

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Timothy Slater, following his release from HMP Hewell, on 24 October 2019

A report by the Prisons and Probation Ombudsman

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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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 Timothy Slater died in hospital from multiple organ failure on 24 October 2019, two days after his release from HMP Hewell. He was 51 years old. I offer my condolences to Mr Slater's family and friends.

The investigation found that the care Mr Slater received at Hewell was equivalent to that which he could have expected to receive in the community.

However, I am concerned that Mr Slater, a double lower limb amputee who used a wheelchair, was restrained when he was taken to hospital. It was not justified by an appropriate risk assessment that took into account Mr Slater's poor physical health and mobility.

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

April 2020

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Summary

Events

1. On 13 September 2019, Mr Timothy Slater was sentenced to 20 weeks in prison for assault. He was sent to HMP Hewell.
2. Mr Slater was a double lower limb amputee and a wheelchair user. He had hepatitis C and a long history of substance misuse.
3. On 28 September, Mr Slater was found lying breathless on his bed, unable to move. Healthcare staff suspected he had suffered a stroke as he had lost all feeling on his right side. They sent him to hospital. He was restrained using single cuffs. Mr Slater was discharged back to Hewell that evening.
4. On 2 October, Mr Slater was taken to hospital for an MRI scan. He was restrained using single cuffs.
5. On 10 October, Mr Slater was admitted to hospital for tests to try to find the cause of his right sided weakness. He was restrained using single cuffs.
6. On 22 October, while still in hospital, Mr Slater was released on home detention curfew (HDC). The following day his condition rapidly deteriorated and he was moved to intensive care. He died there on 24 October.
7. Hospital doctors gave Mr Slater's cause of death as multiple organ failure caused by pneumonia and hepatitis C.

Findings

8. The clinical reviewer found that overall, Mr Slater's care at Hewell was of a good standard and was equivalent to that which he could have expected to receive in the community.
9. We are concerned that Mr Slater was restrained on all three occasions when he was taken to hospital. There is no evidence that the authorising managers took into account Mr Slater's physical health and mobility when deciding that he should be restrained.

Recommendations

- The Governor 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 assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.
- The Governor should revise the prison's escort risk assessment form to make it clear that:
 - healthcare staff must provide information on the prisoner's current state of health and mobility; and

- the authorising manager must confirm that they have taken the prisoner's current state of health and mobility into account in determining the level of security needed.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Hewell informing them of the investigation and asked anyone with relevant information to contact her. No one responded
11. The investigator obtained copies of relevant extracts from Mr Slater's prison and medical records.
12. NHS England commissioned a clinical reviewer to review Mr Slater's clinical care at the prison.
13. We informed HM Coroner for Worcestershire of the investigation. We have sent the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Slater's son-in-law to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. The family raised some issues that were outside the remit of our investigation which have been dealt with in separate correspondence.
15. Mr Slater's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.
16. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Hewell

17. HMP Hewell is an amalgamation of two prisons, the former HMP Blakenhurst and HMP Hewell Grange. The Hewell Grange site continues to operate as an open prison and the Blakenhurst site is a secure, local prison. Care UK provides health services and there is a 20-bed inpatient unit.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Hewell was in June 2019. Inspectors reported that all new arrivals received a comprehensive initial health screening by a registered nurse, who reviewed risks and made onward referrals. A GP or nurse prescriber was available during the evening for complex cases, although later arrivals often missed out on this provision.
19. External hospital appointments were managed well. Although some appointments had been cancelled to facilitate the large number of emergency admissions, the number that had breached the NHS 18-week rule for non-urgent consultant treatment had been minimal in recent months.

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 30 September 2018, the IMB reported that prisoners with disabilities had problems accessing the showers and wheelchair access was poor.

Previous deaths at HMP Hewell

21. Mr Slater was the 16th prisoner to die at Hewell since October 2017. Of the previous deaths, nine were from natural causes, four were self-inflicted, one was a homicide and one is awaiting classification. There are no similarities between Mr Slater's death and previous deaths at Hewell.

Key Events

22. On 13 September 2019, Mr Timothy Slater was sentenced to 20 weeks in prison for assault. He was sent to HMP Hewell.
23. A nurse completed the initial health care screen. She noted that Mr Slater had hepatitis C and a long history of drug and alcohol abuse. Mr Slater, a double lower limb amputee and wheelchair user, was placed in a disabled cell.
24. On 28 September, Mr Slater was found lying breathless on his bed, unable to move. A prison paramedic went to see Mr Slater, and suspected a stroke. He said that Mr Slater needed to go to hospital. Mr Slater was escorted to Worcester Royal Hospital (WRH) by two officers, using the single cuffing method (when the prisoner's wrist is attached to a prison officer's wrist by a set of handcuffs).
25. Mr Slater was returned to Hewell the same evening. He was uncooperative with officers so a nurse was unable to complete a review. In addition, there was no discharge summary from the hospital. The following morning a nurse tried to call the hospital for a verbal handover, but was unsuccessful.
26. On 2 October, Mr Slater was taken to hospital for a magnetic resonance imaging (MRI) scan (a scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body). He was again restrained using the single cuffing method.
27. On 6 October, Mr Slater was told that he had an active hepatitis C infection. He said that he wanted to start treatment even though he was expecting to be released from prison in the next two weeks. He was referred to the hepatology (liver services) clinic at the hospital.
28. On 10 October, the hospital phoned the prison and said that Mr Slater needed to go to hospital to have a lumbar puncture (a procedure that takes fluid from the spine through a hollow needle). He was admitted to hospital where he had tests to try to find the cause of his right sided weakness.
29. On 13 October, he was transferred to the stroke unit. On 18 October, he was transferred to the Royal Orthopaedic Hospital in Birmingham. A MRI scan confirmed he had had a possible spinal stroke and needed further investigations. On 21 October, he was transferred back to the WRH and admitted to the acute stroke unit. While Mr Slater was in hospital, he remained handcuffed to an officer until 22 October when he was released on home detention curfew (HDC).
30. Mr Slater's condition rapidly deteriorated. On 23 October, he was transferred to the hospital intensive care unit where on 24 October, he died.

Contact with Mr Slater's family

31. When Mr Slater died he had been released from prison so initially no family liaison officer was appointed. However, Mr Slater's next of kin got in touch with the prison to find out more information so a family liaison officer was then appointed. The prison did not contribute towards the cost of the funeral as Mr Slater was not in custody at the time of his death.

Cause of death

32. The coroner accepted the cause of death provided by the hospital and no post-mortem examination was conducted. The hospital recorded Mr Slater's cause of death as multiple organ failure caused by pneumonia and hepatitis C. Drug abuse, traumatic brain injury, bilateral lower leg amputation and epilepsy were listed as contributing factors.

Findings

Clinical Care

33. Mr Slater had a number of physical health problems, hepatitis C, and a long history of drug and alcohol abuse. Mr Slater was also in a wheelchair because he had had both legs amputated.
34. The clinical reviewer was satisfied that Mr Slater received appropriate care and treatment at Hewell. He considered the standard of care was equivalent to that he could have expected to receive in the community

Restraints, security and escorts

35. 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.
36. 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 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.
37. Mr Slater was taken to hospital on three occasions while he was at Hewell and was restrained using the single cuffing method each time. On the first occasion, Mr Slater had been found on his bed unable to move and the prison paramedic thought he had suffered a stroke. Mr Slater continued to experience a lack of movement on his right side after his return from hospital.
38. Mr Slater was a Category C prisoner, a double leg amputee and a wheelchair user and had right-sided weakness. Healthcare staff indicated on the risk assessment that Mr Slater's medical condition restricted his ability to escape. However, they did not set out his current medical condition. We are not satisfied that any of the authorising managers who signed the risk assessments took into account Mr Slater's physical health and mobility when deciding that it was necessary for him to be restrained. We therefore make the following recommendations:

The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Governor should revise the prison's escort risk assessment form to make it clear that:

- **healthcare staff must provide information on the prisoner's current state of health and mobility; and**

- **the authorising manager must confirm that they have taken the prisoner's current state of health and mobility into account in determining the level of security needed.**

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