Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Richards a prisoner at HMP Parc on 24 August 2016

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.

Mr Stephen Richards died on 24 August 2016 of liver failure and cirrhosis of the liver, while a prisoner at HMP Parc. Mr Richards was 58 years old. I offer my condolences to Mr Richards' family and friends.

Mr Richards was diagnosed with cirrhosis of the liver before he was sentenced. At his initial prison, healthcare staff failed to obtain information about a hospital appointment in preparation for a liver transplant. When he moved to Parc ten days later, healthcare staff immediately remedied the missed appointment and supported Mr Richards' treatment. However, I am disappointed that the decision to restrain Mr Richards' during the last two weeks of his life was not reviewed earlier.

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 **January 2018**

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Summary

Events

1. On 1 May 2015, Mr Stephen Richards was sentenced to four years in prison for civil offences and sent to HMP Cardiff. He moved to HMP Parc on 11 May 2015.

2. On 1 May, at Cardiff, Mr Richards told the nurse he had non-alcoholic cirrhosis of the liver (scarring of the liver) and a fatty liver, and had outstanding hospital appointments on 7 May for an ERCP (Endoscopic Retrograde Cholangio-Pancreatography - a procedure to examine the pancreatic and bile ducts) and a liver biopsy, in preparation for a possible liver transplant within two years.

3. On 3 May, a different nurse assessed Mr Richards and made a referral to the prison GP on 5 May, and tasked the admin department to obtain further information relating to Mr Richards' outstanding hospital appointment. On 5 May, a prison GP noted Mr Richards' non-alcoholic cirrhosis of the liver, sepsis, and enlarged spleen. She also noted he was obese, had peripheral oedema (swelling), and sallow skin with yellow white of the eye associated with jaundice. She noted to obtain Mr Richards' full medical records.

4. No further information was recorded with regard to Mr Richards' outstanding hospital appointment, and on 11 May he transferred to HMP Parc.

5. When Mr Richards arrived at Parc on 11 May, a prison GP assessed him and noted his concern that he had been transferred jaundiced. Mr Richards told the prison GP that he would need a liver transplant within two years and missed his follow up appointments while at Cardiff.

6. The following day, the prison GP made an urgent referral to the hospital's gastroenterology department and arranged for blood and urine samples.

7. A few days later, on 17 May, Mr Richards' suffered with pain in his right side and vomiting. The following day the prison GP noted that he needed to see a gastroenterologist as soon as possible and alerted staff that if Mr Richards bled, felt unwell, sick, faint or vomited blood he would need to be taken to hospital immediately via ambulance.

8. On the same day, the prison GP spoke with a consultant gastroenterologist at the hospital. They agreed that Mr Richards required an urgent review and that appointments for Mr Richards' were to be treated as urgent and were not to be cancelled or moved for any reason.

9. In July, Mr Richards attended hospital for an ultrasound and gastroscopy, and by early August, the prison GP noted that Mr Richards' blood results were getting worse. On 19 August, Mr Richards suffered with vomiting, abdominal pain and shivering. The prison GP referred him to hospital where an X-Ray identified a small kidney stone.

10. Mr Richards remained in hospital and on 26 August had a stent inserted. He was re-admitted for one day on 29 August due to complications. The stent was removed a month later.

11. Mr Richards had gastroenterology appointments in December, and January 2016. On 25 May, a referral was made to the hospital for a liver transplant on 31 August.

12. On 6 August, blood test results identified significant deterioration in Mr Richards' liver function and he was admitted to hospital. Mr Richards was treated with antibiotics and underwent surgery to remove a gallstone obstruction. After his operation he suffered internal bleeding and renal impairment. On 23 August, hospital specialists agreed that Mr Richards was not fit for a liver transplant. His condition continued to deteriorate and he died the following day at 2.35pm.

Findings

13. Mr Richards was diagnosed with non-alcoholic cirrhosis of the liver before he was sentenced and staff at Cardiff failed to find out the importance of an existing hospital appointment. When Mr Richards transferred to Parc ten days later, healthcare staff immediately arranged an appointment with a specialist and fully supported his ongoing treatment leading to a planned liver transplant in August 2016. We agree with Health Inspectorate Wales that the treatment Mr Richards received at Parc was equivalent to that he could have expected in the community. However, during Mr Richards' last hospital admission, the level of risk he posed as his health deteriorated was not appropriately reviewed. Although the impact of Mr Richards' missed appointment while at Cardiff cannot be known, adequate enquiries and alternative arrangements were not made.

