

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Peter Ryan a prisoner at HMP Doncaster on 28 June 2017

**A report by the Prisons and Probation Ombudsman**

PO Box 70769  
London, SE1P 4XY

Email: [mail@ppo.gsi.gov.uk](mailto:mail@ppo.gsi.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T | 020 7633 4100  
F | 020 7633 4141

## 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*



© Crown copyright 2017

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](http://nationalarchives.gov.uk/doc/open-government-licence/version/3) or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: [psi@nationalarchives.gsi.gov.uk](mailto:psi@nationalarchives.gsi.gov.uk).

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

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 Peter Ryan died on 28 June 2017 of oesophageal cancer while a prisoner at HMP Doncaster. He was 75 years old. I offer my condolences to those who knew him.

We are satisfied that the healthcare Mr Ryan received in prison was equivalent to that which he could have expected to receive in the community. His diagnosis was made in a timely manner and he received good, compassionate care from staff at Doncaster.

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 .....	1
The Investigation Process .....	2
Background Information .....	3
Findings .....	4

# Summary

## Events

1. Mr Peter Ryan received an indeterminate sentence for public protection for sexual offences in September 2006. He spent time at a number of prisons before being moved to HMP Moorland in January 2012 and then to HMP Doncaster in August 2016.
2. On 3 October 2015, while at Moorland, Mr Ryan collapsed in his cell and he was taken to hospital. He subsequently had an operation to remove kidney stones. Investigations revealed he was suffering from oesophageal cancer. A hospital consultant informed him of his condition.
3. In February 2016, Mr Ryan completed a course of palliative radiotherapy treatment and his condition went into remission. Nurses created care plans to manage his personal care and nutrition.
4. In January 2017, while at Doncaster, Mr Ryan complained of difficulty swallowing. He refused to have an oesophageal stent fitted (a small plastic tube put in the food pipe to allow food and drink to pass from the mouth to the stomach) to ease his condition and refused to see his hospital consultant. A prison psychiatrist assessed that Mr Ryan had the mental capacity to make decisions about his healthcare.
5. In May 2017, prison nurses created an end of life care plan and prison GPs prescribed medication to ensure Mr Ryan remained comfortable and pain free. Mr Ryan's condition continued to deteriorate and he died on 28 June.

## Findings

6. The clinical care Mr Ryan received was equivalent to that which he could have expected to receive in the community. The clinical reviewer considered that Mr Ryan's clinical care was well delivered, compassionate and responsive to his needs.
7. Appropriately, prison staff did not restrain Mr Ryan when he was taken to hospital. We also found that prison staff submitted an application for compassionate release at the appropriate time, although this was refused because Mr Ryan's risk of reoffending remained high.
8. We make no recommendations.

## The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Doncaster informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
10. The investigator obtained copies of relevant extracts from Mr Ryan's prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr Ryan's clinical care at the prison.
12. We informed HM Coroner for Doncaster of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
13. The investigator wrote to Mr Ryan's sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.
14. The investigation has assessed the main issues involved in Mr Ryan'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.
15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and this report has been amended accordingly

# Background Information

## HMP Doncaster

16. HMP Doncaster is a local prison, operated by Serco, which holds up to 1,145 remanded and sentenced men. Nottingham Healthcare NHS Foundation Trust provides physical and mental health services, and substance misuse services. HMP Doncaster directly employs qualified paramedics as part of their healthcare team, who respond to emergency calls within the prison.

## HM Inspectorate of Prisons

17. The most recent inspection of HMP Doncaster was in July 2017. Health services had improved considerably since the previous inspection in October 2015 and were reasonably good overall. A wide range of primary care services was available and waiting lists were generally short, although too many patients failed to attend appointments. The management of prisoners with long-term conditions had improved, with several specially trained staff available to patients. The 24-hour in-house paramedic service was an example of good practice.

## Independent Monitoring Board

18. 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 IMB published its annual report for the year to September 2016, shortly after Mr Ryan's death. The Board commented that they had received a high amount of applications about healthcare. The majority of complaints were about the difficulty in accessing healthcare for routine appointments. The Board noted good engagement between nurses and prisoners and praised the new initiative of having paramedics on site to deal with serious emergency issues.

## Previous deaths at HMP Doncaster

19. Mr Ryan was the fifth prisoner to die of natural causes at Doncaster since January 2016. There were no similarities between the circumstances of Mr Ryan's death and the previous deaths at the prison.

## Findings

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

20. On 29 September 2006, Mr Peter Ryan received an indeterminate sentence for public protection for sexual offences and was sent to HMP Leeds. He spent time in several prisons before being moved to HMP Moorland on 17 January 2012. He was moved to HMP Doncaster on 16 August 2016.
21. Mr Ryan had a history of high blood pressure, angina and cardiovascular disease. In 2005 he had a heart attack and was prescribed medication to lower his blood pressure. In 2015, while a prisoner at Moorland, Mr Ryan had a stroke.
22. On 25 August 2015, Mr Ryan collapsed in his cell and a prison GP diagnosed a urinary tract infection and an ambulance took Mr Ryan to hospital. On 26 August, Mr Ryan discharged himself from hospital.
23. When he returned to prison, a prison GP arranged a full set of blood and liver function tests. The results were received on 27 August and showed abnormal results. Mr Ryan refused further investigations into the results and signed a disclaimer to that effect.
24. On 3 October, Mr Ryan collapsed in his cell again and an ambulance took him to hospital. Hospital doctors diagnosed kidney stones and Mr Ryan had an operation to remove them. Hospital doctors treated Mr Ryan with intravenous antibiotics and decided he was too unwell to return to prison until further investigations had been completed.
25. On 14 October, Mr Ryan had an ultrasound scan. The results showed a possible pancreatic mass. A computerised tomography (CT) scan revealed that Mr Ryan was suffering from oesophageal cancer. Hospital doctors told Mr Ryan about his diagnosis and made a referral to an oesophageal cancer specialist.
26. On 11 November, Mr Ryan had a positron emission tomography (PET) scan to determine how to treat his condition. The results showed that Mr Ryan's condition was suitable for palliative radiotherapy treatment only.
27. We are satisfied that Mr Ryan's diagnosis was made in a timely manner and that he was informed of his condition.

