Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Steven Rushworth a prisoner at HMP Rye Hill on 1 June 2017

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.

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

Mr Steven Rushworth died on 1 June 2017 of lung cancer while a prisoner at HMP Rye Hill. He was 67 years old. We offer our condolences to Mr Rushworth's family and friends.

We are satisfied that the healthcare Mr Rushworth received at Rye Hill was equivalent to that which he could have expected to receive in the community. However, when he began to feel nausea and weakness, it would have been better if prison GPs had considered whether the severe pain in his shoulder had an underlying cause.

We are concerned that Mr Rushworth was restrained in the critical care unit in hospital for 12 days after being diagnosed with pneumonia and lung cancer. This is not the first time that we have identified Rye Hill's inappropriate use of restraints. We repeat our recommendation which the Director should address with urgency.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **January 2018**

Contents

Summary

Events

1. On 28 October 2011, Mr Steven Rushworth was sentenced to 13 years in prison for rape and sexual offences and was sent to HMP Altcourse. He said he had heart disease and had had a previous heart attack. On 26 June 2014, he was transferred from HMP Liverpool to HMP Rye Hill.

2. In May 2015, Mr Rushworth was admitted to hospital and had heart surgery following a heart attack. He was admitted to hospital again in October after struggling to breathe and falling and was diagnosed with a urinary tract infection and lower respiratory tract infection. Hospital staff took blood tests and a chest x-ray, which was clear.

3. On 5 April 2016, Mr Rushworth told a prison GP that he had a trapped nerve in his shoulder. Mr Rushworth said he had not had an injury and the pain was worse on movement. The doctor diagnosed rotator cuff pain and prescribed an anti-inflammatory drug and pain relief medication. He later had a cortisone injection (to reduce inflammation and provide pain relief) and physiotherapy. He returned to the healthcare team for the pain a number of times but, after 29 November, did not mention his shoulder.

4. In January 2017, Mr Rushworth complained of chest pain. A nurse arranged for an electrocardiogram (ECG - a reading of the electrical activity of the heart). The results were outside the normal range. A prison GP reviewed Mr Rushworth and noted he was not short of breath, had no chest pains or swallowing problems, but had a loss of appetite which he linked to nausea and chest discomfort. He asked for Mr Rushworth to be weighed weekly and, if no better, to be reviewed by a GP in two weeks. He was reviewed by a GP in February and March and said he was tired all the time.

5. In April, Mr Rushworth was examined by a GP after he again complained of chest pain. A week later a nurse saw him in his cell because he was weak and unable to get up off his knees. His clinical observations were all within the normal range and his weakness was attributed to after effects of a recent vomiting bug. He subsequently reported abdominal pain over five to seven days and was seen by a GP who prescribed a pain killer and a drug to reduce stomach acid.

6. On 27 April 2017, a prison GP reviewed Mr Rushworth because he had fallen over twice in his cell. He noted that Mr Rushworth looked poorly, had lost weight, had a cough, weakness, and a sparse bibasal crackle (a bubbling or crackling sound coming form the base of the lung). He felt there might be an underlying cancer and urgently referred Mr Rushworth for a CT scan of the chest and abdomen (a scan that produces a detailed picture of the chest and abdomen) under the NHS pathway, which requires that patients with suspected cancer be seen by a specialist within two weeks.

7. On 4 May, a nurse went to Mr Rushworth's cell because he had fallen over. The nurse returned an hour later and saw that he was confused and agitated. He was unable to take Mr Rushworth's clinical observations and noted that he was

breathing with difficulty and had an irregular pulse. Mr Rushworth's blood oxygen level was very low (77 per cent) so a nurse gave him oxygen. The nurse asked for an ambulance to be called, which took Mr Rushworth to hospital. Mr Rushworth was not restrained.

8. When Mr Rushworth went to the hospital's critical care unit later that day, officers restrained him using 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). The chain remained in place for the next 12 days.

9. On 7 May, a hospital consultant saw Mr Rushworth and told him that he had pneumonia and lung cancer, which was inoperable.

