

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Keith Bate, a prisoner at HMP Forest Bank, on 18 November 2022

A report by the Prisons and Probation Ombudsman

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

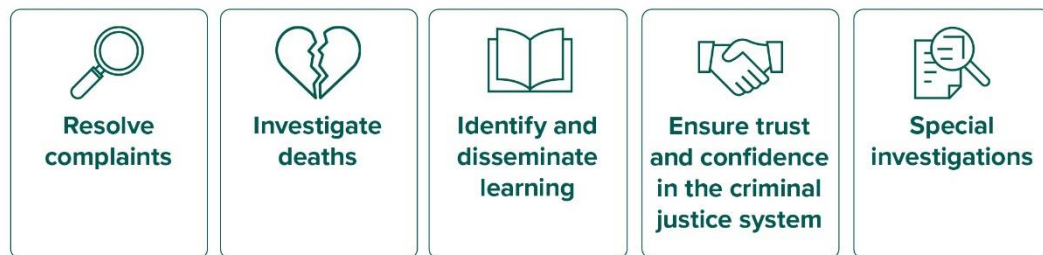
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 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, 2024

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 Keith Bate died in hospital of bronchopneumonia (an acute inflammation of the bronchi within the lungs) on 18 November 2022 while a prisoner at HMP Forest Bank. He also had cystitis (an inflammation of the bladder normally caused by infection) which contributed but did not cause his death. He was 74 years old. I offer my condolences to Mr Bate's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Bate received at Forest Bank was equivalent to that which he could have expected to receive in the community. The clinical reviewer made no recommendations.
5. We are concerned that there were no medical objections from healthcare staff to Mr Bate being restrained, given his health and poor mobility at the time. We are also concerned that despite the authorising prison manager concluding that Mr Bate should not be restrained, he was nonetheless escorted to hospital using an escort chain.

Recommendations

- **The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that their assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.**
- **The Director should commission an investigation into the events of 12 October 2022 to determine why the escort officers did not follow the decision not to restrain Mr Bate and to implement any learning that arises from the investigation.**

The Investigation Process

1. NHS England and NHS Improvement commissioned an independent clinical reviewer to review Mr Bate's clinical care at Forest Bank.
2. The PPO investigator investigated the non-clinical issues relating to Mr Bate's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
3. The PPO family liaison officer wrote to Mr Bate's next of kin, his wife, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not have any questions.
4. The next of kin received a copy of the draft report. She pointed out some factual inaccuracies within the clinical review report. This report has been amended accordingly.
5. 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 Forest Bank

6. Mr Bate was the ninth prisoner to die at Forest Bank since November 2020. Of the previous deaths, four were from natural causes, two were drug-related and two were self-inflicted. There are no similarities between our findings in this investigation report and those of the previous deaths.

Key Events

7. Mr Keith Bate was sentenced to 18 years in prison for sex offences and sent to HMP Forest Bank on 28 September 2022.
8. Before his arrival, Mr Bate had been diagnosed with Parkinson's disease (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves). On 29 September, he was moved to the healthcare unit due to his reduced mobility and risk of falls.
9. At approximately 7.45pm on 12 October, wing staff called healthcare staff to Mr Bate's cell after they found him unresponsive in his chair. His observations were taken and an electrocardiogram (ECG, a test used to check the heart's rhythm and electrical activity) was completed. The ECG did not rule out ischemia (when part of the body is not receiving enough oxygenated blood) so healthcare staff requested an ambulance.
10. Before Mr Bate left the prison, staff completed an escort risk assessment. A nurse completed the medical section. She indicated that Mr Bate's mobility was impaired and that he was attending hospital for life-saving treatment, but she did not object to the use of restraints. She noted that Mr Bate was very unwell, he was admitted as an emergency, and he used a Zimmer frame.
11. An orderly officer completed the security assessment and noted that Mr Bate posed a low risk in all areas, apart from his risk to the public in which he was considered a medium risk. He recorded that Mr Bate used a wheelchair and that his age and mobility affected the level of restraint and his ability to escape.
12. However, the authorising officer and duty manager did not authorise the use of restraints on the basis of Mr Bate's age and presenting health.
13. Despite this, prison records indicate that before Mr Bate left the prison, staff were fully briefed, and cuffs were applied and checked. It is also recorded that staff were told to contact the duty governor if changes to cuffing arrangements were needed. (Forest Bank did not explain why the authorising officer's instructions not to restrain Mr Bate were not followed, as they told us that the officer who restrained him was not currently at work.)
14. At approximately 9.04pm, the ambulance arrived at Forest Bank and took Mr Bate to hospital at 9.30pm, escorted by two officers and restrained 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).
15. On 13 October at 07.30am, an officer noted in Mr Bate's escort paperwork that he was "not cuffed".
16. On 13 October at 2.30pm, the duty manager at Forest Bank visited Mr Bate in hospital. He recorded in the escort paperwork that Mr Bate remained in "resus" (an area in the hospital which deals with urgent and life-threatening conditions) and appeared unwell. He noted that Mr Bate should be restrained with an escort chain when moving through the hospital and should be double cuffed if he left hospital to return to prison due to the risk to the public.

17. On 18 November, Mr Bate died in hospital.

Post-mortem report

18. The post-mortem report concluded that Mr Bate died of bronchopneumonia (a lung infection). He also had cystitis (an inflammation of the bladder) which contributed to but did not cause his death.

Inquest into Mr Bate's death

19. The inquest into Mr Bate's death was held on 1 December 2023 and a verdict of natural causes was recorded.

20. The coroner concluded that Mr Bate's death was due to bronchopneumonia and it was contributed to by cystitis, advanced Parkinson's disease and frailty.

Findings

Restraints, security and escorts

21. 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.
22. A judgment in the High Court in 2007 made it clear that prison staff needed to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when he had a serious medical condition. It said 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.
23. We are concerned about the nurse's decision not to object to the use of restraints given Mr Bate's health at that time, his limited mobility and that he was being admitted for life-saving treatment. When we asked for the reasons for this decision, we were advised that the nurse saw no clinical reason why restraints could not be used. We are concerned that the nurse therefore did not properly take into account Mr Bate's current health and mobility in making this decision.
24. We are also concerned that when an orderly officer completed Mr Bate's security assessment, he assessed that Mr Bate posed a medium risk to the public without proper justification and despite recording that Mr Bate used a wheelchair and that his age and mobility affected the level of restraint and his ability to escape, he still recommended that an escort chain should be used, even though he was also to be accompanied by two escort officers. Although we recognise that the authorising officer did not authorise the use of restraints and in doing so, appropriately considered Mr Bate's age and health, the escort paperwork indicates that his instruction was not followed as Mr Bate left the hospital restrained by an escort chain.
25. We are also very concerned about the duty manager's subsequent decision on 13 October that Mr Bate should be restrained when being moved within the hospital and double-cuffed on his return to prison. There was no intelligence to suggest that Mr Bate posed a danger to the public, was prone to violence or likely to escape. Coupled with the evidence that he was very unwell, elderly, needed life-saving treatment and had poor mobility, we have seen no evidence to justify the prison's decision to restrain him. We therefore make the following recommendation:

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 their assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Director should commission an investigation into the events of 12 October 2022 to determine why the escort officers did not follow the decision not to restrain Mr Bate and to implement any learning that arises from the investigation.

**Adrian Usher
Ombudsman**

July 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 | 020 7633 4100