### Mr Ryan's clinical care

28. On 31 December, Mr Ryan discussed his treatment plan with an oncology consultant at hospital. Mr Ryan completed his palliative radiotherapy treatment on 26 February 2016 and the consultant told him he was in remission. The consultant prescribed Mr Ryan medication to take in prison.
29. Prison nurses created care plans to manage Mr Ryan's personal care and nutritional needs. Nurses saw him daily and prison managers arranged for a prison buddy to assist him with collecting meals on the wing. When prison GPs noted that Mr Ryan was losing weight, they prescribed nutritional drinks and encouraged him to eat regularly.

30. The hospital's oncology team saw Mr Ryan as an outpatient to monitor his condition. On 16 August, he was moved to HMP Doncaster. Nurses continued to follow his care plans and Mr Ryan's condition remained stable.
31. On 19 January 2017, Mr Ryan complained he was having difficulty swallowing and was admitted to hospital. Mr Ryan refused to have an oesophageal stent fitted (a small plastic tube put in the food pipe to allow food and drink to pass from the mouth to the stomach) to help him swallow and he refused to attend two subsequent hospital appointments with his consultant. Mr Ryan told prison GPs the problem had eased and he did not need a stent fitted. Mr Ryan also refused to attend a routine appointment with the hospital's oncology team.
32. On 7 February, a prison GP saw Mr Ryan to encourage him to see the hospital's oncology team. Mr Ryan said he did not want to know any further information about his condition. The GP referred Mr Ryan to a psychiatrist for an assessment.
33. On 22 March, a psychiatrist assessed Mr Ryan and concluded that he had the capacity to make decisions about his healthcare. Mr Ryan agreed to be monitored by the prison's mental health team.
34. On 29 March, Mr Ryan said he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect.
35. On 5 May, Mr Ryan was admitted to hospital with dehydration caused by difficulty in swallowing. Mr Ryan refused to allow hospital doctors to insert a stent and was treated with intravenous fluids.
36. When Mr Ryan returned to Doncaster later that day, nurses created a palliative and end of life care plan. Prison GPs prescribed medication to ensure Mr Ryan remained comfortable and pain free. Mr Ryan's condition continued to deteriorate and he died at 3.40pm on 28 June.
37. The clinical reviewer concluded that prison GPs provided good continuity of care to Mr Ryan and liaised effectively with the hospital's oncology team. We are satisfied that Mr Ryan had the mental capacity to make decisions about his healthcare.

### **Mr Ryan's location**

38. After his cancer diagnosis and discharge from hospital to Moorland on 14 October 2016, Mr Ryan lived in a single cell in the prison's in-patients unit.
39. When he was moved to Doncaster on 16 August 2016, Mr Ryan lived in a single cell in the prison's social care unit. When his health deteriorated, Mr Ryan's palliative care plan allowed for his cell door to remain open to enable nurses to attend to his clinical needs.
40. We are satisfied that Mr Ryan was appropriately located throughout his illness.

## **Restraints, security and escorts**

41. When prisoners have to travel outside the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility.
42. When Mr Ryan was taken to hospital, two officers escorted him and did not restrain him at any time. We find that managers at Moorland and Doncaster took appropriate account of how Mr Ryan's health affected his risk to the public and of escape and decided not to restrain Mr Ryan at any time.

## **Liaison with Mr Ryan's family**

43. On 19 April 2017, the prison appointed a family liaison officer (FLO). She visited Mr Ryan in the healthcare unit and offered support. Mr Ryan told her he did not have any contact with his sister, his nominated next of kin.
44. The same day, the Assistant Director telephoned Mr Ryan's sister to tell her about Mr Ryan's diagnosis. Mr Ryan's sister said she did not want to visit her brother in prison and asked the prison to telephone her when Mr Ryan died. The FLO did so. Mr Ryan's sister did not want any further contact with the prison.
45. Mr Ryan's funeral was held on 14 July. The prison arranged for and paid for the funeral in line with national instructions.
46. We are satisfied that the prison liaised with Mr Ryan's next of kin appropriately and acted in accordance with his sister's wishes.

## **Compassionate release**

47. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.
48. When Mr Ryan's condition deteriorated in April 2017, prison staff asked him if he wanted to make an application for release on compassionate grounds.
49. On 10 May, the prison submitted Mr Ryan's application to the Public Protection Casework Section (PPCS) of Her Majesty's Prison and Probation Service. The Director of Doncaster did not support Mr Ryan's application.
50. On 27 June, the prison was informed that PPCS had not authorised Mr Ryan's release as he did not meet the necessary criteria. Specifically, his risk of reoffending remained high.
51. We consider that compassionate release was appropriately considered.

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations