

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Graham Lilley a prisoner at HMP Doncaster on 23 November 2018

A report by the Prisons and Probation Ombudsman

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 Graham Lilley died in hospital on 23 November 2018 of heart disease while a prisoner at HMP Doncaster. He was 73 years old. I offer my condolences to Mr Lilley's family and friends.

I am satisfied that Mr Lilley received a good standard of care and support at Doncaster, equivalent to that which he could have expected in the community. Healthcare staff reviewed Mr Lilley frequently and appropriately managed his heart condition.

I am concerned that when Mr Lilley suffered a suspected heart attack and was taken to hospital on 17 November, he was restrained using handcuffs. I consider the use of restraints was not justified given Mr Lilley's age and medical condition at the time.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Sue McAllister CB
Prisons and Probation Ombudsman

May 2019

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Summary

Events

1. In April 2016, Mr Graham Lilley was sentenced to 13 years imprisonment for sexual offences. He was moved to HMP Doncaster on 10 March 2017.
2. Mr Lilley had diabetes, which healthcare staff monitored frequently. Staff also monitored Mr Lilley's risk of cardiovascular disease, but he did not always act on the advice healthcare gave him and often refused to take medication.
3. On 21 January 2018, a nurse saw Mr Lilley and noticed he appeared short of breath. After taking his clinical observations, she sent him to hospital by ambulance. Hospital staff treated Mr Lilley for a heart attack and respiratory failure and a consultant cardiologist diagnosed severe left ventricular failure (the left ventricle is the heart's main pumping chamber).
4. On 12 November, a consultant cardiologist saw Mr Lilley and suggested a pacemaker, but Mr Lilley was not sure whether he wanted to go ahead with the procedure. The consultant arranged for a follow-up appointment in six months.
5. On 17 November, a nurse saw Mr Lilley and noticed he had difficulty breathing. She took his clinical observations and sent him to hospital by emergency ambulance. He was restrained with a single pair of handcuffs. Hospital staff diagnosed Mr Lilley with heart failure and severe left ventricular damage. He died in hospital on 23 November.
6. The post-mortem report shows that Mr Lilley died of heart disease, with diabetes as a contributory factor.

Findings

7. We agree with the clinical reviewer that Mr Lilley received a good standard of clinical care at Doncaster, equivalent to that which he could have expected to receive in the community.
8. We consider the use of restraints on Mr Lilley when he was taken to hospital was unjustified given his advanced age and poor health.

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, in all cases:
 - healthcare staff complete the medical section of the escort risk assessment to say whether the prisoner's current medical condition affects their mobility and risk of escape; and
 - authorising managers show that they have taken this information into account when assessing a prisoner's current level of risk.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Doncaster informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
10. The investigator obtained copies of relevant extracts from Mr Lilley's prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr Lilley's clinical care at the prison.
12. We informed HM Coroner for South Yorkshire East District of the investigation. She gave us the result of the post-mortem examination. We have sent the coroner a copy of this report.
13. The investigator wrote to Mr Lilley's daughter to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.
14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Doncaster

15. HMP Doncaster is a local prison, operated by Serco, which holds up to 1,145 remanded and sentenced men. CareUK provides physical and mental health services, and substance misuse services. HMP Doncaster directly employs qualified paramedics as part of their healthcare team, who respond to emergency calls within the prison.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Doncaster was in July 2017. Health services had improved considerably since the previous inspection in October 2015 and overall, were reasonably good. A wide range of primary care services was available and waiting lists were generally short, although too many patients failed to attend appointments. The management of prisoners with long-term conditions had improved, with several trained staff available to patients. The 24-hour in-house paramedic service was an example of good practice.

Independent Monitoring Board

17. 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 IMB reported that Doncaster held a high number of ageing prisoners and expressed concerns that the healthcare team did not have any specialist older care available onsite. They noted that mental health care was only available in office hours and there was no on-call system, leaving prison staff and physical healthcare staff to do work that the mental health team should be doing.

Previous deaths at HMP Doncaster

18. Mr Lilley was the 13th prisoner to die at Doncaster since November 2015. Of the previous deaths, nine were due to natural causes and three were self-inflicted. There has been one self-inflicted death since. We have raised the inappropriate use of restraints in a previous investigation, in November 2018.

