Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Nelson Richards, a prisoner at HMP Exeter, on 14 June 2015

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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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*

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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 Nelson Richards died suddenly in hospital of a pulmonary embolism on 14 June 2015, while at prisoner at HMP Exeter. He was 51 years old. I offer my condolences to Mr Richards' family and friends.

Mr Richards was being treated in hospital for a non life-threatening, autoimmune condition. He had previously not cooperated with blood tests which had led to a delay in the diagnosis of his condition, but this did affect the eventual outcome. Mr Richards had been in hospital for a month at the time of his death, which was sudden and unexpected. I am satisfied that Mr Richards received a good standard of healthcare while he was at Exeter, which was at least equivalent to that he could have expected to receive in the community. However, I am concerned that Mr Richards was restrained throughout his stay in hospital, without appropriate risk assessments, which fully took into account his health condition and security risk.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2016**

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Summary

Events

1. On 1 March 2005, Mr Nelson Richards was remanded to HMP Exeter. He was convicted and sentenced to 13 years, 10 months in prison. In 2012, he was released on conditional licence twice, but returned to HMP Exeter after breaching the licence conditions. In April 2013, doctors treated him for a knee injury. They suspected he might have a deep vein thrombosis (DVT), but investigations confirmed he did not.

2. In January 2015, Mr Richards developed a sore on his nose and a prison doctor diagnosed impetigo. His skin condition spread and was resistant to treatment, but Mr Richards would not let doctors take blood tests to investigate. By May 2015, the rash covered much of his head and torso and he was admitted to hospital. Two officers stayed with him at all times and used an escort chain to restrain him.

3. The hospital diagnosed pemphigus vulgaris, an autoimmune disease, and doctors prescribed oramorph for the pain. On 6 June, a visiting prison nurse noted that Mr Richards was covered in weeping sores and his pain was not adequately managed. On the morning of 14 June, Mr Richards collapsed in a toilet cubicle at the hospital while attached to an officer by an escort chain. Hospital staff were unable to resuscitate him and recorded his death at 8.20am. A post-mortem examination found that Mr Richards had died of a pulmonary embolism with an underlying cause of pemphigus vulgaris.

Findings

4. Initially, Mr Richards hindered doctors' attempts to diagnose him more accurately by refusing to have blood tests, but the clinical reviewer considered that this had no bearing on his death. We are satisfied that Mr Richards received a good standard of care at the prison, at least equivalent to that he could have expected to receive in the community. However, there is evidence that the handcuffs caused Mr Richards additional pain and discomfort because of his skin condition. We are concerned that managers authorised the use of restraints while Mr Richards was in hospital, without properly taking this into account.

Recommendations

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- 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.

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The Investigation Process

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

6. The investigator obtained copies of relevant extracts from Mr Richards' prison and medical records. She interviewed four members of staff in July and August 2015.

7. NHS England commissioned a clinical reviewer to review Mr Richards' clinical care at the prison.

8. We informed HM Coroner for Exeter and Greater Devon of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

9. One of the Ombudsman's family liaison officers contacted Mr Richards' wife, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She was concerned that Mr Richards had been restrained by an escort chain in hospital and the she had learnt of his death before being informed by the prison.

10. Mr Richards' family received a copy of the initial report. The solicitor representing the family wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

11. The prison also considered our initial report and did not raise any factual inaccuracies. They submitted an action plan addressing our recommendations which is annexed to this report.

Background Information

HMP Exeter

12. HMP Exeter is a local prison holding about 500 men. Dorset NHS University Foundation Trust provides 24-hour health services and runs a wide range of clinics.

HM Inspectorate of Prisons

13. The most recent inspection of HMP Exeter was in August 2013. Inspectors found that healthcare provision had improved and prisoners could access services quickly. A major refurbishment of the primary care centre had improved the environment. In the Inspectorate's survey, more prisoners than at comparator prisons were positive about the quality of healthcare.

