PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

Investigation into the death of a man at hospital in April 2012 while a prisoner at HMP Risley

Report by the Prisons and Probation Ombudsman for England and Wales

March 2012

This is the report of the investigation into the death of a man, a prisoner at HMP Risley. He died at hospital in April 2012, where he had been admitted earlier that day. He was 69 years old. A post-mortem report recorded his cause of death as cardiac failure, pulmonary fibrosis and ischaemic heart disease. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. A clinical reviewer reviewed the clinical care the man received at Risley. Staff at Risley cooperated with the investigation.

The man arrived at Risley on 15 November 2010. He was an older prisoner with serious health problems, which were exacerbated by his continued smoking. He was seen frequently by prison healthcare staff and referred to hospital for assessment and treatment of various conditions. In April 2012, his health deteriorated rapidly. On 7 April, he experienced severe breathing difficulties and was taken to hospital, where he died soon after.

The investigation concludes that the man was generally well cared for at Risley and that, overall, he received a level of clinical care at the prison equivalent to what he might have expected in the community. However, when he was diagnosed with a chest infection two days before he died, the clinical reviewer considers it would have been better practice for him to have been reviewed daily rather than the five day review which was planned. It is also of concern that he mistakenly feared he had cancer, yet healthcare staff did little to explain his condition or reassure him. Finally, it is disappointing that, when he went to hospital for outpatient appointments, restraints were used without a fully balanced risk assessment to justify their use, particularly as this issue arose in a previous death at the prison.

This report was shared with the man's family at the draft stage. They were concerned that he was not mistaken about his diagnosis of oral cancer. Paragraph 20 of this final report discusses this issue further. It has been confirmed that he was very likely to have had cancer of the mouth.

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 **March 2013**

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SUMMARY

1. The man was sentenced to six years imprisonment on 28 September 2010 and initially went to HMP Manchester. On 15 November 2010, he moved to HMP Risley. He did not have good health and, during his time at Risley, he had extensive contact with health services both in the prison and the community.

2. A reception health screen at Risley recorded that he had a history of ischaemic heart disease disease (in which fatty deposits build up causing reduced flow to the heart), peripheral arterial disease (narrowing of the arteries that resticts blood flow to the limbs), diabetes, had problems with lipid metabolisim (a disorder that is harmful to many organs of the body) and had been exposed to asbestos in the past. He smoked 25 cigarettes a day.

3. A standard chest X-ray in March 2011 indicated abnormalities. This was followed by a CT scan (computerised tomography, which give detailed images of the inside structures of the body). On 27 June he was given diagnoses of pulmonary fibrosis (the development of excess connective tissue in the lungs, resulting in difficulty breathing) and emphysema also known as chronic obstructive pulmonary disease (COPD - when the airflow to the lungs is restricted or obstructed).

4. In April, the man saw a maxillo-facial surgeon at hospital, following a referral for severe mouth ulcers. The professor confirmed a diagnosis of leukoplakia, a common, potentially pre-cancerous disease of the mouth that involves the formation of white spots on the tongue and mouth.

5. On 23 August, a specialist registrar in respiratory medicine at another hospital informed the prison that the man's diagnosis of emphysema was due to smoking and the pulmonary fibrosis due to past asbestos exposure. He was told that while they could offer some treatment for the emphysema, it was unlikely that the fibrosis could be treated and was likely to progress over time.

6. On 16 November the man saw a nurse specialist at Risley, who advised him to tell health care immediately if he developed any symptoms of a chest infection. Between November 2011 and April 2012, he had a number of healthcare appointments, most of which were related to his leukoplakia.

7. On 4 April 2012, after wing officers were concerned about his health, a staff nurse saw the man and recorded that he was breathless and dizzy. A prison doctor saw him later that day and he said he did not have any chest pain, and explained that his breathlessness was a result of walking to healthcare. All the observations taken were normal.

8. The following day the man was seen by a nurse. He told her that he had been unable to walk to healthcare (we understand that he was taken by wheelchair) and that he felt as if air was not getting to his lungs. He was assessed and diagnosed with an acute lower respiratory tract infection and

prescribed medication. He was referred for a CT scan on 10 April at hospital and was to be reviewed at Risley in five days.

