Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Derek Robb, a prisoner at HMP Elmley, on 31 July 2022

A report by the Prisons and Probation Ombudsman

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

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.

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 Derek Robb died in hospital of an extensive lung infection on 31 July 2022 while a prisoner at HMP Elmley. He was 55 years old. I offer my condolences to Mr Robb's family and friends.

The clinical reviewer concluded that the mental health and substance misuse care Mr Robb received was equivalent to that which he could have expected to receive in the community. However, Mr Robb's physical health care on 29 July was only partially equivalent. She makes recommendations for the Head of Healthcare to improve clinical practice, detailed in the annexed review.

We found that Mr Robb did not engage with healthcare medications or appointments on several occasions, which lead to increased health vulnerability. Staff made efforts to encourage Mr Robb's compliance throughout his time at Elmley. However, we are concerned about the decision to restrain Mr Robb when he became severely unwell and required hospital treatment on 30 July. The duty governor authorised the decision without consulting healthcare professionals or medical records. This appears to be a cultural issue within the prison and must be addressed to ensure restraint decisions are compliant with Prison Service policy and the 2007 Graham Judgement.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Adrian Usher
Prisons and Probation Ombudsman **August 2023**

Contents

Summary 1

The Investigation Process..........3

Background Information..........4

Key Events..........5

Findings..........8

Summary

Events

1. On 18 August 2021, Mr Derek Robb was recalled to HMP Elmley. Mr Robb was diabetic and had substance misuse issues and a personality disorder. Healthcare made the appropriate referrals to support services, but Mr Robb's engagement was mixed and this led to poor diabetes management.

2. At 10.46am on 29 July 2022, Mr Robb was found unresponsive in his cell. A Senior Officer (SO) called a code blue (an emergency radio code for when someone is struggling to breathe). Healthcare staff took Mr Robb's observations and recorded that his blood pressure was dangerously low, his heart rate was elevated and his blood sugar levels were high. Mr Robb refused to go to hospital and signed a disclaimer to that effect. An emergency response nurse asked an SO to check on Mr Robb throughout the day. Officers completed regular checks on Mr Robb and did not record any concerns. There was no further contact with healthcare.

3. On the morning of 30 July, Mr Robb told an SO that he felt worse. At around 9.53am, a SO called a code blue. Healthcare responded and recorded that Mr Robb was weak, had shallow breathing and chest pain. He was cold, dehydrated and falling asleep. His blood sugar level was very high.

4. At 10.39am, an ambulance arrived and took Mr Robb to hospital. The Duty Governor authorised 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) for the transfer.

5. Mr Robb was treated in intensive care. At 6.00pm on 30 July, Mr Robb died.

Findings

Clinical observations

6. The clinical reviewer concluded that the mental health and substance misuse care Mr Robb received was equivalent to that which he could have expected to receive in the community. However, there were issues with Mr Robb's physical healthcare on 29 July, which was only partially equivalent to the care he could have expected to receive in the community.

7. When Mr Robb became unwell on 29 July, nursing staff completed a set of clinical observations. The results indicated a need for hospital care but Mr Robb refused the transfer. Healthcare asked officers to monitor Mr Robb and call another code blue if they had any concerns. They had no further contact with Mr Robb that day. The clinical reviewer concluded that this was not sufficient in the circumstances, given Mr Robb's observation results. Although the clinical reviewer is unable to measure the impact of this omission on the outcome for Mr Robb, further observations may have resulted in quicker hospital treatment or exploration of a transfer to the inpatient unit at Elmley.

8. The clinical reviewer makes recommendations for improved clinical practice. Since Mr Robb's death, the Head of Healthcare has implemented a new system for follow up observations when a prisoner is unwell and refusing treatment.

Restraints

9. When Mr Robb went to hospital on 30 July, the Governor authorised use of an escort chain. The healthcare section of the escort risk assessment form was not completed. In interview, the Governor told us that she made the decision to restrain Mr Robb without the input of healthcare, which was common practice in emergency situations at Elmley. She said that nurses could add to the assessment as prisoners pass through reception on their way out of the prison, but Mr Robb was picked up at his houseblock.

