

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Staley a prisoner at HMP Nottingham on 13 May 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



© Crown copyright 2015

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Peter Staley died from lung cancer, which had spread to other parts of his body, in hospital on 13 May 2016. Mr Staley was 70 years old. I offer my condolences to his family and friends.

Mr Staley died within a few days of being diagnosed with cancer. Although the investigation found some deficiencies in providing secondary health assessments and recording the reasons for non-attendance for healthcare appointments, I agree with the clinical reviewer that, overall, the care Mr Staley received at HMP Nottingham was equal to that he could have expected in the community and prison staff could not have prevented his death.

However, I am concerned that prison managers did not appropriately take into account Mr Staley's limited mobility, poor health and terminal diagnosis, when deciding that he should remain restrained during his final admission to hospital, when he had entered the last stage of his life.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

January 2017

Contents

Summary	1
The Investigation Process	3
Background Information	4
Findings.....	5

Summary

Events

1. On 21 May 2015, Mr Peter Staley was remanded to HMP Nottingham. He was subsequently sentenced to 14 years in prison for sexual offences.
2. Mr Staley had a history of heart disease and depression, which healthcare staff reviewed and treated in prison. In September, he complained to a nurse about physical health problems, but he failed to attend an appointment with a prison GP to discuss this. Between October 2015 and February 2016, he missed several medical appointments, for blood tests, bowel screening and with nurses.
3. In mid-April, nurses reviewed Mr Staley, at the request of prison staff and prisoners, because he had felt unwell for several weeks and had lost a substantial amount of weight. He remained unwell and his blood oxygen level was low. On 25 April, the prison GP examined Mr Staley and referred him urgently to the Nottingham Cancer Centre for suspected cancer. He also diagnosed a chest infection and prescribed antibiotics.
4. On 3 May, while Mr Staley was still waiting for an outpatient appointment, a nurse and a prison doctor found that his blood oxygen level was still low and he had difficulty breathing. They suggested that he should be admitted to hospital, but Mr Staley refused to go. The next day, another GP explained to him that the prison could no longer care for him safely, and he agreed to be admitted.
5. On 9 May, a hospital consultant told Mr Staley that he had lung cancer, which had spread to his brain. He died four days later.

Findings

6. Mr Staley did not receive a secondary health screen when he first arrived at prison, so there was no baseline information with which to subsequently compare his weight and clinical observations. In spite of feeling unwell for some time, Mr Staley missed a number of healthcare appointments and the reasons were not recorded. Although it may be that he chose not to attend most of them, we do not know if staff followed this up, or alerted him to the implications and risks. We note that the issue of non-attendance at appointments has been raised by the Independent Monitoring Board.
7. We are satisfied that the prison GP appropriately referred Mr Staley to a specialist for suspected cancer and promptly sent him to hospital when it became clear that healthcare staff could not provide the level of care required for his deteriorating condition. We agree with the clinical reviewer that Mr Staley's care at Nottingham was good and equivalent to that he could have expected to receive in the community.
8. We consider that prison staff who completed risk assessments for Mr Staley's admission to hospital did not take sufficient account of his poor mobility and his deteriorating health in determining his risk and the use of restraints was not justified.

Recommendations

- The Head of Healthcare should ensure that healthcare staff offer all new prisoners a secondary health screen, and that this is recorded.
- The Head of Healthcare should ensure that prisoners are notified of their appointments and if they do not attend, the reasons for non-attendance are written on the prisoner's medical record.
- The Governor and Head of Healthcare must 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.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Nottingham informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
10. The investigator obtained copies of relevant extracts from Mr Staley's prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr Staley's clinical care at the prison.
12. We informed HM Coroner for Nottinghamshire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
13. One of the Ombudsman's family liaison officers wrote to Mr Staley's son to explain the investigation and to ask if he had any matters he wanted the investigation to consider, but she did not receive a response.
14. The investigation has assessed the main issues involved in Mr Staley's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.
15. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.
16. Mr Staley's son received a copy of the initial report. He did not make any comments.

Background Information

HMP Nottingham

17. HMP Nottingham is a local prison serving the courts in Nottinghamshire and Derbyshire and holds around 1,060 adult and young adult male prisoners.
18. Nottinghamshire Healthcare NHS Foundation Trust provides primary healthcare services 24-hours a day, seven days a week. GPs are available Monday to Friday, with occasional evening and weekend cover. The Gables Medical Practice provides an out-of-hours service at night and weekends.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Nottingham was in February 2016. Inspectors reported that all new arrivals received a comprehensive health screening and that the primary care team delivered a variety of nurse-led clinics, including life-long condition clinics. They found that access to external hospital appointments had deteriorated since their last inspection in September 2014, and a lack of escort officers had contributed to prisoners waiting too long for necessary treatment.
20. Inspectors noted that a palliative care pathway was available and there were good links with palliative care and end of life services.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to February 2016, the IMB reported that there had been difficulties recruiting healthcare staff, which had caused delays in the delivery of services to prisoners. They also found that the level of non-attendance at appointments remained unacceptably high, varying between 50% and 79%. Prisoners complained that refusal to attend was often cited as the reason for not attending, when, in fact, they had either not received notice of the appointment, had not been unlocked or collected from their cell to attend or were attending activities.

Previous deaths at HMP Nottingham

22. Mr Staley was the third person to die of natural causes at HMP Nottingham since January 2015. There were no significant similarities with the circumstances of the other deaths.

Findings

The diagnosis of Mr Staley's terminal illness and informing him of his condition

23. On 21 May 2015, Mr Peter Staley was remanded into custody, charged with historic sexual offences and sent to HMP Nottingham. (On 23 October, he was sentenced to 14 years in prison.)
24. At an initial health screen, a nurse noted that Mr Staley was a smoker, with a history of heart disease and depression, but she did not record his weight or blood pressure. Mr Staley did not receive a secondary health assessment. Healthcare staff regularly reviewed Mr Staley's existing medical conditions and medication.
25. On 11 September, during a mental health review with a mental health nurse, Mr Staley was concerned about his existing physical health problems. She referred him to the prison GP, but he did not attend the appointment booked for 15 September. Mr Staley subsequently failed to attend appointments booked in October 2015, for blood tests and, in February 2016, for the nurse triage and the bowel screening service. No reasons were recorded.
26. On 16 April 2016, a prison officer asked healthcare staff to review Mr Staley. He had told the officer that he had lost four stones in weight in the past year, and had a constant headache and back pain, but did not want to bother a prison GP. Four days later, a nurse assessed Mr Staley. She noted that he was generally unwell, with aching joints, wheezing, a cough, dehydration and low blood oxygen levels and made an appointment with the prison GP for 22 April. Mr Staley did not attend and no one recorded the reason why.
27. On 24 April, prisoners told healthcare staff that Mr Staley was unwell. A nurse examined him in his cell and he again reported that he had felt unwell for several weeks and that he was losing weight, his bowels were loose and he had been incontinent of urine the previous night. When asked why he had not attended recent appointments, he replied that he would "rather die than go to hospital". She noted that Mr Staley looked thin and his blood oxygen levels were low, so she urgently referred him to the prison GP. She checked him again later in the day and noted that he would need a wheelchair to go to healthcare as he could not walk long distances.
28. A prison GP assessed Mr Staley on 25 April. He suspected Mr Staley might have cancer and urgently referred him to the Nottingham Cancer Centre, under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks. The GP also diagnosed a chest infection and prescribed antibiotics and nutritional supplements. Mr Staley refused to be admitted to hospital, and said that he did not want to be treated at hospital.
29. On 26 April, Mr Staley again refused treatment at hospital. Although no one recorded the reasons for his refusal, healthcare staff tried to arrange an urgent appointment at another hospital.
30. At a review on 3 May 2016, a nurse found that Mr Staley was short of breath, his blood oxygen level and blood pressure were low, and he was unsteady on his

feet. She consulted a prison GP about Mr Staley's management and created a care plan to manage his personal care. Mr Staley again refused to go to hospital and asked to remain with his cellmate who was happy to act as a 'buddy', collecting his meals and making him drinks.

31. On 4 May, a prison GP noted that Mr Staley's previous symptoms persisted and there were no breath sounds in his right lung. The GP told Mr Staley that the prison could no longer care for him safely. Mr Staley agreed to be admitted to hospital, where doctors initially diagnosed pneumonia and treated him with intravenous antibiotics, oxygen therapy and strong pain relief.
32. On 9 May, a hospital consultant told Mr Staley that he had incurable lung cancer, which had spread to his brain, and he would be unlikely to respond to chemotherapy. The ward sister informed the prison.
33. Prison Service Order (PSO) 3050, *Continuity of healthcare*, requires prisons to offer every new prisoner a general health assessment within a week of their arrival, primarily to gather further medical information and provide health education and information. There is no record that anyone offered Mr Staley a second health assessment, therefore no comparisons could be made when he first reported significant weight loss several months later.
34. After Mr Staley first reported concerns about his physical health in September 2015, he failed to attend several healthcare appointments in the following months. As no one recorded the reasons for his non-attendance, we do not know if he chose to ignore them, or if there were administrative issues and there is no evidence that staff followed this up or discussed the implications for Mr Staley's health.
35. When a prison GP eventually examined Mr Staley in April, he immediately detected the possibility of lung cancer and quickly referred him to hospital. We are satisfied that Mr Staley's care was equivalent to that he could have expected to receive in the community. However, new prisoners should be offered a secondary health assessment, in line with national policy, and staff should record the reasons when a prisoner does not attend a medical appointment. We make the following recommendations:

The Head of Healthcare should ensure that healthcare staff offer all new prisoners a secondary health screen, and that this is recorded.

