Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stuart Robert Cunningham, a prisoner at HMP Dovegate, on 13 November 2021

A report by the Prisons and Probation Ombudsman

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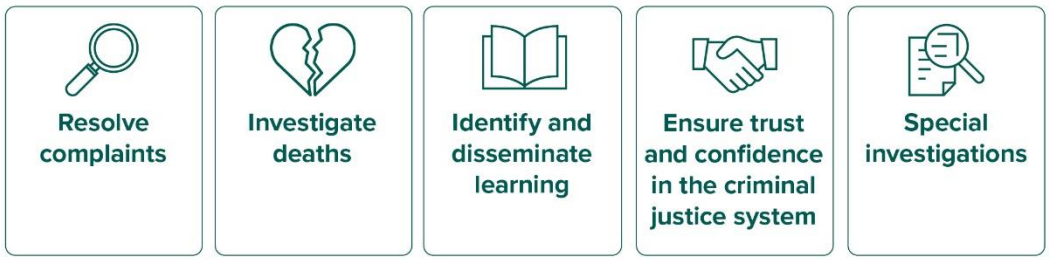
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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 Stuart Cunningham died in hospital of COVID-19 pneumonia on 13 November 2021, while a prisoner at HMP Dovegate. He was 36 years old. I offer my condolences to Mr Cunningham's family and friends.

Mr Cunningham reported COVID-19 symptoms on 2 November. In the early hours of 5 November, he was found collapsed in his cell and was taken to hospital where he died one week later.

The clinical reviewer concluded that the care Mr Cunningham received at Dovegate was equivalent to that which he could have expected to receive in the community. However, she found that Mr Cunningham was not monitored as frequently as he should have been when he showed symptoms of COVID-19.

I am concerned that when Mr Cunningham pressed his cell bell in the early hours of 5 November, half an hour before he was found collapsed, the officer who responded did not contact healthcare staff as he should have done.

I am also concerned that when Mr Cunningham was taken to hospital, he was double cuffed and the appropriate risk assessments were not in place, nor were they completed within 24 hours of his admission to hospital. Mr Cunningham remained restrained when his condition deteriorated, and he was moved to intensive care. Not only was it inappropriate to continue to restrain Mr Cunningham when he was critically unwell, it also put prison staff escorting him at higher risk of contracting COVID-19.

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 **July 2023**

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Summary

Events

1. In May 2017, Mr Stuart Cunningham was sentenced to ten years imprisonment for a firearms offence. He was moved to HMP Dovegate on 14 December.

2. On 23 June 2021, Mr Cunningham was offered, but declined, his first dose of the COVID-19 vaccine.

3. On 27 October, a nurse gave Mr Cunningham two paracetamol tablets at the medication hatch. She did not record the reason.

4. On 1 November, Mr Cunningham was tested for COVID-19 as there were several suspected cases on his wing. (A positive result was received on 6 November.)

5. The next day, a nurse saw Mr Cunningham as he was having difficulty breathing. The nurse consulted with a GP, and they called an ambulance. Paramedics assessed that Mr Cunningham did not need to go to hospital but that he should be monitored closely. That afternoon, a nurse gave Mr Cunningham a pulse oximeter and asked him to record his blood oxygen levels.

6. On 3 November, a nurse reviewed Mr Cunningham and calculated a NEWS2 score of 5, indicating that he required medical attention for possible sepsis. (NEWS2 is a tool used to monitor clinical deterioration.) The nurse considered that Mr Cunningham did not have sepsis and that his symptoms were due to COVID-19.

7. On 4 November, a nurse noted that Mr Cunningham's blood oxygen levels had improved and that his NEWS2 score had fallen to 1 (low risk).

8. At 7.04pm, Mr Cunningham pressed his cell bell and told an officer he needed to see someone from healthcare as his blood oxygen levels were low. The officer called healthcare and told them this.

9. At 10.08pm, a nurse went to see Mr Cunningham, but he appeared to be asleep. He told wing staff to contact healthcare when Mr Cunningham woke up.

10. On 5 November, at 2.58am, Mr Cunningham pressed his cell bell, and shouted to a prison officer that he needed to see a nurse. The officer did not contact healthcare.

