

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Patrick Reilly a prisoner at HMP Hewell on 13 December 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*



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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.

On 13 December 2017, Mr Patrick Reilly died of prostate cancer, which had spread to other parts of his body, while a prisoner at HMP Hewell. He was 76 years old. I offer my condolences to his family and friends.

I am satisfied that the care Mr Reilly received at Hewell was equivalent to that which he could have expected to receive in the community. After Mr Reilly was diagnosed with cancer, healthcare staff appropriately managed his pain. When he neared the end of his life, social care staff visited daily and healthcare staff appropriately managed his pressure sores.

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**

**June 2018**

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# Summary

## Events

1. On 25 August 2014, Mr Patrick Reilly was remanded to HMP Nottingham. On 5 February 2015, he was transferred to HMP Hewell and on 17 April 2015, he was sentenced to 12 years in prison for sex offences.
2. At his initial health screen on 5 February 2015, a nurse noted that Mr Reilly had an outstanding appointment at the lung clinic because a scan taken while in hospital showed that he had a nodule in his lung.
3. On 28 May, a prison locum GP saw Mr Reilly and told him that his lungs had asbestos-related damage. The GP said that a CT scan (an imaging procedure that uses x-rays to create detailed scans) also showed that he had emphysema (lung disease).
4. On 25 November, a prison GP saw Mr Reilly because he had been unable to move from his bed for three days. He had lost weight. The GP sent Mr Reilly to hospital, where hospital staff completed a CT scan and concluded that he had prostate cancer, which had spread to other parts of his body.
5. On 3 December, Mr Reilly went to the Royal Orthopaedic Hospital in Birmingham for an operation to treat compressed nerves in his lower spine.
6. On 24 December, Mr Reilly went to the Princess of Wales Community Hospital, Bromsgrove, for rehabilitation. Mr Reilly had one dose of radiotherapy but refused other treatment. The healthcare team frequently obtained updates from the hospitals about Mr Reilly's health and treatment.
7. On 11 April 2016, Mr Reilly went back to Hewell and went to the inpatient unit. He could shower himself, needed some help with mobility and used a wheelchair. Healthcare staff supported him and encouraged him to eat and drink. He had pain relief. Mr Reilly saw a prison GP locum and said that he did not want anyone to resuscitate him if his heart or breathing stopped.
8. On 20 April, a prison GP told Mr Reilly that the cancer had spread to his spine, which was causing his pain. A nurse referred him to the social care team for support with his personal care but Mr Reilly refused it.
9. From April 2016 to October 2017, Mr Reilly missed three outpatient hospital appointments and was not reviewed by the hospital oncologist for seven months. The medical records note that on two of these occasions, no appropriate transport and no prison staff were available.
10. On 17 November 2017, a prison GP locum saw Mr Reilly who was aware that his condition was getting worse. He did not want to go to a hospice. He had severe pain, and went to hospital for pain management. On 2 December, Mr Reilly returned to Hewell.
11. Mr Reilly's condition deteriorated and he died on 13 December. There was no post-mortem examination, and a hospital doctor said that he died of cancer, which had spread from the prostate.

## Findings

12. Overall, the clinical care that Mr Reilly received at Hewell was equivalent to that which he could have expected to receive in the community. After he was diagnosed with cancer, healthcare staff appropriately managed his pain. He remained independent in terms of his personal care but healthcare supported him when he needed it. They took his vital signs daily and encouraged him to eat and drink.
13. After Mr Reilly's diagnosis and rehabilitation, he went back to Hewell, where he lived in the inpatient unit. We are satisfied that this was an appropriate location for him.
14. When he neared the end of his life, social care staff visited daily to help him with washing and dressing. His pressure sores were appropriately managed and as his health became worse, healthcare staff turned him more frequently to relieve the pressure.
15. However, we are concerned that after his cancer diagnosis, Mr Reilly missed three hospital appointments over a period of 18 months – two of which were because there were no prison staff or appropriate transport available. This meant that Mr Reilly was not reviewed by a hospital oncologist for seven months.
16. Prison staff completed a compassionate release application but a senior manager refused it because Mr Reilly was considered to present a risk of reoffending.

## Recommendations

- The Governor should ensure that there are sufficient staff and transport available so that prisoners are able to attend hospital appointments.

## The Investigation Process

17. 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
18. The investigator obtained copies of relevant extracts from Mr Reilly's prison and medical records.
19. NHS England commissioned a clinical reviewer to review Mr Reilly's clinical care at the prison.
20. We informed HM Coroner for Worcestershire of the investigation who gave us the cause of death. We have sent the Coroner a copy of this report.
21. The investigation has assessed the main issues involved in Mr Reilly'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.
22. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

## Background Information

### HMP Hewell

23. 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 Reilly was at the Blakenhurst site, which comprises six houseblocks, holding around 1,100 men. Care UK provides health services and there is an 18-bed inpatient unit.

