PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in July 2014 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, who died of liver failure in July 2014, while in the custody of HMP Risley. He was 51 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at Risley was undertaken. The prison cooperated fully with the investigation.

In January 2013, the man was sentenced to three years and eight months in prison and sent to HMP Liverpool. He transferred to Risley in February 2014. He had a history of drug and alcohol abuse and had been in prison before. He was positive for hepatitis C but repeatedly declined treatment in prison. At Risley, scans revealed he had chronic liver disease. In June 2014, a prison GP diagnosed him with acute liver failure. An emergency ambulance took him to hospital, where tests revealed suspected liver cancer and cirrhosis. He was restrained in hospital until he became unconscious on 9 July. The prison did not inform his next of kin of his condition until the next day. He remained in hospital until he died.

I agree with the clinical reviewer that the man received a good standard of clinical care at Risley. However, I am concerned that the prison used an escort chain to restrain him in hospital without appropriate medical input into the risk assessment. I also consider that the prison should have informed his family earlier of his admission to hospital.

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 **February 2015**

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SUMMARY

1. The man was sentenced to three years and eight months in prison on 17 January 2013 and sent to HMP Liverpool. He transferred to HMP Risley on 18 February 2014. He had a history of drug and alcohol abuse and had been in prison several times before.

2. On 3 March, a prison GP saw the man and noted he had been diagnosed with hepatitis C but had repeatedly declined treatment in prison. The doctor referred him for a scan of his abdomen which showed an enlarged spleen and irregular liver. Further investigations revealed he was suffering from chronic liver disease. Doctors kept him informed of his declining liver condition.

3. On 27 June, a prison GP saw the man and diagnosed acute liver failure. The hospital admitted him the same day and treated him with oxygen therapy and intravenous antibiotics.

4. While in hospital, investigations found a lesion in the man's liver, which a hospital consultant suspected was malignant. He did not make a diagnosis at that time. The man was also suffering from liver cirrhosis and chronic obstructive pulmonary disease (COPD – lung disease). He was restrained by an escort chain in hospital until he became unconscious on 9 July. The prison did not inform his family of his hospital admission until the next day. His condition continued to deteriorate and he died in hospital a few days later.

5. We agree with the clinical reviewer that the standard of healthcare the man received at HMP Risley was equivalent to that he could have expected to receive in the community. However, we are concerned that restraints were used in hospital without appropriate healthcare input into the risk assessment. We consider that the prison should have informed his next of kin of his hospital admission earlier. We make two recommendations.

THE INVESTIGATION PROCESS

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

7. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. She informed the Governor of the preliminary findings of the investigation, and followed this up in writing.

8. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.

9. We informed HM Coroner for Cheshire of the investigation, who provided the post-mortem report. We have sent the Coroner a copy of this investigation report.

10. One of the Ombudsman's family liaison officers contacted the man's aunt, his nominated next of kin, to explain the investigation. She did not have any specific concerns for the investigation to consider. She was positive about her nephew's treatment by prison staff.

11. The man's aunt received a copy of the draft report but did make any comment. The prison considered our draft report and recommendations and has accepted these. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included at the end of the report.

HMP RISLEY

12. HMP Risley is a medium security prison which holds over 1,000 convicted men. Bridgewater NHS Trust provides healthcare services in the prison. There is 24 hour healthcare cover. There is a doctor in the prison during the day and at night there are nurses on duty. There is no inpatient facility. Prisoners who need inpatient treatment are referred to other prisons (usually HMP Preston) or to hospital.

HM Inspectorate of Prisons

13. The most recent inspection of Risley was in July 2013. The Inspectorate found that the overall standard of healthcare was good and that the health and social care needs of prisoners had become more complex. Some good levels of care and a wide range of clinics were provided. Prisoners complained about access to GPs and nurses and inspectors noted a high level of missed appointments and that some prisoners were not informed of appointments. Health promotion activities were impressive.

Independent Monitoring Board

14. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published report for the year to March 2013 the IMB commented there was a wide age range of patients visiting healthcare frequently. There were now two permanent doctors which had decreased the need for locum doctors.