11. At 3.30am, Mr Cunningham pressed his cell bell again. An officer found Mr Cunningham lying on the floor of his cell, unresponsive but breathing. The officer called a 'code blue' (a medical emergency code used when a prisoner is unconscious or having breathing difficulties) over his radio.

12. A nurse responded to the code. Mr Cunningham was struggling to breathe and had a NEWS2 score of 8, indicating he needed emergency medical treatment. The prison called an ambulance and Mr Cunningham was admitted to hospital.

13. On 7 November, Mr Cunningham was moved to intensive care and on 11 November, he was placed in a medically induced coma. He died at 6.50pm on 13 November.

Findings

14. Mr Cunningham had not left Dovegate in several months, so he contracted COVID-19 in the prison. He had asthma, but this condition did not put him in the clinically vulnerable category, so he was not advised to shield. The clinical reviewer found that the care Mr Cunningham received was equivalent to that which he could have expected to receive in the community. However, she raised some concerns.

15. It is possible that healthcare staff could have identified that Mr Cunningham had COVID-19 symptoms on 27 October if they had recorded why he asked for paracetamol.

16. Mr Cunningham was not monitored properly after he was seen by paramedics on 2 November. Despite a nurse recording that Mr Cunningham's clinical observations should be checked again in two hours, they were not checked for over 12 hours.

17. The nurse should not have ruled out Mr Cunningham having sepsis as well as, or instead of, COVID-19 when his NEWS2 score was 5 on 3 November.

18. The clinical reviewer considered that the prison should have a clear policy to support staff in assessing whether patients are able to use pulse oximeters.

Response to cell bell

19. We are concerned that the officer who responded to Mr Cunningham's cell bell at 2.58am on 5 November, did not contact healthcare staff as he should have done.

20. Although calling healthcare staff 30 minutes sooner may not have resulted in a different outcome for Mr Cunningham, it could have resulted in him getting help earlier and not collapsing in his cell.

Restraints

21. We are concerned that Mr Cunningham was double cuffed when he was taken to hospital. There was no healthcare input to the escort risk assessment, nor was the assessment signed off by a senior officer.

22. We are concerned that Mr Cunningham continued to be restrained using an escort chain when he was moved to intensive care on 7 November. Not only was this unnecessary and undignified for Mr Cunningham but it put escorting staff at increased risk of contracting COVID-19 as they had to remain in the same room while Mr Cunningham was ventilated.

Recommendations

- The Head of Healthcare should ensure that when over the counter medication is requested and administered, staff document the reason the medication was given.
- The Head of Healthcare should ensure that when a prisoner requires close monitoring and repeat clinical observations as recommended by a medic or

advanced practitioner (such as paramedics in Mr Cunningham's case), staff complete clinical observations in accordance with the recommended care plan.

- The Head of Healthcare should ensure that staff also consider the possibility of co-existing health conditions when a patient is symptomatic or if they tested positive for COVID-19.
- The Head of Healthcare should develop a local policy/pathway to support the pulse oximeter programme which should ensure that staff know how to assess a patient's competency to use the device and give clear instructions on when a prisoner's self-monitoring record is checked.
- The Director should ensure that prison staff contact healthcare staff promptly, when prisoners report pain or other symptoms suggesting they are unwell.
- The Director and Head of Healthcare should ensure that clear communication channels are in place to enable both healthcare and prison staff to share information about the care needs of prisoners, and that information is effectively disseminated to relevant staff.
- 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, in all cases:
- healthcare staff complete the medical information section of the escort risk assessment to say whether the prisoner's current medical condition affects their mobility and risk of escape;
- the assessment is countersigned by an authorising manager to show that they have taken this information into account when assessing a prisoner's current level of risk.
- The Director should ensure that managers authorise the removal of restraints for COVID-19 positive, non-category A prisoners needing ventilation or intensive care unit treatment, in line with the Standard Operating Procedure, Escorts & Bed watches – COVID-19, unless abnormal circumstances apply.

The Investigation Process

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

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

25. The investigator interviewed six members of staff at Dovegate between 29 December 2021 and 16 February 2022.

26. NHS England commissioned an independent clinical reviewer to review Mr Cunningham's clinical care at Dovegate.

27. We informed HM Coroner for Staffordshire South of the investigation. He provided us with the cause of death. We have sent the coroner a copy of this report.

