

**INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE
DEATH OF A MAN AT HMP RISLEY IN JULY 2007**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

January 2008

This is the report of an investigation into the death of a man in July 2007 at HMP Risley. He died of natural causes and was 70 years old.

This investigation was undertaken by one of my colleagues. Both he and I would like to thank the Governor of Risley and his staff for their participation in the investigation.

The clinical reviewer was identified by Warrington Primary Care Trust (PCT) to undertake a review of the man's clinical care. I appreciate his assistance and report.

In circumstances such as those described here, where a prisoner has died from natural causes, the findings of the clinical review play a large part in my report. The review of the man's care shows that, broadly speaking, he received good care whilst in Risley. However, there were some concerns and questions about provision for prisoners with long-term chronic diseases. There are three recommendations as to how the prison and the PCT can improve the care they provide to prisoners with long-term conditions. In this version of the final report the Prison Service has partially accepted one of the recommendations and fully accepted the other two.

The man was not in contact with any of his family and so the prison arranged and paid for his funeral. Staff from Risley were the only people present. There was also a memorial service in the prison chapel so that the man's fellow prisoners could pay their respects. I judge that this was all handled well and with sensitivity.

This report has been anonymised for publication on my website.

Stephen Shaw CBE
Prisons and Probation Ombudsman

January 2008

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SUMMARY

The man was serving a prison sentence at HMP Risley. He was 70 years old when he collapsed in his cell in July 2007. His cellmate alerted staff, and attempts were made to revive him. Unfortunately, they were without success.

Having been sentenced to four years' imprisonment in October 2002, with a further three years' supervision, the man was allocated to Risley. He was already diagnosed with epilepsy, and was not in good health. He had numerous contacts with healthcare and the records show over 50 incidences of fits, loss of consciousness, suspected fits or collapses, plus a number of other contacts following asthma attacks and chest pains. In December 2003, the man became depressed, partly linked to the frequency of his fits, and threatened to take his own life. He was placed on self harm support and monitoring arrangements for a time.

The man was due to be released on licence in early 2005. The anticipation caused him some distress, and again he was placed on special self harm monitoring and support. He was released on 25 February 2005, with a condition to report to an Approved Premises (a hostel run by the Probation Service). He failed to do so and his licence was revoked. He was arrested the following day and returned to prison.

The man's health continued to be poor and his contact with healthcare resumed. He persisted in smoking 25 cigarettes a day despite efforts to persuade him to stop. He seemed unconcerned about his health, did not always comply with his medication and, despite guidance, his inhaler technique was poor. Referral to a specialist regarding the episodes of loss of consciousness suggested that they were not epileptic fits, and he was referred to a second specialist. However, there was a delay in making the referral and he was awaiting an appointment when he died.

The man's health deteriorated further from April 2007, and he attended healthcare up to three times a day to use the nebulising machine. Consideration was given to providing a machine in his cell, but his previous lack of compliance with medication, coupled with his own reluctance, meant that he continued to be treated in healthcare.

At 9:08pm on 3 July, the man's cellmate alerted staff that he had collapsed. Healthcare were told and staff quickly attended. An ambulance was called, and the man was moved out of his cell so staff could attempt resuscitation. They were unsuccessful and he was moved to a private room and staff began the procedures that follow the death of a prisoner. The duty governor, chaplain, and head of healthcare all returned to the prison, the chaplain giving him the last rites. The care team attended to ensure that staff had support available. The man's cellmate was supported and relocated to another cell.

Unable to trace any relatives wishing to be involved, the prison arranged the funeral in the man's home area. The service was conducted by the prison

chaplain and attended by a representative of the Governor. The prison also held a service in the prison chapel for the man's fellow prisoners.