9. One morning a few days later healthcare staff were called to the wing as the man was breathless. Observations were taken and he was advised to continue with his prescribed medication. At 9.00am a nurse went to see him, as his condition had worsened. He took observations, administered oxygen therapy and requested an emergency ambulance.

10. The man was taken to hospital, where his condition continued to deteriorate. At approximately 10.50am doctors requested that his family be contacted. He died at 12.09pm and his family arrived shortly after.

11. We agree with the clinical reviewer that the man received a level of care that was equivalent to what he could have expected in the community. However we make three recommendations about the regularity of review for patients with a number of chronic conditions who have an acute episode; staff updates on the condition of a patient; and appropriate risk assessment for the use of restraints. We do not think that any of these would have altered the outcome for him.

THE INVESTIGATION PROCESS

12. The Ombudsman's office was informed of the man's death on 8 April 2012. The investigator issued notices to staff and prisoners to inform them of the investigation process and for anyone with information to contact her. No responses were received.

13. The investigator visited Risley on 17 April and met the duty governor, the Head of Healthcare, the prison family liaison officers and the prison liaison officer. She obtained copies of the man's prison records, including his prison medical record.

14. In July 2012, the investigator returned to Risley to interview relevant staff. After the interviews, written feedback was given to the governor.

15. The local PCT appointed a clinical reviewer to review the clinical care the man received in custody. His review was delayed due to the late receipt of the post-mortem report. The final review was received on 24 September 2012.

16. HM Coroner for the City of Liverpool was informed of the investigation and provided a copy of the post-mortem report. The Coroner will be sent a copy of this investigation report.

17. One of the Ombudsman's family liaison officers contacted the man's sister, to outline the purpose of the investigation and give his family the opportunity to raise any questions or concerns about his care at Risley.

18. The man's sister asked for the following to be considered as part of this investigation:

- Why, with his existing health problems, was his chest infection not seen as more serious and requiring admission to hospital?
- Was the response to his chest infection appropriate, given that he had asbestosis.

19. The man's sister said that he had spoken very highly of the care he received from the nurses in the prison. She also described the contact and support she had from a chaplain at Risley as especially helpful.

20. The draft version of this report was shared with the man's sister. She was concerned that our report stated her brother mistakenly believed he had cancer of the mouth. She contacted his NHS consultant for more information (The NHS is outside of the remit of this office.) The consultant confirmed in a letter to her that biopsies taken were highly suspicious of squamous cell carcinoma requiring primary surgery. He stated that "on balance I think he was suffering from oral squamous cell carcinoma and would have required a major operation".

21. Further enquires with HMP Risley produced a letter dated 3 April 2012 to a doctor, which clearly states that biopsies taken indicated a high suspicion of

squamous cell carcinoma. This letter was not included in the original records provided to this office and the clinical reviewer. When interviewed as part of the investigation, the doctor did not refer to this letter and in view of his answers, did not appear to know it existed. But it is clear that the man's belief he had cancer of the mouth was not mistaken at all.

22. We are satisfied that, as the man died from cardiac failure, pulmonary fibrosis and ischaemic heart disease, and not cancer, it is not necessary to carry out any further investigation. However we would point out to the prison the unnecessary anxiety and upset caused to the family by what can only be put down to poor record keeping. There is no suggestion that his clinical care at the prison was negatively affected by this.

23. The man's sister also said that she believes that he had breathing difficulties for much longer than we state in this report. When visiting him at the prison, she had noticed he was severely out of breath.

24. She also asked us to point out an inaccuracy in the clinical review, which states that her brother was homeless before going into prison. She says this was not the case, he had his own home.

HMP RISLEY

25. HMP Risley is a category C training prison which holds up to 1,085 adult male prisoners.

26. Healthcare services are commissioned by the National Health Service (NHS), through the local Primary Care NHS 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.

HM Inspectorate of Prisons (HMIP)

27. The last inspection of Risley by HMIP was in February 2011. The Inspectorate noted :

> "There is still much to be done to ensure that the prison becomes a fully effective establishment that meets the range of prisoners' diverse needs and prepares them appropriately for release through useful work and effective interventions. Nevertheless, Risley is a much safer, cleaner and more decent prison than before – a better and more purposeful place for prisoners (and as they often told us, a better place for the prison staff to work). The governor and the prison staff are to be commended on the improvements."