10. A nurse at Rye Hill co-ordinated Mr Rushworth's discharge with the hospital's occupational therapist discharge facilitator. Prison staff prepared for his return to prison, completing an assessment of his needs, fitting a hospital bed and equipment in a cell and arranging carers.

11. On 26 May, hospital staff discharged Mr Rushworth. When he returned to Rye Hill, he fell over in the admissions department at Rye Hill. A nurse saw him and said he was pale, and felt unwell and weak. She asked for an ambulance, which took Mr Rushworth back to hospital.

12. Mr Rushworth remained in hospital until his death on 1 June. There was no post-mortem examination. A hospital doctor gave the cause of death as lung cancer. A heart attack and an abnormal heart rhythm also contributed to his death.

Findings

13. Mr Rushworth had an ongoing shoulder pain from April 2016. It is unclear whether this pain went away and Mr Rushworth did not mention it when he saw a prison GP in January 2017. The start of the shoulder pain could have been a symptom of the lung cancer but, because there were no other signs, we found that the GP acted reasonably.

14. In January 2017, when Mr Rushworth began to show signs of nausea and weakness, prison GPs treated him for this. Between January and April, they should have considered that the shoulder pain and his general ill health could have been due to an underlying malignancy. The clinical reviewer said that the general feeling of being unwell, together with the unknown cause of the shoulder pain, should have led the healthcare team to consider whether he had an underlying condition before the end of April. However, she did not consider that the progression of the disease and the ultimate outcome for Mr Rushworth would have been different if he had been referred to hospital a few weeks or a month earlier.

15. We are satisfied that when the prison GP reviewed Mr Rushworth on 27 April 2017, he made a referral under the two-week wait pathway.

16. We do not consider it appropriate that Mr Rushworth was restrained for 12 days after he was diagnosed with cancer on 5 May. He was a seriously ill man and, while his offences were of a serious nature, the circumstances of his ill health

would not suggest he posed any serious risk of escape or current risk to the general public.

17. When Mr Rushworth was admitted to hospital on 4 May 2017, the prison healthcare staff had difficulty in gaining clinical updates from hospital staff. Hospital staff preferred to pass information to the prison escort staff for relay back to healthcare. The prison escort staff are not clinical professionals and should not be expected to have this type of information shared with them. This is not in line with the NHS code of confidentiality and best practice for the continuity of prisoners' health care outlined in Prison Service Order (PSO) 3050 on Continuity of Healthcare.

Recommendations

- The Head of Healthcare should ensure that prison doctors consider the potential for underlying malignancy when a patient presents with chronic shoulder/chest pain and later develops a general feeling of nausea, loss of appetite and being unwell.

- The Head of Healthcare should agree a system of communication between the hospital and Rye Hill healthcare to avoid reliance on information being passed on by non-clinical staff.

- 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 Investigation Process

18. 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 him. No one responded.

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

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

21. We informed HM Coroner for Northampton of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.

22. The prison informed the investigator that Mr Rushworth had no known next of kin.

23. The investigation has assessed the main issues involved in Mr Rushworth'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.

24. We shared the initial report with the Prison Service. There were no factual inaccuracies.

Background Information

HMP Rye Hill

25. HMP Rye Hill is run by G4S and holds more than 600 men convicted of sex offences. G4S Forensic and Medical Services provide primary, physical and mental health services. The prison does not have an inpatient facility.

HM Inspectorate of Prisons

26. 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. After the prison changed its role to take sex offenders in 2014, services had not sufficiently adapted to meet the needs of the new population.

27. There were healthcare 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

28. 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 March 2017, the IMB reported that healthcare provision remained under pressure and was a cause for concern. They found that recruiting and retaining suitable healthcare staff was an ongoing problem. They said the current service needed further investment and improvement if it was to ensure it was giving prisoners the same level of care they would receive in the community.

Previous deaths at HMP Ryehill

29. Mr Rushworth was the eighth person to die from natural causes at Rye Hill since June 2016. We have previously made recommendations about the inappropriate use of restraints.

