Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Douglas Richardson a prisoner at HMP Holme House on 6 October 2017

A report by the Prisons and Probation Ombudsman

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: 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*

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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.

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 Douglas Richardson died on 6 October 2017 of liver cancer while a prisoner at HMP Holme House. He was 60 years old. We offer our condolences to Mr Richardson's family and friends.

I am satisfied that Mr Richardson received a good standard of care while at Holme House, equivalent to that which he could have expected to receive in the community. The day to day management of his conditions was of a good standard, including comprehensive care plans, which were in place to manage the symptoms of his condition. In addition to the regular reviews by healthcare staff, there was good input from Macmillan nurses.

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 **March 2018**

Contents

Summary 1

The Investigation Process 2

Background Information 3

Findings 4

Summary

Events

1. On 20 January 2017, Mr Douglas Richardson was sentenced to 3 years in prison for sexual offences. He was sent to HMP Durham.

2. Before being sent to prison, Mr Richardson attended Freeman Hospital, Newcastle where a mass was found in his liver. On 7 February, Mr Richardson attended a hospital for a liver biopsy. The results showed the mass in his liver was malignant (cancerous) and inoperable.

3. Hospital staff considered that palliative chemotherapy was the only treatment option available for Mr Richardson. Despite advice from hospital and healthcare staff, Mr Richardson said he would not consider chemotherapy until he had been released from prison. Healthcare staff and Macmillan nurses continued to review Mr Richardson as his condition declined.

4. On 5 October, Mr Richardson was moved to the palliative care suite at the prison. He died on 6 October at 6.30am.

Findings

5. We are satisfied that Mr Richardson received a standard of care that was equivalent to that which he could have expected to receive in the community.

6. Mr Richardson’s medical records show comprehensive care plans were in place to manage his condition. Links were made with external bodies, which advised and assisted healthcare staff to ensure that Mr Richardson’s care requirements were met.

7. We make no recommendations.

The Investigation Process

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

9. The investigator obtained copies of relevant extracts from Mr Richardson's prison and medical records.

10. NHS England commissioned a clinical reviewer to review Mr Richardson's clinical care at the prison.

11. We informed HM Coroner for Teesside of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

12. The investigator wrote to Mr Richardson's next of kin to explain the investigation and to ask if she had any matters he wanted the investigation to consider. She did not respond to our letter.

13. The investigation has assessed the main issues involved in Mr Richardson'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.

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

Background Information

HMP Holme House

15. HMP Holme House is a local prison in Stockton on Tees holding over 1,200 men. Most are on remand, or recently convicted by courts in the local area. G4S provides health services at the prison. There is a 24-hour inpatient unit with 16 beds and palliative care facilities.

HM Inspectorate of Prisons

16. The most recent inspection of Holme House was in July 2017. Inspectors noted that healthcare services had deteriorated since their previous inspection, mainly due to staff shortages and poor clinical governance. They considered the range of primary healthcare services available at the prison was good, but waiting times for GP appointments were problematic.

17. They were pleased to note that healthcare staff provided compassionate care to those prisoners with complex care needs but their efforts were undermined by an impoverished regime. Mental health provision at the prison was good but high demand and staff shortages occasionally affected the efforts to deliver that care. Prisoners with social care needs were identified promptly and received good support.

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. In their latest annual report for the year to December 2016, the IMB reported that they were concerned about the healthcare unit's staffing levels, the waiting times for primary care appointments, the ability of the healthcare provider to meet the needs of prisoners and the ability of the prison to escort prisoners to outside appointments.

Previous deaths at HMP Holme House

19. Mr Richardson was the fifth prisoner to die of natural causes at Holme House since January 2016. There has been one natural cause death since Mr Richardson's death. There were no significant similarities with those deaths.

Findings

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

20. On 20 January 2017, Mr Douglas Richardson was sentenced to 3 years in prison for sexual offences. He was sent to HMP Durham. On 24 May, his sentence was reduced on appeal to 18 months.