28. Regarding health services the report said:

> "Relationships between the prison and NHS agencies were good. The health care environment was being upgraded. Robust clinical governance arrangements were in place. There was an appropriate range of primary care and life-long condition clinics but no triage system. Patients waited too long in health care for escorts. There was a good system to notify patients about the outcome of diagnostic tests. The dental service provided good care. The pharmacy service was satisfactory but medicines administration provided little confidentiality. Access to external appointments and primary and secondary mental health services was good. "

Independent Monitoring Board (IMB)

29. 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. The IMB made the following comments specifically about improvements in the healthcare provision:

> "A new model of GP Practice has been introduced which has significantly reduced the need for locum GP's, this should improve the continuity of GP care. The nursing team is now at maximum with no vacancies. The administrative team has also

been redesigned and now has 2 assistants working with the office manager."

Previous deaths at Risley

30. Since 2009, there have been four deaths through natural causes at Risley, including that of the man. We have raised the issue of appropriate use of restraints in one of these investigations and are therefore concerned to be raising this again in this report.

KEY EVENTS

31. The man was sentenced to six years imprisonment on 28 September 2010. He had been in prison before. He was initially sent to HMP Manchester, and transferred to Risley on 15 November 2010.

32. A nurse completed an initial health screen and recorded that the man had been diagnosed with diabetes mellitus five or six years previously and that he had angina (chest pain due to the reduced oxygen to the heart). He did not drink alcohol, but smoked 25 cigarettes a day. He was offered advice to help stop smoking and attended his first appointment for smoking cessation on 16 December. Another nurse told the investigator that he continued to smoke up until his death but had cut down the amount.

33. The man told the nurse that he had an outstanding appointment at hospital on 9 December 2010. The nurse recorded that he was receiving the following prescribed medication: atenolol (for high blood pressure), folic acid (assist in reduction of anemia), GTN Spray (help with heart function), isotard nocorandil (to treat angina), omeprazole (to reduce the amount of acid produced in the stomach), paracetemol, pioglitazone (for diabetes), gabapentin (for the relief of nerve pain) and a hydroxocobalamin injection (vitamin B12 that is given when there are problems with absorption of this vitamin from the gut). He said that he felt okay and he was considered fit for work and to live on a standard prison wing and share a cell.

34. On 18 November 2010, a prison doctor saw the man after he had obtained his medical records from Manchester prison. He noted that he had a history of ischaemic heart disease, had suffered a myocardial infarction and had a bypass graft in 1992 and another in 2000. He had pain in his left leg when walking and had been seeing a vascular surgeon at hopital. The doctor examined him and further diagnosed peripheral ischaemia (reduction in blood flow resulting in decreased oxygen to the tissues). He re-prescribed the medication he had been taking. He also noted mild left ventricular failure (a heart condition) for which he prescribed furosemide.

35. The doctor arranged to obtain the man's notes from the vascular surgeon and cardiologist at hospital. He also arranged for blood tests and an EGC (an electrocardiogram,which records the rhythm and electrical activity of the heart), and for the man to receive a vitamin B12 injection. He referred him to a nurse for an Ankle Brachial Index to measure the ratio of the blood pressure in the lower legs to the blood pressure in the arms. He saw the vascular surgeon at hospital on 7 December, not 9 December, as he had indicated at reception.

36. On 10 December, the doctor saw the man again. He said that he had seen the vascular surgeon and was waiting for an arteriogram (an imaging test that uses X-rays and a special dye to see inside the arteries). He told the doctor that he had previously seen a cardiologist in 2000, after a heart attack. He said he did not get breathless on exertion and had no couging or chest pain. The doctor noted an abnormality when listening to his chest and recorded that

he should continue with frusemide and he arranged further blood tests. He also referred him to a cardiologist for an echocardiogram at the hospital. (An echocardiogram uses sound waves to build up a detailed picture of the heart.)

37. The man was seen as part of his smoking cessation programme on 29 December. He said that he had reduced his smoking from 25 to 10 cigarettes a day but was told that he could not continue with the programme if he continued smoking. At the next session, 12 January 2011, he was still smoking and was not allowed to continue with the programme

38. On 11 January 2011, a nurse saw the man as he had large mouth ulcers on the inside of his bottom lip. A diagnosis is not recorded in his medical records, but however after discussion with the doctor, orabase (an anti-inflammatory paste) was prescribed.