### HM Inspectorate of Prisons

24. The most recent inspection of HMP Hewell was in September 2016. Inspectors reported that the prison had many challenges and areas of serious concern. Inspectors acknowledged that Care UK had inherited a poor service but while they had made some improvement, significant work was still needed. They found that healthcare staff shortages had significantly affected service delivery, though agency staff had been recruited to cover shortages and recruitment campaigns had been run to fill vacancies. Inspectors found that healthcare areas, 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

25. 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 30 September 2016, the IMB was concerned that the newly appointed healthcare providers had not provided an acceptable standard of care, as they had promised. Late provision of regular medication on the houseblocks 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

26. Mr Reilly was the fourth prisoner to die from natural causes at Hewell since December 2017. There were no significant similarities between the deaths.

## Findings

27. On 25 August 2014, Mr Patrick Reilly was remanded to HMP Nottingham. On 5 February 2015, he was transferred to HMP Hewell and on 17 April 2015, he was sentenced to 12 years in prison for sex offences.
28. **The diagnosis of Mr Reilly's terminal illness and informing him of his condition**
29. At his initial health screen on 5 February 2015, a nurse noted that Mr Reilly had an outstanding appointment at the lung clinic because a scan taken while in hospital showed he had a nodule in his lung. He also had an outstanding appointment at the fracture clinic and had his arm in a sling. The nurse noted that while Mr Reilly had been at Nottingham, he had jumped from a third-floor balcony and fractured his forearm.
30. On 6 February, a prison GP saw Mr Reilly. The prison GP gave him tramadol (pain relief) for his arm fracture. He noted that while he was in hospital for his broken arm, Mr Reilly had had a CT scan of his chest, abdomen and pelvis, which showed the nodule in his lung. He said that he had had another CT scan and was waiting for the results. The prison GP asked for healthcare staff to chase up the hospital discharge letters.
31. On 8 February, a nurse saw Mr Reilly for his second health screen. He was due to have another CT scan in Nottingham so healthcare staff organised for this to take place at a local hospital.
32. On 11 February, another nurse carried out an older person's assessment. Mr Reilly said that he had pain in his back and arms. The nurse asked a doctor to increase Mr Reilly's tramadol.
33. On 28 May, A prison locum GP saw Mr Reilly with the results of the CT scan. He told him that his lungs had asbestos-related damage. Mr Reilly said that he used to work in coal mines, lagging pipes with asbestos. The prison locum GP said that the CT scan also showed he had emphysema and prescribed him a salbutamol inhaler. Mr Reilly also had chronic obstructive pulmonary disease (COPD - inflamed airways and damaged air sacs in the lungs) and a nurse created a COPD care plan.
34. On 10 November, a nurse saw Mr Reilly because he said his back pain had been worse since the tramadol dose had been reduced. He said that he was not eating and was losing weight. The nurse planned to increase the tramadol dose and for a GP to review him.
35. On 20 November, a nurse saw Mr Reilly in his cell because he was unable to move and had severe back pain. She noted that he was also dehydrated. She asked Mr Reilly to drink more fluids and planned for him to see a nurse prescriber.
36. On 25 November, a prison GP saw Mr Reilly who said that he had been unable to walk around for three days and could not move from his bed. He had lost

weight. The GP sent Mr Reilly to the Alexandra Hospital, Redditch, where he had a CT scan and hospital staff diagnosed him with prostate cancer.

