Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Baldwin, a prisoner at HMP Garth, on 20 December 2021

A report by the Prisons and Probation Ombudsman

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

© Crown copyright, 2023

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 John Baldwin died from pneumonia (a lung infection) on 20 December 2021. He died in hospital while a prisoner at HMP Garth. He also had oesophageal cancer (cancer of the food pipe) which contributed to but did not cause his death. He was 80 years old. We offer our condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care that Mr Baldwin received at HMP Garth was of a satisfactory standard. She found that the care delivered was appropriate, compassionate and responsive. She found that he had the relevant care plans in place and access to appropriate services.

5. However, she was concerned that healthcare staff at HMP Lincoln did not send a clinical letter to healthcare staff at Garth after Mr Baldwin had been transferred to explain his health needs.

6. Mr Baldwin's family was not updated when his health deteriorated when he was last sent to hospital.

7. We are concerned that when he was sent to hospital on 10 December 2021, Mr Baldwin was restrained, even though his health had deteriorated.

8. We are also concerned that Garth did not provide the investigator with all of the relevant documents relating to the use of restraints, which meant that we could not determine whether the decision-making process on 7 December was appropriate.

Recommendations

- The Head of Healthcare at HMP Lincoln should ensure that systems are implemented to review and escalate clinical information after a prisoner has been released or transferred.

- The Governor and Head of Healthcare should ensure that:

    - staff notify a prisoner's next of kin as soon as possible when they become seriously ill, in line with PSI 64/2011; and

    - HMP Garth has a rota of trained family liaison officers available so that the next of kin are informed promptly when a prisoner is seriously ill or dies.

- The Governor and the 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;
    - authorising managers show that they have taken this information into account when assessing a prisoner's current level of risk;
    - risk assessments are regularly reviewed to consider changes in the prisoner's medical condition while they are in hospital; and
    - that all risk assessment reviews are clearly documented.
- The Governor should ensure that all evidence about a death in custody, including electronic evidence, is retained and promptly made available to the Prisons and Probation Ombudsman, in line with PSI 58/2010.

The Investigation Process

9. NHS England commissioned an independent clinical reviewer to review Mr Baldwin's clinical care at HMP Garth.

10. The PPO investigator has investigated non-clinical issues, including Mr Baldwin's location, the security arrangements for his hospital escort/s, liaison with his family and whether compassionate release was considered.

11. The PPO family liaison officer wrote to Mr Baldwin's daughter to explain the investigation. She had questions relating to Mr Baldwin's location, medical treatment, family communication and the cause of death. She asked for a written apology from the prison for their lack of communication after Mr Baldwin became seriously ill and had been sent to hospital. We have addressed her questions in this report and by way of separate correspondence.

12. Mr Baldwin's daughter received a copy of the draft report. She made some comments relating to the findings which has resulted in an additional paragraph being added to the report. Other comments have been addressed through separate correspondence.

13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Previous deaths at HMP Garth

14. Eight prisoners died at Garth in the two years before Mr Baldwin's death, five of whom died from natural causes, two were self-inflicted deaths and one was a drug-related death. Two prisoners have died from natural causes at Garth since Mr Baldwin's death.

15. In an investigation into the death of a prisoner in October 2021, we found that the prisoner's health and mobility were not taken into account when deciding to restrain him. The prison has not yet produced its action plan detailing how it will address this failing.

Key Events

16. On 21 August 2020, Mr Baldwin was sentenced to ten years and six months in prison for sex offences and he was sent to HMP Lincoln.

17. Mr Baldwin stayed in hospital from 28 October to 20 March 2021 while he waited for surgery for an abdominal aortic aneurysm (a bulge in the wall of the large artery below the heart).

18. On 29 July, Mr Baldwin went to an appointment at the vascular clinic.

19. On 3 August, Mr Baldwin was transferred to HMP Garth. Before he was transferred, a nurse assessed him. Mr Baldwin told him that he was unhappy to be moving away from his family but that he had no medical issues which would prevent his safe transfer.

20. Mr Baldwin had a number of health concerns, including a history of deep vein thrombosis (DVT, a blood clot in a vein), skin cancer, abdominal aortic aneurysm, chronic obstructive pulmonary disease (COPD, a lung disease) and high cholesterol in the blood.

