Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Harold Day, a prisoner at HMP Five Wells, on 25 September 2024

A report by the Prisons and Probation Ombudsman

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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 Harold Day died in a hospice of leukaemia on 25 September 2024, while a prisoner at HMP Five Wells. He was 87 years old. We offer our condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care Mr Day received at Five Wells was equivalent to that which he could have expected to receive in the community.

5. We found that the decision to apply restraints to Mr Day when he was taken to hospital on 14 August and to leave him in restraints for the next six days while in hospital, was not justified given his age, his poor mobility and poor health.

Recommendations

- The Director should ensure that:
    - all staff undertaking risk assessments for prisoners attending hospital understand the legal position on the use of restraints, including that their assessments fully take into account the prisoner's health and mobility, and are based on the actual risk the prisoner presents at the time; and
    - a robust quality assurance process is implemented to check that these measures are in place and effective.

The Investigation Process

6. HMPPS notified us of Mr Day's death on 25 September 2024.

7. NHS England commissioned an independent clinical reviewer to review Mr Day's clinical care at HMP Five Wells.

8. The PPO investigator investigated the non-clinical issues relating to Mr Day's care.

9. The Ombudsman's office wrote to Mr Day's daughter to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.

10. We shared our initial report with HMPPS and the prison's healthcare provider, Practice Plus Group. HMPPS pointed out that the recommendation should be made to the Director rather than the Governor, which we have amended in this report. HMPPS provided an action plan which has been annexed to this report.

Previous deaths at HMP Five Wells

11. Mr Day was the third prisoner to die at Five Wells. The two previous deaths were from natural causes. In a previous investigation, we identified the inappropriate use of restraints on a very unwell prisoner. The prison told us that security managers would deliver training to staff on the legal position for the use of restraints.

Key Events

12. In March 2016, Mr Harold Day was sentenced to 18 years in prison for sexual offences. He was moved to HMP Five Wells on 6 March 2024. Mr Day had multiple medical conditions including chronic kidney disease, osteoarthritis and dementia.

13. On 9 March, Mr Day attended an appointment with occupational health due to mobility problems. They assessed him as needing a walking stick and grab rails for his cell. Due to his mobility problems, Mr Day had a Personal Emergency Evacuation Plan (PEEP, for a person who may need assistance to evacuate a building or reach a place of safety in the event of an emergency).

14. On 14 August, Mr Day showed signs of jaundice (yellowing of the skin caused by poor function of the liver, gall bladder or kidneys), bruising and ankle/leg oedema (fluid build-up under skin), along with blood test results that indicated pancytopenia (reduced/out of range results for all blood cells). Following advice from the Out of Hours GP, Mr Day was taken to hospital. He was accompanied by two prison officers who applied single cuffs (where a set of handcuffs is used to attach a prisoner's wrist to an officer's wrist).

15. In the early morning of 15 August, once Mr Day was settled in a hospital bed, officers changed the restraint from single cuffs to an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner's wrist and the other to an officer's wrist).

16. A bedwatch log dated 15 August describes how a nurse helped Mr Day move from one bed to another and helped him to sit up in bed.

17. A prison risk assessment dated 17 August describes Mr Day as being bed bound.

18. On 20 August, a prison manager authorised that no restraints should be used on Mr Day and staff removed the escort chain.

19. While in hospital, Mr Day was diagnosed with acute myeloid leukaemia (a cancer of the white blood cells). He was given a blood transfusion (to replace red blood cells/increase haemoglobin) and intravenous antibiotics for neutropenic sepsis (systemic infection caused by too few white blood cells).

20. Mr Day returned to Five Wells on 22 August.

21. On 27 August, Mr Day returned to hospital following a decline in his health. He was then transferred to a hospice on 17 September where he stayed until his death on 25 September.

Cause of death

22. The Coroner accepted the cause of death provided by a hospice doctor and no post-mortem examination was carried out. The doctor gave the cause of death as acute myeloid leukaemia.

Findings

Clinical findings

23. The clinical reviewer concluded that the care Mr Day received at Five Wells was of a good standard overall and was equivalent to that which he could have expected to receive in the community. She made two recommendations that were not directly linked to Mr Day's death, which the Head of Healthcare will wish to address.

Non-clinical findings

24. 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.

25. We consider that restraints should not have been applied to Mr Day when he was taken to hospital on 14 August, given he was 87 years old, with poor mobility and poor health. Mr Day then remained on an escort chain for six days in hospital. A risk assessment dated 17 August noted that Mr Day was bed bound. We can see no justification for using restraints on Mr Day given the negligible risk of escape.

26. The investigator put this to the Head of Security at Five Wells, who said she was unable to comment as she had not been working at the prison at the time. She said that as Five Wells was a Category C prison, it was standard practice for prisoners to be single cuffed when taken to hospital, though she also said that cuffing arrangements would depend on the prisoner's health and mobility.

27. In our view, the decision to restrain Mr Day was clearly disproportionate. We recommend:

The Director should ensure that:

- **all staff undertaking risk assessments for prisoners attending hospital understand the legal position on the use of restraints, including that their assessments fully take into account the prisoner's health and are based on the actual risk the prisoner presents at the time; and**

- **a robust quality assurance process is implemented to check that these measures are in place and effective.**

Adrian Usher
Prisons and Probation Ombudsman **July 2025**

Inquest

At the inquest, held on 8 September 2025, the Coroner concluded that Mr Day died from natural causes.

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