Independent Monitoring Board

14. 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 most recently published annual report for 2013, the IMB said that health services were generally good but there had been problems with continuity of healthcare.

Previous deaths at HMP Exeter

15. Mr Richards was the seventh prisoner to die of natural causes at Exeter since 2012. We have made recommendations about risk assessments for the use of restraints before.

Key Events

16. On 1 March 2005, Mr Nelson Richards was remanded to HMP Exeter. In April 2006, he was sentenced to13 years, ten months and six days, for deception and fraud. He transferred to HMP Leyhill in 2010. Mr Richards was released on conditional licence twice in 2012, but was recalled to prison and returned to Exeter in November 2012. He received a further sentence of 5 years in February 2015, for offences committed while on licence.

17. In April 2013, Mr Richards injured his knee when he broke the fall of another prisoner who had jumped from the landing. After the accident, doctors thought he might have developed DVT. He refused to have blood tests, but an ultrasound scan showed no evidence of DVT.

18. On 16 January 2015, Dr A prescribed Mr Richards mupirocin, a drug generally used to treat impetigo (a highly contagious skin infection). On 24 January, the doctor noted that the skin on Mr Richard's nose was healing well, but on 6 February, she recorded that the skin on his nose had deteriorated but the infection had not spread. She prescribed amoxicillin (an antibiotic) and hydrocortisone (for inflammation of the skin) and took swabs.

19. Dr B reviewed Mr Richards on 9 February, and prescribed fucidin – another ointment for skin infections. Dr A saw Mr Richards again on 13 February. The results of the first swab had not yet come back, but she recorded a diagnosis of impetigo. On 17 February, Dr A took a further swab and requested the results of the first one. When the swab results came they showed no abnormalities. On 19 February, Mr Richards refused to have blood tests.

20. On 1 April, Nurse A noted that Mr Richards' lower left leg was swollen and hot. He said he was not in pain but he had woken up vomiting and shivering the two previous nights. Dr A examined him the next day and diagnosed cellulitis (a bacterial infection of the deeper layers of the skin) and found no signs of DVT. She noted that the skin on his nose had a thick crust and was black in places. She requested a further swab and an urgent dermatology appointment.

21. On 9 April, Mr Richards refused to attend an appointment with Dr A and on 21 April, he refused to go to his dermatology appointment.

22. On 8 May, Dr C noted that Mr Richards had new lesions on his chest and scalp and prescribed a high dose of flucloxacillin (an antibiotic). On 11 May, officers

reported that Mr Richards had widespread lesions and was refusing to leave his cell. He agreed to have a swab taken.

23. On 13 May, nurses told Dr B that Mr Richards' condition had got worse. The doctor referred Mr Richards for another urgent dermatology appointment and sent photos to the dermatology team. A microbiology consultant told the doctor that the swab results suggested impetigo. Dr B prescribed Mr Richards zopiclone (to treat insomnia) and a special skin cream.

24. On 14 May, Nurse B noted that Mr Richards' skin had peeled off when they removed his dressings and that he could not lie down due to painful lesions on his back and head. The next day, almost all the skin on his back had peeled and there was blistering on his neck and abdomen. Dr A telephoned a consultant at the Royal Exeter and Devon Hospital, who agreed to see him immediately. A manager decided that he should be escorted by two officers and restrained by 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.)

25. Mr Richards was admitted to hospital as an inpatient and doctors initially diagnosed cellulitis. They treated him with intravenous antibiotics and oramorph (liquid morphine) as he was in pain. Mr Richards continued to refuse blood tests but, on 21 May, doctors diagnosed pemphigus vulgaris (a rare autoimmune disease which causes the skin to blister).

26. On 27 May, one of the escort officers, Supervising Officer, SO A, noted that Mr Richards had blisters on his wrist caused by the handcuffs. Mr Richards said that he was being considered for recategorisation to category D (the lowest security category). The SO recorded that this had not been confirmed and that restraints were appropriate. On 1 June, an officer moved the handcuff from Mr Richards' left to his right wrist, as Mr Richards' skin had broken. By 3 June, escort officers described him as experiencing extreme pain. This was gradually controlled.