39. On 12 January, a nurse discussed the man's blood results with a doctor. His erythrocyte sedimentation rate (ESR), C-reactive protein (CRP) were raised, indicating inflamation, so the doctor prescribed augmentin, an antibiotic.

40. A further blood test taken on 27 January showed that the man had low haemoglobin (low red blood cells/iron). The following day the doctor examined him and diagnosed anaemia (a lack of healthy red blood cells). The doctor made an urgent referral to a general physician at Warrington hospital. Further blood tests were requested and he was referred to an endocrinologist (a specialist in hormone related disorders). The doctor said that throughout the man's time at Risley they routinely carried out blood tests because of his varying chronic diseases.

41. The prison received a letter from the hospital on 7 February, saying that the man's recent X-ray suggested he might have pulmonary fibrosis (the development of excess connective tissue in the lungs, resulting in difficulty breathing). On 8 February, the consultant cardiologist wrote recommending he stopped smoking and had inhaler therapy. He started another smoking cessation programme and an inhaler was prescribed to help with his breathing.

42. On 14 February, the man attended hospital for an echocardiogram. On 22 February, after he had seen the cardiologist at hospital, a doctor reviewed his medications and prescribed ramipril (for the treatment of heart failure). On 28 February, he went to hospital day surgery for angioplasty (when a small balloon is used to stretch the artery and improve blood flow) and for a stent to be inserted (to treat narrowing in an artery). The discharge summary sheet comments that there were no complications and that an appointment had been arranged for 6-8 weeks time to assess the results.

43. An entry on 8 March in the man's medical records states that a standard chest X-ray was abnormal, but no further information about this was recorded.

44. On 28 March, the man saw a doctor about the sores in his mouth and a possible diagnosis of leukoplakia (mouth disease) of left membrane was

made. He was referred to a facial surgeon. He attended the maxillo-facial department at hospital in early April; biopsies were taken and he was diagnosed with leukoplakia. He was given a follow up appointment at hospital on 7 November 2011. He was referred and seen by a dental surgeon. A review in May found no malignancy.

45. The man attended hospital on 15 June for a CT scan (computerised tomography which gives detailed images of the inside structures of the body). The results were received by a doctor on 27 June and were consistent with fibrosis and emphysema. The doctor subsequently reviewed all of his medication and he was regularly seen and reviewed throughout July and August. He was treated for oral thrush in July 2011.

46. A specialist registrar in respiratory medicine at the hospital wrote in a letter of 23 August, that he had told the man that he had emphysema due to smoking and the fibrosis was most likely linked to past asbestos exposure. He had been informed that they were able to offer some treatments for his emphysema, but it was unlikely that they could treat the diagnosis of fibrosis, which was likely to progress over time.

47. A respiratory specialist at the hospital examined the man on 1 September and said he seemed well, but he was still smoking. A respiratory advanced practitioner saw him again at the hospital on 18 October and informed him that the pulmonary fibrosis was progressive and likely to be life-limiting. A nurse specialist at Risley saw him on 16 November for a six-monthly COPD review and advised him to attend the surgery as soon as possible if he developed any symptoms of a chest infection.

48. On 28 September, the man was again seen about his leukoplakia and oral thrush. A nurse prescribed him metronidazole (for the treatment of bacterial infections) and amoxicillin (an antibiotic).

49. On 27 October, a nurse saw the man and noted that the leukoplakia had worsened and prescribed fluconazole, (an anti fungal medication), betamethasone and yellow soft paraffin (for inflamed skin), fortijuice liquid (nutritional supplement) and benzydamine mouth wash. The treatment was to be reviewed in one week but he did not attend the follow up appointment.

50. On 7 November, a maxillo-facial surgeon at the hospital saw the man and noted that the leukoplakia had worsened and arranged further biopsies. He was reviewed at Risley on 10 November and continued with his prescribed medication, but said he was worried about having more biopsies. On 6 December 2011, he told healthcare staff that the pain had worsened and he had decided to go ahead and have oral biopsies.

51. Between January 5 and 29 March 2012, the man was seen many times about his leukoplakia treatment while he waited for an appointment for further biopsies, for which surgery was needed. A nurse told the investigator that the surgery was cancelled by the hospital on more than one occasion, and he did not have it before he died.