21. During his initial healthscreen, Mr Richardson told the nurse that he had liver cancer and was awaiting the results of tests from a hospital. He also told the nurse he had a history of blood clots in his lungs for which he received anticoagulant injections (blood thinning treatment to minimise the occurrences of blood clots).

22. The nurse noted Mr Richardson was a heavy smoker and offered him smoking cessation advice, which he declined. He accepted cessation advice in April and successfully gave up smoking. The nurse referred Mr Richardson to, a prison GP for review who noted that despite his many health issues, Mr Richardson appeared well and fully understood it was highly likely that he had liver cancer. He asked for Mr Richardson's community GP records so that he could clarify his medical history.

23. The community records showed that Mr Richardson had had tests before he entered prison. Hospital letters confirmed computerised tomography (CT) and magnetic resonance imaging (MRI) scans had identified a mass in Mr Richardson's biliary tract. Hospital staff suspected he had developed hilar cholangiocarcinoma, more commonly known as biliary tract cancer, affecting the liver, gall bladder and bile ducts. They decided the best course of treatment for Mr Richardson was to undergo a liver resection (a surgical intervention to remove the affected parts of the liver). Before the biopsies could be taken, Mr Richardson was sent to prison.

24. On 28 January, a Macmillan nurse, a specialist in palliative care reviewed Mr Richardson. She noted he was fully aware of his possible diagnosis and in relatively good spirits. She discussed the treatment options and medications with him. She compiled care plans to manage his ongoing care and continued to review him regularly over the weeks that followed.

25. On 7 February, Mr Richardson attended the hospital for a liver biopsy. The results confirmed the mass in his liver was malignant and inoperable. Hospital staff decided that palliative chemotherapy was the only treatment option available for him.

26. On 23 March, a Macmillan nurse, a palliative care nurse, reviewed Mr Richardson. She noted that he fully understood his recent diagnosis of cancer and that his condition was inoperable. She discussed the benefits of chemotherapy treatment to ensure he had the facts to help him make an informed choice. Mr Richardson told her he did not want to have chemotherapy while in prison because he felt he would not be able to cope. He told her he

would not make a decision until he had discussed it with members of his family. She agreed to attend his next hospital review with him for support, and to ensure he understood the details of the treatment to help him make that decision.

27. On 20 April, the oncology team at the hospital discussed the chemotherapy treatments available, and the benefits and side effects with Mr Richardson. He told hospital staff he did not want to talk about his prognosis, preferring not to know. He was happy for that discussion to be had with the nurse. Hospital staff told her Mr Richardson had between four and six moths to live without treatment. If he chose to accept chemotherapy treatment he could possibly extend that prognosis to approximately 11 months.

28. On 27 May, following lengthy discussions with his family, Mr Richardson decided to have chemotherapy treatment. He discussed his decision with the oncology team at a hospital during a review on 6 June. However, he told hospital staff that while he had decided to accept chemotherapy, he wanted to wait until after his release from prison on 19 October before starting treatment. Hospital staff told him he might not be fit enough to undergo the treatment at that time and should consider starting the treatment earlier. Mr Richardson said he was willing to take that risk.

29. On 14 June, Mr Richardson was transferred to HMP Holme House to be closer to his family. A nurse carried out an initial healthscreen following his arrival. She noted his pre-existing conditions and medications. She also noted a nurse had agreed to continue to review Mr Richardson following his transfer to ensure the continuity of his care.

30. On 23 June, a nurse reviewed Mr Richardson. She noted he felt much more settled at Holme House and was considering starting chemotherapy treatment prior to his release. She noted he was coping with his pain well but he complained that he struggled to sleep because of being in a shared cell.

31. On 28 June, a prison GP reviewed Mr Richardson. Mr Richardson told him that he wanted to apply for early release on compassionate grounds (ERCG). He completed the healthcare section of the form on his behalf and forwarded it to other relevant departments for completion. Mr Richardson's application was refused because he did not meet the criteria for ERCG at that time. A second application was made on his behalf in September.