21. On 17 August, a healthcare administrator at Lincoln uploaded a clinical letter from a hospital consultant vascular surgeon onto Mr Baldwin's medical records. She did not tell Garth about it. The letter said that Mr Baldwin had reported food sticking in his throat when he ate. The consultant told Mr Baldwin to see a prison GP, as he may need an oesophago-gastroscopy (an examination of the interior of the stomach). Two further copies of the same letter were uploaded to the medical records on 18 and 20 August.

22. On 23 November, a prison GP reviewed Mr Baldwin. He found and read the letter from the hospital consultant vascular surgeon. The GP reviewed blood tests which showed that Mr Baldwin may have anaemia. He referred him to a specialist under the NHS suspected cancer pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks.

23. On 7 December, a prison GP reviewed Mr Baldwin's blood test results. He thought that Mr Baldwin may have internal bleeding and sent him to hospital. Before he left, a nurse completed Mr Baldwin's observations and noted that he had a National Early Warning Score (NEWS2, a tool to detect and respond to clinical deterioration) score of 0. (A score above 7 indicates the need for an emergency response.) Mr Baldwin was sent to hospital and returned the same day with no discharge paperwork. We do not know if Mr Baldwin was restrained when he went to hospital, as Garth did not provide the escort risk assessment.

24. Before he left, prison staff completed an escort risk assessment. A nurse noted in the medical records that she had competed the medical section and said that if he should be restrained that the escorting officers should use 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).

25. On 10 December, a nurse saw Mr Baldwin because prison officers said that he looked unwell. She noted that he was grey, his lips were pale, and he was responsive but confused. She noted that his blood oxygen level was very low so

gave him oxygen. She took his observations but did not assess his NEWS2 score. She asked for an ambulance.

26. At about 11.00am, a prison GP saw Mr Baldwin because his condition had deteriorated. He noted that Mr Baldwin had a recent history of severe lethargy, severe anaemia and low blood oxygen saturation. He took his observations but did not assess his NEWS2 score. Ambulance paramedics took Mr Baldwin to hospital, restrained.

27. Before Mr Baldwin left, prison staff completed an escort risk assessment. A nurse completed the medical section. She did not object to the use of restraints and noted that Mr Baldwin did not have any medical conditions which might affect his ability to escape. She noted that he did not have a heart condition and that the escort did not relate to a medical condition which may require lifesaving treatment. She noted that his mobility was not impaired.

28. A security collator noted that Mr Baldwin had a personal emergency evacuation plan (PEEP). A security analyst noted that Mr Baldwin's risk to the public and risk of escape was low. The Acting Head of Security and Intelligence authorised that two officers escort Mr Baldwin and that he should be restrained with an escort chain.

29. On 13 December, hospital staff told Mr Baldwin that he had oesophageal cancer (cancer of the gullet or food pipe).

30. On 16 December, the Acting Head of Security and Intelligence reviewed the escort risk assessment and spoke to the ward doctor about Mr Baldwin's condition. The doctor told him that she had no concerns about the use of restraints. She confirmed that Mr Baldwin had cancer but said that he was not at the end of life. The Acting Head asked the Head of Safer Prisons and Equalities to inform Mr Baldwin's family of his condition the next day.

31. On 17 December, Mr Baldwin's daughter received a phone call from the hospital to inform her of her father's condition. She rang Garth to discuss this with them and left a message to be called back.

32. The same day, the Head of Safer Prisons and Equalities telephoned Mr Baldwin's daughter and told her of his condition. She told the Head that she was upset with Garth, as the hospital had already informed her that he was unwell. The Head apologised for not contacting her earlier and said that she would appoint a family liaison officer on 20 December as it was the weekend and no one available.

33. That day, two of Mr Baldwin's daughters emailed a prison manager, who no longer worked at Garth, complaining about the lack of communication with the family. The prison manager forwarded these emails to Garth's Business Management Unit and, on 19 December, to an Acting Governor.

