Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Raymond Shiels a prisoner at HMP Moorland on 26 February 2018

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 Raymond Shiels died of pancreatic cancer on 26 February 2018 while a prisoner at HMP Moorland. He was 67 years old. I offer my condolences to his family and friends.

I am satisfied that the healthcare that Mr Shiels received at Moorland was equivalent to that which he could have expected to receive in the community.

However, I am concerned that after Mr Shiels went to hospital on 3 February he was restrained in hospital for two weeks even though he had terminal cancer, his health was failing and he was assessed as a low risk of escape.

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 **September 2018**

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Summary

Events

1. Mr Raymond Shiels was serving a 15-year sentence for sex offences. He was transferred to HMP Moorland on 17 October 2016.

2. At his initial health screen when he arrived at Moorland, a nurse noted that Mr Shiels had had three small strokes in 2013, had been dependant on alcohol, and had had two paracetamol overdoses before he went to prison. He also had chronic obstructive pulmonary disease (COPD - inflamed airways and damaged air sacs in the lungs), depression, post-traumatic stress and indigestion. Healthcare staff prescribed Mr Shiels medication accordingly.

3. Mr Shiels had limited engagement with the healthcare department and lived in a cell on a standard wing. On 19 January 2018, a prison GP saw Mr Shiels, who said that he was not eating well. The GP found that he had lost 16 kilograms (about 2.5 stones) since his initial health screen. Because there had been no clinical need to weigh Mr Shiels after his health screen, it was not clear if the weight loss had happened gradually or over a short period of time.

4. The prison GP referred Mr Shiels urgently for a chest x-ray and blood tests under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.

5. On 2 February, after he returned from hospital, the prison GP reviewed Mr Shiels and noted that he now had jaundice (yellowing of the skin). The GP suspected the jaundice might be a symptom of pancreatic cancer and made another urgent referral under the two-week rule.

6. On 3 February, Mr Shiels went to hospital, where he was diagnosed with pancreatic cancer. As treatment was not possible, Mr Shiels agreed to have palliative care.

7. The medical section for the hospital escort risk assessment was not completed. The Head of Operations decided that two officers should escort Mr Shiels who should have a single handcuff applied.

8. Because Mr Shiels had to stay in hospital, a custodial manager reviewed his risk assessment. He noted that Mr Shiels was now being restrained by 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). He noted that Mr Shiels was a frail 67-year-old man, that his risk to the public was being managed by prison staff and that his risk of escape was minimal. He recommended that Mr Shiels should continue to be restrained with an escort chain.

9. Between 3 February and 14 February, officers at the hospital frequently noted that Mr Shiels' health had deteriorated.

10. On 7 February, a prison manager went to the hospital but did not review the level of restraints. On 13 February, a prison manager reviewed the level of restraints and considered that it was still appropriate. On 16 February, another prison

manager reviewed the level of restraints and authorised the removal of the escort chain.

11. On 26 February, Mr Shiels died in hospital.

Findings

Clinical care

12. The clinical reviewer found that the healthcare that Mr Shiels received at Moorland was good and equivalent to that which he could have expected to receive in the community. He did not often go to healthcare but his pre-existing conditions were monitored. A prison GP acted appropriately when Mr Shiels' health deteriorated and referred him under the two-week wait rule.

13. Mr Shiels lost 16 kilograms between October 2016 and January 2018. While this was a dramatic weight loss, there was no mechanism in place for clinicians to have identified it before he presented in January 2018.

Restraints

14. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances. We are concerned that Mr Shiels was restrained from 3 February (when he was admitted to hospital) until 16 February, even though he had been diagnosed with cancer, was receiving palliative care and his health was deteriorating.

Recommendations

- The Governor 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

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

16. The investigator obtained copies of relevant extracts from Mr Shiels' prison and medical records.

17. NHS England commissioned a clinical reviewer to review Mr Shiels' clinical care at the prison.

18. We informed HM Coroner for South Yorkshire East of the investigation who gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

19. The investigator wrote to Mr Shiels' son and daughter to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They did not respond to our letter.

20. The investigation has assessed the main issues involved in Mr Shiel'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.

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

Background Information

HMP Moorland

22. HMP Moorland is a Category C resettlement prison near Doncaster and holds up to 1,000 men. Nottinghamshire Healthcare NHS Trust runs healthcare services at the prison, including primary care, mental health and substance misuse services. The prison does not have an inpatient facility or full-time nursing cover.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Moorland was conducted in February 2016. Inspectors reported that healthcare staffing levels and the skill mix were appropriate, but high demand and continuing vacancies had placed significant pressure on frontline staff. They noted that a dedicated lead on older prisoners had recently been identified but that prisoner needs had not been fully assessed. (During our investigation, we found that this function no longer exists.)

