

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Patrick Ryan a prisoner at HMP Hewell on 27 March 2017

**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*



© Crown copyright 2015

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 Patrick Ryan died in hospital on 27 March 2017 of pneumonia due to cancer, while a prisoner at HMP Hewell. He was 69 years old. I offer my condolences to Mr Ryan's family and friends.

Mr Ryan had been suffering from a range of symptoms, including back pain, stomach pain and constipation, for several months. Healthcare staff treated him with pain relief and medication for constipation, but failed to consider all his symptoms collectively and address the causes. Had they done so, Mr Ryan's cancer diagnosis might have been made sooner, although given that his cancer was widespread the delay may not have affected the outcome.

We agree with the clinical reviewer's conclusion that the standard of care Mr Ryan received was not equivalent to that which he could have expected to receive in the community. We are concerned that prison staff used handcuffs to restrain Mr Ryan when he was taken to hospital, and staff continued to restrain Mr Ryan in hospital, while he was seriously ill. The use of restraints was not justified given Mr Ryan's poor health and lack of 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.

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

**October 2017**

## Contents

Summary .....	1
The Investigation Process .....	2
Background Information .....	3
Key Events .....	4
Findings .....	6

# Summary

## Events

1. Mr Patrick Ryan arrived at HMP Hewell on 21 November 2016. He had several long-standing health problems, including high blood pressure, polyps (small growths) of the gall bladder, alcohol problems, thyroid problems, constant neck pain, spasms and chronic headaches and fibromyalgia (a long term condition that causes pain all over the body). Healthcare staff prescribed pain relief.
2. Healthcare staff and prison GPs saw Mr Ryan in February and March 2017 for pain relief and constipation treatments, but no one considered the possibility of an underlying condition. After a prison GP noted high calcium levels in a blood test, staff arranged for him to go to hospital on 7 March. On 17 March Mr Ryan was diagnosed with cirrhosis of the liver, pneumonia and ascites (excess fluid in the abdomen) and on 20 March he was diagnosed with widespread cancer. He remained in hospital, where he died on 27 March.

## Findings

3. The clinical reviewer found that healthcare staff managed Mr Ryan's health complaints reactively, treating the symptoms rather than addressing the causes. Staff missed opportunities to consider Mr Ryan's symptoms collectively, which may have indicated a more serious illness. They did not create care plans or arrange multi-disciplinary meetings to discuss Mr Ryan's complex conditions. We agree with the clinical reviewer that Mr Ryan's care was not equivalent to the care that he could have expected to receive in the community.
4. Prison managers authorised the use of restraints when Mr Ryan first went into hospital and no one authorised their removal until eight days later. We consider that the use of restraints was not justified, given Mr Ryan's poor health and lack of mobility.

## Recommendations

- The Head of Healthcare should ensure that clinicians consider a prisoner's overall symptoms in a holistic manner, so that any indicators of disease progression are quickly acted upon.
- The Head of Healthcare should ensure that care plans are developed and regularly reviewed for all chronic conditions, particularly where frequent requests for medication are made.
- The Head of Healthcare should ensure that multi-disciplinary meetings are held at regular frequency in cases where a prisoner has complex conditions and multiple prescriptions for medication.
- 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 the prisoner and are based on the actual risk the prisoner presents at the time.

## The Investigation Process

5. The investigator issued notices to staff and prisoners at HMP Hewell informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
6. The investigator obtained copies of relevant extracts from Mr Ryan's prison and medical records.
7. The investigator interviewed two members of staff over the telephone on 2 June 2017. We suspended the investigation from 28 July 2017 until 30 August as we waited for the post mortem results. We apologise for the delay this may have caused.
8. NHS England commissioned a clinical reviewer to review Mr Ryan's clinical care at the prison.
9. We informed HM Coroner for Worcestershire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
10. The investigator contacted Mr Ryan's family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They did not respond.
11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

# Background Information

## HMP Hewell

12. HMP Hewell is an amalgamation of two prisons, the former HMP Blakenhurst, and HMP Hewell Grange. The Hewell Grange site continues to operate as an open prison and the Blakenhurst site is a secure, local prison. Mr Ryan was at the Blakenhurst site, which comprises six houseblocks, holding around 1,100 men. Care UK provide health services.