Recommendations

- The Governor and Head of Healthcare at Cardiff should ensure that new prisoners do not miss hospital appointments unless there are properly justified, exceptional and fully recorded reasons.

- The Director and Head of Healthcare at Parc 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

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

15. The investigator obtained copies of relevant extracts from Mr Richards' prison and medical records.

16. Health Inspectorate Wales commissioned a review of Mr Richards' clinical care at the prison.

17. We informed HM Coroner for Bridgend & Glamorgan Valleys of the investigation who sent the results of the post-mortem examination. We have given the coroner a copy of this report.

18. The investigator wrote to Mr Richards' sister, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked us to consider the impact of Mr Richards' missed hospital appointment while at HMP Cardiff and whether it contributed to or caused his death.

19. The investigation has assessed the main issues involved in Mr Richards' 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.

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

21. Mr Richards' sister received a copy of the initial report. The solicitor representing Mr Richards' sister wrote to us pointing out some factual inaccuracies and/or omissions. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

Background Information

HMP Parc

22. HMP Parc is a medium security private prison run by G4S, which holds around 1,600 convicted men and young adults on remand or convicted. It also has a unit for around 60 young people under 18.

23. The prison has a palliative care suite and adapted cells to fit hospital beds. The unit employs staff with additional training to support the prisoners' needs. There is 24-hour general healthcare, palliative care facilities and a local GP practice provides GP services, including out of hours cover.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Parc was in January 2016. Inspectors reported that support for prisoners with complex health needs, including lifelong conditions, was generally good. However, there were concerns about delays and cancellations to hospital appointments and recommended prompt access to external appointments and waiting times from referral to attendance to be monitored.

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 February 2016, the IMB reported that where there was previously an overwhelmingly negative perception of access to healthcare by prisoners, the introduction of a patient liaison officer and "healthcare champions" on the wing has had a positive impact.

Previous deaths at HMP Parc

26. Mr Richards is the second prisoner to die from natural causes at Parc since January 2016. There have been four deaths since. There were no significant similarities between the investigations.

Key Events

27. On 1 May 2015, Mr Stephen Richards was sentenced to four years in prison for civil offences and sent to HMP Cardiff. He moved to HMP Parc on 11 May 2015.

28. On 1 May, at Cardiff, Mr Richards was assessed by a nurse. She observed large swellings to both legs below the knee, which Mr Richards confirmed was due to non-alcoholic cirrhosis of the liver (scarring of the liver). Mr Richards told her he was waiting to have his gallbladder removed, that he had a pain in his spleen and he was waiting for a liver transplant in the next two years. Mr Richards was not taking any medication, as he did not want it to affect his liver.

29. She noted Mr Richards had outstanding hospital appointments on 7 May for a liver biopsy and an ERCP (Endoscopic Retrograde Cholangio-Pancreatography - a procedure to examine the pancreatic and bile ducts).

30. On 3 May, a nurse assessed Mr Richards and made a referral to the prison GP on 5 May. She tasked the admin department to obtain further information relating to Mr Richards' outstanding hospital appointment. On 5 May, a prison GP assessed Mr Richards. Mr Richards told her he had cirrhosis of the liver, a fatty liver, sepsis and cellulitis in January, and now had an enlarged spleen. Upon examination, she noted that he had sallow skin, yellow tinged sclera (white of the eye) and some varicose veins. She noted he was obese with peripheral oedema (accumulation of fluid causing swelling), an enlarged liver and that she was unable to feel his spleen. She recorded a plan to get Mr Richards' medical record regarding further management.

31. No further information was recorded with regard to Mr Richards' outstanding hospital appointment, and on 11 May, Mr Richards transferred to HMP Parc. A nurse declared him as fit for transfer.

32. When Mr Richards arrived at Parc, a prison GP assessed him. He noted the cirrhosis of the liver and his concern that Mr Richards had been transferred jaundiced. Mr Richards told him in late 2014 he injured his foot and his left leg became so swollen that he was admitted to hospital for 28 days for intensive treatment for sepsis before being transferred to the hospital's liver unit. An MRI scan suggested that he had severe non-alcoholic cirrhosis, exacerbated by his infection, and was told that he would need a liver transplant within two years. Mr Richards told him that he had missed his follow up appointments while at Cardiff.