### Mr Reilly's clinical care

37. On 3 December, Mr Reilly went to the Royal Orthopaedic Hospital in Birmingham for an operation to treat compressed nerves in his lower spine. On 15 December, Mr Reilly went back to the Alexandra Hospital. The palliative care team saw him and he had physiotherapy for his mobility. On 24 December, Mr Reilly went to the Princess of Wales Community Hospital, Bromsgrove, for rehabilitation. Mr Reilly had one dose of radiotherapy but refused other treatment. The healthcare team frequently obtained updates from the hospitals about Mr Reilly's health and treatment.
38. On 11 April 2016, Mr Reilly went back to Hewell. He went to the inpatient unit and had a hospital bed. He could shower himself, needed some help with mobility and used a wheelchair. Mr Reilly saw a prison locum GP and said that he did not want anyone to resuscitate him if his heart or breathing stopped. He signed an order to that effect.
39. Mr Reilly looked after himself and healthcare staff supported him and encouraged him to eat and drink. He had oromorph pain relief in addition to his other prescribed pain medication.
40. A nurse created care plans for the risk of dehydration and nutrition. She assessed Mr Reilly as being at very high risk of having pressure sores.
41. On 20 April, A prison locum GP saw Mr Reilly. He told him that the cancer had spread to his spine, which was causing the pain.
42. On 27 April, a nurse referred him to the social care team for support with his personal care but on 22 June, Mr Reilly refused it.
43. On 20 September, a healthcare manager spoke to the palliative care team at the hospital who said that the healthcare team were doing everything they could and did not have to change anything about Mr Reilly's palliative care.
44. On 3 February 2017, a prison locum GP reviewed Mr Reilly who said that he was happy being cared for in the inpatient unit and did not want to go to a hospice.
45. On 29 May, a nurse created an end of life care plan with Mr Reilly. Healthcare staff treated Mr Reilly for pressure sores on his left buttock and right thigh. In June, he refused to allow healthcare staff to review his pressure sore areas but he allowed social care staff to support him with his hygiene needs.
46. On 17 November, a prison locum GP saw Mr Reilly who was aware his condition was getting worse. He was sent to hospital for pain management because he was in severe pain. On 2 December, Mr Reilly returned to Hewell. A healthcare assistant noted that he was at extremely high risk of getting pressure sores. She updated his care plan to turn him regularly. Mr Reilly had a urinary catheter and was incontinent of faeces.

47. The clinical care that Mr Reilly received was equivalent to that which he could have expected to receive in the community. After he left hospital having been diagnosed with cancer, healthcare staff appropriately managed his pain with strong painkillers. He remained independent while supported by healthcare staff, used his wheelchair to move around, mixed with his peers and joined in daily activities.
48. When he neared the end of his life, social care staff visited daily to assist him with washing and dressing. His pressure sores were appropriately managed and as his health became worse, healthcare staff turned him more frequently to relieve the pressure.
49. However, we are concerned that on three occasions between April 2016 and October 2017, after Mr Reilly had been diagnosed with cancer, he missed three outpatient hospital appointments and was not reviewed by the hospital oncologist for seven months. The medical records note that on two of these occasions, no appropriate transport and no prison staff were available. While the prison records do not give any further information about what happened, we are concerned that Mr Reilly did not see an oncologist for a number of months. We make the following recommendation:

**The Governor should ensure that there are sufficient staff and transport available so that prisoners are able to attend hospital appointments.**

50. The clinical reviewer also found that hospital letters were not routinely scanned onto Mr Reilly's medical record after hospital or clinic appointments.

### **Mr Reilly's location**

51. After Mr Reilly's diagnosis and rehabilitation, he went back to Hewell and stayed in the inpatient unit, where he had a hospital bed. He said that he did not want to go to a hospice and wanted to stay at Hewell with his peers and staff whom he knew well. We are satisfied that prison and healthcare staff appropriately managed Mr Reilly's location.
52. On 12 September 2017, a prison governor authorised staff to leave Mr Reilly's cell door open to allow for his best care and pain management.
53. When Mr Reilly returned to Hewell from hospital on 2 December, his condition deteriorated and he died on 13 December. There was no post-mortem examination. A hospital doctor established that he died of cancer, which had spread from the prostate.

### **Restraints, security and escort**

54. When prisoners travel outside of 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.

55. When Mr Reilly went to hospital on 17 November 2017, officers did not use restraints. A custodial manager said that officers should not restrain Mr Reilly in hospital because of his serious ill health. Officers did not restrain him.

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

56. On 15 September 2017, the Safer Custody Hub Manager appointed a family liaison officer and a deputy family liaison officer. The deputy liaison officer and the Deputy Governor (who is also Head of Operations Security) saw Mr Reilly who said that he did not have a next of kin because all his family and friends had died.
57. Deputy liaison officer remained in contact with Mr Reilly as his health deteriorated and discussed with him the arrangements for when he died.
58. Mr Reilly's funeral took place on 2 January 2018. The prison contributed to the cost in line with national instructions.

### **Compassionate release**

59. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they have a terminal illness and have a life expectancy of less than three months.
60. On 8 September 2017, a prison GP completed the medical section of the compassionate release application. He noted that Mr Reilly had prostate cancer and widespread bone cancer. The prison GP noted that his condition had deteriorated over recent months. He gave Mr Reilly a prognosis of one to three months, and said that he needed specialist palliative care.
61. On 13 September, a probation officer noted that Mr Reilly posed a high risk of serious harm to children and if released, the risk would remain high. The probation officer noted that Mr Reilly had no family or friends and she was concerned that if he was released to a hospice, it was likely that children would visit other patients.
62. On 3 October, A prison governor refused the application because Mr Reilly still presented a significant risk of re-offending.
63. We are satisfied that Hewell appropriately started the compassionate release process, considered whether compassionate release was suitable for Mr Reilly, and their decision not release him because he was a risk of re-offending was reasonable.

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