Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Richardson a prisoner at HMP Whatton on 9 July 2016

A report by the Prisons and Probation Ombudsman
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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*

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 Richardson died on 9 July of colon cancer, while a prisoner at HMP Whatton. He was 69 years old. I offer my condolences to Mr Richardson's family and friends.

I am satisfied that Mr Richardson received a good standard of clinical care at Whatton. All of Mr Richardson's care needs were met and a move to the prison's palliative care suite allowed him to spend quality time with his family before he died. I am pleased that an application for Mr Richardson's early release on compassionate grounds was submitted but the process took too long.

However, I am not satisfied that the decision to use restraints when Mr Richardson went to hospital was made with the required healthcare input. I am disappointed to have to raise this matter with Whatton again.

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**

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Summary

Events

1. On 11 January 2013, Mr Peter Richardson was sentenced to 16 years imprisonment for sexual offences and sent to HMP Nottingham. He transferred to HMP Rye Hill on 15 May 2014.

2. Mr Richardson suffered from type 2 diabetes and had a hernia. He smoked cigarettes, but initially was not offered smoking cessation advice.

3. On 26 March 2015, a prison GP detected crackles in Mr Richardson's chest and made a referral for an urgent echocardiogram (ECG - visual imaging of the heart). Mr Richardson continued to suffer with shortness of breath and, on 13 April, another prison GP diagnosed Mr Richardson with heart failure and immediately referred him to hospital.

4. While Mr Richardson was in hospital, further investigations identified terminal cancer of the colon, lungs and liver. When he returned to Rye Hill, a palliative care plan was put into place, including ongoing support from cancer nurses.

5. Mr Richardson asked to be relocated to a prison closer to his family, and on 14 December 2015, he was moved to HMP Whatton. A nurse assessed Mr Richardson as independently mobile and able to wash and dress himself. He declined smoking cessation advice. A GP prescribed medication for his diabetes and high blood pressure, along with pain management and nutritional drinks.

6. A cancer nurse provided care and support to Mr Richardson and ensured he remained as comfortable as possible. Mr Richardson became frail and hurt his ribs after a fall on 14 April 2016. His health continued to deteriorate and he began to receive 24-hour care.

7. On 9 May, Mr Richardson moved to the palliative care suite at Whatton known as The Retreat. Healthcare staff supervised him and he received regular visits from his family. He died on 9 July.

Findings

8. The clinical reviewer considered that Mr Richardson received a good standard of care at the prison. He was referred to hospital at the earliest opportunity and his care at Whatton was well coordinated. We are satisfied that his care was equivalent to that he could have expected to receive in the community, and we are pleased that the prison provided appropriate support to Mr Richardson's family.

9. We are pleased that an application for Mr Richardson's early release on compassionate grounds was submitted but the process took longer than is acceptable. Although this did not affect Mr Richardson or his family, the Governor must address it.

10. We are not satisfied that Mr Richardson was restrained appropriately when he went to hospital. The risk assessment was based on insufficient medical input, and information on how his condition affected his risk.

Recommendation

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

The Investigation Process

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

12. The investigator obtained copies of relevant extracts from Mr Richardson's prison and medical records.

13. NHS England commissioned a clinical reviewer to review Mr Richardson's clinical care at the prison.

14. We informed HM Coroner for Nottinghamshire of the investigation and sent them a copy of this report.

15. The investigator wrote to Mr Richardson's sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.

16. The investigation has assessed the main issues involved in Mr Richardson'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.

17. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Whatton

18. HMP Whatton in Nottinghamshire is a medium security category prison holding up to 841 men convicted of sex offences.

19. Nottinghamshire Healthcare Foundation Trust provides healthcare services at the prison. The healthcare centre is open seven days a week. GPs from a local practice provide specialist clinics for older prisoners and those with chronic conditions and there is an out-of-hours service. There are no inpatient beds, but there is a palliative care suite in the healthcare centre called The Retreat, for end of life care.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Whatton was in February 2012. Inspectors reported that the quality of healthcare was good, and relationships between healthcare and prison staff were effective. They noted that the prison's palliative services were impressive.

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 May 2016, the IMB reported that an issue remains with healthcare support outside of the working hours where agency staff fail to turn up to provide care for terminally or chronically ill patients. A business case to improve physical healthcare facilities was prepared, but turned down because the NHS capital money is no longer available.

Previous deaths at HMP Whatton

22. Mr Richardson was the eighth prisoner to die from natural causes at Whatton since January 2015. There have been two other deaths since.

23. Although generally our investigations have found a high standard of end of life healthcare at the prison, we have made previous recommendations about the use of restraints without comprehensive risk assessments to justify their use.

Findings

The diagnosis of Mr Richardson's terminal illness and informing him of his condition at HMP Rye Hill

24. On 11 January 2013, Mr Peter Richardson was sentenced to 16 years in prison for sexual offences and sent to HMP Nottingham. He transferred to HMP Rye Hill on 15 May 2014.