33. The prison GP made an urgent referral to the hospital's gastroenterology department and arranged for blood and urine samples. He noted if there were any signs of tremor, confusion, or fever that he would need to be assessed urgently and probably require a hospital admission. Mr Richards was located in a ground floor cell.

34. On 17 May, Mr Richards requested to see a nurse. A nurse noted he had a pain in his right side and had vomited, which had made him feel a little better. She booked a GP appointment the following day and Mr Richards declined the offer of pain relief.

35. The following day, the prison GP noted that Mr Richards needed to see a gastroenterologist as soon as possible, as he was at risk of a gastro-intestinal bleed. He also noted that having retrieved most of Mr Richards' medical notes that he had a poor prognosis without the prospect of a transplant. Mr Richards told him that he wanted to know his prognosis and exactly what was wrong. The prison GP explained that there were many unknowns and that he would need further evaluations with an endoscopy (a nonsurgical procedure used to examine the digestive tract), fibroscan (a technique similar to ultrasound that measures the stiffness of the liver) and possibly a liver biopsy. He noted if Mr Richards bled, felt unwell, sick, or faint he would need an immediate assessment and if he vomited blood, he would need to be admitted to hospital.

36. On the same day, the prison GP spoke with a consultant gastroenterologist at the hospital. They agreed that Mr Richards did not need to be admitted to hospital at that time but that he did need an urgent review. The prison GP instructed the admin team to ensure that any appointments were to be treated as urgent and were not to be cancelled or moved for any reason.

37. A prison GP, noted on 23 June, that Mr Richards was suffering with pain in his upper abdomen and that he was awaiting further investigations at hospital. Mr Richards declined any pain relief and he noted to review if his condition became worse. On 23 and 31 July Mr Richards attended hospital for an ultrasound and gastroscopy.

38. On 7 August, a prison GP noted that Mr Richards' blood results were getting worse. He planned twice-daily observations and if Mr Richards showed signs of a low temperature, severe shivering, abdominal pain, darkened urine, spontaneous bleeding into the skin, they were to be treated with caution and discussed with the GP on call. The prison GP discussed his blood results with a doctor at the hospital who confirmed that it was not necessary to admit Mr Richards into hospital at that time.

39. On 19 August, Mr Richards suffered with vomiting, abdominal pain and shivering. The prison GP diagnosed possible appendicitis and referred him to the hospital. An X-Ray identified a small kidney stone. He remained in hospital and on 26 August had a stent inserted. On 27 August, he returned to Parc. Two days later he was re-admitted to the hospital's urology department as he was passing blood in his urine. He was transfused with platelets and returned to Parc the same day. The stent was removed a month later.

40. A prison GP, reviewed Mr Richards on 1 September. He noted that his symptoms had not deteriorated, and although he was still bleeding intermittently, he felt better than he did. He noted a review in two weeks.

41. On 4 September, a prison GP examined Mr Richards and noted he was well in himself, but that if his clotting did not improve over the following two weeks that he would speak to the other prison GP again. On 21 September, a prison GP reviewed a clotting screen blood test and decided that no further action was required.

42. On 23 November, the chaplain asked a prison locum GP to look at Mr Richards as he appeared jaundiced. Mr Richards told the prison locum GP that he did not

feel any more jaundiced than usual and felt well. He noted that he had no fevers or chills, and normal bowel function. He felt his abdomen and could just about feel the liver edge. He noted that he had a urology appointment on 27 November. However, the hospital cancelled that appointment and re-scheduled it for 29 December.

43. On 8 January 2016, a prison GP examined Mr Richards as he reported feeling unwell with periods of confusion and slurred speech. He conducted further blood tests and sent a letter updating Mr Richards' gastroenterology consultant whom he was due to see for a check-up on 13 January. On 13 January, the consultant scheduled an EEG to assess Mr Richards' brain function.

44. On 1 March, the prison received a hospital appointment for an EEG on 7 March, which they could not facilitate due to short notice. This was immediately rearranged for 8 April.

