently in use. Highpoint have confirmed that they are now using this new form. They showed us recent examples, which all included a contribution from a medical professional. We are satisfied that the implementation of new national policy requirements will prevent further issues and make no recommendation.
29. The inquest into Mr Tottem's death was held on 14 August 2023 and concluded that he died of natural causes.

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