Findings

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

30. On 28 October 2011, Mr Steven Rushworth was sentenced to 13 years in prison for rape and sexual offences and was sent to HMP Altcourse. At his initial health screening, a nurse noted he was a smoker and weighed 102kg (the ideal body weight for Mr Rushworth's height was 72kg).

31. The prison GP noted that Mr Rushworth had heart disease and had previously had a heart attack. He prescribed amlodopine, atenolol, aspirin, bendroflumethiazide, and glyceryl trinitrate spray for high blood pressure and angina.

32. On 1 August 2012, Mr Rushworth was transferred to HMP Liverpool and on 26 June 2014, he was transferred to HMP Rye Hill.

33. On 27 June 2015, a nurse saw Mr Rushworth as a medical emergency. He was short of breath, had pain on his right side and nausea. She recorded that his pulse and temperature were high and he was sweating. Paramedics saw Mr Rushworth and admitted him to hospital, where staff diagnosed a heart attack. He had cardiac surgery and surgeons fitted a stent (a small tube used to treat narrow or weak arteries).

34. On 5 April 2016, a prison GP saw Mr Rushworth, who said he had a trapped nerve in his shoulder. Mr Rushworth said he had not had an injury and the pain was worse on movement. The GP diagnosed rotator cuff pain and prescribed an anti-inflammatory drug and pain relief medication. Mr Rushworth later had a cortisone injection into the joint (to reduce inflammation and pain) and physiotherapy. On 14 October, a physiotherapist recorded that Mr Rushworth had gradual onset right shoulder pain and pain around the scapula down the arm to the elbow. He gave Mr Rushworth exercises to do. On 29 November, Mr Rushworth saw him again for his shoulder pain.

35. Mr Rushworth remained under the care of the hospital cardiology department. A prison GP saw Mr Rushworth on 14 April, and noted he may have chronic obstructive pulmonary disease (COPD - inflamed airways and damaged air sacs in his lungs) and prescribed him steroids.

36. On 6 October, Mr Rushworth fell over in his cell. He told a nurse he was struggling to breathe and was dizzy. She took his clinical observations, which were within the normal range. Due to his condition and his previous history of heart disease, she called an ambulance. Paramedics admitted Mr Rushworth to hospital. Hospital staff diagnosed a urinary tract infection and lower respiratory tract infection. They took blood tests and a chest x-ray, which was clear.

37. On 21 January 2017, Mr Rushworth said that he had had chest pains in the night. A nurse took his clinical observations, which were within the normal range. Mr Rushworth said he had chest pain after coughing. She did not record signs of a lung condition. She arranged for an electrocardiogram (ECG - a reading of the

electrical activity of the heart) which a healthcare assistant carried out on 26 January. The results were outside the normal range.

38. A prison GP reviewed Mr Rushworth later that day. He noted Mr Rushworth was not short of breath, had no chest pains or swallowing problems but had a loss of appetite which he linked to nausea and chest discomfort. He prescribed omeprazole to lower stomach acid and co-magaldrox to relieve the symptoms of indigestion and heartburn. He asked for Mr Rushworth to be weighed weekly and, if no better, to be reviewed by a GP in two weeks.

39. On 28 January, a nurse weighed Mr Rushworth. She noted his weight as 80.6kg. He said he was tired and lethargic all the time. A prison GP saw Mr Rushworth on 23 February, and noted his weight as 78kg. He said his appetite was a little better. A week later he saw him again, noted he was not eating much and considered giving him food supplements.

40. On 11 April, Mr Rushworth told a nurse he had a pain under his right rib through to his back. A prisoner GP then examined Mr Rushworth and asked for blood tests. A nurse took the blood tests the next day. Mr Rushworth told her he had a constant chest pain. She gave him mucogel for heartburn and indigestion.

41. On 15 April, a nurse saw Mr Rushworth in his cell because he was weak and unable to get up off his knees. She took his clinical observations, which were all within the normal range. She said his weakness was probably due to the after effects of the recent vomiting bug. (The Head of Healthcare subsequently confirmed to us that there was a sickness bug in April 2017, and it affected Mr Rushworth.)

42. A nurse checked Mr Rushworth the next day. He said he had lower abdomen pain, was sick and had loose bowels. She recorded that the pain was probably due to the sickness and diarrhoea. She told him to drink water. Mr Rushworth said he wanted to go to hospital but she told him it was not possible because of the bug.

43. On 19 April, Mr Rushworth told a prison GP that he had had abdominal pain for five to seven days. He prescribed dihydrocodeine, a strong painkiller, and omeprazole, to reduce stomach acid.

44. The next week, Mr Rushworth fell over twice in his cell so, on 27 April, a prison GP reviewed him. He noted Mr Rushworth had weight loss, a cough, weakness, looked poorly and had a sparse bibasal crackle (a bubbling or crackling sound coming form the base of the lung). He thought there might be an underlying cancer. He urgently referred him for a CT scan of the chest and abdomen under the NHS pathway, which requires that patients with suspected cancer be seen by a specialist within two weeks.

45. On 30 April, Mr Rushworth had another fall in his cell. A nurse noted that he was pale and slightly confused. She took his clinical observations; his blood pressure was normal (102/72), his pulse rate high (118 beats per minute), and blood oxygen level normal (95 per cent). She asked a GP to review him as soon as possible.

46. On 4 May, an appointment letter arrived for Mr Rushworth to see the respiratory team at hospital on 22 May. The appointment was a week and a half overdue. A prison GP saw Mr Rushworth and noted he "looked dreadful". He completed a second two-week wait referral because Mr Rushworth had pain when swallowing.

47. Later that day, a nurse went to Mr Rushworth's cell because he had fallen again. He took Mr Rushworth's blood pressure which was low (94/60) and pulse rate which was within the normal range. He returned an hour later and saw that Mr Rushworth was confused and agitated. He was unable to take Mr Rushworth's clinical observations and saw that he was breathing with difficulty and had an irregular pulse. His blood oxygen level was very low (77 per cent) so he gave him oxygen. He arranged for an ambulance, which took Mr Rushworth to hospital.

48. Hospital staff admitted Mr Rushworth to the critical care unit because he had septic shock (low blood pressure due to an infection) due to pneumonia. He also had possible underlying cancer as chest x-rays showed hardened tissue in the right lower area of the lungs. After a CT scan, a hospital consultant told him they were treating him for pneumonia and that he had lung cancer.

49. On 7 May, a hospital consultant saw Mr Rushworth and told him he had pneumonia and lung cancer, which was inoperable.

50. Mr Rushworth had an ongoing shoulder pain from April 2016. The clinical reviewer found it was unclear if this pain went away. However, Mr Rushworth did not mention the pain when he saw a prison GP in January 2017. The start of the shoulder pain could have been a symptom of the lung cancer but because there were no other signs, the clinical reviewer found that the GP acted reasonably.

51. When Mr Rushworth began to show signs of nausea and weakness, prison GPs treated him for this. As time went on, the clinical reviewer found that prison GPs should have considered other potential causes. She found that the general feeling of being unwell with the unknown cause of the shoulder pain could have prompted consideration of another underlying condition before the end of April 2017. However, she did not consider that the progression of the disease and the ultimate outcome for Mr Rushworth would have been different if he had been referred to hospital a few weeks or a month earlier. We make the following recommendation:

    The Head of Healthcare should ensure that prison doctors consider the potential for underlying malignancy when a patient presents with chronic shoulder/chest pain and later develops a general feeling of nausea, loss of appetite and being unwell.

52. We are satisfied that when a prison GP reviewed Mr Rushworth on 27 April 2017, he made a referral under the two-week wait pathway. The hospital made the appointment outside of the two-week period, a week and a half late. Nevertheless, Mr Rushworth was admitted as an inpatient on 4 May, and was diagnosed shortly afterwards, so this did not delay his diagnosis.

