Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Anderson a prisoner at HMP Risley on 8 January 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.

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 Anderson died on 8 January 2017 of a heart attack in hospital while a prisoner at HMP Risley. Mr Anderson was 59 years old. I offer my condolences to Mr Anderson's family and friends.

The investigation found that, while much Mr Anderson's care was satisfactory and equivalent to that which he could have expected to receive in the community, healthcare staff missed the opportunity to arrange specialist medical intervention when his condition started to deteriorate. However, the clinical reviewer did not consider that this affected the outcome.

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**

Contents

Summary

Events

1. On 4 October 2016, Mr Peter Anderson was sentenced to 12 months in prison for a sexual offence and sent to HMP Liverpool. On 9 December, he was moved to HMP Risley.

2. Mr Anderson had a history of poor health, which included an irregular heart rate, ischaemic colitis (inflammation of the bowel) and chronic kidney disease. Mr Anderson had a stoma (a small opening on the surface of the abdomen to divert the flow of faeces into a colostomy bag) after bowel surgery in 2010. Prison GPs prescribed appropriate medication.

3. On 24 December a nurse saw Mr Anderson, who complained of abdominal and back pain and constipation. He arranged a GP appointment for 27 December but Mr Anderson did not attend. The same day, Mr Anderson did not collect his prescribed medication.

4. On 27 December, prison officers asked nurses to assess Mr Anderson because he had not left his cell or eaten for three days. A nurse diagnosed possible sepsis and paramedics took Mr Anderson to hospital by ambulance.

5. Mr Anderson initially responded to treatment and hospital doctors planned to discharge him back to Risley. On 7 January 2017, Mr Anderson had a heart attack and was moved to the intensive care unit. His condition continued to deteriorate and he died at 6.30pm on 8 January.

Findings

6. When Mr Anderson arrived at Risley nurses created appropriate care plans to manage his long term medical conditions. On 24 December, he complained of abdominal pain and constipation. A nurse arranged a GP appointment for 27 December. Mr Anderson did not attend this appointment or collect his prescribed medication. We agree with the clinical reviewer that healthcare staff missed the opportunity to arrange specialist medical intervention when Mr Anderson's condition started to deteriorate. The clinical reviewer did not consider that this affected the outcome for Mr Anderson.

7. We are satisfied that otherwise the care offered to Mr Anderson was equivalent to that which he could have expected to receive in the community.

Recommendations

- The Head of Healthcare should ensure that if a prisoner does not attend a GP appointment, this is followed up and the reasons for non-attendance are written on the prisoner's SystmOne medical record.
- The Head of Healthcare should ensure that there are effective processes to ensure that prisoners receive their medication as prescribed and that failure to attend to collect medication is followed up with the reasons recorded.

The Investigation Process

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

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

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

11. We informed HM Coroner for Cheshire, Halton and Warrington of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

12. The investigator wrote to Mr Anderson's friend to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond to our letter.

13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Risley

14. HMP Risley is a medium security training prison, which holds over 1,000 convicted men. Bridgewater Community Healthcare NHS Trust provides healthcare services in the prison. There is 24-hour healthcare cover. There is a doctor in the prison during the day and at night there are nurses on duty. Prisoners who need inpatient treatment are referred to other prisons (usually HMP Preston) or to hospital. Lifeline provides substance misuse services.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Risley was in June 2016. Inspectors reported that health services were reasonable but governance and oversight were underdeveloped. The range of primary care services was adequate, although prisoners waited too long to see a GP. Inspectors noted that there were not enough custody staff with basic life support skills and there were no automated external defibrillators on the wings.

Independent Monitoring Board

16. 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. The most recent report to March 2016, states that there was a multi-disciplinary approach to wellbeing across the prison and plans to expand the healthcare services provided.

Previous deaths at HMP Risley

17. Mr Anderson was the fifth prisoner to die of natural causes at Risley since January 2014. There were no significant similarities with the circumstances of the previous deaths

Key Events

18. On 4 October 2016, Mr Peter Anderson was sentenced to 12 months in prison for a sexual offence and sent to HMP Liverpool. On 9 December, he was moved to HMP Risley.

19. When he arrived at Liverpool, Mr Anderson completed an alcohol detoxification programme. On 20 October, hospital doctors admitted Mr Anderson to hospital with an acute kidney infection. On 27 October, he went to hospital again suffering from pneumonia. Investigations revealed that Mr Anderson had liver cirrhosis (scarring of the liver caused by long-term liver damage) and hospital doctors made a non-urgent referral to a liver specialist and a urologist. These appointments did not take place before Mr Anderson's death on 8 January.

20. At an initial health screen at Risley on 9 December, a nurse noted that Mr Anderson had a history of poor health, which included an irregular heart rate, ischaemic colitis (inflammation of the bowel) and chronic kidney disease. Mr Anderson had a stoma (a small opening on the surface of the abdomen to divert the flow of faeces into a colostomy bag) after bowel surgery in 2010. He had poor mobility and used a walking stick. Nurses contacted Mr Anderson's community GP to obtain his medical history and list of prescribed medication, and created care plans to manage his medical conditions.