10. We have viewed the CCTV footage from 30 July, which showed that Mr Robb was weak, breathless and walking very slowly. This supports descriptions in Mr Robb's health records. We conclude that restraining Mr Robb was inappropriate in the circumstances. We are also concerned that the current process for escort risk assessments at Elmley means not every decision involves medical input, despite requirements in Prison Service policy and the Graham Judgement 2007.

Recommendations

- The Governor should ensure that all duty governors responsible for authorising risk assessments are aware of the requirement to consider both the health and reoffending risks at the time of the escort.

- The Governor and Head of Healthcare should ensure that healthcare input into all escort risk assessment decisions, in line with Prevention of Escape: External Escorts Policy Framework and the Graham Judgement.

The Investigation Process

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

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

13. The investigator interviewed two members of staff at Elmley on 29 November 2022.

14. NHS England commissioned a clinical reviewer to review Mr Robb's clinical care at the prison. They jointly interviewed seven members of disciplinary and healthcare staff.

15. We informed HM Coroner for Kent Mid & Medway 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 Robb's next of kin, to explain the investigation and to ask if they had any matters they wanted us to consider. We did not receive a response.

17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Elmley

18. HMP Elmley holds around 1,100 remanded or sentenced prisoners. Oxleas NHS Foundation Trust took over the healthcare service in April 2022, which provides 24-hour care. Change Live Grow provides the psychosocial substance misuse service. Elmley also have an on-site inpatient unit which holds 22 beds and is staffed by two nurses and two healthcare assistants.

HM Inspectorate of Prisons

19. The most recent full inspection of HMP Elmley was in March 2022. Inspectors reported that there were not enough healthcare staff to provide a high-quality service, which caused delays and a lack of consistency. The termination of the previous healthcare provider's contract had contributed to the staff shortages and had had a harmful impact on the service. There was suitable risk assessment of prisoners being escorted to hospital, although not all risk assessment decisions had input from healthcare staff. Patients on the inpatient unit received reasonably good care.

Independent Monitoring Board

20. 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 31 October 2021, the IMB said that health provision at Elmley had been patchy due to staffing difficulties. They said that although the system was largely effective at identifying heath issues, it was critically under pressure.

Previous deaths at HMP Elmley

21. Mr Robb was the 15th prisoner to die at Elmley since July 2020. Of the previous deaths, ten were from natural causes, three were self-inflicted and one was drug related. There were no similarities between our findings in this investigation and the investigation into the previous deaths.

Key Events

22. On 18 August 2021, Mr Derek Robb was recalled to HMP Elmley for not complying with the conditions of his licence.

23. At his initial health screening, healthcare staff recorded that Mr Robb was diabetic and his blood sugar level was elevated. He also had substance misuse issues and a personality disorder. Staff made referrals to the substance misuse and mental health teams who made appropriate care plans and provided continuity of his medications.

24. On 19 August, Mr Robb was reviewed by the prison GP, who recorded that Mr Robb had recently been admitted to hospital for diabetic ketoacidosis (a life-threating condition where the body starts to run out of insulin) while in the community. The GP decided that Mr Robb should not be allowed to have his insulin in his cell until his blood sugar levels had settled.

25. During his time at Elmley, Mr Robb often refused his insulin medication or refused the full dose of his insulin medication. He was also non-compliant with his diabetic diet and decided not to attend several primary care and outpatient appointments to monitor his diabetes. Staff made continuous efforts to engage with Mr Robb with his medication and appointments. When healthcare did take his blood sugar readings, they were often elevated or high.

26. On 7 April 2022, Mr Robb attended the diabetes clinic at the local hospital. The hospital consultant increased his dose of insulin and noted that Mr Robb's nerve pain in his feet was getting worse.

27. On 14 July, Mr Robb had another appointment at the hospital diabetes clinic. Hospital staff changed his insulin doses and created a plan to try and manage his blood sugar levels.

28. On 27 July, the prison chronic pain multi-disciplinary meeting discussed Mr Robb's nerve pain in his feet. They noted that the nerve pain was a consequence of his poorly controlled diabetes, and the current pain medication was reducing the pain, but he was looking pale. They planned to prescribe a topical pain relief cream and book Mr Robb in for a blood test.