Mr Rushworth's clinical care

53. When hospital staff informed Mr Rushworth of his diagnosis, he said he did not wish anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect.

54. On 5 May, a nurse spoke to a nurse Sister at the critical care unit at the hospital. The Sister did not want to give information about Mr Rushworth's condition and care. The nurse set up a password but the nurse Sister said she could not disclose the information but was prepared to give the information to the officers at Mr Rushworth's bedside.

55. On 9 May, a nurse saw Mr Rushworth on the hospital ward. She said hospital staff were treating him with intravenous antibiotics for pneumonia before considering treatment for the cancer.

56. On 11 May, the lung cancer multidisciplinary team discussed Mr Rushworth's condition. They sent a summary of the meeting to the prison GP.

57. Healthcare staff thereafter obtained regular updates from the hospital about Mr Rushworth's care. It is unfortunate that hospital staff preferred to pass information to the officers at his bedside about his condition rather than directly to members of the healthcare team. The Head of Healthcare said she tried to use passwords to enable hospital staff to pass confidential information about Mr Rushworth's clinical care, but the hospital preferred to pass the information directly to the officers. We are satisfied that the healthcare team did what they could in the circumstances to set up a suitable communication method with the hospital.

58. Nevertheless, this was not a satisfactory state of affairs. Prison escort staff are not clinical professionals and should not be expected to have this type of information shared with them. This is not in line with the NHS code of confidentiality and best practice for the continuity of prisoners' health care outlined in Prison Service Order (PSO) 3050 on Continuity of Healthcare. We make the following recommendation:

    The Head of Healthcare should agree a system of communication between the hospital and Rye Hill healthcare to avoid reliance on information being passed on by non-clinical staff.

59. On 19 May, the Head of Healthcare spoke to hospital staff who said they were assessing Mr Rushworth for safe discharge. A prison GP noted on 26 May that when they discussed him at a meeting, they assessed that Mr Rushworth had high care needs and requested a cancer review.

Mr Rushworth's location

60. Mr Rushworth lived in a single cell on a standard wing. On 4 May 2017, he was admitted to hospital.

61. Rye Hill has a working relationship with Northamptonshire County Council Social Services and a link worker saw Mr Rushworth at the hospital and prepared an assessment of his post-discharge needs on 24 May. She sent the assessment to

A social care officer at Rye Hill, who organised the conversion of a cell and care for his discharge.

62. The Head of Healthcare co-ordinated Mr Rushworth's discharge with the hospital's occupational therapist discharge facilitator who ordered a hospital bed and suitable equipment, which they delivered on 26 May. The service delivery manager prepared the cell containing the bed and the equipment.

63. That day, hospital staff discharged Mr Rushworth. In the prison's admissions' department, he stood up and fell over. A nurse saw him. She said he was pale, feeling unwell and weak. She took his clinical observations. Mr Rushworth's blood pressure was high (102/87), his pulse rate normal (95 beats per minute), and blood oxygen level slightly low (94 per cent). Officers called an ambulance, which took him back to the hospital. This was an unfortunate incident, which caused strain on an already ill man. We are satisfied that the prison appropriately prepared for his return.

64. Mr Rushworth remained in hospital until his death on 1 June. There was no post-mortem examination after his death. The pathologist gave the cause of death as lung cancer. A heart attack and an abnormal heart rhythm also contributed to his death.

Restraints, security and escorts

65. 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.

66. When Mr Rushworth went to hospital on 4 May, healthcare and prison staff completed a risk assessment. A nurse noted there was no medical objection to the use of restraints. A prison manager noted that Mr Rushworth should not be restrained due to his health but that if he improved, cuffs should be applied. Two officers escorted him unrestrained.

67. At 11.25am on 5 May, the Head of Community Engagement noted that the hospital consultant could not medically confirm that there was anything wrong with Mr Rushworth and that there was no risk of his imminent death. She noted that she could not confirm he had the ability to escape. She authorised the application of 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). Later that day, officers removed the restraints for Mr Rushworth to have a CT scan and then reapplied them.