## HM Inspectorate of Prisons

13. The most recent inspection of HMP Hewell was in September 2016. Inspectors reported that the prison had many challenges and areas of serious concern. On healthcare Inspectors acknowledged that Care UK had inherited a poor service but, while they had made some improvement, significant work was still needed. Healthcare staff shortages had significantly affected service delivery. However, agency staff had been recruited to cover shortages and recruitment campaigns had been run to fill vacancies. Areas in healthcare, including the inpatient area, were dirty and poorly ventilated. The waiting area for vulnerable prisoners had prominent racist and violent graffiti and what appeared to be blood on the walls. The high rate of 'failure to attend' healthcare appointments had shown recent improvement.

## 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 latest annual report, for the year to September 2016, the Board was concerned that the newly appointed healthcare providers had not been able to provide the promised, acceptable standard of care. Late provision of regular medication on the house blocks had caused considerable disruption and the use of a large number of agency nurses had led to a lack of continuity in patient care.

## Previous deaths at HMP Hewell

15. Mr Ryan was the fourth prisoner to die from natural causes at Hewell since January 2015. There were no significant similarities with the circumstances of the previous deaths.

## Key Events

16. On 21 November 2016, Mr Patrick Ryan was sentenced to 10 years in prison for sexual offences and sent to HMP Hewell. Mr Ryan had several longstanding health problems, including high blood pressure, polyps (small growths) of the gall bladder, alcohol problems, thyroid problems, constant neck pain, spasms and chronic headaches and fibromyalgia (a long term condition that causes pain all over the body). Healthcare staff prescribed pain relief.
17. On 20 February 2017, Mr Ryan complained that he could not get out of bed as he had worsening sciatica pain with leg spasm, stomach spasm, chest pain when coughing, nose bleeds and constipation. A paramedic examined him and noted his observations. She diagnosed constipation and fever of an unknown origin (PUO) and arranged for Mr Ryan to receive paracetamol and she made a GP appointment.
18. Mr Ryan told a nurse on 23 February that his community GP had diagnosed fibromyalgia and he regularly had flare ups. He said that the medication healthcare staff had prescribed was not working for him. She arranged for a prison GP to examine Mr Ryan. The GP examined Mr Ryan shortly afterwards. He noted that there was no mention of fibromyalgia in the community GP summary. He said that Mr Ryan might benefit from physiotherapy and placed him on the physiotherapy waiting list as a high priority to assist with pain. The next day Mr Ryan complained to the nurse about his ongoing pain and constipation. She noted he had not been taking his medication and told him that he was on the waiting list for physiotherapy.
19. On 3 March, a prison GP examined Mr Ryan as he said that he had not opened his bowels for two weeks, despite taking laxatives. The GP diagnosed an impacted stool and some of the stool was removed manually. The GP prescribed continued laxative use and arranged blood tests for Mr Ryan.
20. On 6 March, Mr Ryan told a nurse that he still had not opened his bowels. The nurse asked the prison GP to review him. A locum prison GP examined him and arranged for him to have an enema. A GP reviewed the blood test results and noted that Mr Ryan's serum calcium level was abnormal. The GP said that an appointment should be made for Mr Ryan to see a GP. Later that night, a nurse noted Mr Ryan had a big bowel movement, had no nausea or vomiting but was complaining about pain in his shoulder blades and back of neck. She arranged for a GP review in the morning.
21. During the early hours of 7 March, the nurse examined Mr Ryan again, as he told her he was still constipated and the stomach pain was worse and his blood pressure was very high. She called an ambulance. Paramedics attended and took Mr Ryan to hospital. Two officers escorted Mr Ryan and used handcuffs to restrain him.
22. Hospital staff initially diagnosed cholecystitis (inflammation of the gall bladder). Prison managers authorised the continued use of handcuffs. After further tests, on 14 March, hospital staff diagnosed liver cirrhosis, pneumonia and ascites (excess fluid in the abdomen). They decided to treat him palliatively. Escorting

staff continued to use handcuffs until 15 March when a prison manager decided they were no longer necessary.