THE INVESTIGATION PROCESS

1. My investigator visited HMP Risley and spoke to staff who knew the man. He interviewed seven members of staff and one prisoner. Notices were posted to staff and prisoners about the investigation, inviting contributions if necessary. In addition, the investigator studied all relevant prison records relating to the man who died. These included his main prison record, medical records and statements made by staff. The investigator also visited a cell on E wing identical to the man's cell.
2. Warrington Primary Care Trust identified a medical practitioner to carry out a review of the man's clinical care. I am grateful to the clinical reviewer for undertaking this review. My investigator discussed aspects of the man's treatment with both healthcare staff at Risley and with the clinical reviewer.
3. My investigator contacted Her Majesty's Coroner for Cheshire to inform him of the nature and scope of my investigation and request a copy of the Post Mortem report. Upon completion, my report will be sent to the Coroner to assist in his enquiries into the man's death.
4. The man had not left details for any next of kin. The prison and the police made efforts to trace his family, but no-one wished to be involved. Consequently, my family liaison officers were unable to speak to any of the man's family.

HMP RISLEY

5. Risley is a modern, purpose built prison which opened in 1964. It is a category C training prison with a capacity of 1,085. Its original function was as a male and female remand centre. Following a major disturbance in 1989, the male part of the prison became a training prison, and in 1992 a sentenced male prisoner allocation centre was introduced. During the latter part of the 1990s, the female prison and allocation centre roles were removed and Risley became a category C training establishment for over 800 male prisoners. The prison was further expanded and refurbished, and in 2003 a new wing was opened (G wing) bringing the capacity of the establishment to over 1,000, making it the largest category C prison in the country. E wing, where the man was located, is the vulnerable prisoners' wing.

Healthcare

6. Healthcare staff are available in Risley 24 hours a day. By day, there is a doctor in the prison; at night, cover is provided by nursing staff. Prisoners who require in-patient treatment are referred to other prisons or to outside hospital. In the event of an emergency, Risley has not used identifying codes to indicate different types of incident. However, in light of a recommendation in one of my previous reports I am led to believe that such a system is being introduced from January 2008.

Previous deaths at Risley

7. This is the third death which my office has investigated since I became responsible for investigating all deaths in custody in April 2004. The circumstances of this man's death are different to the previous two.

Night state

8. At night the prison is locked up and the number of staff in the establishment is much lower than during the day. The Night Orderly Officer (NOO) is in overall charge of the prison and has an Assistant Night Orderly Officer (ANOO). The NOO visits each wing at intervals through the night. Wings are in the care of night patrol officers, responsible for monitoring security and safety. The number of officers on patrol varies from wing to wing.
9. The NOO (or the Assistant Night Orderly Officer) carries cell keys. Wing patrol officers carry cell keys in a sealed pouch and local instructions state that these are for emergency use only. The instructions further say that:
 - i. under normal circumstances authority to unlock a cell at night will be given by the Night Orderly Officer;
 - ii. under normal circumstances no cell will be opened unless three members of staff are present;
 - iii. where there is, or appears to be, immediate danger to life, cells may be unlocked with one member of staff;

- iv. the Control Room must be informed and a response gained before such action is taken;
- v. the Night Orderly Officer will deploy staff immediately to the cell.

Her Majesty's Chief Inspector of Prisons (HMCIP)

10. The most recent HMCIP inspection was unannounced and took place in February 2006. None of the issues raised in that report are relevant to the circumstances of the man's death.