Previous deaths at HMP Risley

15. There were three deaths due to natural causes in the year before the man's death. We have raised the issue of the use of restraints without an appropriate risk assessment before.

KEY EVENTS

16. The man was sentenced to three years and eight months in prison for robbery on 17 January 2013 and sent to HMP Liverpool. He transferred to HMP Risley on 18 February 2014. He had a history of drug and alcohol abuse and had been in prison before.

17. On 18 February, a prison nurse carried out the man's initial health screen at Risley. She noted he was taking methadone and referred him to the prison's substance misuse service. She noted that he was a heavy drinker and said that he was positive for hepatitis C. He had hair loss on his chest, which can be a symptom of liver disease and the nurse made an appointment for the hepatitis C clinic.

18. On 21 February, the man did not attend the hepatitis C clinic appointment. On 3 March, a prison GP saw him and noted he had hepatitis C and that he refused any treatment in prison. He declined a referral to the hepatitis C nurse but agreed to attend hospital for a liver scan. He refused a blood test.

19. On 25 March, the man attended hospital and a scan of his abdominal area showed he had an enlarged spleen and an irregular liver which needed further investigation. An MRI scan on 4 June showed his liver was enlarged and irregular and there was a nodule measuring 2.3cm in the left lobe of his liver. The hospital asked the prison to arrange a contrast scan for him.

20. On 17 June, a nurse saw the man and noted his swollen abdomen. She arranged a blood test to check if his hepatitis C was active and for a liver function test. The liver function test results, received later that day, were outside normal levels.

21. On 18 June, a prison GP noted that the man had symptoms of chronic liver disease which included mild ascites (fluid in the abdominal cavity) and insomnia. The same day an advanced nurse practitioner prescribed him zopiclone to help him sleep.

22. On 19 June, the prison's healthcare department wrote to the hospital and requested a contrast scan. There is no record that this scan took place before his death.

23. On 23 June, the advanced nurse practitioner noted that the man looked very yellow. She prescribed a further dose of zoplicone and arranged to see him again after the contrast scan had taken place.

24. On 27 June at 3.20pm, the healthcare manager asked a GP to see the man because he looked extremely unwell. He was jaundiced, had a swollen abdomen and bruising on his arms. The GP diagnosed acute hepatic failure, which can be a sign of de-compensatory liver disease. (This is a serious condition which develops in patients with severe alcoholic liver disease and cirrhosis.) At 3.50pm an emergency ambulance took him to hospital.

Two officers escorted him and used handcuffs for the journey. In hospital they used an escort chain (a long chain with a handcuff on each end, one of which is attached to the prisoner and the other to an officer).

25. In hospital, the man had a blood test that showed he was positive for hepatitis C. Hospital staff treated him with oxygen to improve his saturation levels and antibiotics. On 2 July, he had a CT scan, and further investigations on the 4 July showed a lesion in his liver. A consultant gastroenterologist suspected malignancy, but did not make a diagnosis at the time. He was also suffering from liver cirrhosis and chronic obstructive pulmonary disease (COPD). The consultant told him about his medical condition the same day.

26. On 8 July, the man vomited blood. Hospital staff gave him antibiotics and a vitamin K injection (to help the blood clot). His condition continued to deteriorate and records show he became unconscious at approximately 8.10am on 9 July. His liver and kidneys had failed. He died a few days later.

Family Liaison

27. On 9 July, the prison appointed the prison chaplain as the family liaison officer. He visited the man's aunt, his nominated next of kin, at home at 9.55am on 10 July and informed her of his condition.

28. The family liaison officer remained in regular contact with the man's aunt and arranged visits for her and other family members at the hospital. On the day the man died, before the prison was able to do so, hospital staff informed his aunt that he had died when she telephoned for an update on his condition. The family liaison officer visited her at her home the same day and agreed to conduct the funeral service. The prison contributed to funeral costs, in line with national guidance.

Support for staff and prisoners

29. A Governor's notice informed staff and prisoners of the man's death and offered support. A senior manager spoke to the escort staff and offered appropriate support.

Post-mortem

30. A post-mortem examination found that the man died from decompensated liver failure, liver cirrhosis and hepatocellular carcinoma (liver cancer).

