

A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man at a hospice  
in February 2013 while in the custody of HMP Risley**

## ***Our Vision***

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

This is the investigation report into the death of a man, a prisoner at HMP Risley. He died of kidney failure at a hospice in February. He was 77 years old. I offer my condolences to his friends.

The investigation was carried out by an investigator. A clinical investigator conducted a clinical review of the standard of healthcare the man received at Risley.

The man had a number of chronic medical conditions when he was first sentenced to prison in 1999, including diabetes. His diabetes caused problems with his kidneys and, by July 2011, he had developed chronic kidney disease. In January 2013, the hospital said that his condition was terminal. He wanted to stay at Risley, where he remained for most of illness. When healthcare staff could no longer manage his pain effectively, he moved to a hospice in February. He died later that day at 11.20pm.

I am satisfied that, overall, Risley did a good job caring for the man. The prison ensured that his wishes were considered at all times and he received a standard of care which was equivalent to that which he could have expected in the community. However, the decision to use restraints when he was being taken to the hospice was not justified and resulted in a dying man being restrained, although he posed no risk of harm or escape. I am pleased that the governor has accepted that this was inappropriate and I trust this case will inform future practice.

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

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

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## SUMMARY

1. In June 1999, the man was sentenced to life imprisonment, with a minimum of three years to serve. He went to HMP Leicester and told nurses at his initial healthscreen that he had been diagnosed with type 2 diabetes in 1997.
2. The man transferred to Risley on 6 November 2002. His diabetes was well monitored by specialists, although his kidneys were affected and, by July 2011, he had developed chronic kidney disease. He was admitted to hospital on several occasions in 2012 and treated for urinary tract infections. His physical and mental health declined. By November 2012, agency carers were looking after him at the prison. He did not want to transfer to an inpatient unit at another prison and asked to stay at Risley until he died.
3. When he was discharged from a stay in hospital on 22 January 2013, the hospital advised that the man was in the terminal phase of kidney failure. Palliative care plans were put in place in consultation with specialists at the local hospice. Despite his wish to remain at Risley, it was decided that his pain needed to be managed by the specialist palliative care team at a hospice. He transferred to the hospice one morning in February, where he died at 11.20pm the same day.
4. The man was restrained using an escort chain on his journey from Risley to the hospice on the day he died. The prison has accepted that this was disrespectful and could not be justified. The Governor has indicated that changes have been made to avoid a similar situation occurring again. The clinical reviewer concludes that his care at Risley was equivalent to that he could have expected to receive in the community. We make two recommendations about hospital appointments and the use of restraints.

## THE INVESTIGATION PROCESS

5. The Ombudsman was notified of the man's death on 13 February 2013. The investigator issued notices informing staff and prisoners at HMP Risley of the investigation and asking anyone with relevant information to contact her. She spoke to four prisoners who wrote to her in response to these notices.
6. The investigator visited HMP Risley on 28 February. She met the Governor and staff and prisoners who had known the man. She obtained copies of his medical and prison records and visited the wing where he lived and the healthcare unit. She gave preliminary feedback to the Governor, which she followed up in writing on 4 March.
7. The local Primary Care Trust (PCT) appointed a clinical reviewer to review the man's clinical care at Risley.
8. HM Coroner for Cheshire was informed of the investigation and a copy of the report has been sent to him.
9. The man had no identified next of kin to involve in the investigation, but five prisoners who socialised and cared for him raised concerns with the investigator that a change in the regime for older prisoners had hastened the decline in his condition. From November 2011, older prisoners without allocated activities were locked in their cells during the core working day. We found no evidence this affected his health. The Governor identified this as an issue when he joined Risley in January 2012 and commissioned a review of the care for older prisoners. This was ongoing at the time this report was written. A daily programme of activities was introduced in May 2012 (including outside exercise, carpet bowls, library sessions, reading and reminiscence groups), to provide purposeful activity for retired prisoners out of their cells.
10. The investigation has assessed the main issues involved in the man's care including his diagnosis and treatment, his location and security arrangements, whether compassionate release was considered and whether appropriate palliative care was provided.

## **HMP Risley**

11. HMP Risley is a category C training prison which holds over 1,000 adult male prisoners. Healthcare services are commissioned by the local Primary Care Trust (PCT). There is 24 hour healthcare cover. By day, there is a doctor in the prison and at night there are nurses on duty. There is no inpatient facility. Prisoners who require inpatient treatment are referred to other prisons (usually HMP Preston) or to hospital.

## **HM Inspectorate of Prisons (HMIP)**

12. The last inspection of Risley was in February 2011. HMIP found that Risley was a safer, cleaner and more decent prison than when it was last inspected in 2008. It described Risley as a nicer place to be for prisoners and staff, that relationships between the prison and NHS agencies were good, with a range of primary care and life-long condition clinics.

## **Independent Monitoring Board (IMB)**

13. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. The most recent IMB annual report for Risley covers the year to March 2012 and noted an improvement in healthcare provision.

## **Previous deaths at HMP Risley**

14. There were three investigations completed into deaths at Risley in the year before the man died, two of which were due to natural causes. There were no direct similarities in the circumstances of these deaths.

## ISSUES

### The diagnosis of the man's terminal illness

15. The man was born in 1936. On 17 June 1999, he was sentenced to life imprisonment with a minimum period to serve of three years before he could be considered for release.
16. At his initial healthscreen at HMP Leicester, the man told healthcare staff that he had about a number of health conditions, including type 2 diabetes (not insulin dependent).
17. The man transferred to Risley in 2002 where he was well monitored by the diabetic clinic. He developed kidney disease caused by his diabetes, which by July 2011 had developed to stage 4 chronic kidney disease (severely reduced kidney function with the need to plan for end stage kidney failure).
18. In November 2012, the man became increasingly incontinent and required greater assistance with his daily living activities. He developed a kidney infection and on 10 December was admitted to hospital, where he was diagnosed with urosepsis (a secondary infection of the bloodstream which has spread from a urinary tract infection). He was prescribed antibiotics and discharged back to Risley on 15 December.
19. On 24 December, the man's condition had further deteriorated. He was disorientated and was not eating or drinking. A prison doctor examined him and diagnosed a possible urinary tract infection. The doctor arranged for him to be admitted to hospital where he was treated for anaemia (iron deficiency) and presumed biliary sepsis (a severe infection). He was discharged back to Risley on 22 January, with a terminal prognosis.
20. The clinical reviewer notes:

“I am clear that the healthcare team at HMP Risley addressed these clinical issues in a competent and professional manner. The Consultant Renal Physician was actively involved on supporting the Healthcare Team in the management of the man's renal and associated problems (anaemia and hypertension). ... An examination of the medical notes indicates that from about April/May 2012 his general condition began to deteriorate. He needed additional support which was provided by a care team.”
21. The man suffered from a chronic condition which at the beginning was not necessarily life threatening. He was promptly referred to specialists when his condition deteriorated and was managed by Risley in partnership with hospital consultants. We are satisfied that the diagnosis of his terminal illness was timely and appropriate.

## **Informing the man about his condition and treatment**

22. The man knew that he was diabetic before entering HMP Risley and was told when his associated kidney disease developed in 2005. His kidney function was monitored and, in November 2008, he was told that he had developed chronic kidney disease. By July 2011, his condition had deteriorated significantly and, in January 2013, he was discharged from hospital with a terminal diagnosis and active treatment was not possible. The clinical reviewer comments:

“The patient [the man] was kept informed of the fact that his condition was deteriorating ...When asked about resuscitation, he was unable to handle the complex information and make a statement.”

23. We are satisfied that over the years the man was kept informed about his progressive kidney disease but, by January 2013, he was too confused to understand his terminal prognosis.