52. On 5 January 2012, the man asked the Head of Healthcare if he could have a single cell as he felt he needed to come to terms with his diagnosis. (It is not clear which diagnosis he was referring to.) He was advised that this would be discussed with the residential governor. The man was given a single cell, but the records are not clear when this happened.

53. On 2 April the man's sister wrote to the Head of Healthcare and expressed her concerns after her brother had told her that he had been diagnosed with cancer.

54. On 4 April, while collecting his medication, pharmacy staff noted that the man did not appear well. A nurse examined him and found he was pale with a yellow tinge to his skin and eyes. He told her that when walking over to healthcare he had become breathless and dizzy. She noted that he had COPD. He told her that he had recently been diagnosed with cancer of the mouth. This appears to have been a mistaken belief by him and there is no record that anyone discussed this with him. After resting he said he felt better. Observations were taken and he appeared to be breathing with ease, with no evidence of wheezing or coughing. In the afternoon, a doctor saw him, who told him that he did not have a cough or chest pain. He said he had become breathless as a result of walking to healthcare. He was recorded as looking pale, but his observations were all normal. The doctor requested a blood test to rule out anaemia.

55. The next day, 5 April, a nurse saw the man, who said that he had been unable to walk to healthcare. (It appears that he was taken by wheelchair.) He said that he felt that air was not getting to his lungs and his symptoms were the same day and night. She diagnosed an acute lower respiratory tract infection and prescribed claritromycin (an antibiotic), prednisolone (a steroid) and a vitamin tablet. An appointment was made for a neck and chest CT scan at hospital on 10 April and a review was planned in five days.

56. At 5.45am on 7 April, a nurse was called to G wing as the man was feeling breathless. She noted that he looked pale, but was not unduly breathless and was able to talk in full sentences. He said that he did not think that the medication was helping. She took his observations and advised him to continue with the antibiotic and steroid therapy. She requested that healthcare staff should check him later that morning.

57. At approximately 9.00am a nurse was called to G wing as the man was suffering from increased shortness of breath. He said that he looked grey and was having great difficulty breathing. The nurse administered oxygen therapy as his oxygen saturation levels were exceptionally low. Because he was aware of his COPD, the nurse called an emergency ambulance, which arrived at 9.45am. He was taken to hospital. He was accompanied by an officer and was not restrained.

58. At 10.55am, at the suggestion of the hospital the chaplain, also the prison family liaison officer (FLO), contacted the man's sister to let her know that her

brother was very ill. His family arrived at the hospital just after he died at 12.09pm.

Contact with the man's family

59. As the man's health deteriorated the chaplain was appointed as the prison family liaison officer and arranged for the family to attend the hospital. He went to the hospital to support the family after he died and visited them at his mother's home on 12 April. In line with national guidance, the prison offered financial assistance with the funeral. The FLO remained in contact with the family and conducted the funeral.

Informing staff and prisoners

60. Staff and prisoners were informed of the man's death by a notice from the Governor and support was offered if needed. All prisoners subject to suicide and self-harm monitoring were reviewed.

61. Escort and healthcare staff involved the man's care were appropriately debriefed and supported.

Results of the post-mortem

62. The post-mortem report comments that the man suffered from pulmonary fibrosis which was regarded as asbestos related. The post-mortem report concluded that he died of the following:

1a Cardiac Failure

2 Pulmonary Fibrosis and Ischaemic heart disease.

ISSUES

Clinical care

63. During his time at Risley, the man had extensive contact with health services in the prison and was also taken to hospital a number of times. He had a history of ischaemic heart disease, peripheral arterial disease and diabetes. He also had problems with lipid metabolism and had been exposed to asbestos. During his time at Risley he was also diagnosed with chronic obstructive pulmonary disease, pulmonary fibrosis and leukoplakia.

64. While the man was generally an unwell man, his conditions were well managed and he did not begin to experience serious breathing problems until about a week before he died.

65. The clinical reviewer noted that the man received good quality care at Risley. He was satisfied that his long term conditions were properly managed and appropriate action was taken in a timely manner. His assessment was that the man's care was equivalent to that he could have expected to receive in the community.

66. However, the clinical reviewer identified some concerns around the management of the man's acute chest infection diagnosed on 5 April, which we discuss below.