ISSUES

Clinical care

31. The clinical reviewer considered that the care the man received at Risley was good. She said that the GP's proactive review when he arrived at Risley was good practice.

32. The clinical reviewer noted that the man did not engage in treatment and screening for hepatitis C until he became unwell in the months before his death. Prison GPs kept him fully informed of the change in his liver condition. His liver function continued to deteriorate in hospital and he developed irreversible liver failure which caused his death. We agree with the clinical reviewer that his care in prison was appropriate and equivalent to that he could have expected to receive in the community.

Restraints, security and escorts

33. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital, and a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and 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 about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change. It said that handcuffing a prisoner receiving chemotherapy (and by implication, other life saving treatment) was degrading and that this was likely to be regarded as inhumane unless justified by other relevant considerations.

34. The man went to hospital on 27 June and a security risk assessment assessed him as a high risk to hospital staff and the public, with a history of violence, threats and a high risk to females. (This was based on previous offences directed towards women he had been in a relationship with.) It did not record his level of risk of escape but noted that there were no escape risk markers. The healthcare section did not record any objection to the use of restraints. However, there was no information about his condition or how this impacted on his risk of escape. Two officers accompanied him and restrained him with by a single handcuff for the journey and an escort chain in hospital.

35. The man remained very sick and hospital staff treated him with oxygen therapy and intravenous antibiotics. On 8 July he experienced frequent episodes of vomiting blood and was extremely unwell. Prison managers reviewed his risk assessments in hospital but there is no evidence that they

considered his health at the time or consulted medical staff about how his condition affected his mobility and risk of escape.

36. At 8.10am on 9 July, one of the escorting officers contacted the duty governor and said the man was unconscious. At 9.15am, the duty governor gave the officers permission to remove the escort chain.

37. We are concerned that there was insufficient healthcare input into the man's initial risk assessment on 27 June, and later when managers reviewed the assessment. The High Court judgement is clear that medical opinion about the prisoner's ability to escape has to be considered as part of any risk assessment. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Liaison with the man's family

38. On 10 July, the family liaison officer visited the man's aunt, his nominated next of kin, and informed her of his condition. After this she was able to visit her nephew. There is no evidence that the prison discussed with the man before that, whether he wanted his family informed.

39. Prison Service Instruction (PSI) 64/2011 Safer Custody requires:

> "Where prisoners have a terminal illness or suffer an unpredicted and/or rapid deterioration in their physical health, prisons must have in place procedures for supporting the prisoner, engaging with their next of kin or nominated person and providing support for staff."

40. As well as the procedures in PSI 64/2011 – Prison Rule 22(1) states:

> "If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed."

41. By the time the prison informed the man's aunt that he was in hospital, he was unconscious and there was very little time before he died. We consider that the prison should have informed his aunt on 27 June, when he was first admitted to hospital. We make the following recommendation:

The Governor should ensure, in line with Prison Service guidance, that the next of kin of seriously ill prisoners are informed as soon as possible and that they are able to visit them in hospital without unnecessary delay.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

2. The Governor should ensure, in line with Prison Service guidance, that the next of kin of seriously ill prisoners are informed as soon as possible and that they are able to visit them in hospital without unnecessary delay.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible
1	The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.	Accepted	The Risk assessment document will be amended to fully take into account the health of each prisoner and ensure that this is based on the actual risk the prisoner presents at the time. The Head of Safer Custody will produce an information sheet for staff completing risk assessments so that they fully understand the legal position.	31 January 2015 Head of Healthcare Head of Safer Custody Head of Security
2	The Governor should ensure, in line with Prison Service guidance, that the next of kin of seriously ill prisoners are informed as soon as possible and that they are able to visit them in hospital without unnecessary delay.	Accepted	The Head of Safer Custody and Head of Healthcare will set up a process to ensure that up to date information is shared about a prisoner's condition and the next of kin are informed at the earliest opportunity once a prisoner is considered to be seriously ill so that they are able to visit them in hospital without unnecessary delay.	31 January 2015 Head of Safer Custody Head of Healthcare