68. The CT scan showed Mr Rushworth had lung cancer and pneumonia. Despite the fact that he had a catheter and pain relief, was having further tests, was not eating and officers described him as being quite poorly, they continued to restrain him.

69. On 17 May, a senior prison manager updated the risk assessment, authorising the removal of restraints because of the diagnosis of lung cancer. He recorded that Mr Rushworth was unlikely to escape, as he would then not receive his medication and care to prolong life. A hospital nurse told him he would be physically unable to make a determined escape bid.

70. We are concerned that Mr Rushworth's risk was not assessed using the tests required by the High Court judgement. The senior manager authorised the use of an escort chain because a consultant could not confirm there was anything wrong with Mr Rushworth. We do not regard this as material to the question of the appropriateness of the use of restraints. Mr Rushworth was clearly an older, ill man who had been the subject of an unplanned hospital admission due to his deteriorating symptoms. When a CT scan later showed a cancer, officers continued to restrain him despite his worsening condition.

71. The senior manager also recorded that she could not confirm whether Mr Rushworth had the ability to escape, but it is unclear what evidence she used to reach this judgement nor why mechanical restraints should have been necessary when Mr Rushworth, who was frail and in very poor health, was already under the supervision of escorting staff. Their presence clearly mitigated the low risk of escape or any broader risk to prison staff, hospital staff or the public.

72. A senior prison manager told us that officers who were with Mr Rushworth in hospital said that they believed he appeared to enjoy the attention he was receiving from nurses, that he was getting gratification from intimate care and that he may be being dishonest about his mobility and general health. While these observations, which are recorded in the bedwatch log and happened after his diagnosis are important, they should not outweigh the serious nature of Mr Rushworth's diagnosis and the clinical opinion of healthcare and hospital staff who had determined that his symptoms were serious enough to require an unplanned hospital admission. The officers were not medical professionals and it is possible that the hospital's insistence on discussing Mr Rushworth's clinical care with them, rather than with healthcare staff at the prison, meant that the prison did not recognise the full seriousness of Mr Rushworth's condition. In fact, he lived for less than four weeks after his cancer was diagnosed.

73. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances. We do not consider it appropriate that Mr Rushworth was restrained after he was diagnosed with cancer on 5 May. He was now a seriously ill man and, while his offences were of a serious nature, the circumstances of his ill health would not suggest he was any current risk to the general public and posed a minimal risk of escape. We make the following recommendation:

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.

Liaison with Mr Rushworth's family

74. Rye Hill appointed a prison manager as the family liaison officer. Mr Rushworth had said he had no next of kin, but Rye Hill had recorded a partner as his next of kin. She tried to telephone her but, when she rang her, she put the phone down. She asked Cheshire Police to call at the listed person's address; she told the police officers that she did not want to have anything to do with Mr Rushworth.

75. Prison staff also tried to contact a person they believed was Mr Rushworth's stepson, but the telephone number they had did not connect and other enquiries they made did not locate him.

76. Mr Rushworth's funeral took place on 13 July; the prison arranged and met the costs of the funeral in line with national instructions.

Compassionate release

77. Early release on compassionate grounds is a means by which prisoners who are seriously ill can be permanently released from custody before their sentence has expired. The criteria for early release for indeterminate sentenced prisoners are set out in Prison Service Order (PSO) 4700 and prisoners are usually expected to have less than three months to live. The criteria include that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) within HM Prisons and Probation Service (HMPPS).

78. A senior prison manager told the investigator that the prison considered whether to apply for compassionate release for Mr Rushworth but he did not meet the criteria. He said that Mr Rushworth's risk to children in the community was rated as high and, in addition, he had not received a prognosis of life expectancy from hospital staff. On this basis, he said that they had decided not to apply. He obtained Mr Rushworth's risk to the community from the Offender Assessment System (OASys). He said there would be no benefit to Mr Rushworth being released because he had no next of kin and no one therefore to care for him. We are satisfied that it was reasonable that the prison did not make a formal compassionate release application for Mr Rushworth.

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