21. On 12 December, a prison GP reviewed Mr Anderson's prescribed medication. He noted that Mr Anderson suffered from charcot joints (a progressive degenerative disease caused by nerve damage) which meant he was unable to feel pain in his ankles. He arranged a wheelchair for Mr Anderson to ensure he could move freely around the prison.

22. On 24 December a nurse saw Mr Anderson, who complained of abdominal and back pain. He recorded his blood pressure, pulse and oxygen saturation as normal and his temperature as elevated (38.2). Mr Anderson had liquid faeces in his colostomy bag, and complained of constipation. He advised Mr Anderson to increase his fluid intake to improve his abdominal pain. He arranged a GP appointment for 9.40am on 27 December, but Mr Anderson did not attend. Healthcare staff did not record why he failed to attend or encourage him to attend.

23. The same day, Mr Anderson did not collect his in-possession medication from the pharmacy. Pharmacy staff did not inform healthcare or investigate why he had not collected his medication. Mr Anderson did not receive his medication between 24 and 27 December.

24. At 2.30pm on 27 December, prison officers asked a nurse to assess Mr Anderson because he had not left his cell or eaten any food for three days. A nurse saw Mr Anderson and noted he had soiled himself. He complained of a painful back, right elbow and lower abdominal pain. She noted that Mr Anderson was dehydrated, his temperature was elevated (38.3) and his pulse was fast and irregular (127-147 beats per minute). Mr Anderson's respiratory rate was raised (20 breaths per minute) and he was confused and disorientated.

25. The nurse diagnosed possible sepsis (a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and

organs). She arranged an emergency ambulance to take Mr Anderson to hospital. The paramedics arrived at 3.15pm and took control of Mr Anderson's care. The ambulance left the prison at 4.09pm. Two prison officers accompanied Mr Anderson and did not use restraints. Hospital doctors diagnosed an inflamed gall bladder and a foot infection and prescribed intravenous antibiotics.

26. On 6 January 2017, hospital doctors told prison nurses that Mr Anderson's stoma was bleeding and he needed to see a specialist before he returned to Risley. At 3.32pm on 7 January, Mr Anderson had a heart attack. The duty governor contacted Mr Anderson's friend, his nominated next of kin, and told him Mr Anderson was in hospital. At 6.42pm, Mr Anderson was moved to the intensive care unit.

27. At 3pm on 8 January, Mr Anderson's friend visited him in hospital. Mr Anderson's condition continued to deteriorate and Mr Anderson's friend gave hospital doctors his consent to withdraw treatment. Mr Anderson died at 6.30pm.

Contact with Mr Anderson's family

28. On 8 January, the prison appointed the acting deputy Governor as a family liaison officer. At 11.15am, he telephoned Mr Anderson's friend, his nominated next of kin, and arranged to meet him at the hospital. He offered condolences and support.

29. At 4.55pm, Mr Anderson's friend told the family liaison officer he was going home. He asked him to telephone him when Mr Anderson died. Shortly after Mr Anderson died at 6.30pm, he telephoned Mr Anderson's friend in accordance with his wishes.

30. The next day, the family liaison officer spoke to Mr Anderson's friend on the telephone. He remained in contact with Mr Anderson's friend until his funeral on 1 February. The prison contributed towards the costs in line with national policy.

Support for prisoners and staff

31. The prison posted notices informing other prisoners of Mr Anderson's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Anderson's death.

Post-mortem report

32. The coroner concluded that the cause of death was acute myocardial infarction (heart attack). Mr Anderson also suffered from coronary artery atheroma (fatty deposits on or within the inner lining of an artery, often causing an obstruction to the blood flow).

Findings

Clinical care

33. Overall, the clinical care Mr Anderson received was satisfactory, but there were some learning points for healthcare in the prison.

34. On 24 December 2016 a prison nurse assessed Mr Anderson, who complained of abdominal pain and constipation. The nurse arranged a GP appointment for 27 December, when GPs returned to work after the Christmas period. The clinical reviewer considered that Mr Anderson's medical history, in particular his stoma, was sufficient to require further investigation and an earlier GP appointment. The Head of Healthcare told us that GPs were on duty on 24 December and an out of hours emergency GP service operated on 25 and 26 December. Nurses provided 24 hour cover as usual.

35. On 27 December, Mr Anderson failed to attend his GP appointment or collect his prescribed medication. The clinical reviewer was concerned that healthcare staff did not investigate this further. When prison staff alerted healthcare later that day that Mr Anderson was unwell, he had not left his cell or eaten for three days. The clinical reviewer considered that nurses missed the opportunity to assess Mr Anderson's condition sooner and arrange earlier medical intervention. We make the following recommendations:

    The Head of Healthcare should ensure that if a prisoner does not attend a GP appointment, this is followed up and the reasons for non-attendance are written on the prisoner's SystmOne medical record.

    The Head of Healthcare should ensure that there are effective processes to ensure that prisoners receive their medication as prescribed and that failure to attend to collect medication is followed up with the reasons recorded.

36. The clinical reviewer was satisfied that nurses appropriately assessed Mr Anderson on 27 December. They quickly sent him to hospital, in accordance with the National Institute for Health and Care Excellence (NICE) guidance for the recognition and early management of sepsis.

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