32. On 11 July, a multi-disciplinary team (MDT) meeting was held with representatives involved with Mr Richardson's care. His care plans were reviewed and updated and treatment plans were discussed. It was noted that while he still did not want to discuss his prognosis, he was happy for healthcare staff to be made aware. Regular MDT meetings continued to be held to discuss and manage his care as his condition progressed.

33. Healthcare staff assisted by a nurse continued to review Mr Richardson regularly over the weeks that followed. The nurse arranged for specialist equipment to be provided to Mr Richardson as his condition deteriorated, including a pressure sore relieving mattress and a personal wrist alarm to attract the attention of staff should he need it.

34. On 11 September, a prison GP reviewed Mr Richardson. He noted Mr Richardson was complaining of increasing pain in his upper abdomen. He adjusted his pain relief to try to ease his symptoms. He also noted Mr Richardson's appetite was diminishing and prescribed Fortisip dietary supplements. Mr Richardson told the prison GP he had decided he would not undergo any chemotherapy treatment until his release from prison. He also said he wanted to sign a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order (which means that, in the event of cardiac or respiratory arrest, no attempt at resuscitation will be made, all other appropriate treatment and care would continue to be provided). Staff were informed that the DNACPR was in place.

35. The following day, a Macmillan nurse reviewed Mr Richardson. She noted he appeared frail and, although he continued to be self caring, he was finding it increasingly difficult. She noted he accepted that he might not survive until his release date. She told him his application for ERCG was progressing and that the prison hoped to get a response soon.

36. On 21 September, a nurse from the palliative care team reviewed Mr Richardson. She noted he had developed abdominal ascities (a condition in which fluid builds up in the abdominal cavity causing swelling and pain) causing him to be short of breath and have difficulty eating. She contacted staff at a hospital for advice and they agreed to review him. On 25 September, hospital staff drained the fluid from Mr Richardson's abdomen. He was returned to the prison the same day.

37. On 3 October, a prison GP reviewed Mr Richardson. He had asked Mr Richardson's family to attend the review so he could answer any questions they might have. He noted Mr Richardson had lost weight and despite an improvement in his symptoms since the draining of fluid from his abdomen, the abdominal pain had returned. He spent time speaking to Mr Richardson and his family, telling them what they could expect as his condition deteriorated and answering any questions about his illness and medications he had been prescribed.

38. A nurse reviewed Mr Richardson the same day. She noted Mr Richardson's condition had deteriorated since her last meeting with him. He told her he was experiencing increased pain in his abdomen and was becoming very short of breath. She suggested he move to the inpatient unit in healthcare, but he told her he was happy where he was and wanted to stay on the houseblock among his friends and peers. She arranged for healthcare staff to review him three times per day and arranged with prison officers on Mr Richardson's houseblock for his door be left open at night to allow healthcare staff access should they need it. She also asked that they visually check him three times throughout the night to ensure his well being. Mr Richardson's care plans were updated to reflect his worsening condition and increased level of observations.

39. On 5 October, Mr Richardson asked to be moved into the healthcare inpatient unit. He was located in the prison's palliative care suite. A prison GP reviewed his medications. He noted that although Mr Richardson was in pain, he appeared happy and settled following the move.

40. At 3.29am the following morning, a nurse reviewed Mr Richardson after he asked to be sent to hospital. He felt his pain would be better controlled there than in prison. She noted his

breathing rate had increased but had become shallow and his abdomen appeared to be distended, indicating a recurrence of the build up of fluid. A nurse told Mr Richardson she could treat his pain with alternative prescribed medications, which he agreed. She noted that she was unsure if he would survive the journey to hospital and thought he would be better staying at the prison rather than risking an admission to hospital. She continued to monitor him through the night.

41. At 5.00am, a nurse reviewed Mr Richardson after he complained of pain. She noted he was agitated. She fitted a cannula to his right arm (a thin tube inserted into a vein to enable medication to be administered) and gave him 5 millilitres of oramorph (liquid morphine for pain relief). She noted his breathing had become laboured so adjusted his bed. She noted an improvement.

42. At 6.20am, a nurse noted Mr Richardson as being comfortable with signs of movement. At 6.30am, a nurse reviewed him and found no sign of movement or breathing. She telephoned for an emergency ambulance and paramedics arrived at 6.45am. At 7.40am, a senior nurse confirmed Mr Richardson had died.

Mr Richardson's clinical care

43. We agree with the clinical reviewer that the clinical care Mr Richardson received at Holme House was of a good standard and equivalent to that which he could have expected to receive in the community. Healthcare staff promptly reviewed Mr Richardson on the occasions he became unwell and appropriately referred him to secondary care providers.

44. Following the diagnosis of cancer in February 2017, Mr Richardson received a good standard of emotional and supportive care by both healthcare staff and specialist palliative care nurses. There is evidence that Mr Richardson and his family were involved and consulted on the decisions made about his care. All treatment options were discussed frankly with Mr Richardson and at a pace that was acceptable to him, and which helped him make an informed choice about his treatment. All treatment was provided in a timely and appropriate manner and there is evidence of good care plans in place to manage his conditions.

45. The clinical reviewer also found that the end of life care Mr Richardson received while at Holme House was of a good standard. In particular, a Macmillan Nurse who was involved in his care both at Durham and at Holme House ensured his continuity of care.

46. Although Mr Richardson's medical records show he received a good standard of care, the clinical reviewer has made a recommendation which we do not repeat in this report but which the Head of Healthcare will wish to address.

Mr Richardson's location

47. Mr Richardson lived in a shared cell on a houseblock. He felt supported by his friends and had daily reviews from nurses to ensure he was coping, managing his medication and pain.

As his condition deteriorated, healthcare staff liaised with secondary care providers and had good input from Macmillan nurses to enable them to provide him with specialist equipment.

48. Mr Richardson was well consulted on where he wanted to be located in the prison. When he asked to move to the palliative care suite, his wishes were accommodated immediately.

49. We are satisfied that Mr Richardson was appropriately located throughout his illness and his needs were met in line with his wishes.

Restraints, security and escorts

50. When prisoners have to 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.

51. On the occasions Mr Richardson attended hospital, he was escorted by two prison officers and was unrestrained. We consider the decisions on restraint were appropriate.

Contact with Mr Richardson's family

52. Following Mr Richardson's arrival at Holme House, the prison appointed, the Acting Head of Safer Prisons and Equality, and a Prison Officer as Family Liaison Officers. Both had regular contact with the family, who were kept updated about his condition.

53. On 2 October, following a deterioration in his condition, the Acting Head of Safer Prisons and Equality, contacted Mr Richardson's daughter who he had nominated as his next of kin. She offered her the opportunity to have an extended visit with Mr Richardson in the privacy of the palliative care suite and to include any other members of the family who also wanted to attend. The family visited Mr Richardson regularly and were kept updated about his condition.

54. At 8.40am on 6 October, following Mr Richardson's death, the officer and the Governor visited Mr Richardson's daughter at her home address to inform her of her father's death and to offer her support and guidance.

55. The family liaison team remained in contact with the family offering them support and advice. They made good efforts to discuss any issues the family had and offered advice and assistance with any difficulties they were experiencing.

56. Mr Richardson's funeral was held on 3 November. The prison contributed to the funeral costs in line with national policy.

57. We are satisfied there was good, supportive liaison with Mr Richardson's next of kin.

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 are suffering from a terminal illness and have a life expectancy of less than three months.

59. In June 2017, Mr Richardson asked for early release on compassionate grounds. His application was refused because he did not meet the criteria for ERCG at that time. A second application was made in September, which was successful but Mr Richardson died before his release could be arranged.

60. We are satisfied that the prison appropriately discussed compassionate release with Mr Richardson and that his wishes were considered.

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