Independent Monitoring Board

24. 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 February 2017, the IMB reported that overall, the range of healthcare provision, including mental health, substance misuse and the arrangements for social care, compared well with services available to the general population. There had been an improvement in the availability of escorts to take prisoners to hospital.

Previous deaths at HMP Moorland

25. Mr Shiels was the ninth person to die at Moorland since February 2014, and the fourth to die from natural causes. There are no significant similarities with the circumstances of the previous deaths.

Findings

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

26. Mr Raymond Shiels was serving a 15-year sentence for sex offences. He was transferred to HMP Moorland on 17 October 2016.

27. That day, a nurse saw Mr Shiels for his initial health screen. She noted that he had had three small strokes in 2013, had previously been dependant on alcohol, and had two paracetamol overdoses before he went to prison. Mr Shiels also had depression, post-traumatic stress and indigestion.

28. Healthcare staff prescribed Mr Shiels salbutamol, symbicort and tiotropium bromide inhalers for COPD, liquid food supplements to increase his weight, aspirin to prevent blood clots, simvastatin to lower cholesterol and sertraline for depression.

29. Between 12 September and 28 November 2017, a senior pharmacist technician reviewed Mr Shiels weekly for smoking cessation support. He told the investigator that he did not notice any obvious deterioration in Mr Shiels' health during this time.

30. On 19 January 2018, a prison GP saw Mr Shiels because prison staff said he looked unwell. Mr Shiels said that he was breathless, but that this was normal for him. The GP thought that he might have a respiratory infection and prescribed him carbocisteine. Mr Shiels also said that he was not eating well, and the GP found that he had lost 16 kilograms since his initial health screen. Because Mr Shiels had not been weighed after his health screen, it was not clear if the weight loss had happened gradually or over a short period of time.

31. Because of Mr Shiels' weight loss, the prison GP referred him urgently for a chest x-ray and blood tests under the two-week wait rule.

32. On 29 January, a prison GP reviewed the blood test results and noted that Mr Shiels' liver function tests were slightly high.

33. On 2 February, after he returned from hospital, a prison GP reviewed Mr Shiels. He noted that he now had jaundice (a yellowing of the skin) but Mr Shiels said he could not remember when this started. The GP suspected the jaundice might be caused by pancreatic cancer and made another urgent referral under the two-week wait rule.

34. On 3 February, Mr Shiels went to hospital. Hospital staff decided to admit him and found that he had pancreatic cancer and that treatment was not possible. Mr Shiels agreed to have palliative care.

35. Healthcare staff regularly spoke to hospital staff to obtain updates on Mr Shiels' condition which got worse. On 26 February, he died in hospital.

Mr Shiels' clinical care

36. We are satisfied that the healthcare that Mr Shiels received at Moorland was good and equivalent to that which he could have expected to receive in the community. Even though Mr Shiels did not often go to the prison's healthcare department, his pre-existing conditions, including COPD, were appropriately monitored and he had access to the healthcare team for his health needs. When Mr Shiels' health got worse, a prison GP appropriately referred him to specialists at the hospital.

37. While in hospital, Mr Shiels said that he did not want to be resuscitated if his heart or breathing stopped. Healthcare staff and hospital staff created an end of life care plan. Hospital staff referred Mr Shiels for palliative care support, and he spoke to them about the plan.

38. Mr Shiels had access to end of life care which allowed him to die in comfort and with dignity.

Mr Shiels' weight loss

39. Mr Shiels lost 16 kilograms between October 2016 and January 2018. Although this was a dramatic weight loss, there was no mechanism in place for clinicians to identify it until Mr Shiels presented in January 2018. While we recognise that in a community setting, Mr Shiels would similarly have had to present to GPs before he was referred for further investigation, we are mindful that he was not in the community: he was an older prisoner in the care of the State.

40. We acknowledge that there was no obvious means by which healthcare staff might have identified Mr Shiels' weight loss sooner. We can only speculate whether a more robust framework for the management of older prisoners, such as the routine measurement of key health indicators, might have done so and whether that might have led to an earlier diagnosis of his pancreatic cancer.

Mr Shiels' location

41. Before Mr Shiels went to hospital on 3 February, he lived independently on a standard wing. We are satisfied that while at Moorland, Mr Shiels' location on a standard wing was appropriate because he did not have complex nursing, medical or social needs.

42. Healthcare staff planned to move Mr Shiels to a nursing home which had 36 rooms and cared for people who were terminally ill.

