Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Raymond Cartwright, a prisoner at HMP Risley, on 6 August 2023

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

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.

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.

Mr Raymond Cartwright died from the complications of long-term hepatitis C infection leading to liver cancer on 6 August 2023, while a prisoner at HMP Risley. He was 55 years old. I offer my condolences to Mr Cartwright's family and friends.

The clinical reviewer found that the clinical care that Mr Cartwright received was equivalent to that he could have expected to receive in the community. However, his treatment for hepatitis C was delayed by missed appointments, the reasons for which are unclear. There was also insufficient detail on the escort risk assessments when Mr Cartwright went to hospital to fully evidence staff's decision making about restraints. I make recommendations on both these matters.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

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

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Summary

Events

1. On 18 October 2019, Mr Raymond Cartwright was sentenced to five and a half years imprisonment for Class A drugs offences.

2. On 14 February 2022, Mr Cartwright was released from prison on licence. He was recalled to prison on 8 December 2022, after breaching the conditions of his licence. He initially went to HMP Altcourse but moved to HMP Risley two weeks later.

3. On his return to prison, staff put Mr Cartwright on a methadone treatment programme to help him with his opioid addiction. In December, Mr Cartwright tested positive for the hepatitis C virus (an infectious disease which affects the liver). His treatment was delayed by missed appointments and by him needing to attend another court case.

4. In May 2023, Mr Cartwright began a treatment programme for his hepatitis C infection. However, he became severely ill in June and spent a month in hospital where doctors diagnosed him with liver cancer. He returned to prison at the end of July.

5. Mr Cartwright became very ill again on 5 August and returned to hospital. He refused further treatment and died on 6 August.

Findings

6. The clinical reviewer found that the care Mr Cartwright received was of a standard equivalent to that which would have been expected in the community. However, Mr Cartwright failed to attend several clinical appointments relating to his hepatitis C infection and Risley did not record the reasons for his non-attendance. The high number of missed clinical appointments was an issue highlighted by HM Inspectorate of Prisons (HMIP) in their report following their inspection in April 2023.

7. Mr Cartwright was restrained on both occasions he went to hospital in June and August 2023. There were deficits in the recording of the information that went into the decision making on both occasions.

Recommendations

- The Governor and Head of Healthcare should agree protocols for recording the reasons for missed clinical appointments, audit these and appropriately address any emerging issues.

- The Governor should ensure that the medical sections of risk assessments are fully completed, and in circumstances where this is genuinely not possible, the authorising officer should indicate why, and when restraint levels will be reassessed.

The Investigation Process

8. HMPPS notified us of Mr Cartwright's death on 6 August 2023.

9. The investigator issued notices to staff and prisoners at HMP Risley informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

10. The investigator obtained copies of relevant extracts from Mr Cartwright's prison and medical records.

11. NHS England commissioned a clinical reviewer to review Mr Cartwright's clinical care at the prison.

12. We informed HM Coroner for Cheshire of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

13. The Ombudsman's family liaison officer contacted Mr Cartwright's partner to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.

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

Background Information

HMP Risley

15. HMP Risley is a medium security resettlement prison which holds over 1,000 convicted men. Greater Manchester Mental Health NHS Foundation Trust provides healthcare services in the prison. Change, Grow, Live provides substance misuse services. There is 24-hour healthcare cover.

HM Inspectorate of Prisons

16. The most recent inspection of Risley was in April 2023. Inspectors reported that, in general, the health care provision was good and that prisoners were treated with decency and respect by professional and committed staff. They noted that blood-borne virus screening was offered routinely during the reception screening.

17. Inspectors reported concerns about the level of non-attendance of prisoners at clinical appointments. Although they found this had improved in the months before the inspection, they said it remained relatively high. They also said that too many hospital appointments were cancelled and that a high proportion of these were cancelled by the prison due to the lack of escorting officers or wheelchair transportation.

18. Inspectors reported that Change, Grow, Live (CGL) delivered a good, integrated clinical and psychosocial substance misuse service for prisoners. Managers provided strong leadership to a highly motivated and caring team. There was a drug strategy in place with collaborative partnership working evident between the service and the prison.

Independent Monitoring Board

19. 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. At the time of writing, the 2023 report was yet to be published. In their 2022 annual report, the IMB singled out a project for testing for hepatitis C as a new initiative.