34. At 1.30pm on 17 December, Mr Baldwin's condition deteriorated after he was given a blood transfusion. Prison officers who were with him at the hospital telephoned the Head of Safer Prisons and Equalities. At 2.35pm, she authorised that the restraint could be removed. At 6.00pm, she telephoned the officers and told them to reapply the restraint until she had an update from the hospital about his condition. She authorised that Mr Baldwin could telephone his family.

35. On 19 December, the Head of Safer Prisons and Equalities telephoned Mr Baldwin’s daughter and gave her a password to contact the hospital directly.

36. At 5.15am on 20 December, Mr Baldwin fell out of bed. He had a heart attack and became unresponsive. Two officers telephoned Garth and asked for permission to remove the restraint. A Custodial Manager (CM) authorised that the restraint could be removed. Mr Baldwin died at 5.40am.

37. On 20 December, the Head of Safer Prisons and Equalities telephoned Mr Baldwin’s daughter to inform her of his death. Later that day, the Head appointed a Senior Officer (SO) as the family liaison officer (FLO). The FLO telephoned Mr Baldwin’s daughter and offered her condolences.

38. On 22 December, Mr Baldwin’s daughter sent copies of the emails she had been sending to the previous prison manager to the FLO. She was upset that the family had not received a response.

39. On 23 December, the FLO spoke to the Acting Governor about the family’s email chain. The Acting Governor and the Head of Safer Prisons and Equalities rang Mr Baldwin’s daughter to apologise for not communicating their father’s illness to her sooner and to answer the family’s questions.

40. On 29 December, the Head of Safer Prisons and Equalities responded to both of Mr Baldwin’s daughters who had emailed the prison. She offered her condolences. She also emailed all the duty governors, clarifying the guidance about appointing a family liaison officer and contacting the nominated next of kin when a prisoner becomes unwell.

Post-mortem report

41. There was no post-mortem examination. The coroner accepted the cause of death provided by a hospital doctor that Mr Baldwin died from pneumonia (a lung infection). He also had oesophageal cancer (disease of the food pipe) which contributed to but did not cause his death.

Clinical Findings

Mr Baldwin’s clinical care

42. The clinical reviewer found that the clinical care that Mr Baldwin received at Garth was of a satisfactory standard. She was satisfied that relevant care planning was in place for Mr Baldwin’s clinical conditions and that he had access to appropriate services. The clinical reviewer found that the care delivered to Mr Baldwin was appropriate, compassionate, and responsive.

43. The clinical reviewer made three recommendations to Garth which did not directly relate to Mr Baldwin’s death, but which the Head of Healthcare will need to address. The clinical reviewer found that healthcare staff at Lincoln did not inform healthcare staff at Garth that they had received a letter from the hospital consultant vascular surgeon, describing Mr Baldwin’s symptoms and that he may need a referral for an OGD. It was not until over three months later that a prison GP at Garth found the consultant’s letter in Mr Baldwin’s medical records.

44. We cannot say if this would have affected the outcome for Mr Baldwin’s cancer diagnosis. However, earlier diagnosis might have allowed him to access life-prolonging treatment, given him time to see his family before his death and allowing him access to a palliative care pathway. We therefore make the following recommendation:

    The Head of Healthcare at HMP Lincoln should ensure that systems are implemented to review and escalate clinical information after a prisoner has been released or transferred.

Non-Clinical Findings

Liaison with Mr Baldwin's family

45. Prison Rule 22 states that prisons should inform a prisoner's next of kin immediately if a prisoner becomes seriously ill. Prison Service Instruction 64/2011 on safer custody says that if a prisoner has an unpredicted or rapid deterioration in their physical health, an appropriate member of prison staff should engage with their next of kin to provide information and support. If a prisoner's health deteriorates, a family liaison officer should be appointed immediately and the next of kin should be contacted.

46. Garth made no contact with Mr Baldwin's daughter when he was sent to hospital on 7 and 10 December with suspected internal bleeding. There were further missed opportunities to inform the family when Mr Baldwin received a diagnosis of cancer. His family was told of his condition by the hospital and not by Garth. Mr Baldwin's family was upset at the lack of communication from prison staff and emailed a person they believed to be the Governor. This prison manager, who had left Garth, forwarded the emails to the Acting Governor. However, they were not actioned for a further 4 days when the Acting Governor and the Head of Safer Prisons and Equalities rang the family to apologise.