43. On 26 February, Mr Shiels died at hospital before he could move to the nursing home. A post-mortem examination revealed that he had pancreatic cancer. He also had lung disease (emphysema).

Restraints, security and escorts

44. On 3 February, before Mr Shiels went to hospital, a support officer completed an escort risk assessment. Mr Shiels' risk to the public was assessed as medium, the risk of escape as low and the likelihood of outside assistance as low. The medical section was not completed. The officer noted that restraints were to be

used and not removed for medical treatment. The Head of Operations noted that two officers must escort Mr Shiels who should be restrained with a single handcuff.

45. Because a hospital doctor said that Mr Shiels had to stay in hospital, a custodial manager reviewed the risk assessment. He noted that a hospital doctor had taken blood tests but did not have the results. He noted that two officers were with Mr Shiels and he was being restrained by an escort chain. He noted that Mr Shiels was a frail 67-year-old man, that prison staff were managing his risk to the public and that his risk of escape was minimal. He recommended that Mr Shiels should remain restrained with an escort chain.

46. Between 3 February and 14 February, officers at the hospital noted Mr Shiels' health got worse. They noted that hospital staff put him on a drip, gave him a CT scan and pain relief medication. They recorded that hospital staff gave him intravenous medication and that he struggled to talk because of his deteriorating health. They noted that hospital staff gave him a nebuliser and oxygen and they planned to give him a stent (a procedure to widen blocked or narrow coronary arteries). They also recorded that Mr Shiels had an endoscopy and an x-ray and that by 9 February Mr Shiels was struggling to talk and breathe.

47. On 7 February, the Head of Security visited Mr Shiels in hospital. He did not review the risk assessment. On 13 February, he reviewed the risk assessment and noted that the use of an escort chain remained appropriate.

48. On 16 February, the Head of Security reviewed the risk assessment and authorised the removal of the escort chain, which officers did. The reason for this decision is not recorded.

49. 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.

50. 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.

51. We are concerned about the prison's approach to risk. There was no obvious reason, evidenced in the paperwork, to justify restraints based on their assessment of risk. Further, the prison failed to consider the impact of Mr Shiels' health on his risk, as required by the High Court judgement, when he went to hospital. We are particularly concerned that, after he was admitted to hospital, even though he had been diagnosed with cancer, was receiving palliative care, his health was deteriorating and it was accepted by the prison that his risk of escape was minimal and risk to the public was managed by escorting staff, senior staff still considered the use of restraints appropriate. We find these

decisions, on the facts, indefensible. It was not until 16 February, ten days before Mr Shiels died, that the restraint was removed. 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 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 Shiels' family

52. On 7 February, a hub manager was appointed as the family liaison officer. On 12 February, she spoke to Mr Shiels' ex-wife because she had been unable to contact Mr Shiels' son, his identified next of kin. She asked Mr Shiels' ex-wife to ask Mr Sheils' son to contact her.

53. On 13 February, the hub manager received a telephone call from Mr Shiels' daughter. She told her that Mr Shiels had cancer and was not expected to live more than three months. She told her that he was in hospital and that the family could visit him.

54. Mr Shiels' son and daughter visited him in hospital on 14 February and on a number of further occasions.

55. On 26 February, the hub manager told Mr Shiels' daughter that his condition was worse. Mr Shiels' daughter said she was aware because she was at the hospital with her brother.

56. On 27 February, a hospital nurse told the family that Mr Shiels had died. The hub manager spoke to Mr Shiels' daughter and offered her condolences and support.

57. The hub manager remained in contact with Mr Shiels' family. Mr Shiels' funeral took place on 4 April. The prison contributed to the costs in line with national instructions.

Compassionate release

58. 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 a life expectancy of less than three months.

59. Release on temporary licence (ROTL) can be granted for precisely defined and specific activities which cannot be provided in prison. A risk assessment is completed to ensure that a prisoner's temporary release does not present unacceptable risks. The governor of the prison can grant the temporary licence and will decide on whether the prisoner is to be accompanied by staff.

60. On 19 February, a hub manager completed a compassionate release application and a ROTL application. The compassionate release application was not authorised before Mr Shiels died.

61. On 23 February, Mr Shiels signed a ROTL form, which allowed him to be released subject to licence conditions, to receive medical care and treatment at the hospital and at the nursing home. The terms of the ROTL started on 21 February, and expired on 1 March. The number of escorting officers at the hospital was reduced from two to one.

62. We are satisfied that the prison completed compassionate release and ROTL applications and that Mr Shiels was released on temporary licence before he died.

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