Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jackie Stewart-Murphy, a prisoner at HMP Whatton, on 11 February 2024

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

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. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. Mr Jackie Stewart-Murphy died of bowel ischaemia (blood flow to the intestines is reduced or completely cut off) on 11 February 2024, while a prisoner at HMP Whatton. He was 59 years old. We offer our condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care Mr Stewart-Murphy received at Whatton was equivalent to that which he could have expected to receive in the community.

5. The clinical reviewer made one recommendation not directly related to Mr Stewart-Murphy's death which the Head of Healthcare will wish to address.

6. When Mr Stewart-Murphy was admitted to hospital in February 2024, he was inappropriately restrained. His previous heart attack and failing health were not properly considered.

Recommendation

- 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 authorising managers show on the risk assessment that they have taken this information into account when assessing a prisoner's current level of risk.

The Investigation Process

7. HMPPS notified the PPO of Mr Stewart-Murphy's death on 11 February 2024.

8. NHS England commissioned an independent clinical reviewer to review Mr Stewart-Murphy's clinical care at HMP Whatton.

9. The PPO investigator investigated the non-clinical issues relating to Mr Stewart-Murphy's care.

10. Mr Stewart-Murphy did not name a next of kin and none could be identified following his death.

11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Whatton

12. There were fifteen deaths from natural causes at Whatton in the three years before Mr Stewart-Murphy's death, two of which were because of COVID-19. There was also a self-inflicted death. Our investigation into the death of a man in February 2021 found that restraints were inappropriately used on an older prisoner who was in poor health.

Key Events

13. On 2 February 2007, Mr Jackie Stewart-Murphy was sentenced to imprisonment for public protection (IPP) for sexual offences. On 16 November 2012, Mr Stewart-Murphy transferred to HMP Whatton.

14. In 2016, Mr Stewart-Murphy underwent bypass surgery for a blocked femoral artery (major artery in the leg). He was discharged from the vascular surgeons' clinic in August 2016, and he was monitored annually by the healthcare team at Whatton with blood tests and blood borne virus screening.

15. During the night of the 25 January 2024, Mr Stewart-Murphy told officers that he felt unwell with chest pain. As HMP Whatton does not have 24-hour healthcare he was transferred to outside hospital.

16. Before he left for hospital, prison staff completed an escort risk assessment. As there were no healthcare staff on duty, no one completed the healthcare assessment. Staff noted that Mr Stewart-Murphy was a low risk of escape and low risk to the public and hospital staff. The night manager, following a telephone conversation with the duty operational manager, authorised the use of an escort cable (a length of strong metal cable with a handcuff at either end, one attached to the prisoner's wrist and the other to an officer). Mr Stewart-Murphy remained restrained throughout his hospital stay.

17. In hospital, Mr Stewart-Murphy was diagnosed with a STEMI (a type of heart attack caused by a blockage of the coronary artery). He returned to Whatton on the 29 January 2024, with a number of medications for his heart.

18. On 9 February, Mr Stewart-Murphy became unwell. He required oxygen to help him breathe. Healthcare staff decided to transfer him to outside hospital.

19. Prison staff completed an escort risk assessment before Mr Stewart-Murphy left for hospital and concluded that he should be restrained using an escort cable.

20. A nurse completed the healthcare information section of the escort risk assessment. She stated that there were no objections to the use of restraints, that the restraints could not cause injury or pain and that Mr Stewart-Murphy's current state of health/mobility did not impact his ability to escape. She noted that the restraints may need to be removed for the hospital to conduct their investigations.

21. Mr Stewart-Murphy was treated for an ischaemic bowel and a blood clot in his lungs and remained on an assisted breathing machine. Mr Stewart-Murphy was not considered for surgery as it was agreed by the surgeons at Queens Medical Centre, Nottingham, that the risk of death was too high.

22. At 7.50pm on 10 February, officers obtained permission to remove restraints due to Mr Stewart-Murphy's deteriorating health.

23. On 11 February, Mr Stewart-Murphy died.

24. There was no post-mortem examination. A hospital doctor concluded that Mr Stewart-Murphy died due to intestinal failure caused by bowel ischaemia (reduced blood flow to the intestines).

25. Mr Stewart-Murphy did not name a next of kin and none could be identified.

Findings

Restraints, security and escorts

26. 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. 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. 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.

27. Mr Stewart-Murphy was a 59-year-old man, who had a history of poor health including a heart-attack that occurred two weeks prior to his death.

28. Between January and February 2024, Mr Stewart-Murphy was twice sent to the hospital in a medical emergency. On the first occasion, the healthcare section of escort risk assessment was not completed (as healthcare staff were not on duty at the time), and an escort cable was authorised for use throughout Mr Stewart-Murphy's stay in hospital, despite a hospital doctor diagnosing that he had experienced a heart attack. On the second occasion, healthcare staff completed the medical section but did not object to the use of restraints despite Mr Stewart-Murphy having shortness of breath that required oxygen. In hospital, prison staff were given permission to remove the restraints a day after he was admitted.

29. Mr Stewart-Murphy's symptoms and medical history on each of these occasions, in line with the High Court judgement, meant that his risk could have been effectively managed by the officers accompanying him without the use of restraints. The decision to restrain him was not proportionate to his risk.

30. We frequently raise concerns about how well healthcare staff understand, or feel empowered, to make a meaningful contribution to the risk assessment process, such as in this case. In March 2024, we recommended that NHS England develop national guidance for establishments to develop local standard operating procedures for healthcare input into restraints risk assessments. This recommendation was accepted, and NHS England told us that they are working with HMPPS to review the Prevention of Escapes – External Escorts Policy Framework, with particular focus on the escort risk assessment. This work is planned for completion by October 2024.

31. Following the death of a prisoner in February 2021, we identified that the man had been inappropriately restrained in hospital. In response, Whatton stated that they would add a new section to the escort risk assessment that required the manager completing any assessment to confirm that they had considered the Graham judgement. This section was absent from Mr Stewart-Murphy's risk assessments.

32. We have not made any further recommendations about the use of restraints at Whatton in the three years since this prisoner died. Nevertheless, it is important that staff properly consider the prisoner's age, health and mobility when determining the appropriate use of restraints. We make the following recommendation:

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 authorising managers show on the risk assessment that they have taken this information into account when assessing a prisoner's current level of risk.

Inquest

33. The inquest into Mr Stewart-Murphy's death concluded on 3 October 2024 and returned a verdict of natural causes.

Adrian Usher
Prisons and Probation Ombudsman **September 2024**

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