45. On 25 May, a prison GP made a referral to the hospital for a liver transplant on 31 August.

46. On 4 August, a prison GP assessed Mr Richards as he was suffering with abdominal pain. He conducted blood tests. On 6 August, the results identified significant deterioration in Mr Richards' liver function and a prison GP advised that he be sent to hospital and that he should not return to Parc until he had been assessed by a gastroenterologist.

47. As with all his previous hospital visits, single cuffs were applied to Mr Richards with instruction to reduce this to an escort chain during treatments. Due to Mr Richards' low mood, restraints were removed on 17 August.

48. In hospital, Mr Richards received antibiotics and on 11 August, an MRI identified a gallstone in his bile duct. After an operation to remove the blockage, Mr Richards suffered internal bleeding and significant renal impairment. On 23 August, hospital specialists agreed that Mr Richards was not fit for a liver transplant. His condition continued to deteriorate and he died the following day at 2.35pm.

Contact with Mr Richards' family

49. On 17 August, Mr Richards told a chaplain that although he maintained contact with his children and his sister, he did not want them to know how serious his condition was.

50. On 18 August, the prison appointed a chaplain as the family liaison officer. The chaplain explained to Mr Richards' sister her role in supporting Mr Richards and his family through his illness. She visited Mr Richards in hospital and spoke with him and his family regularly.

51. Mr Richards' sister was with him when he died. The chaplain visited the hospital and offered her condolences.

52. Mr Richards' funeral was held on 8 October. The prison contributed towards the costs, in line with national policy.

Support for prisoners and staff

53. After Mr Richards' death, a senior manager debriefed the staff involved in his care to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

54. The prison posted notices informing other prisoners of Mr Richards' 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 Richards' death.

Post-mortem report

55. The post-mortem concluded that Mr Richards died of a decompensated hepatic failure (liver failure) following surgery to remove a gallstone obstruction, and cirrhosis of the liver.

Findings

Clinical Care

56. Mr Richards was diagnosed with cirrhosis of the liver before he was sentenced. During his reception health screen at Cardiff on 1 May, he told the nurse that he had a gastroenterology appointment on 6 May. A different nurse tasked a healthcare administrator to obtain further information on 3 May. However, they failed to do so and the opportunity to either facilitate the appointment or arrange a local appointment did not happen. The recorded attempts made to ascertain the nature of Mr Richards' appointment and the exploration of alternative arrangements were insufficient. We therefore make the following recommendation:

    The Governor and Head of Healthcare at Cardiff should ensure that new prisoners do not miss hospital appointments unless there are properly justified, exceptional and fully recorded reasons.

57. When Mr Richards arrived at Parc, a prison GP identified the significance of the missed appointment in a telephone call to the hospital. He then arranged a local gastroenterology appointment as a matter of urgency. When Mr Richards' condition deteriorated, the prison GP sought advice from specialists and referred him to hospital where necessary. Hospital specialists managed Mr Richards' subsequent treatment and pathway for a liver transplant, supported fully by healthcare staff at Parc. We agree with Health Inspectorate Wales that the standard of care Mr Richards received was equivalent to that he could have expected in the community.

Compassionate Release

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

59. On 17 August, the chaplain asked a senior manager if an application for Mr Richards' release on temporary licence could be considered. He started the process immediately and Mr Richards' offender manager was contacted the following day for her input. However, she was on sick leave until 24 August, and upon her return informed the prison that Mr Richards had a new offender manager. Although I do not make a recommendation, this lack of communication from Mr Richards' new offender manager to the prison caused a delay in the application process, which could easily have been avoided.

Restraints, security and escorts

60. 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.

61. Mr Richards was a category C prisoner imprisoned for civil offences. Healthcare staff did not object to restraints on medical grounds but he was assessed as low risk of escape and low risk of causing harm to staff and the public. On 4 August, a senior manager authorised the use of an escort chain to restrain Mr Richards. While in hospital Mr Richards was largely bed-bound and underwent stent surgery before deteriorating further, by which point on 13 August, Mr Richards asked if his risk assessment could be reviewed. That evening a senior manager visited Mr Richards but there is no record of a review of his risk assessment or his condition at that time. Mr Richards remained restrained until 17 August when a senior manager, authorised the removal of the restraints. There is no evidence that Mr Richards’ risk assessment was reviewed between 6 and 17 August. We therefore make the following recommendation:

The Director and Head of Healthcare at Parc 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.

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