47. After the Head of Safer Prisons and Equalities had spoken to Mr Baldwin's daughter on 17 December, she was unable to appoint a family liaison officer because there were no available family liaison officers as it was a weekend. She said that she would appoint one on Monday 20 December. On Monday morning, she telephoned the family to inform them that Mr Baldwin had died. Later that day, she appointed a SO as the family liaison officer.

48. We acknowledge the actions that Garth have taken to apologise to the family. We also note that the Head of Safer Prisons and Equalities has given additional guidance to all duty governors on notifying the next of kin when a prisoner becomes seriously ill and the allocation of a family liaison officer. However, we are concerned that there were several missed opportunities to inform Mr Baldwin's family of his deteriorating condition after he went to hospital on 10 December and that there was a lack of available family liaison officers over the weekend. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that:

    - **staff notify a prisoner's next of kin as soon as possible when they become seriously ill, in line with PSI 64/2011; and**
    - **HMP Garth has a rota of trained family liaison officers available so that the next of kin are informed promptly when a prisoner is seriously ill or dies.**

Restraints, security and escorts

49. 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.

50. 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. It found that using handcuffs or other restraints on terminally ill or seriously ill prisoners was inhumane, unless justified by security considerations.

51. We are unable to say if Mr Baldwin was restrained when he was sent to hospital on 7 December. However, a nurse said that she had queried the use of restraints for Mr Baldwin when completing the escort risk assessment. Mr Baldwin was restrained with an escort chain when he was sent to hospital on 10 December. He remained restrained in hospital.

52. A nurse had access to Mr Baldwin's medical records and should therefore have known about his health and medical conditions. There is no evidence to justify why there was no clinical objection to the use of restraints given that Mr Baldwin was very unwell. His oxygen saturations had dropped, he was severely lethargic and anaemic, and he was struggling to move independently. Mr Baldwin was restrained in hospital for ten days. Restraints were only removed after Mr Baldwin had collapsed in the early hours of 20 December, the day he died.

53. Mr Baldwin was a Category C elderly prisoner. His security risks were recorded as low. His health had deteriorated, he had COPD, had undergone serious heart surgery and he had a PEEP. The medical risk assessment did not consider his historical health factors, nor did it take into account his current health. The authorising officer did not take these factors into account when he authorised that Mr Baldwin should be restrained.

54. When the Acting Head of Security and Intelligence reviewed the risk assessment on 16 December, the doctor at the hospital said that she had no concerns about the use of restraints. While we understand that the restraints may not have interfered with his medical treatment, by this stage, Mr Baldwin had received a cancer diagnosis and he was seriously ill in hospital.

55. The escort chain was removed temporarily on 17 December but was reapplied a few hours later. The investigator cannot find a reason for reapplying the restraints when Mr Baldwin was bed-bound and required continence pads. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances.

56. We acknowledge that Garth have not yet completed the action plan following the death of a prisoner in October 2021 and therefore the actions may be the same as for this investigation. We make the following recommendation:

The Governor and the 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;**
- **authorising managers show that they have taken this information into account when assessing a prisoner's current level of risk;**
- **risk assessments are regularly reviewed to consider changes in the prisoner's medical condition while they are in hospital; and**
- **that all risk assessment reviews are clearly documented.**

Providing the PPO with relevant documents

57. PSI 58/2010 requires prisons to provide evidence to the Ombudsman's office for the purpose of our investigation. Garth did not supply all of the escort risk assessment documents. This adversely affected our investigation and meant that we could not determine whether Mr Baldwin was restrained and whether the decision-making process when Mr Baldwin was escorted to hospital on 7 December 2021 was appropriate. We make the following recommendation:

    The Governor should ensure that all evidence about a death in custody, including electronic evidence, is retained and promptly made available to the Prisons and Probation Ombudsman, in line with PSI 58/2010.

Inquest

58. The inquest into Mr Baldwin's death concluded on the 24 October 2023. The coroner confirmed that Mr Baldwin died of natural causes.

Caroline Mills
Assistant Ombudsman **April 2023**

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100