25. At his initial health screen, a nurse assessed Mr Richardson. She noted he had type 2 diabetes and placed him on a waiting list for an over 55s retinal screening. She also noted that he smoked cigarettes, but did not offer any smoking cessation advice. A pharmacy technician gave Mr Richardson metformin for his diabetes and simvastin for raised cholesterol. Mr Richardson was reviewed by healthcare staff at least once a month. Until March 2015, nothing else of significance was recorded.

26. On 26 March 2015, a prison GP examined Mr Richardson. He said he had been experiencing a shortness of breath for ten months, and it was getting worse. This was the first time Mr Richardson reported a shortness of breath. The GP noted he did not have any dizziness or giddiness, but there were crackles in his chest and he had an irregular pulse. The GP noted that his oxygen saturation level was 98%. He diagnosed Mr Richardson with a chest infection, prescribed furosemide and made an urgent referral for an echocardiogram (ECG – visual imaging of the heart). Mr Richardson was later referred to hospital, before this appointment took place.

27. On 13 April, Mr Richardson told a nurse that he had been suffering with shortness of breath. She referred him to the prison GP that afternoon. A prison GP noted that Mr Richardson's oxygen saturation level was low (86%) and that he had an irregular heartbeat. He diagnosed acute heart failure, gave him oxygen and requested a non-emergency ambulance.

28. Mr Richardson was taken to hospital, which treated him with intravenous antibiotics. On 16 April, a hospital doctor told a nurse that a chest scan had detected cancerous tumours on Mr Richardson's lungs and liver. On 24 April, a colonoscopy showed cancerous tumours in his colon.

29. Hospital doctors explained Mr Richardson's illness to him, and he returned to prison on 14 May with a palliative care plan in place. His care and support was discussed at a multi-disciplinary team meeting (MDT – a meeting of representatives from each prison department) the following day. Nursing staff planned to review his needs daily, to ensure he was comfortable and able to perform daily activities.

30. On 19 May, a nurse noted that Mr Richardson was able to carry out all aspects of daily living, but was breathless and had become frail. Healthcare staff visited Mr Richardson daily to monitor his physical and mental health, and a prison GP visited him on a weekly basis. Mr Richardson was encouraged to maintain a well balanced diet and reduce his tobacco intake.

31. On 1 July, Mr Richardson returned to hospital. The doctor explained to him that the cancer was too advanced to respond to treatment, and was terminal. Healthcare staff continued to monitor Mr Richardson on a daily basis and cancer nurses visited him regularly to provide support, control his pain and discuss his wishes for end of life care.

32. The clinical reviewer concluded that there was no delay in referring Mr Richardson to hospital. He showed few concerning symptoms early on, and was diagnosed at the earliest opportunity.

Mr Richardson's clinical care at HMP Whatton

33. Due to his terminal diagnosis, Mr Richardson requested a transfer to a prison located closer to his family, and on 14 December, he was moved to Whatton. A nurse carried out his reception health screening. She noted that he had no outstanding hospital appointments and offered smoking cessation advice, which Mr Richardson declined. A prison GP prescribed seven medications for high blood pressure, diabetes, pain management, and meal supplements. Mr Richardson was able to walk independently and carry out his own personal care and was allocated a standard single cell.

34. A prison GP discussed with Mr Richardson whether he wished to be resuscitated in the event that he stopped breathing. He said he did not feel it would be appropriate and a DNACPR (do not attempt cardiopulmonary resuscitation) order was put into place on 7 January 2016.

35. On 21 January 2016, a cancer care nurse introduced herself to Mr Richardson and explained her role in supporting him through his terminal illness. She told Mr Richardson that he would benefit from a wheeled frame with a seat to get around, but he declined.

36. Mr Richardson did not like the menu at Whatton and declined the fortisips supplement drinks. On 28 January, the cancer care nurse noted that he had lost a lot of weight. She telephoned the kitchen to discuss alternative options but there was no answer. On 17 February, she spoke with a member of kitchen staff and asked them to provide Mr Richardson's preferred meal choices. Despite further requests from her, the kitchen failed to provide these meals until she referred the matter to the senior manager responsible for the kitchen, on 16 March.

37. On 29 February, Mr Richardson reported that he found it painful to breathe. A prison GP referred him to hospital with a suspected pulmonary embolism. With limited medical input about Mr Richardson's condition at that time, a senior manager authorised the use of single cuffs during the escort. At hospital, a scan showed that Mr Richardson did not have a pulmonary embolism. He returned to Whatton the following day.

38. Mr Richardson continued to receive regular support but his frailty increased. On 12 April, Mr Richardson fell over in his cell and hurt his ribs. A nurse assessed Mr Richardson and gave him ibuprofen for the pain. On 15 April, Mr Richardson was still in pain. A prison GP assessed him further and prescribed codeine. The

GP noted that occupational therapy was aware of his fall and that he received support on the wing.