28. The PPO family liaison officer wrote to Mr Cunningham's next of kin, his mother, to explain the investigation. She responded to our letter with the following questions;

    1. What is/was the staff testing regime?
    2. Who thought he was ill enough to call the air ambulance?
    3. Who sent it away and why?
    4. Was he even seen by the paramedic?
    5. When did the nurse see him and give him the oximeter?
    6. When was the second ambulance called and when was he taken to hospital?
    7. What was he eating and what medication was he being given?
    8. Why were the prisoners having to care for him?
    9. Why did no one answer his call for help? What time did they finally go to help him?
    10. Practice Plus say they will hold an investigation on themselves? How will this be an unbiased investigation?
    11. Will all phone calls and records be looked into?
    12. Why was not enough done considering his COPD and non-vaccination?

29. Questions 1-3 and 11 will be addressed in separate correspondence. The rest have been answered in this report and the clinical review.

30. Mr Cunningham's family received a copy of the initial report. The solicitor representing them wrote to us, they did not point out any factual inaccuracies, but did reiterate the families concerns about evidence supplied by the prison. The solicitor was also concerned that prisoners who wished to contribute to the investigation may not be aware of how to contact the investigator.

31. Both these points have been addressed in the letter accompanying this report.

32. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS identified some factual inaccuracies and we have amended our report accordingly.

Background Information

HMP Dovegate

33. HMP Dovegate is a Category B prison in Staffordshire, managed by Serco. The main prison holds around 930 remanded and sentenced adult prisoners. There is also a therapeutic community, separate to the main prison, which holds up to 220 prisoners. Practice Plus Group provides 24-hour healthcare services. South Staffordshire and Shropshire Foundation Trust provides mental health services.

HM Inspectorate of Prisons

34. The most recent inspection of HMP Dovegate was in September/October 2019. Inspectors found that healthcare provision was reasonably good overall, clinical staff were trained to deliver immediate life support and that clinical governance meetings were well attended.

Independent Monitoring Board

35. 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 September 2021, the IMB reported that the management of the risk of COVID-19 had been effective in preventing any outbreaks for the year September 2020-21. They also reported that despite significant improvements in waiting times to see GPs, the ongoing situation with COVID-19 had still caused a dramatic rise in waiting times.

Previous deaths at HMP Dovegate

36. Mr Cunningham was the ninth prisoner to die at Dovegate since November 2019. Of the previous deaths, five were from natural causes, two were self-inflicted and one was drug related. None of the previous deaths were COVID-19 related.

37. We have previously made a recommendation to Dovegate about inappropriate use of restraints. The prison accepted our recommendation and responded to say that they had updated their risk assessment to include more medical information and emphasised the importance of considering a prisoner's mobility.

COVID-19 (coronavirus)

38. COVID-19 is an infectious disease that affects the lungs and airways. It is mainly spread through droplets when an infected person coughs, sneezes, speaks or breathes heavily. On 11 March 2020, the World Health Organisation (WHO) declared COVID-19 a worldwide pandemic.

39. COVID-19 can make anyone seriously ill, but some people are at higher risk of severe illness and developing complications from the infection. People at high risk (clinically extremely vulnerable) include those who have had an organ transplant; have severe lung or kidney disease; or are having certain types of cancer or other treatment which significantly increases the risk of infection. Examples of those at

moderate risk (clinically vulnerable) are people over 70; people under 70 with an underlying health condition, such as diabetes, or chronic respiratory, heart, liver or kidney disease; those with a weakened immune system; or who are very overweight. (These lists are not exhaustive.)

40. In response to the initial pandemic outbreak, HM Prison and Probation Service (HMPPS) introduced several measures to try and contain the outbreak - to be implemented at local level, depending on the needs of individual prisons. (An outbreak is defined as two or more prisoners, or staff, who are clinically suspected, or have tested positive for COVID-19 within 14 days.) A key strategy is 'compartmentalisation' to cohort and protect prisoners at high and moderate risk; isolate those who are symptomatic; and separate newly arrived prisoners from the main population. Other measures include social distancing and the use of personal protective equipment (PPE).

41. On 17 September 2021, the Government advised that it was no longer necessary for the clinically vulnerable to shield. This was on the basis that vaccination had reduced the risk to them.

Key Events

42. On 12 May 2017, Mr Stuart Cunningham was sentenced to ten years imprisonment for a firearms offence. He was transferred to HMP Dovegate on 14 December. Mr Cunningham had asthma and was prescribed a salbutamol inhaler.

43. On 23 June 2021, Mr Cunningham was offered, but declined, a first dose of the COVID-19 vaccine. He signed a consent form to say that he understood the risks of not having the vaccine.

44. On 27 October, a nurse gave Mr Cunningham two paracetamol tablets at the medication hatch. She did not record why Mr Cunningham asked for them.

45. On 1 November, Mr Cunningham, along with everyone else on his wing, was tested for COVID-19 because there were several suspected cases on the wing.

46. At around 10.00am on 2 November, a nurse saw Mr Cunningham as he was having difficulty breathing. He told her that he had been feeling unwell for around eight days, and that his breathing had deteriorated over the last three days. She took Mr Cunningham's clinical observations and found that he had a high pulse, a slightly raised temperature and his blood oxygen level was fluctuating between 93-96% (a normal range is 95-100%). She calculated a NEWS2 score of 4. (NEWS2 is a nationally recognised tool to facilitate the early detection of deterioration in health. A score of 4 indicates that the patient requires attention from a registered nurse.) She consulted a prison GP and they decided to call an ambulance.

47. When ambulance paramedics arrived, they concluded that Mr Cunningham did not need to go to hospital as his observations had improved, and his NEWS2 score had reduced to 2. They advised prison healthcare staff to monitor Mr Cunningham closely, and to repeat his clinical observations regularly. The nurse recorded that Mr Cunningham's observations should be checked again in two hours.

48. At 2.00pm, a nurse saw Mr Cunningham and gave him a pulse oximeter and asked him to record his own blood oxygen levels. There is no evidence in Mr Cunningham's medical record (SystmOne) that further clinical observations were taken that day.

49. On 3 November at 1.30am, a nurse took Mr Cunningham's clinical observations. His blood oxygen levels were fluctuating between 95-96%. She told Mr Cunningham to alert staff if his blood oxygen level fell below 92%.

50. At 9.10am, a healthcare assistant took Mr Cunningham's clinical observations. His blood oxygen level was 94%.

51. At 11.00am, a nurse went to see Mr Cunningham after residents and officers raised concerns about his condition. Mr Cunningham said he was not recording his own blood oxygen levels as he thought there was no point. She reminded him of the importance of monitoring his blood oxygen levels.

52. The nurse took Mr Cunningham's clinical observations and found that he had a high temperature and high respiratory rate. She calculated a NEWS2 score of 5. (A score of 5 or more indicates an urgent assessment by acute care professionals in an environment with appropriate monitoring facilities.) She also started the

sepsis pathway (used to detect early signs of sepsis) but made a clinical judgement that Mr Cunningham did not have sepsis and his symptoms were due to COVID-19. She noted that there was no sign of infection or of Mr Cunningham being acutely unwell.

53. At 2.21pm, a healthcare assistant saw Mr Cunningham. She noted that on one occasion Mr Cunningham had recorded his pulse instead of his blood oxygen levels. His blood oxygen level was 94% and his other clinical observations were stable. His NEWS2 score was 1.

54. At 5.49pm, a prison GP prescribed liquid paracetamol to Mr Cunningham as he was having difficulty swallowing the tablets. He did not see Mr Cunningham face-to-face but prescribed this medication at the request of the nurse.

Events from 4 November 2021

55. On 4 November, at 2.50pm, a nurse reviewed Mr Cunningham. His blood oxygen level had improved to 96% and his NEWS2 score was 1.

56. At 7.04pm and 7.19pm Mr Cunningham pressed his cell bell. Both calls were answered by Prison Custody Officer (PCO) A. The first time he responded, Mr Cunningham said that his blood oxygen level was low, and he had been told to ask for healthcare staff if this happened. He said that Mr Cunningham was abusive and swearing, but that he did not appear particularly unwell, was alert and was still able to communicate.

57. PCO A called the healthcare first responder (Hotel 1), told them that Mr Cunningham's blood oxygen level was low and asked for someone to see him. When he answered the second cell bell call, he reassured Mr Cunningham that he had called healthcare and they knew that he needed to be seen.

58. PCO A's shift ended at around 8.00pm. Healthcare had not yet been to see Mr Cunningham. The PCO told the nightshift that Mr Cunningham was still waiting to see healthcare but could not recall who he spoke to.

59. At 10.08pm, a nurse went to see Mr Cunningham. Mr Cunningham appeared to be asleep. The nurse told prison staff that if Mr Cunningham woke up, they should contact healthcare.

60. On 5 November, at 2.58am, Mr Cunningham pressed his cell bell, and PCO B responded. He noted that Mr Cunningham shouted at him, saying he needed to see a nurse, but would not tell him what was wrong. At interview, the PCO said that he did not call healthcare staff as he thought it unlikely that they would attend, and that it did not seem necessary at the time.

61. At 3.30am, Mr Cunningham pressed his cell bell again. PCO B responded and found Mr Cunningham lying on the floor of his cell. Mr Cunningham did not respond to him knocking on the door or speaking to him. He radioed a 'code blue' (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). He did not enter the cell immediately as he could see that Mr Cunningham was breathing and he knew that a Custodial Operations Manager (COM) was on his way. He arrived very quickly. The COM holds an emergency key to all the cells.

62. The nurse responded to the code blue. When he arrived at the cell, the door had not yet been opened.

63. The COM opened the door. He said he had to force the door as Mr Cunningham was on the floor directly behind it.

64. When he entered, the nurse said that Mr Cunningham was unconscious, but that he started to regain consciousness as the nurse assessed him. Mr Cunningham was struggling to breathe and had a NEWS2 score of 8 (indicating he needed emergency medical support).

65. Control room records show that an ambulance was called at 3.34am, and that at 3.40am the prison contacted the ambulance service again to say that Mr Cunningham had COVID-19.

66. At 4.00am, the ambulance arrived at the prison and was escorted straight to Mr Cunningham. Mr Cunningham had fully regained consciousness by this point and was able to walk to the ambulance. At 4.45am, the ambulance left the prison with Mr Cunningham, and he was taken to Queens Hospital Burton.

67. On 6 November, Mr Cunningham's COVID-19 test result was returned as positive. At the time there were significant delays in receiving COVID-19 test results.

68. On 7 November, Mr Cunningham was moved to the hospital's Intensive Treatment Unit (ITU, also known as an Intensive Care Unit – ICU) and placed on a CPAP machine (this machine uses a hose connected to a mask or nosepiece to deliver constant and steady air pressure to help with breathing).

69. On 11 November, Mr Cunningham was placed in a medically induced coma.

70. Mr Cunningham's health continued to deteriorate, and he died at 6.50pm on 13 November 2021.

Cause of death

71. The coroner concluded that Mr Cunningham died of COVID pneumonia. There was no post-mortem.

Findings

Management of Mr Cunningham's risk of infection from COVID-19

72. Dovegate's management of the risk of infection for prisoners and staff from COVID-19 was good. They operated a restricted regime and implemented prevention control measures. They held regular meetings with Public Health England where all positive cases, staff and prisoners, were discussed. This enabled them to have an overview and understanding as to where any outbreaks started and trace movements to identify others at potential risk.

73. Staff testing was implemented, and staff were made aware by a Notice to Staff to ensure all staff were captured by testing prior to entering the establishment. Staff had to undertake weekly COVID-19 tests, which they then had to log on the government website.

74. There was no evidence that Mr Cunningham was in a high-risk group if he contracted COVID-19, and he was not therefore advised to shield. There were also no concerns about the use of Personal Protective Equipment (PPE) at the prison.

75. Despite the measures to control the risk of infection and to protect prisoners, it appears that Mr Cunningham contracted COVID-19 in prison, as he had not left the prison for some months previously. On 1 November, there was an outbreak of COVID-19 on two of the prison's wings, including the wing where Mr Cunningham lived. As a result, a mass testing programme and restricted regime was put in place to limit the spread of the virus, prisoners were not allowed to leave the wings. Prisoners who tested positive were required to isolate in line with HMPPS guidelines. As of 2 November, there were eight men symptomatic of COVID-19 (including Mr Cunningham) and 98 outstanding test results for both wings.

Clinical Findings

76. The clinical reviewer concluded that the care Mr Cunningham received at Dovegate was generally of a good standard and equivalent to that which he could have expected to receive in the community. However, she made several recommendations.

Record keeping

77. When Mr Cunningham was given paracetamol on 27 October at the medication hatch, the nurse who prescribed it did not record why Mr Cunningham had asked for it. In this instance, it could have been a missed opportunity to identify that Mr Cunningham was symptomatic for COVID-19 five days earlier. We recommend:

    The Head of Healthcare should ensure that when over the counter medication is requested and administered, staff document the reason the medication was given.

Monitoring Mr Cunningham after he contracted COVID-19

78. On 2 November, ambulance paramedics concluded that Mr Cunningham did not need to go to hospital but that he should be monitored closely. At 12.50pm, a prison nurse recorded that Mr Cunningham's clinical observations should be checked again in two hours. This check did not take place.

79. At 2.00pm, Mr Cunningham was given a pulse oximeter to monitor his own blood oxygen levels. The next time Mr Cunningham's clinical observations were taken was at 1.30pm on 3 November, over 12 hours since he was seen by the paramedics the previous day.

80. The clinical reviewer had concerns about Mr Cunningham's willingness and ability to use the pulse oximeter. On 3 November, he said he saw no point in taking his blood oxygen readings. Later, a nurse realised that he was recording his pulse, and not his oxygen level.

81. Further to the above, when Mr Cunningham was reviewed by the nurse at 11am on 3 November, his NEWS2 score was 5, which should have triggered a response under the sepsis pathway, where further medical help would have been sought. The nurse completing the assessment did not take this action as she said she was confident that his symptoms were related to COVID-19 and not sepsis. However, there is no way that the nurse could have known that Mr Cunningham did not have sepsis. He had not had a positive test result for COVID-19 at this time. The symptoms of COVID-19 seemed to overshadow the possibility of other underlying health conditions.

82. The clinical reviewer made three recommendations about the management and monitoring of Mr Cunningham after he became symptomatic of COVID-19 which we repeat here:

    The Head of Healthcare should ensure that when a prisoner requires close monitoring and repeat clinical observations as recommended by a medic or advanced practitioner (such as paramedics in Mr Cunningham's case), staff complete clinical observations in accordance with the recommended care plan.

    The Head of Healthcare should develop a local policy/pathway to support the pulse oximeter programme which should ensure that staff know how to assess a patient's competency to use the device and give clear instructions on when a prisoner's self-monitoring record is checked.

    The Head of Healthcare should ensure that staff also consider the possibility of co-existing health conditions when a patient is symptomatic or if they tested positive for COVID-19.

Response to cell bell

83. On 4 November, at 10.08pm, a nurse went to see Mr Cunningham to review him. Mr Cunningham appeared to be asleep. The nurse recorded that he told prison staff that if Mr Cunningham woke up, they should contact healthcare.

84. Despite this, when Mr Cunningham pressed his cell bell on 5 November, at 2.58am, PCO B did not contact healthcare staff. He told the investigator that he did not think it was necessary and mentioned several reasons for this. Mr Cunningham was shouting and would not tell the PCO what was wrong. Also, the PCO said that after consulting with colleagues, he understood that Mr Cunningham might have seen healthcare earlier that evening, and would have to wait until morning, and that it was unlikely that healthcare would respond. Also, the PCO did not seem to be aware that healthcare wanted to see Mr Cunningham if he woke up. Approximately 30 minutes later Mr Cunningham pressed his cell bell and was found by the PCO collapsed on his cell floor.

85. Given that Mr Cunningham regained consciousness, and got to hospital for treatment, it seems unlikely that the outcome for him would have been different if he had been seen by healthcare staff when he pressed his cell bell at 2.58am. However, it would have prevented him from potentially being in distress by himself for a further 30 minutes, and collapsing in his cell, alone.

86. It is also concerning that PCO B did not seem to be aware of the nurse's earlier instruction that healthcare should be called if Mr Cunningham woke up. We recommend:

The Director should ensure that prison staff contact healthcare staff promptly, when prisoners report pain or other symptoms suggesting they are unwell.