23. On 20 March, hospital staff told a senior nurse that Mr Ryan's prognosis was poor as he had widespread cancer with unknown primary site. At hospital, Mr Ryan's condition continued to deteriorate, and he died on 27 March at 8.12pm.

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

24. The prison appointed a prison officer as the family liaison officer (FLO), and also an assistant. Mr Ryan's family and friends visited him in hospital. After his death, the FLO telephoned Mr Ryan's next of kin to tell her of his death. She visited Mr Ryan's next of kin with a prison manager and offered them condolences and support.
25. Mr Ryan's funeral was held on 20 April. The prison contributed to the costs, in line with national policy.

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

26. After Mr Ryan's death, a prison manager debriefed the staff involved in the escort bedwatch to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
27. The prison posted notices informing other prisoners of Mr Ryan'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 Ryan's death.

### **Post-mortem report**

28. The post mortem report shows that Mr Ryan died from pneumonia due to disseminated carcinoma (cancer) of unknown origin with cirrhosis as a contributory factor.

# Findings

## Clinical care

29. Mr Ryan had a history of chronic health problems including generalised pain, high blood pressure and severe constipation. The clinical reviewer identified gaps in the management and review of Mr Ryan's long-term diseases. Healthcare staff did not monitor or investigate his thyroid and blood pressure problems. The clinical reviewer said that healthcare staff responded to Mr Ryan's requests for medication and they reviewed him but concluded his problems were mainly attributable to constipation.
30. The clinical reviewer said that it had not been until 20 February 2017 that healthcare staff noted any deterioration in Mr Ryan's health as he complained of increased pain with episodes of being unable to get out of bed or move independently.
31. The clinical reviewer considered that there were missed opportunities to arrange an earlier referral to hospital. She noted that prison GPs referred Mr Ryan for physiotherapy in February 2017 to try to help with pain management and in March, glycerine suppositories and manual removal were used to deal with his constipation. The clinical reviewer noted that apart from these entries, Mr Ryan's conditions were managed by his own reporting of his level of pain and constipation. The clinical reviewer said that none of the prison GPs appeared to consider that cancer might have been an option to explain Mr Ryan's condition, despite his age, his previous health and frequent complaints of pain and constipation. It was only after healthcare staff noted elevated calcium levels in his blood tests in March 2017 that they arranged for him to go to hospital. The clinical reviewer said that if Mr Ryan had been in the community when he experienced the first episode of worsening pain and unable to get out of bed, it was probable that he would have been admitted to hospital for investigations. However, healthcare staff did not refer him until two weeks later. In view of his advanced cancer, the clinical reviewer said that this may not have affected his outcome. Nevertheless, she considered his care was not equivalent to that which he could have expected to receive in the community.
32. We agree with the clinical reviewer. In prison, a robust system of monitoring should be used to ensure the effective identification of life-threatening conditions. We make the following recommendation:

**The Head of Healthcare should ensure that clinicians consider a prisoner's overall symptoms in a holistic manner, so that any indicators of disease progression are quickly acted upon.**

## Care plans

33. The clinical reviewer said that there were no care plans in place for chronic pain or constipation and healthcare staff tried to manage both conditions by medication alone. The clinical reviewer said Mr Ryan's care was reactive, targeted at managing symptoms and not addressing the causes. She noted that staff did not arrange any multi-disciplinary meetings to review the complexity of Mr Ryan's condition, which would have provided an opportunity for the

healthcare staff to examine all his presenting symptoms. We make the following recommendations:

**The Head of Healthcare should ensure that care plans are developed and regularly reviewed for all chronic conditions, particularly where frequent requests for medication are made.**

**The Head of Healthcare should ensure that multi-disciplinary meetings are held at regular frequency in cases where a prisoner has complex conditions and multiple prescriptions for medication.**

### **Restraints, security and escorts**

34. 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.
35. The risk assessment for Mr Ryan's emergency transfer to hospital on 7 March 2017 concluded that his risk to the public and females was medium, and his risk of hostage taking, escape potential, likelihood of outside assistance, risk to hospital staff and victim were all low. The medical section of the assessment noted there were no objections to the use of restraints and there were no known conditions that increased the possibility that defibrillation may be required. Healthcare staff had not signed the form. The assessment said that double handcuffs (which entail the prisoner having his hands handcuffed in front of him and then having one wrist attached to a prison officer by an additional set of handcuffs) were to be used at all times and two officers should escort him.
36. A prison manager authorised the use of restraints. During interview, he said that he was present when healthcare staff and the ambulance staff attended to Mr Ryan before he left the prison, and his medical condition was relayed to him by the nurse. He confirmed he completed the assessment, and the decision was made to use double handcuffs for the hospital transfer as Mr Ryan was a category B sex offender serving 10 years, with four and a half years left. He said the decision was made that he was to remain double cuffed until he was admitted. Then a manager completing the bedwatch checks would update the risk assessment.
37. In the Person Escort Record Form (PER) the escorts noted at 6.45am that Mr Ryan was writhing around on the bed and it was impractical for him to be double handcuffed. They rang the prison and noted that a prison duty manager gave permission to change the handcuff to a single handcuff. At 12.15pm, the escorts noted that the hospital doctor had told them Mr Ryan would be admitted and the

duty manager gave permission to change from a single handcuff to an escort chain.

38. A prison manager completed the bedwatch escort risk assessment once hospital staff admitted Mr Ryan to hospital. At interview, he was asked what medical information he took into account when completing the risk assessment. He said that he was not a clinician and “was not there to interpret what medical condition he has got”. He said he took advice from the medical information on the form. He was unable to confirm that he had checked for the current information regarding Mr Ryan’s medical condition at hospital. He authorised the use of an escort chain.
39. The prison manager said that reviews of the bedwatch assessments were completed on set days of Monday, Wednesday and Friday. He said healthcare staff did daily telephone hospital checks and if there were any serious change of circumstances, they would advise the duty governor. He said they took advice from Care UK. There was no evidence this happened with Mr Ryan.
40. The escort bedwatch papers noted that Mr Ryan used an oxygen mask, was on a drip, had restricted movement and was confused. On 13 March, the escorts removed the handcuffs for a scan and then reapplied them. Later that day they noted that Mr Ryan attempted to remove the handcuffs but this seemed to be due to confusion rather than a genuine attempt to remove the handcuffs.
41. On 15 March, prison managers gave permission for the escorts to remove the handcuffs and they were never reapplied.
42. We are concerned that a prison manager decided that it would be appropriate to use double handcuffs on Mr Ryan. Double cuffing is usually required for moving category A or category B prisoners in good health. Mr Ryan was not in good health and had spent several months with limited mobility and in constant pain. There were instances when he was too ill to even mobilise to get to healthcare as nurses and GPs had to visit him in his cell. It is hard to conclude that this decision can be justified within the terms of the High Court judgement.
43. When the handcuffs were changed to single handcuffs and then the escort chain, Mr Ryan spent a total of eight days handcuffed to an officer as his health declined.
44. The Prison Service has a responsibility to protect the public, but security must be balanced with humanity and measures must be proportionate to a prisoner’s individual circumstances. When escorting prisoners, any risk assessment should fully take into account their health, their mobility and the impact of their health conditions on their ability to escape.
45. It is difficult to see how the assessments could conclude that an elderly man in poor health, and with limited mobility, had the ability to escape unaided from two escort officers to the extent that mechanical restraints could be justified. We are not satisfied that managers appropriately considered his condition at the time and how this affected his risk.
46. We are also concerned that at Hewell, a prison manager said that management checks are not conducted daily. 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 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 the prisoner and are based on the actual risk the prisoner presents at the time.**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations