

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Gordon Anglesea a prisoner at HMP Rye Hill on 15 December 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*



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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 Gordon Anglesea died on 15 December 2016 of multi organ failure and pneumonia, while a prisoner at HMP Rye Hill. He was 79 years old. I offer my condolences to Mr Anglesea's family and friends.

Although Mr Anglesea should have been referred earlier to a GP, a formal diagnosis and earlier hospital admission would not have affected the outcome and, overall the clinical reviewer concludes that the care he received at Rye Hill was equivalent to the care he could have expected in the community.

I am concerned that the prison sent Mr Anglesea to hospital in an emergency ambulance, but did not make contact with his wife until three days later. I am also concerned that the use of restraints when Mr Anglesea was in hospital was not justified by an appropriate risk assessment which took into account Mr Anglesea's health. It is disappointing that once again I have to draw the prison's attention to their legal responsibility to properly consider the implications of restraining a very ill, elderly man with limited mobility.

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**

**August 2017**

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# Summary

## Events

1. On 4 November 2016, Mr Gordon Anglesea was sentenced to 12 years imprisonment for historical child sex offences. He was admitted into HMP Altcourse before being transferred to HMP Rye Hill on 16 November.
2. Mr Anglesea suffered from a number of medical conditions, including type 2 diabetes, high blood pressure, high cholesterol, acid reflux and depression. Healthcare staff treated these conditions with appropriate medication. Mr Anglesea also had limited mobility and healthcare staff provided him a walking stick and delivered his medication to him on the wing.
3. On 3 December, Mr Anglesea reported problems with his stomach and told a nurse that he had a history of gastritis. This was the first of eight visits to his cell, over four days, by seven different members of the nursing team, because of abdominal pain, nausea, vomiting and breathing difficulties. On each occasion, healthcare staff took his observations, which tended to be normal bar having high blood sugar levels that was typical for someone diabetes. On 4 December, a nurse said she would book him a GP appointment for the following day but there was no evidence that this appointment happened.
4. In the early hours of 7 December, a nurse assessed Mr Anglesea as he was having difficulty breathing. She gave him oxygen therapy and he stabilised.
5. At 2.00pm that day, Mr Anglesea reported having back and stomach pain. A nurse examined him and noted his blood pressure was low and that his lips and nose were turning blue (a symptom associated with a lack of oxygen). At 3.15pm, an ambulance was called and Mr Anglesea was transferred to hospital, restrained by an escort chain
6. Hospital doctors diagnosed Mr Anglesea with pneumonia and, on 10 December, when his health declined, his restraints were removed.
7. The prison attempted to make contact with Mr Anglesea's family on 10 and 11 December. On 12 December, Mr Anglesea's wife contacted the prison and a family liaison officer told her that he was very unwell in hospital. Mr Anglesea's family visited him in hospital on 13 December.
8. Mr Anglesea's condition continued to deteriorate and he died at 8.55am on 15 December.

## Findings

9. Overall, we are satisfied that Mr Anglesea received a standard of clinical care at Rye Hill, equivalent to that he could have expected to receive in the community, although the clinical reviewer noted that between 3 and 7 December, healthcare staff should have referred Mr Anglesea to a GP to make a formal diagnosis.
10. We are not satisfied that the decision to restrain Mr Anglesea when he was taken to hospital was appropriate. The escort risk assessment did not contain any

information about why he should be restrained and there was no input from medical staff.

11. We also found that Mr Anglesea's family were not contacted in a timely manner in line with Prison Rule 22, which requires directors to inform a prisoner's spouse or next of kin when a prisoner becomes seriously ill.

## **Recommendations**

- The Head of Healthcare should ensure that prisoners with ongoing symptoms such as abdominal pain, vomiting and breathing difficulties have their symptoms properly examined and investigated at a timely GP review to determine their root cause.
- The Director 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.
- The Director should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible so that they are able to visit them in hospital without delay.
- The Director should ensure that prisoners' next of kin details are recorded when they arrive at the prison and are updated annually, so that up to date information is available in an emergency.

## The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Rye Hill informing them of the investigation and asking anyone with relevant information to contact her. Three prisoners came forward, and spoke to the investigator on the phone, with concerns about how Mr Anglesea's health was managed.
13. The investigator obtained copies of relevant extracts from Mr Anglesea's prison and medical records.
14. NHS England commissioned a clinical reviewer to review Mr Anglesea's clinical care at the prison.
15. We informed HM Coroner for Northamptonshire of the investigation who provided us with a cause of death. We have given the coroner a copy of this report.
16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
17. Mr Anglesea's wife received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

## Background Information

### HMP Rye Hill

18. HMP Rye Hill is run by G4S and it holds more than 600 men convicted of sex offences. G4S Forensic and Medical Services provides primary physical and mental health services, and Northamptonshire Healthcare NHS Foundation Trust (NHFT) provides secondary mental health services. The prison does not have an inpatient facility.

### HM Inspectorate of Prisons

19. The most recent inspection of HMP Rye Hill was in August 2015. Inspectors noted that the prison held a complex mix of serious offenders and some frail older men who needed significant levels of care. The inspection found that the quality of healthcare services was the weakest area of the prison. Services had not sufficiently adapted to meet the needs of the new population, when the prison had changed its role to take sex offenders in 2014. There were staff shortages and the available staff were not deployed efficiently. There were long waiting times for most clinics. A small group of regular GPs had run daily clinics since January 2015, which had improved consistency and prisoners' perceptions of service provision. However, prisoners waited up to three weeks for routine GP appointments. Prisoners had good access to pharmacy staff for advice.

### Independent Monitoring Board

20. 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 report for the year to March 2016, the IMB commented that healthcare provision remained under pressure and was a cause for concern. An NHS Health and Social Care Assessment in June 2015 found several areas that breached regulations of the Health and Social Care Act 2008. The healthcare management team and the senior management team were urgently addressing these issues. The IMB further comment that staffing shortages meant there were sometimes weekends where only two nurses and one healthcare assistant were on duty. They also felt that bed watches and end of life care had put pressure on the staffing of the prison as a whole on several occasions.

### Previous deaths at HMP Rye Hill

21. Mr Anglesea was the seventh prisoner to die from natural causes at Rye Hill since January 2015. There has been one death since. We have made previous recommendations concerning the proper use of escort risk assessments.

## Key Events

22. On 4 November 2016, Mr Gordon Anglesea was sentenced to 12 years imprisonment for historical child sex offences. He was admitted into HMP Altcourse and, on 16 November, he was transferred to HMP Rye Hill.
23. During Mr Anglesea's initial health screen at Rye Hill, a nurse recorded that Mr Anglesea had depression, type 2 diabetes, high blood pressure, high cholesterol, acid reflux and limited vision in right eye due to diabetes. Due to problems with his mobility, he was given a walking stick and healthcare staff brought his medication to him. The nurse referred him to the GP and to the relevant chronic disease monitoring clinics. Healthcare staff prescribed appropriate medication to treat these conditions.
24. Between 16 November and 3 December, Mr Anglesea had little contact with healthcare staff, except to raise concerns about suffering pain when urinating. A prison GP referred him to the urology clinic, but the symptoms were resolved on their own and Mr Anglesea did not attend a urology appointment on 30 November.
25. In the early hours of 3 December, a nurse spoke to Mr Anglesea through the hatch on his cell door. He told her that he had vomited a few times but said that he had a history of gastritis and believed it was the cause. He also said he was dehydrated and that his blood sugar level was 9.6mmol/L (for someone with type 2 diabetes, normal levels are between 4.0 to 7.0mmol/L when fasting and under 8.5mmol/L 90 minutes after eating). She advised him to drink plenty of fluids and tell healthcare staff if his condition worsened.
26. A nurse reviewed Mr Anglesea in his cell at 9.58am on 4 December, as he had reported feeling drowsy. He performed a set of observations and noted his blood pressure and pulse were normal. His blood sugar was raised at 13.5mmol/L. He reassured Mr Anglesea, requested some paracetamol and advised him to eat and drink more.
27. At 5.04pm that day, a nurse saw Mr Anglesea in his cell and noted that his blood sugar was raised at 12.8mmol/L, though he had received insulin.
28. At 8.21pm on 5 December, a nurse saw Mr Anglesea in his cell after he complained of abdominal pain, which he thought was caused by not receiving his omeprazole prescription (used to treat acid reflux). She said she would look into this and checked his observations, which were normal except his raised blood sugar level (14.6mmol/L). She recorded on Mr Anglesea's medical record that his drug chart said that the omeprazole prescription was unavailable, though she tasked the pharmacy department to reissue it. He received his omeprazole prescription on 7 December.
29. At 10.50pm on 5 December, a nurse reviewed Mr Anglesea in his cell after wing staff raised concerns about his health. Mr Anglesea was still complaining of dizziness, vomiting and indigestion. She took his observations, which were normal except his raised blood sugar level (12.1mmol/L). She told him that she would book him an appointment with the doctor.