The Head of Healthcare should ensure that prisoners are notified of their appointments and if they do not attend, the reasons for non-attendance are written on the prisoner's medical record.

36. The clinical reviewer has made additional recommendations that the Head of Healthcare's will need to address.

Mr Staley's clinical care

37. After Mr Staley's diagnosis, his hospital consultant immediately arranged palliative care. Mr Staley confirmed that he did not want to be resuscitated if his heart or breathing stopped.

38. On 12 May, the hospital held a multi-disciplinary team meeting. Attendees included ward staff, prison healthcare staff, the prison governor and the prison chaplain. They discussed Mr Staley's terminal diagnosis and palliative care. His condition had deteriorated and they agreed to prescribe end of life anticipatory medication. Mr Staley died on 13 May.
39. A post-mortem examination concluded that Mr Staley died from metastatic adenocarcinoma of the lung (lung cancer that had spread to other parts of the body).
40. All Mr Staley's treatment after his diagnosis took place in hospital, which is outside the remit of this investigation. However, we are satisfied that prison healthcare staff obtained updates about his condition and fully participated in the decision-making about his management.

Mr Staley's location

41. Mr Staley lived in a shared cell on a standard residential wing with his long-term cellmate and he refused the offer of a move to a single cell. At a social care assessment on 27 April, he said that he felt able to look after himself and did not want social care, or equipment as this would affect his dignity. As his condition worsened, he moved to the bottom bunk. His cellmate, prison and healthcare staff all supported him.
42. Mr Staley eventually agreed to be transferred to hospital when his symptoms further deteriorated and prison healthcare were unable to provide the level of care he needed. Once in hospital, he decided that he wanted to die there.
43. We are satisfied that Mr Staley's accommodation was in line with his wishes and appropriate for his needs and that he was well supported by staff and other prisoners.

Restraints, security and escorts

44. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.
45. On 4 May, a security administrator completed a risk assessment which concluded that Mr Staley was a medium risk to the public, children and females but a low risk of escape and to hospital staff. A nurse completed the medical information section of the form. She ticked to say there were no objections to the use of restraints, but gave no information on his medical condition or how this had affected his ability to escape. Elsewhere on the risk assessment, it was noted that Mr Staley had limited mobility and used a wheelchair.

46. The Head of Residence authorised two officers to accompany Mr Staley and restrain him with an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). Officers restrained Mr Staley until 12 May, except for a short time on 6 May, when the restraints were removed to allow him to shower.
47. On 12 May, the Head of Safer Custody re-assessed his risk and noted that Mr Staley was at the end of his life. She authorised officers to remove the escort chain and it was not used again.
48. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances. We are not satisfied that staff took sufficient account of Mr Staley's physical condition and limited mobility, exacerbated by severe breathlessness, when completing the initial risk assessment. Mr Staley's medical condition steadily deteriorated after his admission to hospital and, while regular management visits to the hospital took place, the appropriateness of using restraints was not reassessed with due consideration of the requirements of the High Court judgment. We make the following recommendation:

The Governor and Head of Healthcare must 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 Mr Staley's family

49. Mr Staley's offences were against members of his family. He had no contact with his family or friends while in prison and no named next of kin. On 10 May, the prison appointed the Head of Safer Custody as Mr Staley's family liaison officer and Mr Staley confirmed that he did not want any contact with family or friends.
50. After Mr Staley's death, the prison made extensive efforts to contact his family, through the police and other agencies. The Head of Safer Custody finally spoke to a family member on 17 June and broke the news of his death. She continued to support members of his family until after the funeral. In line with national policy, the prison arranged and paid for Mr Staley's funeral which was held on 28 July.
51. We are satisfied that the prison complied with Mr Staley's wishes about family contact and appropriately liaised with his family after his death.

Compassionate release

52. Prisoners can be released before their sentence has finished, on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.
53. As Mr Staley died four days after the diagnosis of his terminal illness, there was insufficient time for the prison to make an application for compassionate release.

**Prisons &
Probation**

Ombudsman
Independent Investigations