Previous deaths at HMP Risley

20. Mr Cartwright was the eleventh death in three years at Risley. Of the previous deaths, seven were from natural causes, and three were self-inflicted. There are no significant similarities in our findings in Mr Cartwright's case with the previous deaths.

Key Events

21. On 18 October 2019, Mr Raymond Cartwright was sentenced to five and a half years imprisonment for possession and supply of Class A drugs.

22. On 14 February 2022, Mr Cartwright was released from prison on licence. On 8 December, following the theft of alcohol, Mr Cartwright was recalled to prison for breaching the terms of his licence. He was admitted to HMP Altcourse.

23. Mr Cartwright had a long history of prison sentences associated with both his use and supply of drugs. On his return to prison, he said that he had been using heroin and crack cocaine. He tested positive for opioids and was placed on a methadone treatment programme.

24. On 21 December, Mr Cartwright transferred to HMP Risley. The prison had recently begun a routine testing programme for hepatitis C. Mr Cartwright tested positive for the virus. He had a diagnosis of hepatitis C and liver damage, dating back nearly 20 years. Mr Cartwright also had a history of intravenous drug use, which has a strong association with the spread of hepatitis C through shared needles.

25. On 27 January 2023, Mr Cartwright did not attend an appointment with a specialist nurse to discuss his hepatitis C infection. This was the first of several similar appointments that Mr Cartwright missed. Healthcare staff did not record the reasons for his non-attendances.

26. Mr Cartwright did not attend an appointment with the specialist nurse on 20 February. He also missed his next appointment on 31 March as he was transferring back to Altcourse to attend court in relation to offences associated with his recall to prison.

27. Mr Cartwright returned to Risley on 6 April, and staff added him back onto the hepatitis C clinic list. However, Mr Cartwright continued with his non-attendance of appointments. As he had an active hepatitis C infection, in May, the specialist nurse at Risley consulted with a hospital team about treatment for Mr Cartwright, and they endorsed the prescription of antiviral medication for him. Mr Cartwright began the antiviral treatment towards the end of May.

28. On 8 June, Mr Cartwright successfully completed his methadone treatment programme and no longer needed to use the medication.

29. Shortly after 4.00pm on 26 June, Mr Cartwright became seriously ill with breathlessness, chest pain, and a fast heart rate. His clinical observations recorded a NEWS2 score of 8 (NEWS is a nationally accredited scoring tool used to assess clinical deterioration based on a standardised set of observations; heart rate, blood oxygen levels, breathing rate, temperature, blood pressure and level of consciousness). A score over 7 indicates an urgent clinical response is required. Mr Cartwright was taken to hospital, restrained by handcuffs, and accompanied by two prison officers.

30. On 28 July, Mr Cartwright returned to Risley with a diagnosis of a pulmonary embolism (when a blood clot blocks a blood vessel in the lungs) and liver cancer. He had lost around four stone in weight since April.

31. On 5 August, Mr Cartwright was unwell again and a nurse assessed him shortly after 6.00am. He was vomiting, had chest pains, an elevated heart rate and a low blood oxygen level. The nurse requested an ambulance, but Mr Cartwright refused to go to hospital as he was expecting a visit from his partner that day. However, by 7.45am his pain was so bad he agreed to go to hospital. Once again, he was restrained by handcuffs escorted by two prison officers.

32. At the hospital, a doctor spoke to Mr Cartwright and confirmed that he was very unwell and that if he got any more unwell, they would not have any further treatment options. Mr Cartwright declined any treatment. He continued to deteriorate and died the next day.

Contact with Mr Cartwright's family

33. Prison staff liaised with Mr Cartwright's partner in June and July, and she visited him in hospital on those occasions. Prison staff told her when he went to hospital on 5 August. She was with him in hospital when he died. The family liaison officer (FLO) maintained contact with Mr Cartwright's partner following his death to help with funeral arrangements and the return of Mr Cartwright's property. The prison contributed to funeral expenses in line with national policy.

Support for prisoners and staff

34. The prison posted notices informing other prisoners of Mr Cartwright's death and offering support. Staff were also signposted to support if they felt they needed any.

Post-mortem report

35. The post-mortem report concluded that Mr Cartwright died from complications of the hepatitis C virus associated with liver cirrhosis (scarring of the liver caused by long term liver damage), with disseminated hepatocellular carcinoma (cancer which has spread throughout the liver).

Findings

Clinical care

36. The clinical reviewer concluded that the care Mr Cartwright received was of a standard equivalent to that which he would have been received in the wider community. However, she was concerned about the lack of information regarding his missed healthcare appointments.

Non-attendance of healthcare appointments

37. Staff did not record the reasons why Mr Cartwright failed to attend so many of his initial hepatitis C clinical appointments. The Head of Healthcare told the clinical reviewer that if a prisoner does not attend for their appointment, it is recorded in their medical record but without any explanation as to why.

38. Mr Cartwright had an extensive history of not attending appointments going back many years. However, following their inspection in April 2023, HMIP also expressed concerns about the high non-attendance rate of prison healthcare clinical appointments, as well as hospital appointments. Risley need to be able to audit clinical non-attendance in order to address this issue. We recommend:

    The Governor and Head of Healthcare should agree protocols for recording the reasons for missed clinical appointments, audit these and appropriately address any emerging issues.

Escort Risk Assessments

39. 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.

40. 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 he has a serious medical condition. The judgment indicated 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.

41. When Mr Cartwright went to hospital on 26 June 2023, the risk assessment form for the escort and bedwatch did not have any of the medical section of the form filled in. The security section was filled in and noted some recent aggression towards staff. Head of Safer Custody, who was the duty governor, authorised the use of a single handcuff (which means one part of the handcuff is on the prisoner's wrist and the other part on an officer's wrist) and noted that it was, "Appropriate to security category and available intel." She made no reference to Mr Cartwright's health in the decision making, although the authorising manager's section does include a

standard wording printed paragraph which says, “Medical advice has been sought as part of this Risk Assessment and utilised to inform an overall opinion.” Later in hospital, Mr Cartwright was transferred to the lesser restraint of an escort chain (which involves a handcuff on a wrist of a prisoner and an officer, linked together with a chain).

42. On 5 August, when Mr Cartwright was taken to hospital again, healthcare staff filled in the medical section of the risk assessment. In the tick box section, it said that there were no medical objections to the use of restraints, that there were no mobility issues, or medical or physical conditions that would restrict the ability to escape, that there was no lifesaving treatment involved, and that there was no need to remove restraints for treatment or consultation. The only handwriting in the medical section said, “Blue light ambulance – no raised concerns”. Staff did not detail Mr Cartwright’s cancer or physical condition, including that he had lost four stone in recent months. The member of staff did not sign the medical section, so we do not know who completed it.

43. The Acting Head of Safer Custody was the duty governor on the day. He authorised Mr Cartwright be restrained with a single handcuff, accompanied by two officers. Several hours later, following information from the hospital that Mr Cartwright was seriously ill, he authorised the removal of restraints at 3.50pm.

44. The medical section in the first risk assessment was not completed. Risley were unable to establish who had filled in the unsigned medical section in the second risk assessment. In response to a query from the investigator, the Safer Custody Hub Manager said that the reason it was not signed was because Mr Cartwright went out as an emergency. The investigator asked if Risley had a written policy or guidance for completing risk assessments for emergency responses, but Risley were unable to provide one.

45. It is important for prisons to comply with the Graham Judgement and to make risk assessments appropriate to the circumstances of the individual rather than just considering their security categorisation for example. The most significant aspect of Mr Cartwright’s situation in both June and August, was his medical circumstances, and on both occasions there was very little information on the risk assessments about this. Neither was there any explanation about this by the authorisers or any timescale indicated for a reassessment. While it is important not to delay transfer to hospital in emergencies, managers need to evidence what steps they have taken to establish the facts when signing off risk assessments. We recommend:

The Governor should ensure that the medical sections of risk assessments are fully completed, and in circumstances where this is genuinely not possible, the authorising officer should indicate why, and when restraint levels will be reassessed.

Governor to note

46. The investigator first requested the documents to investigate Mr Cartwright’s death on 7 August 2023. While we received some documents the same month, despite repeated requests, the investigator did not receive all of the requested documents until 9 January 2024, over five months since his initial request.

47. We bring the Governor's attention to this issue.

Inquest

48. In May 2024, the inquest into Mr Cartwright's death concluded that Mr Cartwright died of natural causes.

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