27. On 6 June, Nurse B visited Mr Richards in hospital and noted that he was covered in weeping sores and shedding large areas of skin. She did not consider his pain was well controlled and thought it would be almost impossible to nurse him safely in prison.

28. On 10 June, Officer A wanted to get permission to remove the escort chain while a nurse changed his dressings, but was unable to speak to a manager. The officer assessed the risk himself and removed the chain.

29. On 12 June, Mr Richards was noted to be hallucinating - possibly as a result of all the steroids or the pain relief medication. (His pain relief seemed to be controlled better by this point). An escort officer, Officer B, asked, prison manager, A, for permission to remove the escort chain while Mr Richards had a bath, but the prison manager refused.

30. At approximately 7.40am on 14 June, Mr Richards asked to go to the toilet. Officer B was the officer attached to the escort chain and he and Officer C stood outside the toilet. Officer B felt the chain move suddenly and looked into the cubicle. Mr Richards was sitting, slumped, on the toilet. He was unresponsive. Officer D gave Officer B the keys for the handcuffs and went to get a nurse. A nurse arrived quickly and called for help. Officer B could not get into the cubicle and removed the handcuff from his wrist rather than from Mr Richards'. More hospital staff arrived but were unable to resuscitate Mr Richards. At 8.20am, they recorded that he had died.

Contact with Mr Richards' family

31. On the morning Mr Richards died, prison manager, A, went to see Mr Richards' wife to inform her of his death and offer condolences and support. However, she had already heard through a distant relative.

32. Mr Richards' funeral was on 30 June. In line with Prison Service instructions,, the prison contributed to the costs.

Support for prisoners and staff

33. After Mr Richards' death, prisoner manager, An debriefed Officer B and Officer D to offer his support and that of the staff care team.

34. The prison posted notices informing other prisoners of Mr Richards' death and offering support if the needed it.

Post-mortem report

35. After a post-mortem examination, the coroner gave the cause of death as a pulmonary embolism with underlying pemphigus vulgaris.

Findings

Clinical care

36. The first indication that Mr Richards was ill was in January 2015. Although the original diagnosis of impetigo turned out to be incorrect, it was a reasonable assumption at the time and supported by the hospital microbiologist. It was later established that he had pemphigus vulgaris – a rare autoimmune condition characterised by blistered skin. The condition worsened over the next few months, but Mr Richards would not allow staff to take blood tests to investigate the root cause. He did not develop the classic symptom of pemphigus (blisters rather than sores) until May 2015.

37. Pemphigus is a rare condition and pulmonary embolism is not a common complication of pemphigus. Previous concerns that Mr Richards might have a deep vein thrombosis in his leg had been investigated and ruled out by specialists. (DVTs are clots which become embolisms when they break free.) The clinical reviewer was satisfied that none of Mr Richards' medical conditions before 2015 contributed to the pulmonary embolism that caused his death. It is also unlikely that Mr Richards' previous refusal of blood tests and a swab contributed to his death.

38. In April 2015, prison doctors investigated a fresh concern that Mr Richards might have DVT, but decided it was cellulitis. The post-mortem examination found that the risk factors contributing to the embolism were likely to have been Mr Richards' prolonged bed rest in hospital and the fact his blood was 'sticky' due to widespread inflammation.

39. The clinical reviewer concluded that prison healthcare staff appropriately investigated Mr Richards' symptoms as far as he would allow. They referred him to dermatology specialists when this was needed. Mr Richards had been in hospital for a month before his sudden death. The clinical reviewer considered that the standard of healthcare Mr Richards received while he was at Exeter was at least equivalent to that he could have expected to receive in the community. We are satisfied that Mr Richards received good care at the prison.

Restraints

40. 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 mobility.