The Director and Head of Healthcare should ensure that clear communication channels are in place to enable both healthcare and prison staff to share information about the care needs of prisoners, and that information is effectively disseminated to relevant staff.

Restraints, security and escorts

87. 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 considers the prisoner's health and mobility. 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. 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.

88. Prison Service Instruction 33/2015, External Prisoner Movement, defines the policy and guidance for the external escort of prisoners. It says that the normal practice is for category B and E-List prisoners to be double cuffed while on an escort and all other prisoners should be single cuffed unless the individual's risk assessment indicates that double cuffs are required. It also says that restraints will not normally be used when a prisoner's medical condition, advanced age or physical impairment renders restraints inappropriate.

89. Mr Cunningham was doubled cuffed when he was escorted from Dovegate. Double cuffing is when the prisoner's hands are handcuffed in front of them, and one wrist is attached to a prison officer by an additional set of handcuffs. Mr Cunningham was a Category B prisoner, assessed as medium risk of harm to the public, a medium risk of hostage taking, a medium risk of escape with a medium risk of outside assistance. However, there is no information on the document to support these risk assessments.

90. The medical section of the risk assessment was not completed, nor was the risk assessment signed off by a senior manager. When asked, the prison stated that as this was an emergency escort, there was not time to fully complete the document. The ambulance was called at 3.34am, and the ambulance did not leave the establishment until 4.45am. We consider this enough time for a more robust risk assessment to have been completed and signed off by a senior manager.

91. Prison Service Instruction 33/2015, External Prisoner Movement, states that a full escort risk assessment must be completed as soon as is practicable, but in any event within 24 hours of the prisoner leaving the establishment. No such document has been provided during this investigation. It is difficult to conclude whether it was appropriate for Mr Cunningham to be restrained using a double cuff due to lack of information on the escort risk assessment. We therefore recommend:

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, in all cases:

- **healthcare staff complete the medical information section of the escort risk assessment to say whether the prisoner's current medical condition affects their mobility and risk of escape; and**
- **the assessment is countersigned by an authorising manager to show that they have taken this information into account when assessing a prisoner's current level of risk.**

92. On 6 November, at 4.09pm, a record in the bedwatch log shows that an officer on bedwatch spoke with a COM and explained that there was an issue with Mr Cunningham's restraints. They stated that Mr Cunningham was struggling to move with them on and to find the right position to breathe as easily as possible. Records show that the COM said he would speak with the Head of Security to assess if the cuffs could be removed. It is not clear whether any action was taken as a result of this conversation.

93. On 7 November, at 10.12am, the level of restraint was reduced to 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 prison advised that this was changed as the hospital wanted Mr Cunningham to be positioned on his front. On the same day, Mr Cunningham was moved to the hospital's Intensive Treatment Unit (ITU, also known as an Intensive Care Unit – ICU) and placed on a CPAP machine. (This machine uses a hose connected to a mask or nosepiece to deliver constant and steady air pressure to help with breathing.)

94. Standard Operating Procedure, Escorting & Bed watches – COVID-19, sets out the procedure for escorting prisoners to hospital for treatment. It says that in

normal circumstances where a category B, C or D prisoner needs to be ventilated or receive treatment from a hospital's intensive care unit, staff will remain outside the unit and observe the prisoner through an observation window.

95. As Mr Cunningham remained restrained using an escort chain it is clear that officers remained with him. This placed the officers at an increased risk of catching COVID-19. We are concerned that the Standard Operating Procedure was ignored, as there is nothing to suggest that there were unusual circumstances surrounding Mr Cunningham's treatment. We recommend:

The Director should ensure that managers authorise the removal of restraints for COVID-19 positive, non-category A prisoners needing ventilation or intensive care unit treatment, in line with the Standard Operating Procedure, Escorts & Bed watches – COVID-19, unless abnormal circumstances apply.

96. On 11 November, at 12.20pm, Mr Cunningham's restraints were removed as he had been placed in a medically induced coma.

Inquest

97. The inquest, heard on 4 September 2023, concluded that Mr Cunningham died from natural causes.

Prisons & Probation Ombudsman
Independent Investigations

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