KEY FINDINGS

11. The man was remanded into custody in June 2002, and was held in HMP Altcourse. After sentence in October, he was received in Risley on 25 October 2002.
12. It was noted at reception that the man suffered from poor health. He was asthmatic and had been diagnosed as having epilepsy. His sentence was punctuated with numerous incidences of fits or suspected fits and asthma attacks. Between sentencing and his death, medical records indicate in the region of 80 fits or suspected fits, ten asthma attacks, ten incidents of chest pain, and a dozen occasions when the man collapsed. For these reasons, he was in frequent contact with healthcare.
13. The man had a long history of smoking – some 50 years – and smoked about 25 cigarettes a day. He did not take a great interest in his own health and showed poor motivation when staff tried to persuade him to do so. Often his contacts with healthcare came as a result of fellow prisoners alerting staff when he had collapsed or appeared to be suffering a fit. Compliance with his medication was poor, as was his technique when using his inhaler despite staff attempts to help him be more effective. He also resisted numerous staff attempts to help him to stop smoking.
14. Having suffered a number of fits, asthma attacks and collapses in the space of a few weeks, the man was taken to the Accident and Emergency Department of an outside hospital on 29 November 2003. He was admitted to the hospital on 4 December, and remained there for six days until 10 December. He continued to suffer with fits and occasions in which he collapsed.
15. On 30 December 2003, the man was placed on F2052SH (the then system of special observations and support for prisoners at risk of self-harm). His recent health had been particularly bad. He was depressed, was concerned at the frequency of fits and had threatened to take his own life. He remained on F2052SH until 21 January 2004.
16. The man continued to suffer from a number of fits, collapses and asthma attacks. In February 2004, a partial assessment of his lung function showed his capacity as poor. However, his medical record does not show whether the significance was properly evaluated. A specialist report on 29 April indicated that the man had not been taking his prescribed medication.
17. On 18 June, staff responded to the cell bell to find the man standing in his cell with a ligature made from a bin-liner attached to the curtain rail. He said that he wanted to take his own life. The man was again placed on F2052SH, and remained so for 12 days.
18. In early 2005, the man was preparing for release on licence, which he faced with a considerable degree of apprehension. On 14 February, he expressed

thoughts of self-harm which again led to him being placed on F2052SH. He remained on special observations for two days.

19. The man was released on licence on 25 February 2005 and left the prison at 9:30am. One of the conditions of his licence stipulated that he must report to an Approved Premises (a hostel) at 1:00pm. However, he failed to do so, and did not contact the Probation Service. His licence was revoked and he was arrested the following day.
20. The man was returned to HMP Altcourse where he was placed on self-harm and suicide prevention support and observation measures because he had been recalled so soon after release. He remained in Altcourse until 18 March 2005 when he was re-allocated to Risley.
21. The man was not a well man, and even when not suffering from any attack, his oxygen saturation levels were low. Between his return to Risley in March 2005 and his death in July 2007, he continued to suffer a number of fits and suspected fits. Healthcare staff worked closely with him through this time. This included yet more attempts (again unsuccessful) to persuade him to give up smoking.
22. From April 2007, the man's health began to deteriorate further. Between then and his death, there were some 55 occasions when he consulted healthcare in relation to breathing difficulties. He was due to have an echocardiogram (a test for the function of the heart) at an outside hospital on 29 May. However, it was cancelled due to a lack of staff available to provide an escort. The decision was taken in consultation with medical staff.
23. As his health deteriorated, he visited healthcare every day to be treated with a nebuliser. Towards the end of his life, he attended up to three times a day. Consideration was given to allowing him to keep a nebuliser in his cell, as other prisoners had been allowed to do. But his history of poor compliance with his medication, along with his history of poor technique in using his inhaler, meant that this option was rejected. The man had also indicated that he did not want to use a nebuliser in his cell.
24. On 1 July, the man complained of shortness of breath on a number of separate occasions. Healthcare requested that an out-of-hours doctor attend, although in the event an emergency care practitioner was sent. There was a delay between the request being made at 4:15pm and the visit at 8:30pm. The emergency care practitioner assessed that the man might have left ventricular failure.
25. On the morning of the day he died, healthcare staff discussed the possibility of transferring him to HMP Preston which has in-patient facilities. But Preston only treats prisoners who are acutely ill, whereas the man was suffering from a chronic illness.

3 July 2007

26. At 9:08pm the cell bell on the man's cell was activated. Two night patrol officers on E wing responded to the call. The man's cellmate told them that the man had collapsed. The officers could see that the man was lying on the cell floor and was being supported by his cellmate.
27. The cellmate said that the man was mumbling to him, and the first night patrol officer told my investigator that he could see that the man was breathing. The man had often required medical assistance after collapsing, suffering fits, or suffering asthma attacks in the past. This had included occasions during the night. The officers did not judge that they needed to break the seal on their cell keys at this stage, and the second patrol officer radioed through to Control that healthcare assistance was required. The first night patrol officer opened a running time log of events.
28. At 9:10pm, Control told the Assistant Night Orderly Officer (ANOO) to collect a nurse from healthcare immediately and take them to E wing. He went to healthcare and collected the staff nurse.
29. In the meantime, Control had contacted the staff nurse and told her that the man had collapsed and that she was required on E wing. The nurse was familiar with the man and the state of his health, having treated him on numerous occasions in the past. She therefore took a nebuliser, a blood pressure machine, and a Sats machine (for checking oxygen levels) and went with the ANOO to E wing.
30. Control also informed the Night Orderly Officer (NOO) that the man had collapsed, and he made his way immediately to E wing. The NOO, the ANOO, and the staff nurse all arrived on E wing at 9:13pm, five minutes after the cell bell rang.
31. The ANOO opened the cell door and the staff nurse and the NOO went in. The staff nurse looked at the man and immediately requested an ambulance, even before checking his blood pressure, pulse or breathing. The first night patrol officer contacted Control and requested an ambulance at 9:15pm.
32. The staff nurse administered oxygen to him, but he showed little if any response. She and the NOO attempted to perform cardio-pulmonary resuscitation (CPR) in the cell. However, the cell was quite small, and the man had fallen at an angle with his head by the wall, and his cellmate was still present. This rather cramped space made it difficult to perform CPR, so staff moved the man out of the cell onto the landing and continued there. The staff nurse inserted an airway tube into the man's mouth and staff carried out cycles of assisted breathing and chest compressions.
33. While the staff nurse and the NOO continued to perform CPR, the ANOO went to the gate so he was ready to escort the ambulance when it arrived. However, a paramedic was also dispatched to the prison, and he reached the

gate before the ambulance. The ANOO therefore took the paramedic to E wing before returning to the gate to continue to await the ambulance.

34. The staff nurse presented the man's medical history to the paramedic, and he inserted a longer tube into the man's airway. He observed his reactions to the resuscitation attempts, and checked the reading on the defibrillator. The man was not responding. At 9:30pm, the paramedic asked the staff nurse and the NOO if they all agreed that attempts at resuscitation should stop. At 9:33pm, staff began to carry out the tasks necessary when a prisoner dies.
35. The ambulance arrived at 9:32pm, and the ANOO escorted the ambulance staff to E wing. At 9:43pm, the officer assisted the ambulance staff to lift the man onto the ambulance trolley and off the wing and into the NOO's office so that he was afforded some privacy.
36. Other staff who had been contacted arrived in the prison. They included the chaplain, the duty governor, the head of healthcare, and two officers from the Care Team. A member of Independent Monitoring Board also attended, as did a Detective Sergeant. The chaplain read the man's last rites.

The man's cellmate

37. The man's cellmate had been understandably quite distressed by events, and a number of staff made efforts to ensure his wellbeing throughout. When staff were performing CPR on the man on the landing, staff ensured that the cell door was pushed to (though not shut) so that the cellmate did not have to witness it. As soon as possible, he was taken for a cup of tea and to sit on the wing landing rather than be next to events.
38. Staff asked another prisoner, an older man who would be a calming influence, if the man's cellmate could move into his cell with him for the rest of the night. He agreed and, even though he was a non-smoker, was content for the man's cellmate to smoke by the window if he felt he needed to. It was explained to the man's cellmate that it was standard procedure that he would need to hand over his clothing, and new clothes were provided for him.
39. As well as being protected from seeing staff attempting to resuscitate the man and being relocated to another cell, the cellmate was spoken to by a number of staff through the evening. This included the chaplain, the NOO, and the duty governor, all of whom were concerned to reassure and settle him. The member from the Independent Monitoring Board also spoke with the man's cellmate.
40. When interviewed by my investigator, the cellmate was accompanied by his wing representative. Although the man's cellmate accepted that staff had taken trouble to look after him on the night the man died, his wing representative expressed concern at how events had affected him in the following weeks. He seemed to have lost his appetite, was sleeping for long periods, and his wing representative was concerned that he might be suffering from depression.

41. Healthcare records show that the man's cellmate was seen by the doctor the morning after the man had died. He was subsequently seen a number of times that week. He was also referred to the community psychiatric nursing team, was seen by the prison's psychiatrist, and was referred on to other psychiatric services. In interview, the head of healthcare, noted that the man's cellmate had missed some psychiatric appointments, but had not been seen by the doctor in recent weeks. He undertook to arrange for him to see the doctor again within a few days.