Events of 29 – 31 July 2022

29. At 8.15am on 29 July, an officer unlocked the cells on Mr Robb's house block. When she unlocked Mr Robb's cell, she wished him good morning and he replied. In interview, the officer noted that Mr Robb was still in bed, but this was not unusual for him.

30. At around 9.40am, a supervising officer (SO) asked the emergency response nurse to come and examine Mr Robb because he was too unwell to leave his bed. Mr Robb told the SO that he was unwell because of changes to his insulin. The nurse informed the SO that healthcare could only come to the house block in an emergency and suggested Mr Robb was taken to the prison outpatient clinic so she could see him straight away. The SO informed the nurse that Mr Robb was refusing

to be transferred to the outpatients unit. She reiterated that she could only attend the house blocks in an emergency. She asked the house block nurse, to check Mr Robb's blood sugar. He checked Mr Robb but did not record any blood sugar level results in his medical record.

31. At 10.46am, Mr Robb became unresponsive and the SO called a code blue (an emergency radio code for when someone is struggling to breathe). Healthcare attended and found that Mr Robb was alert and responsive. Mr Robb's blood pressure was dangerously low, his heart rate was elevated, and his blood sugar levels were high. Mr Robb refused to go to hospital and said that he would 'smash up' the ambulance if he was made to go. Mr Robb was asked to sign a disclaimer confirming that he was refusing a transfer to hospital, which he did. A nurse stood down the ambulance and asked the SO to check on Mr Robb throughout the day. She advised the SO to call a code blue if Mr Robb got worse or changed his mind about going to hospital.

32. At 11.40am and 3.15pm, officers went into Mr Robb's cell to check on him. They did not note any concerns. At 2.40pm, the house block nurse went to Mr Robb's cell to give him his routine medication. In interview, he said that Mr Robb looked much better that he had looked earlier on in the day.

33. At 6.35pm, 7.55pm, 10.20pm and 12.30am, officers checked Mr Robb through the observation hatch in his cell door. They did not note any concerns.

34. At 5.20am on 30 July, an officer arrived on the house block to complete a roll check. She looked into Mr Robb's cell and reported no issues.

35. At 8.45am, an officer unlocked Mr Robb's cell.

36. At 9.51am, the SO went into Mr Robb's cell to see how he was feeling. In interview, the SO told us that Mr Robb reported feeling worse and needed to go to hospital. At 9.53am, the SO called a code blue. Healthcare responded and recorded that Mr Robb was weak, had shallow breathing and chest pain, was cold, dehydrated and falling asleep. His blood sugar level was very high.

37. At 10.39am, the ambulance arrived and the SO organised parking directly outside the house block. The ambulance took Mr Robb to hospital. The Duty Governor authorised the escort officers to restrain Mr Robb 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). She also authorised escort officers the power to remove the escort chain in an emergency. She did not consult healthcare.

38. On the way to hospital, an officer recorded that Mr Robb was very subdued and struggled to breathe.

39. At around 1.15pm, Mr Robb stopped breathing and hospital staff began cardiopulmonary resuscitation (CPR). They asked officers to remove the escort chain, which they did in accordance with the approved risk assessment. Hospital staff intubated Mr Robb and put him in a medical coma. They took him to intensive care.

40. At 6.00pm on 30 July, Mr Robb died.

Contact with Mr Robb’s family

41. Elmley appointed a family liaison officer who informed Mr Robb’s next of kin that he was in hospital. They were with Mr Robb when he died.

42. Elmley offered to contribute to Mr Robb’s funeral expenses, in line with national policy.

Support for prisoners and staff

43. After Mr Robb’s death, the staff care team offered support to the escorting officers.

44. The prison posted notices informing other prisoners of Mr Robb’s death, offering support.

Post-mortem report

45. The post-mortem concluded that Mr Robb died of an extensive lung infection (a spreading infection), abscess formation (a mass filled with puss due to infection) and necrosis (a cell injury with causes the cells to die prematurely).

Findings

Clinical Findings

46. The clinical reviewer concluded that Mr Robb's mental health and substance misuse care was equivalent to that which he could have expected to receive in the community. However, there were issues identified with the physical health care provided to Mr Robb on 29 July, which was only partially equivalent to that which he could have expected to receive in the community.