Management of acute chest infection diagnosed on 5 April 2012

67. The man was diagnosed by a nurse on 5 April with an acute lower respiratory tract infection. He was prescribed vitamins, clarithromycin and prednisolone. The nurse recorded that he was to be reviewed in five days and later that day an appointment was made for a CT scan of his neck and chest at hospital on 10 April. When interviewed, the nurse said that she assessed the degree of urgency. She did not feel he needed to go to hospital that day, and was satisfied that he could be effectively managed by the healthcare department in the prison. She said he was content with this, and did not appear overly concerned about his breathing difficulties. His main concern was the leukoplakia. She said that he was not struggling to breathe so she was not unduly alarmed.

68. The clinical reviewer is satisfied that initial diagnosis and medication were broadly correct. However, as the man was a smoker, was diagnosed with a respiratory tract infection and had two pre-existing lung conditions, he considers a review in five days was not sufficient. He says that he should have been reviewed daily. He concludes that there should have been full consideration of his pre-existing conditions before deciding on a management plan.

The Head of Healthcare should ensure that when patients with more than one chronic condition develop an acute episode, an urgent referral

to hospital should be considered and documented and their care should be reviewed daily.

The man's belief that he had cancer

69. The man was first diagnosed with leukoplakia in April 2011. Leukoplakia is a common, potentially pre-cancerous disease of the mouth that involves the formation of white spots on the mucous membranes of the tongue and inside of the mouth. Despite the increased risk associated with having leukoplakia, many people with this condition never get oral cancer.

70. On 28 November 2011, a nurse recorded that the man was worried about having oral biopsies, as he did not see the benefit in subjecting himself to pain if he only had two years to live. She did not query this belief with him but did note it in his medical record. She told the investigator that he had mentioned to her that he had cancer and though he had just two years to live. She was aware that that the leukoplakia was pre-cancerous yet there is nothing in his record to indicate that she reassured him about this.

71. On 4 April 2012, another nurse wrote in his medical record that the man told her that he had recently been diagnosed with cancer of the mouth. There is no evidence that she discussed this with him or checked his record.

72. Also in April 2012, the man's sister wrote to the head of healthcare, and said that her brother and told her that he had cancer in several places in his mouth and jaw and was upset and confused. The records show that the Head of Healthcare went to see him to obtain his permission to speak to his sister, but there is nothing to indicate he offered him any support or advice. There was never any diagnosis of cancer in any correspondence from the hospital and in an earlier letter dated 9 May 2011 the maxillo-facial surgeon clearly states that there was no malignancy. It is possible that he was told this was pre-cancerous and misunderstood what this meant.

73. The Head of Healthcare also appeared confused about the situation as he told the investigator on 17 April, that he believed the man had cancer of the mouth, and had been given a prognosis of two years in November 2011. He later checked with the nurse practitioner who said the leukoplakia was pre-cancerous.

74. It appears that the man believed he had cancer and only two years to live and that this misapprehension seems to have been shared by some nursing staff. It is important that all staff involved in the care of patient are fully up to date with their condition, which is easily achieved through appropriate briefing and effective use of healthcare records. Healthcare staff should have been able to reassure him about this.

The Head of Healthcare should ensure that all healthcare staff involved in a prisoner's care are fully informed of all diagnoses and treatment and that these are fully explained to the prisoner.

75. Paragraphs 20 – 22 of this final report discuss further information from the man's NHS consultant provided to this office by his sister. This shows that his biopsies were highly suspicious of squamous cell carcinoma which would need primary surgery. It is highly likely that he had been told this at his appointment in early April 2012. The prison had received a letter to this effect, but this was not in the records provided to this investigation. We are satisfied that our recommendation is still relevant.

Restraints

76. When prisoners are escorted to hospitals, a risk assessment should be completed which considers the risk posed to the public by the prisoner, their potential for escape and the likelihood of outside assistance. The assessment informs the decision about the number of escorting officers and the type of restraint to be used if they are needed. The risk assessment should effectively balance security needs with the health and dignity of the prisoner, and be reviewed by prison managers each day that a prisoner is in hospital and amended as necessary. The assessment should include medical opinion about how the prisoner's condition impacts on his risk.

77. We have viewed all the risk assessments competed for the man's escorts to hospital from his first escort on 7 December 2010, to the most recent. When he went to hospital in April 2012, as an emergency, he was not restrained. It is recorded that an assessment was to follow, but this was not completed as he died that same day. We are satisfied that the decision to take him to hospital without restraints was appropriate.