41. A judgment in the High Court in 2007, made it clear that prison staff need to distinguish between the 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 prison staff must take into account medical opinion about the prisoner's ability to escape and keep this under review as circumstances change.

42. When the hospital initially admitted Mr Richards on 15 May, the medical portion of the risk assessment document was not completed. The Head of Healthcare, said that he was not aware of the medical section on the risk assessment document. (Although the prison has previously accepted a recommendation about this matter addressed to the Governor and the Head of Healthcare.)

43. The security section of the risk assessment noted that in 2006, on the advice of the police, Mr Richards had been refused permission to attend his father's funeral because of his escape risk. It also said that he was now considered potentially to be a category D (the lowest security) prisoner. Despite this, his risk of escape was assessed as medium. The deputy governor, A, decided that he should be accompanied by two escort officer using an escort chain and that staff should use double handcuffs if they had any security concerns. 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. We cannot see how they would have been appropriate for a category C prisoner like Mr Richards, irrespective of his skin condition.

44. On 27 May, SO A recorded that Mr Richards had blisters caused by the escort chain cuff and that he had said that the Prison Service was considering his re-categorisation to category D. The SO told the investigator that he did not move the handcuff, even though it had caused blisters and he did not make any enquiries about Mr Richards' categorisation. He said he told Mr Richards to raise his concerns with the nurses and the duty manager as he did not have the authority to change the risk assessment. On a subsequent escort duty he noticed someone had put an elastic bandage between Mr Richards' skin and the handcuff. On 28 May, prison manager, B, completed a management check but did not record anything about the restraints causing blisters. On 1 June, another officer moved the handcuff to the other wrist as Mr Richards' skin had broken.

45. From 3 June to 11 June, escort officers described Mr Richards as being in extreme pain. On 6 June a prison nurse, Nurse B, visited Mr Richards. She told the investigator that the sores were not on his lower arms and that there was a bandage underneath the escort chain handcuff. She considered him to be mobile and said that if she had had any concerns about the use of restraints she would have reported it to security staff at the prison.

46. However, at the time, Nurse B had recorded that he was 'absolutely covered in weeping sores'. The post-mortem report also said that his arms were covered in healed, crusting bullae (blisters). The fact that he had a bandage underneath the handcuff suggests there was a problem with his skin in that area and an officer had moved a handcuff for that reason. One of the officers, who was with Mr Richards when he died, told the investigator that his recollection was that Mr Richards had sores on his forearms, including in the area near the handcuff.

47. On 10 June, Officer A removed Mr Richards' handcuffs while a nurse changed his dressings. There was no problem and he reported this to a manager later. Two days later, prison manager, A, refused an officer permission to remove Mr Richards' restraints, while he had a bath. Despite Mr Richards' skin condition, prison manager, A, said this was because he did not regard a bath as medical treatment.

48. We are not satisfied that healthcare staff were properly consulted about whether it was appropriate for Mr Richards to be handcuffed, in the light of his condition or that there was a satisfactory security assessment, based on his actual risk at the time. The fact that the deputy governor suggested that double handcuffs might be used indicates that the risk was over-estimated. Although there were management checks of security arrangements while Mr Richards was in hospital, there is no evidence that the need for continuing use of restraints was reviewed or that managers asked healthcare staff or clinicians at the hospital for a view.

49. After a death at Exeter in July 2014, we made a recommendation about the need for risk assessments for the use of restraints to take into account the prisoner's heath condition. The prison accepted the recommendation and said that all staff would be reminded of the 2007 High Court judgment and that duty governors would ensure that this was done for all future risk assessments. There is no evidence that this was done in Mr Richards' case. We repeat our previous 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.

Contact with Mr Richards' family

50. Mr Richards' wife family was upset that she found out that he had died before staff from the prison arrived to tell her. This was unfortunate, but we consider it was outside the prison's control. We are satisfied that the prison followed the correct procedures and went to inform Mr Richards' wife without unnecessary delay

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