30. A nurse saw Mr Anglesea in his cell on 6 December at 10.42am. Mr Anglesea said that he felt he had indigestion and had produced dark vomit that night. The nurse took Mr Anglesea's observations and his blood sugar level (17.0mmol/L) and pulse (98 beats per minute) were high. The nurse told him that the pharmacy could not issue more omeprazole without a valid prescription. The nurse said that this would be discussed with the GP that afternoon, but there is no evidence that this happened.
31. At 3.15am on 7 December, a nurse saw Mr Anglesea in his cell as he was having difficulty breathing and had a pain in his stomach. She took his observations and found he had low oxygen levels of 88% (normal levels for a man Mr Anglesea's age is between 94 and 96%). She gave him oxygen therapy for 15 minutes, after which his levels increased and stabilised at 97%. Mr Anglesea told her that the pain in his stomach had subsided and she advised him to report any further problems immediately to staff.
32. At 2.00pm, Mr Anglesea reported having back and stomach pain. A nurse examined him and noted his abdomen was tender and soft. She found his blood pressure was very low (47/31), his blood sugar was raised (16.3mmol/L) and he had cyanosis to his lips and nose (a bluish discoloration due to a lack of oxygen). At 3.15pm, she asked for an emergency ambulance and the control room immediately called for one, which arrived at the prison at 3.31pm. Paramedics took over his care and, at 4.05pm, he was transferred to hospital. Mr Anglesea was accompanied by two officers, who restrained him with an escort chain (an escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer).
33. Hospital doctors diagnosed Mr Anglesea with pneumonia, which was treated with intravenous antibiotics. Mr Anglesea's condition began to deteriorate and, according to the bedwatch history log, officers removed the escort chain on 9 December following authorisation by the deputy Director.
34. Mr Anglesea's condition declined further and he died at 8.55am on 15 December.

#### **Contact with Mr Anglesea's family**

35. On 9 December, the prison appointed a family liaison officer. After speaking with Mr Anglesea at the hospital to obtain his wife's telephone number, she attempted to call his wife at 5.00pm that day, but did not get an answer and the answer machine was too full to leave a message.
36. The family liaison officer attempted to contact Mr Anglesea's wife at 11.25am, 4.00pm and 6.30pm on 10 December and at 9.45am, 2.00pm and 5.50pm on 11 December. On each occasion, her calls were not answered. She then contacted Mr Anglesea's daughter to ask her to contact his wife.
37. On 12 December, Mr Anglesea's wife contacted the prison and the family liaison officer told her that Mr Anglesea had been admitted to hospital on 7 December. She explained that she had made a number of attempts to contact her.
38. The family liaison officer made arrangements so that Mr Anglesea's family could visit him in hospital on 13 December.