After the man's death

42. A short hot debrief was held that night for staff involved. The following morning, a follow-up meeting was held to ensure that everything was in order. Any outstanding issues were allocated to specific members of staff to address. This included ensuring that all prisoners at risk of suicide or self harm were reviewed in case the man's death had had a detrimental effect on them. It also included ensuring that Care Team services were offered to all staff involved. As noted above, the Care Team attended E wing to support staff at the time. All staff interviewed said that they were offered appropriate support.

43. The man had listed his probation officer as next of kin. However, when contacted, the officer said she had only dealt with him on a very few occasions. The police and the prison made further efforts to trace any family, but only succeeded in locating an elderly, distant cousin who did not wish to be involved.

44. As no family had been traced, the prison arranged and paid for the man's funeral. It was held in the town from which the man originated. The prison's chaplain conducted the funeral, and the head of reducing re-offending attended to represent the Governor. In addition, the prison arranged a memorial service in the chapel. The man's fellow prisoners could therefore attend and pay their respects.

ISSUES

Clinical care

45. As noted, a review of the man's medical care was undertaken on behalf of Warrington Primary Care Trust. The clinical reviewer finds that, as a whole, the man received appropriate treatment in prison, equitable with that which he could have expected in the community. As well as his main medical conditions, his subsidiary health needs, such as a hernia, were addressed in an appropriate manner.
46. Although coronary artery disease was suspected, the man did not show any overt signs, which may be explained by his sedentary lifestyle in prison. Healthcare also diagnosed his right sided cardiac failure, and took the view that it did not require treatment on a long-term basis. Moreover, medication prescribed to him was kept under review and changed as was required. The screening which took place on reception properly addressed his mental health. However, the clinical reviewer comments that, whilst the man received care of an appropriate standard, it was not delivered to a set plan and he was not given continuous oxygen therapy.
47. The man was in the main appropriately treated for his episodes of loss of consciousness. Healthcare staff correctly judged that he did not present the pattern of a typical epileptic fit, and that his symptoms were not brought under control by anti-epilepsy medication. The man was referred to a consultant neurologist in November 2003 who confirmed that the symptoms were not epileptic in origin. Tests did show an aneurysm of one of the cerebral arteries, and the man remained under treatment for this.
48. Although the neurologist advised in January 2004 that the man's symptoms were not due to epilepsy, he was not referred to an alternative specialist until March 2007. The absence of a referral was not recognised when he was taken to Accident and Emergency. The reasons for his loss of consciousness remained unexplained at the time of his death. It is the view of the clinical reviewer that this did not materially contribute to the man's death, but that follow-up should have been earlier. The reviewer notes that there has been a turnover of medical staff at the prison and lack of continuity may have played a part in the delay.
49. The man was correctly diagnosed with, and received appropriate treatment for, his chronic obstructive pulmonary disease (COPD, a result of damage to the lungs, usually through smoking). He was treated appropriately each time he came to healthcare for his COPD, but no overall plan was put into place to manage his condition.
50. In interview, a fellow prisoner expressed concern that the clinical review should address the care the man received in the last six months of his life when his health appeared to be deteriorating. Whilst the reviewer feels the overall treatment to be broadly appropriate, prisoners who present themselves to healthcare for frequent treatment for similar symptoms should receive an

early diagnosis, and this should be picked up in a management plan. The man was seen regularly in the asthma clinic. His lung function was measured on a number of occasions, and his symptom control until April 2007 seemed to be satisfactory. However, the severity of his underlying condition was not properly established.

The Head of Healthcare should consider systems to ensure that management plans are put in place for patients, which includes ensuring secondary appointments are followed up where necessary.