## **The man’s medical appointments and treatment**

### *Appointments*

24. According to the electronic medical records, the man had a number of missed appointments because the wrong type of vehicle was requested by the prison. He missed an appointment on 18 June 2012, as the taxi did not have wheelchair access. On 5 September, he did not attend a hospital appointment with a kidney specialist, as the prison had again ordered a vehicle without wheelchair access. There were further difficulties with transport on 3 December, when he was due to attend the audiology department (an appointment re-scheduled from 9 November). This re-scheduled appointment was not kept as the prison had again requested the wrong vehicle.
25. There is no information in the medical record about what the missed appointment on 18 June was for, or if it had been re-scheduled. There is an entry on 15 June regarding a hospital appointment scheduled for 20 July, although again there is no information about it or that the man attended.
26. A hospital specialist in chronic kidney disease wrote to the prison on 4 July, as the man did not attend the elderly care clinic on 20 June. There is no corresponding entry in the medical record about this missed appointment, which he eventually attended in September.
27. On 9 August, the man had a bout of diarrhoea, so he missed an appointment for a scan on his abdomen, which was rescheduled to 16 August. It is unclear from the medical records if he went to this appointment. While there is an entry on 11 September noting that he was not to eat or drink after midnight before an appointment on 12 September, there is no specific information about what this was for or that he went to hospital.

28. The missed appointment to the kidney specialist on 5 September was rescheduled to 4 October. There is no record that the man attended this appointment.

**The Governor and Head of Healthcare should ensure that hospital appointments are clearly recorded, cancelled only as a last resort and with full reasons documented, and that appropriate transport is provided.**

#### *Treatment*

29. The consultant nephrologist (a kidney specialist) recorded that the man's kidney function was reasonably stable, albeit deteriorating, and that there was no clinical indication that dialysis would have been beneficial. The clinical reviewer agrees that dialysis would not have been appropriate.
30. The man was beginning to struggle with his personal care. On 8 July 2012, he was referred for a social care assessment. None was provided at this time, but assistance was arranged on 1 August, after he had been admitted twice to hospital following a transient ischaemic attack (TIA – a mini stroke caused by a temporary disruption of the blood flow to the brain). Initially, an external healthcare agency provided twice weekly assistance with his personal hygiene. This was increased at the request of the healthcare manager on 25 October.
31. Over the weekend of 10-11 November, the man had diarrhoea several times, and his cell was not cleaned properly and the external agency was unable to provide a carer until 11 November. Healthcare staff raised concerns about his social care needs on 12 November with the healthcare manager, who explained that this was a prison issue and not a matter for healthcare. The external healthcare agency was not available after another episode of diarrhoea on 16 December, when a nurse and her colleague helped him to clean himself and his cell.
32. The man's treatment options were limited to managing his symptoms, rather than curing his underlying illness. Risley reacted promptly when they assessed that they were not able to meet his care needs. The provision of social care for older prisoners or those who are very ill has previously been identified as a problem in other PPO investigations and is an ongoing issue. Despite the difficulties with the external healthcare agency providing staff on occasion, Risley healthcare staff ensured his needs were met. The clinical reviewer concludes that his treatment at Risley was equivalent to that he could have expected in the community.

#### **The man's pain relief and medication**

33. The man was prescribed medication as directed by the prison doctor and in consultation with hospital specialists. When he was at Risley, healthcare staff regularly reviewed his care plan and he was made as comfortable as possible. On 10 February, a nurse examined him. He was in pain and his pain relief medication was increased. A doctor examined him the next day and, as he still appeared to be in pain, arrangements were made for him to be transferred to a

hospice. He was not in pain until the days before his death, when he was reassessed and it was agreed that specialist intervention at a hospice was more appropriate.

34. We agree with the clinical reviewer that the man's medication and pain relief was managed appropriately.

### **Palliative care**

35. The NHS document 'The route to success in end of life care – achieving quality in prisons and for prisoners' sets out how an end of life care pathway might be implemented in prisons. It helps carers to plan when and how care will be delivered, and helps patients make choices about how they are cared for towards the end of their lives.
36. As the man struggled to keep his cell clean, and had reduced mobility, another prisoner was assigned as his carer to help him with hygiene and collect his meals. As his condition worsened, in addition to the prison carer, Risley organised for an external healthcare agency to provide care and he was provided with a specialist bed and hoist.
37. A doctor referred the man to North Cheshire Palliative Care Group on 21 December 2012, for an expert care review, a prognosis and treatment plan, and for consideration for transfer to a hospice. A palliative care consultant arranged to visit him at Risley on 28 December to make a full assessment of his needs, but this did not happen as he was in hospital.
38. The man was discharged back to Risley on 22 January. A doctor referred him for another palliative care assessment on 24 January. In a letter to all healthcare services, dated 29 January (countersigned on 1 February by the doctor), another doctor confirmed that he would be 'not for resuscitation' in the event of a heart attack. An end of life pathway was to be considered if there was a further deterioration. Both prison doctors recorded that he was unable to comprehend the complexity of the discussion regarding resuscitation and end of life care.
39. During a telephone discussion between the palliative care consultant at the hospice and the prison doctor on 6 February, it was agreed the man should have only palliative care treatment. At the time he was not in any pain so there was no need for the consultant to visit Risley and advise about his medication. When he complained he was in pain and became distressed, it was agreed that he should transfer to the hospice for specialist palliative intervention to manage his pain.
40. After his return to the prison in January with a terminal prognosis the man was assigned 24 hour care from an external healthcare agency. His emotional needs were also well considered, evidenced by the number of daily interactions with prison and healthcare staff and ongoing contact with his friends on the wing.
41. We are satisfied that healthcare and agency staff provided a good standard of care, with attention to the man's needs when he was at Risley. An appropriate

end of life plan was implemented, and he was transferred to a hospice when specialist pain relief was needed.

### **The man's location**

42. Until July 2011, the man was reasonably mobile and able to move about his wing. Due to his reducing mobility, he had a personal emergency evacuation plan (PEEP) agreed on 8 April 2012. On 14 May 2012, he told a doctor, officers and his friends that he did not want to move to HMP Preston (where there is an inpatient unit) as he was settled at Risley, where he had friends and was satisfied with his healthcare. He was examined by a consultant for the care of the elderly at hospital on 20 July 2012. He was subsequently given walking aids and a wheelchair.
43. On 25 October, the man told the healthcare manager that he did not want to be transferred to another prison and at the November review of his care plan, it was agreed that he would be assigned a carer (another prisoner) to assist him with cleaning his cell, collecting his meals and other daily needs. He was moved to a larger cell on the same wing, which had already been adapted for those with care and mobility problems.
44. On 10 December, the man was admitted to hospital for five days. When he returned to the prison, the level of care he received from the external healthcare agency was increased. On 21 December, a doctor examined him. Blood test results indicated that his kidney function was deteriorating, but he refused to go to hospital or be transferred to another prison. On 24 December, he was readmitted to hospital as he had another urinary tract infection.
45. The man returned to Risley on 22 January. While the prison had respected his wishes to remain at Risley, in the end staff were unable to manage his pain sufficiently. In February he was transferred to a hospice for specialist palliative care. He died there later the same day.
46. We agree with the clinical reviewer that the man was located appropriately. His wish to remain at Risley was respected for as long as possible. He was well supported by staff and prisoners and the final decision to move him to a hospice was appropriate to meet his needs.

### **Compassionate release**

47. Release on compassionate grounds is a means by which prisoners who are seriously ill (generally with a life expectancy of less than three months) can be released from custody. A doctor completed a medical report for compassionate release on 11 December and an assessment was made by the prison probation officer the next day. Other relevant information about the man's risk and accommodation options was collated and considered by the Governor on 23 January 2013. The application was not supported, as he had no address or release plan and he wanted to stay at Risley.

48. The man had no family support and, in the absence of a suitable release plan and in accordance with his wishes, we consider that it was appropriate not to pursue an application for release on compassionate grounds.

### **Liaison with the man's family**

49. The man did not have any known living relatives. He had been at Risley for many years and was a well known and liked member of his wing. The prison ensured that those caring for him were told of his death, and they told the investigator that they had been well supported by staff. His funeral was held at the prison on 28 February, which was well attended by those wishing to pay their respects.

### **Restraints, security and bed watch**

50. The Prison Service has a duty to protect the public when escorting prisoners out of prison and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. 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 which also takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process. It deemed that handcuffing a prisoner receiving chemotherapy (and, by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.
51. The escort risk assessment completed in February considered that the man had impaired mobility, was a low risk of harm/escape and was a 'very sick man'. Despite his condition a prison manager authorised that an escort chain (a two metre long chain with a cuff at either end) should be applied during the ambulance journey. Restraints were applied at 10.25hrs when the ambulance left Risley, and removed at 10.50hrs when the escort arrived at the hospice.
52. When interviewed, the prison manager explained that she did not believe that she had the authority to allow the man to be transferred without restraints. The investigator spoke to a number of staff, all of whom believed that they had no authority to make this decision, and that restraints had to be applied at least during transportation of any prisoner.
53. In response to the investigator's initial feedback and the concerns about the use of restraints, the Governor commissioned his own investigation into why restraints were applied. A copy of this report was sent to the investigator on 7 March. The prison investigation concluded that a previous instruction by the then acting governor stated that staff had no authority to allow someone to leave the prison unrestrained. This continued to be the widely held

understanding amongst prison managers, which the Governor says he has now changed.

54. Security measures must be proportionate to a prisoner's individual circumstances. When the man was taken to the hospice he was very weak and at the final stage of life, yet was unjustifiably restrained during his ambulance journey. Given the widespread understanding that a minimum of an escort chain had to be used, we do not criticise any individual member of staff, but it is important that all those taking decisions about the use of restraints for prisoners who are ill understand the implications of the High Court Judgement and follow the Prison Service guidance which followed it. We make the following recommendation:

**The Governor should ensure that risk assessments for prisoners taken to hospital or hospices fully take into account individual circumstances and are based on the actual risk the prisoner presents.**

## RECOMMENDATIONS

1. The Governor and Head of Healthcare should ensure that hospital appointments are clearly recorded, cancelled only as a last resort, with full reasons documented, and that appropriate transport is provided.

### ACCEPTED

*In terms of healthcare provision all hospital appointments all recorded clearly within "SystmOne" electronic based patient record and appointment ledger and escorts are booked by the office manager.*

*Transport is arranged by the prison service and any special needs are informed by the healthcare department. Appointments are rarely cancelled but could possibly be cancelled for the following reasons.*

1. *The patient refuses to attend and after speaking to an appropriate health professional who explains the risks and consequences may sign a medical disclaimer.*
2. *The hospital cancels the appointment and rearranges it.*
3. *There are insufficient escorting resources to deal with exceptionally high demand on a particular day or there is an emergency situation within the prison. In these instances patients are triaged by the GP to determine if any appointments could be rearranged without causing harm or distress to the patient.*
4. *If all the patients needed to go out urgently on a particular day as described above this would be referred to the Governor who would assess the resources available.*

*Health care staff has been reminded that all cancellations must be recorded in the patients notes with the reason for the cancellation and arrangements made for rearrangement.*

*Target: Completed and ongoing. To be reviewed January 2014.*

2. The Governor should ensure that risk assessments for prisoners taken to hospital or hospices fully take into account individual circumstances and are based on the actual risk the prisoner presents.

### ACCEPTED

*Risk assessments have now been amended and there is an option for Managers to consider no restraints.*

*The risk assessment has also been reviewed and there is a new version awaiting approval which flows better ensuring the Manager has all the information they need to make an informed decision about the level of restraint used.*

*All Managers will be reminded that when considering cuffing arrangements they must be proportionate to the risks posed by the individual prisoner, having full regard to his or her clinical condition. It must also be regularly reviewed to take account of the prisoner's changing circumstances.*

*Target: 31 August 2013. To be reviewed January 2014.*