



Learning lessons bulletin

Fatal incidents investigations issue 2

Restraints

This Learning Lessons Bulletin examines the lessons that can be learned about risk assessment and use of restraints for seriously ill and dying prisoners.

With more prisoners serving longer sentences and more sentenced later in life, people aged 60 and over are now the fastest growing age group in the prison estate. Prisoners of all ages can suffer from serious health problems, and the risk of cancer and heart disease increases significantly for older people. An older and ailing population brings new challenges and the past decade has seen deaths from natural causes outstrip self-inflicted deaths as the principal cause of death in prison custody. In 2011-12, there were 142 deaths in custody from natural causes, an increase of 20 over the previous year.

Prisons have sought to adjust to these challenges and care for the elderly and infirm is an area of improving practice. For example, investigations have identified a more planned approach to managing terminal illness, with more prisoners receiving palliative care equivalent to that provided in the community. However, prisons can struggle to balance security with humane and dignified treatment for the increasing numbers of people dying in their care. Too often, I have been obliged to criticise the use of restraints in such cases. This bulletin is designed to encourage lessons to be learned.

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Restraints

When a prisoner travels to hospital a risk assessment is conducted to determine security arrangements. This considers the probable harm to others the prisoner poses in the event of an escape, and their motivation and ability – both physical and in terms of outside resources – to escape.

Through this assessment, the prison decides whether and how to restrain the prisoner. Typically a prisoner is escorted by two prison officers, although this can be reduced or increased depending on the perceived risk. The different options for use of restraints are:

No restraints: close supervision by the escorting officers is considered sufficient to maintain security.

Closeting/escort chain: a length of lightweight chain is cuffed at one end to the prisoner and at the other to a prison officer. This allows a degree of privacy, for example during medical consultations.

Single cuff: the prisoner is handcuffed to a prison officer.

Double cuff: the prisoner's hands are cuffed together and a second pair cuffs the prisoner to a prison officer.

Policy and Law

In 2007, the High Court held in the case of *Graham v the Secretary of State for Justice* that using handcuffs on Mr Graham while he was receiving life saving chemotherapy infringed Article 3 of the Human Rights Act which prohibits inhuman or degrading treatment.

The judgement established the importance of individual context when considering risk. An adequately founded risk of escape or harm when the prisoner is fit does not necessarily hold true when that same individual is ill and receiving treatment. Medical opinion regarding the prisoner's ability to escape must therefore be considered as part of the assessment process. The forms used by many prisons currently ask only for medical objections to the use of the restraints, rather than requiring an assessment of their appropriateness and how the prisoner's medical condition impacts on risk. Separate assessments should consider the level of restraint during transportation to the hospital and during the prisoner's stay in hospital to reflect the different environments. These should be reviewed whenever there is a change in circumstances.

Advice for prisons is outlined in 'Prisoner Escort and Bedwatch Function', a concordat between the National Offender Management Service (NOMS) and the National Health Service. The concordat notes that, following the *Graham* judgement, using restraints on terminally or seriously ill patients should be considered inhumane except when justified by security considerations. It goes on to say:

"Levels of restraint used on prisoners must at all times be proportionate to the perceived security risks and be balanced by consideration of care and decency for the prisoner."

Deaths in custody

Based on detailed information collected from over 500 PPO investigations into deaths of prisoners from natural causes between 2007 and October 2012¹, around two thirds of the prisoners were known to have been admitted to hospital or a hospice in the last six months of their lives. The majority had been restrained while in hospital and it was identified in 51 investigations that the level of restraints used had been inappropriate.

Between January and October 2012, the Ombudsman published 23 reports into natural deaths where the restraints used were regarded as inappropriate.

The common themes include:

- prisoners who were already ill when attending hospital, remaining in restraints even after their condition declined further or was diagnosed as terminal;
- concerns raised by escort or medical staff not being appropriately considered;
- routine use of restraints according to the prisoner's security category, offence or previously assessed risk rather than the actual risk the prisoner presented at the time;
- inconsistency about when or whether to remove restraints;
- restraints remaining in place even as release on compassionate grounds is being sought.

Three examples of cases where such concerns have been raised are outlined below. These took place in 2011 and 2012.

¹The Ombudsman investigated 647 deaths of prisoners from natural causes in this period.

Case study 1

Mr A had been in custody for several decades before an urgent health referral led to a diagnosis of terminal cancer. Mr A's health declined rapidly resulting in his admission to hospital. He died less than a month after first reporting his symptoms.

A risk assessment determined that Mr A should be restrained using an escort chain. In hospital, a bedwatch log was kept by the escorting officers and detailed the decline in Mr A's health. Despite the fact that the log should be read as part of regular checks by prison managers there was no evidence that the information prompted any reconsideration of security arrangements. Nor did it seem that the original risk assessment was reviewed during the ten days Mr A was in hospital, despite his rapidly declining condition. He died while handcuffed by the chain to a prison officer.

Mr A's condition was not confirmed as terminal to the prison until two days before he died. However, restraints were not removed despite Mr A's serious illness, his shortness of breath and inability to move far from his bed. The lack of consideration given to the impact his health had on his security risk meant he was treated in a disrespectful, undignified and inhumane way during his final illness.

Case study 2

Mr B had been in prison a number of years and had a history of heart and breathing problems as well as lung cancer. His lung cancer returned almost two years after diagnosis, and four months before his death, after it initially appeared that treatment had been successful.

Mr B was admitted to a hospice on two occasions in four months. He was in his seventies and an ill man. At the hospice, staff usually moved him in a wheelchair, and by his second stay, Mr B was bedridden. Both times the risk assessment determined that he was to be restrained using an escort chain.

The first time at the hospice, his restraints were briefly removed but were reapplied on the instruction of a different manager at the prison. Both escort and nursing staff raised concerns with the Governor about the restraints. The risk assessment for Mr B was regularly reviewed but, despite being terminally ill, and incapable of posing a risk to others while under observation by prison officers, he remained in restraints.

On his second admission to the hospice, a doctor noted that the escort chain was injuring Mr B's wrists and, following a request to the prison, the chain was removed. He remained at the hospice, unrestrained, until his death a few days later.

The Ombudsman noted that whenever restraints are used the risk assessment must accurately reflect the risk posed at that time, to ensure restraints are proportionate and maintain human dignity.

Case study 3

Mr C was a Category A prisoner, meaning he was considered a significant risk to the public in the event of escape. He had spent over a decade in custody before he was diagnosed with terminal cancer. The palliative care he received at the prison was of a high standard; however there were concerns about the level of restraint used when outside the prison.

When attending hospital for diagnosis, Mr C was restrained using double cuffs and escorted by three officers. The risk assessments took some account of the state of Mr C's health because, as his condition deteriorated, the restraint was reduced to an escort chain. However, the escort chain remained in place even after Mr C was put into a medically induced coma for four days following a diagnostic procedure when there was no possible risk of escape. There was no evidence that the removal of restraints was considered at this time or that a medical opinion about his condition was considered as part of the risk assessment.

Lessons to be learned

Lesson 1 – Sufficient weight should be given to a prisoner's current health and mobility when considering the risk they pose to the public.

There is, inevitably, a balance to be struck between decency and security. However our investigations have shown that the correct balance is not consistently being achieved. Too often an overly risk averse approach is taken when frail, immobile or even unconscious prisoners remain restrained.

Lesson 2 – If concerns about restraints are raised by escort or medical staff these should be responded to.

A fresh risk assessment which explicitly addresses the issues raised is appropriate in order to justify continuing the use of restraints.

Lesson 3 – Medical opinion should be a key consideration in any risk assessment.

Whenever a risk assessment is completed, the state of the prisoner's health at the time and how this impacts on risk should be assessed rather than relying on assessments about risk when the prisoner was fit and well. It is clear that in cases of serious illness, the level of risk posed by a prisoner can change rapidly. It is important that changes in the prisoner's condition prompt an immediate review of their restraints to prevent them remaining in place longer than necessary.

The Prisons and Probation Ombudsman investigates complaints from prisoners, those on probation and those held in immigration removal centres. The Ombudsman also investigates all deaths that occur among prisoners, immigration detainees and the residents of probation approved premises. These bulletins aim to encourage a greater focus on learning lessons from collective analysis of our investigations, in order to contribute to improvements in the services we investigate, potentially helping to prevent avoidable deaths and encouraging the resolution of issues that might otherwise lead to future complaints.

The Prisons and Probation Ombudsman's vision is:

To be a leading, independent, investigatory body, a model to others, that makes a significant contribution to safer, fairer custody and offender management.

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