78. The man was first taken to an external appointment at hospital on 7 December 2010. The risk assessment for that escort records that he was a low risk to the public, low risk of taking a hostage, and low risk of escape and likelihood of outside assistance. As additional comments it was noted that he had no escape history but that this is his first escort and he was a risk to children. The risk assessment recommendation ticked the box for double cuff and the box for escort chain. The senior manager decision on the form was "Double cuff. Restraints not to be removed".

79. Double cuffing entails the prisoner having his hands cuffed in front of him and then having one wrist attached to a prison officer by an additional set of handcuffs. This is usually required for moving category A or category B prisoners in good health. When, exceptionally, double cuffs are used for a category C prisoner like the man the Prison Service requires that reasons should be recorded in writing. There is no evidence to support the decision to double cuff him and we can see no reason why it would be justified. As an exceptional procedure we are surprised that the hospital escort risk assessment form used at Risley includes the option of the use of double cuffs as a standard recommendation.

80. On all subsequent escorts a risk assessment document was completed. On each occasion the man was restrained with a single cuff and/or an escort chain. On all occasions he continued to be assessed as low risk to the public,

low risk of hostage taking, low escape potential and low likelihood of outside assistance. It is therefore difficult to see how the use of restraints was justified. Although there is a requirement that risk assessments should take into account medical opinion, all of the risk assessment documents we looked at just had a box circled to say there was no medical objections to the use of restraints, rather than any consideration of how his health impacted on his risk.

The Governor should ensure that use of restraints for prisoners being taken to hospital is fully justified by risk assessments that balance both security and the prisoner's health and consider the actual risks posed by the prisoner at that time.

CONCLUSION

81. The man arrived at Risley in November 2010 with a history of poor health. During his reception health screen it was recorded that he had a number of chronic conditions. COPD, pulmonary fibrosis and leukoplakia were all diagnosed while at Risley.

82. He attended numerous hospital appointments to manage and review his health conditions and it appears that Risley managed his chronic conditions well. However it would have been better to keep him under daily review when he diagnosed with a chest infection. We are concerned that escort risk assessments did not sufficiently take into account his health and how this impacted on his risk. Although he was assessed as low risk restraints were used.

83. He believed that he had mouth cancer, but this was not the case. Healthcare staff did not do enough to inform him of his condition and provide reassurance.

RECOMMENDATIONS

The Service response is shown below each recommendation is italics

1. The Head of Healthcare should ensure that when patients with more than one chronic condition develop an acute episode, an urgent referral to hospital should be considered and documented and their care should be reviewed daily.

   Accepted: *Head of Healthcare for Risley has stated that this is achievable and that a daily "review" could be conducted without necessarily inconveniencing or worrying the patient. In reality this is what happens but we accept that this must also be documented daily. All of the team will be instructed accordingly.*

2. The Head of Healthcare should ensure that all healthcare staff involved in a prisoner's care are fully informed of all diagnoses and treatment and that these are fully explained to the prisoner.

   Accepted: *Risley's Head of Healthcare has stated that discussing their diagnoses with patients is also accepted and, again, is generally what happens in practice. The team will be reminded of the importance of recording a summary of conversations with patients relating to their diagnoses. This will improve the way that information is shared between the team as each member of the team has access to the record and reviews it when they see the patient. Given the exceptionally high number of patients who have a clinical diagnosis it wouldn't be practicable to discuss each patient with all of the team at every intervention. However where patients experience an acute episode of an illness or there is a change in diagnosis, the care of these patients is discussed daily at "hand-over" meetings.*

3. The Governor should ensure that use of restraints for prisoners being taken to hospital is fully justified by risk assessments that balance both security and the prisoner's health and consider the actual risks posed by the prisoner at that time.

   Accepted: *Tthe process for assessing all prisoners ahead of attending an external medical appointment allows for an individual assessment of the prisoner. This should take into account recent history and known risk factors; we recognise that the current Security Information Reporting system does not allow for the accurate transfer of recent escort history between establishments, which often results in prisoners being double cuffed on their first escort from HMP Risley. The introduction of the Mercury security system should provide more information to enable a more accurate assessment to take place. The Security Governor will liaise with the Head of Healthcare to ensure that all available and relevant information that could impact on the decision concerning the level of restraints applied is provided as part of the assessment process.*