39. On 28 April, an occupational therapist assessed Mr Richardson. She referred him to physiotherapy for a walking frame assessment. She obtained a tall walking frame, urinal bottle, and perching stall to reduce his fear and risk of falls, and to help him move around the prison. As his mobility declined, she continued to assess Mr Richardson every few weeks.

40. On 7 May, a nurse noted that Mr Richardson was receiving 24-hour care. Mr Richardson told her that he was very pleased with his care and that when his health deteriorated he would like to go to the palliative care suite within the prison, known as The Retreat.

41. On 9 May, a nurse was called to Mr Richardson's cell. He had a drooping face and slurred speech, but he was able to understand and respond to questions. After a discussion between healthcare staff and Mr Richardson, he was moved to The Retreat. A prison GP assessed Mr Richardson later that day and discussed the management of his deterioration with his family present.

42. Mr Richardson remained in The Retreat, where his family visited him on a regular basis. Mr Richardson frequently received medical supervision and his mobility was assessed when required. His condition gradually declined and he died on 9 July.

43. A doctor gave the cause of death to the coroner as metastatic adenocarcinoma of sigmoid colon (colon cancer, which spread to other parts of the body).

44. We are satisfied that Mr Richardson received a good standard of healthcare at the prison, equivalent to that he could have expected to receive in the community. The clinical reviewer concluded that Mr Richardson was well supported by healthcare staff, including regular support from a specialist cancer care nurse. The clinical reviewer made a recommendation to include a member of kitchen staff when implementing care plans. Although we do not repeat the recommendation here, the Head of Healthcare will need to address this.

Mr Richardson's location

45. When Mr Richardson arrived at Whatton on 14 December 2015, he was allocated a standard single cell. On 9 May 2016, when his condition deteriorated he moved to The Retreat to receive full palliative care. We are satisfied that Mr Richardson was appropriately located throughout his time at Whatton.

Restraints, security and escorts

46. 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

47. When a prison GP referred Mr Richardson to hospital on 29 February 2016, An officer assessed Mr Richardson as a medium risk to the public and a low risk in all other areas. For medical input, a nurse ticked a box to state that there were no medical objections to Mr Richardson being restrained. However, she did not provide any information about Mr Richardson's condition and whether it affected his ability to escape, and instead wrote that it was not applicable. Based on this information a senior manager authorised the use of single cuffs during the escort.

48. Medical opinion about the prisoner's ability to escape requires a full written explanation about their condition at the time of the escort and how that affects the level of risk they pose. At the time of escort, Mr Richardson had lost weight, had reduced mobility and was generally unwell, with known terminal cancer. A senior manager made a decision to restrain Mr Richardson without a fully considered risk assessment. We therefore 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 on the use of restraints 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 Richardson's family

49. On 8 January 2016, the prison appointed an officer as the family liaison officer and he introduced himself to Mr Richardson's family. The prison also appointed a senior manager and another officer as temporary family liaison officers. They all maintained regular contact with Mr Richardson's family.

50. Mr Richardson's family visited him on a regular basis and were with him when he died. An officer offered his condolences and ongoing support.

51. The prison held a memorial service for Mr Richardson on 21 July, attended by five family members. Mr Richardson's family arranged the funeral, which was held on 27 July. The prison contributed towards the costs of the funeral in line with national policy.

52. We are satisfied that Mr Richardson and his family were appropriately supported throughout his illness, and after his death.

Compassionate release

53. Prisoners can be released from custody before their sentence has expired 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.

54. On 21 January 2016, the cancer care nurse noted that Mr Richardson, his daughter and the prison had discussed compassionate release. On 9 March, Mr

Richardson told a prison GP that he wanted to remain in prison where he would receive the end of life care he needed.

55. On 7 April, Mr Richardson told the cancer care nurse that his family wanted him to move to an outside hospice, and that if there was not a bed available they would be happy to accommodate him. The process of applying for early release on compassionate grounds began.

56. On 18 April, a prison GP completed the medical section of the application, and stated that Mr Richardson's prognosis was six months. On 10 May, when the application was completed, the Governor submitted it to the Public Protection Casework Section (PPCS) of the National Offender Manager Service.

57. The PPCS requested further medical information from the prison. On 26 June, Mr Richardson and his family asked for the application to be withdrawn because they were happy with the standard of care he was receiving at The Retreat.

58. We are satisfied that the wishes of Mr Richardson and his family were fully considered throughout this process, and that he was able to choose where he died. However, the application for Mr Richardson's early release on compassionate grounds took significantly longer than is acceptable. Whereas on this occasion we do not make a recommendation because his wishes were fully considered, the Governor must be satisfied that in future, thorough and timely applications are submitted, ensuring that the PPCS has all of the information required.

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