39. On 15 December, after Mr Anglesea's death, the family liaison officer and the Director of Rye Hill visited his wife's home to break the news of his death and to offer their condolences and support. The family liaison officer continued to support Mr Anglesea's wife until the date of his funeral.
40. Mr Anglesea's funeral took place on 9 January 2017. The prison contributed towards the funeral costs in line with national policy.

#### **Support for prisoners and staff**

41. After Mr Anglesea's death, the prison posted notices informing staff and prisoners of Mr Anglesea's death, and gave information of where to gain support if required.

#### **Cause of death**

42. A doctor at the hospital confirmed that Mr Anglesea died from multi-organ failure caused by community acquired pneumonia. The coroner accepted this cause of death and no formal post-mortem was performed.

# Findings

## Clinical care

43. On 3 December 2016, Mr Anglesea had the first of eight visits to his cell, over four days, by seven different members of the nursing team. On each occasion he had abdominal pain, nausea, vomiting and breathing difficulties. A referral to a GP for a diagnosis was not made and staff accepted Mr Anglesea's self-diagnosis of indigestion due to lack of omeprazole.
44. The clinical reviewer commented that the lack of a formal diagnosis and the lack of a review by a GP meant that there was doubt from all nursing staff. However, as Mr Anglesea's observations were mostly normal, apart from some raised blood sugars consistent with his diabetes, we agree with the clinical reviewer that an earlier admission to hospital was unlikely to have changed the outcome for Mr Anglesea.
45. While we agree with the clinical reviewer that the overall care that Mr Anglesea received at Rye Hill was equivalent to the care expected in the community, we consider that he should have been referred to a GP after presenting with consistent, ongoing symptoms. We make the following recommendation:

**The Head of Healthcare should ensure that prisoners with ongoing symptoms such as abdominal pain, vomiting and breathing difficulties have their symptoms properly examined and investigated at a timely GP review to determine their root cause.**

## 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 Mr Anglesea was taken to hospital on 7 December, a risk assessment document was completed but it did not make any assessment of Mr Anglesea's condition at that time and there was no medical input. A security analyst completed an assessment of Mr Anglesea and determined that he presented a medium risk to the public and of escape. Given his known condition at the time it is hard to see the basis for this conclusion. There is no evidence whether or how this document was used for a prison manager to decide on the level of restraint. Yet, it is clear in Mr Anglesea's bedwatch logs that he was restrained by an escort chain when he went to hospital.

48. On 9 December, the deputy Director authorised officers to remove the restraints from Mr Anglesea when his condition began to deteriorate, although the risk assessment was not updated until 13 December.
49. While we note that the restraints were removed when Mr Anglesea's health deteriorated, we are not satisfied that there was an appropriate risk assessment when Mr Anglesea went to hospital on 7 December. He was an elderly man with limited mobility in very poor and declining health. There is no medical input into whether Mr Anglesea's condition affected his risk of escape as required in the High Court judgment. Whenever restraints are used, the risk assessments must accurately reflect the risk posed at that time to ensure proportionality and to maintain human dignity. We make the following recommendations:

**The Director 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.**

### Family liaison

50. Prison Rule 22 requires governors and directors to inform a prisoner's spouse or next of kin when that prisoner 'becomes seriously ill'. While the family liaison officer made clear attempts to contact Mr Anglesea's wife after being appointed on 9 December, we consider that his wife should have been contacted on 7 December. Mr Anglesea's condition was sufficiently serious for the prison to have called an emergency ambulance and we therefore would have expected his wife to have been notified at that stage.
51. Furthermore, it is clear that the prison did not obtain contact details for Mr Anglesea's wife when he arrived at Rye Hill because the family liaison officer had to visit him in hospital before they did so. The prison should have obtained these details earlier. We make the following recommendations:

**The Director should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible so that they are able to visit them in hospital without delay.**

**The Director should ensure that prisoners' next of kin details are recorded when they arrive at the prison and are updated annually, so that up to date information is available in an emergency.**

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