51. The man had an appointment to go to hospital for an echocardiogram on 29 May, but it was cancelled due to the lack of an escort being available. The decision was made after consultation with healthcare staff. I have not checked the frequency with which this has happened to other prisoners, but the head of healthcare may wish to check how often prisoners have to miss hospital appointments due the unavailability of an escort.
52. Prison healthcare is not linked into wider Primary Care Trust initiatives, including guidance, care initiatives and staff training. As such, they were not able to avail the man of the benefits of assessment by the community matron, which might have led to him being assessed for continuous oxygen therapy. Nor were they linked into the Quality and Outcomes Framework (which aims to improve the management of chronic diseases) or the National Institute for Health and Clinical Excellence guidelines for long term conditions. Nor are they linked to the new PCT agenda on chronic disease management (although I understand that this is currently under review).

The Head of Healthcare should liaise with the PCT to ensure that healthcare are linked into wider PCT initiatives which would benefit staff and patients.

53. The prison doctor was confident that the man received appropriate care in Risley. However, he stated in interview with the clinical reviewer that he had wanted the man to be transferred to HMP Preston which provides in-patient healthcare for prisoners. Transfer was not possible because of the prison's acceptance criteria. There is a memorandum on the man's medical file from the deputy healthcare manager dated the morning of his death which says that the man would benefit from in-patient facilities. No option other than Preston seems to have been considered up to this point.
54. The prison doctor also felt that the man would have benefited from receiving oxygen on a continuous basis, which he would have done in the community. He did comment that it was possible that the man might have died sooner in the community because of his reluctance to ask for help.
55. Many of the man's contacts with healthcare stemmed from fellow prisoners alerting staff when he was unwell. The prison doctor said that there are a number of prisoners who have high dependency levels that cannot be met at the prison. There is currently no register of prisoners who require long-term

healthcare, whether or not their needs can be met at Risley, and there is no system to alert the Governor or the Chief Executive of the PCT to their needs.

The Governor, PCT Chief Executive and Head of Healthcare should consider introducing a register of prisoners with long-term care needs that cannot be met at Risley, and management plans to ensure that the needs of these prisoners are met.

Response to the man's death

56. I was impressed at the speed and content of the staff response when the man collapsed for the last time. A nurse was in his cell within five minutes of his cellmate pressing the cell bell. Staff moved him out of his cell and attempted to resuscitate him. When he was pronounced dead he was moved to a private space. His cellmate was well supported on the night that he died. When alerted to events, the duty governor, head of healthcare, and prison chaplain all came back to the prison. The care team attended for the benefit of staff who might have needed them.
57. I was also impressed with the way the prison organised the man's funeral in the absence of any family willing to do so. Arranged in his home area, conducted by the prison chaplain, and the only attendee being a representative of the prison, this was a sensitive way of dealing with the funeral. There was also a memorial service in the prison chapel for the benefit of any fellow prisoners who wished to attend.
58. The man's cellmate was treated with sympathy and understanding at the time. He was followed up by healthcare the next day and in subsequent weeks. However, he missed one or two appointments and his care slipped a little. I was pleased to see that, when speaking to my investigator, the head of healthcare agreed to arrange for him to be seen and assessed further in the very near future. While I make no recommendation, I would draw to the Governor's attention the need to ensure ongoing care for prisoners who may have suffered an upsetting experience.

RECOMMENDATIONS

59. The Head of Healthcare should consider systems to ensure that management plans are put in place for patients, which includes ensuring secondary appointments are followed up where necessary.

This recommendation has been partially accepted by the Prison Service. Management plans are in place. There are resource implications for the number of escorts available. Alternatives to alleviate the numbers of out-patient appointments are being investigated i.e. telemedicine and review of services that can be provided within the prison e.g. IV therapies.

60. The Head of Healthcare should liaise with the PCT to ensure that Healthcare is linked into wider PCT initiatives which would benefit staff and patients.

This recommendation has been accepted by the Prison Service. They note that links with the PCT are improving with services from the PCT coming into HMP Risley. However, there are financial implications linked to this.

61. The Governor, PCT Chief Executive and Head of Healthcare should consider introducing a register of prisoners with long-term care needs that cannot be met at Risley, and management plans to ensure that the needs of these prisoners are met.

This recommendation has been accepted by the Prison Service. The register will improve once Healthcare is fully computerised. The target date for commencement is February 2008.