47. On 29 July, officers found Mr Robb unwell in his cell and rightly called a code blue. A prison nurse responded and completed Mr Robb's clinical observations. Mr Robb's blood pressure was dangerously low and required hospital treatment, but Mr Robb refused to go to hospital and threatened to damage the ambulance if he was transferred, so this was not actioned. He signed a disclaimer to confirm he was refusing the transfer. In interview, healthcare staff said they had no concerns and that Mr Robb was offered a bed in the prison inpatient unit, but he refused. This was not recorded in Mr Robb's medical record. The officers on the wing were asked to keep an eye on Mr Robb and recall the code blue if there was any sign of deterioration. Officers checked on Mr Robb by going into his cell or looking through his cell observation hatch. They did not note any concerns.

48. The clinical reviewer was concerned that healthcare staff did not complete any follow up observations on Mr Robb and relied on checks by non-clinical staff without relevant training. The clinical reviewer was unable to measure the impact of this omission on the outcome for Mr Robb but follow up from healthcare might have sped up Mr Robb's access to treatment in hospital or the inpatients unit.

49. In interview, a nurse told us that under the previous healthcare provider at Elmley, this was standard practice. We found that when Mr Robb died, Elmley's healthcare was transitioning into a new provider and was consulting on its clinical processes before any changes were made. The clinical reviewer identified that this area of practice was not compliant with national healthcare guidelines and makes a recommendation that the process is reviewed.

50. Since Mr Robb's death, the Head of Healthcare has completed a review and made improvements. Healthcare staff now hold a 1.00pm multi-disciplinary handover, which actively checks whether there are any prisoners who have received emergency healthcare throughout the day and assigns staff to further observations. The Head of Healthcare confirmed that this new handover will ensure proper follow-up in all future cases.

Non-Clinical Findings

Lack of engagement

51. We found that Mr Robb did not engage with healthcare appointments or medications on several occasions, which meant his health conditions were poorly managed. Staff made consistent efforts to encourage Mr Robb's engagement, to reduce the risk of his health deteriorating.

Restraints

52. 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* (the PSI in place at the time of Mr Robb's death) 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.

53. 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.

54. When Mr Robb was transferred to hospital by ambulance on 30 July, the Duty Governor authorised his restraint with an escort chain. The Duty Governor did not involve healthcare in the risk assessment, despite Mr Robb's poor health and left the healthcare section of the form blank. We found no evidence that Mr Robb's health condition was considered when the decision was made. In interview, The Duty Governor told us it was standard practice to make restraints decisions without healthcare input in the event of an emergency. The Duty Governor said that at Elmley, the expectation was for reception healthcare staff to complete their section of the assessment as the prisoner exits the prison through reception. However, the SO organised for Mr Robb to enter the ambulance directly from the house block, without passing through reception.

55. We are concerned that the escort risk assessment process at Elmley does not ensure meaningful healthcare input into escort risk assessments, in line with national policy, to ensure the Graham Judgement is upheld. It is unclear how healthcare staff can contribute to risk assessments after a decision has been made by a Governor, and challenge decisions on medical grounds if appropriate. Elmley's healthcare service operates 24/7 and it is therefore reasonable for Governors to be expected to contact healthcare in advance of completing their assessment, even if this is required at pace, to ensure prisoners' latest medical notes are considered.

56. We have viewed the CCTV footage from 30 July, which showed that Mr Robb was weak, breathless and walking very slowly. This supports healthcare's record of his presentation. Based on his presentation on the CCTV and in his medical record we consider that the decision to restrain Mr Robb was inappropriate. We are also concerned about the reported culture of Governors making restraint decisions without medical input in emergencies, which must be addressed to ensure decisions comply with the Graham Judgement. We note that a new national escorts policy framework has been introduced since Mr Robb died, which includes a specific requirement for medical input into the decision-making process for escort risk assessments and this is reflected in the new national template. We make the following recommendations:

    The Governor should ensure that all duty governors responsible for authorising risk assessments are aware of the requirement to consider both the health and reoffending risks at the time of the escort.

The Governor and Head of Healthcare should ensure that healthcare input into all escort risk assessment decisions, in line with Prevention of Escape: External Escorts Policy Framework and the Graham Judgement.

Inquest

57. The inquest into Mr Robb's death concluded on 11 October 2023, with a verdict of natural causes.

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