Key Events

19. On 8 April 2016, Mr Graham Lilley was sentenced to 13 years imprisonment for sexual offences and sent to HMP Nottingham. He was moved to HMP Doncaster on 10 March 2017.
20. Mr Lilley was aged 72 and had diabetes, which was controlled with self-administered insulin. Healthcare staff created a diabetes care plan, prescribed appropriate medication and reviewed him frequently. Staff monitored his risk of cardiovascular disease and suggested a statin (a medication to treat high cholesterol and to prevent heart disease), but he declined. Mr Lilley smoked cigarettes and although he refused support to stop, records show that he switched to using an electronic cigarette.
21. On 21 January 2018, prison staff asked a nurse to review Mr Lilley as he appeared short of breath. He noted that Mr Lilley had a low oxygen saturation level of 88% (normal being 95-100%) and a high pulse rate of 136bpm (normal being 60 – 100bpm). He completed a National Early Warning Score assessment (NEWS – a scoring system to assess clinical deterioration in patients) and based on Mr Lilley’s observations, he scored him 10 (high clinical risk). He sent him by ambulance to Doncaster Royal Infirmary.
22. Hospital staff admitted Mr Lilley and treated him for a heart attack and respiratory failure. Mr Lilley had an echocardiogram (an ultrasound scan of the heart) while in hospital and a consultant cardiologist diagnosed severe left ventricular failure (the left ventricle is the heart’s main pumping chamber).
23. On 28 January, Mr Lilley returned to Doncaster and a nurse saw him for a review. The next day, prison staff moved Mr Lilley to a more accessible wing and an advanced nurse practitioner prescribed heart failure medication, as directed by hospital specialists. She also added Mr Lilley to the prison’s complex care list and requested a cardiology follow-up appointment in three months.
24. On 5 February, at a diabetes review, Mr Lilley told the advanced nurse practitioner that he had stopped taking furosemide (a medication used to treat fluid build-up due to heart failure) as it made him urinate throughout the night. She explained the importance of furosemide in the treatment of heart failure and suggested a statin to reduce his cholesterol level, but he declined, stating it made him “feel funny”.
25. On 16 February, a prison GP saw Mr Lilley to discuss his non-compliance with medication and to explain the benefits of taking furosemide and the risks of not taking it. The prison GP recorded that he was satisfied Mr Lilley understood and that he had sufficient mental capacity to make decisions about his treatment.
26. On 16 April, the advanced nurse practitioner saw Mr Lilley for a diabetic review and noted that, in February, a blood test to check average blood sugar level over recent months (HbA1c) indicated a high blood sugar level of 96mmol/mol (the target being 48 mmol/mol). She recorded that Mr Lilley had not been taking metformin (a medication used to treat diabetes) and provided diet, lifestyle and medication advice.

27. On 14 May, a consultant cardiologist saw Mr Lilley at Doncaster Royal Infirmary and suggested a myocardial perfusion scan (a test that uses a radioactive substance, known as a tracer, to assess blood flow to the heart). The long-term view was to assess Mr Lilley's suitability for a cardiac resynchronisation therapy defibrillator (a type of pacemaker).
28. On 23 May, a nurse saw Mr Lilley for a review after he reported shortness of breath to prison staff. She noted that Mr Lilley was sitting in a chair breathing normally and conducted an electrocardiogram (to monitor the electrical impulses to the heart). She noted that it showed left bundle branch block (LBBB – a blockage of electrical impulses to the heart's left ventricle) and contacted a prison GP who advised that Mr Lilley was awaiting a heart scan and requested a specific blood test to measure his troponin level (an indicator of damage to the heart).
29. On 24 May, the prison GP reviewed Mr Lilley's blood test result and recorded that although he had a raised troponin level of 0.081ug/L (normal being 0.00-0.40ug/L), it was unlikely to be indicative of a heart attack. She diagnosed angina (chest pain or pressure due to not enough blood flow to the heart) and prescribed amlodipine (a medication to prevent chest pain caused by angina).
30. Over the next five months, healthcare staff monitored and reviewed Mr Lilley frequently. Staff prescribed appropriate medication, monitored his blood sugar level, conducted diabetes reviews and discussed his care at regular multidisciplinary team (MDT) meetings.
31. On 12 November, a consultant cardiologist saw Mr Lilley at Doncaster Royal Infirmary and diagnosed significant left ventricular dysfunction. He suggested a pacemaker, but Mr Lilley was not sure whether he wanted to go ahead with the procedure. The consultant arranged for a follow-up appointment in six months and gave Mr Lilley an information leaflet to consider.
32. On 17 November, at 11.15pm, prison staff asked a nurse to see Mr Lilley for a review, as he appeared short of breath. When she arrived, she noticed that Mr Lilley was struggling to breathe and was unable to talk in full sentences. She recorded a high blood pressure reading of 136/84 mmHg (normal being 140/90 mmHg -120/80 mmHg) and an oxygen saturation level of 75% and gave him 15 litres of oxygen via a mask. She recorded a NEWS score of '9' (high clinical risk) and, suspecting a heart attack, she sent him to Doncaster Royal Infirmary by emergency ambulance at 12.10am. Two officers escorted Mr Lilley and restrained him using a single pair of handcuffs. They removed the handcuffs in the ambulance, following a request from a paramedic.
33. Hospital staff admitted Mr Lilley to the Intensive Care Unit where he was sedated and treated for heart failure and a severely damaged left ventricle. Prison healthcare staff kept in frequent contact with the hospital for updates on his condition. Mr Lilley's condition deteriorated and despite attempts to get his heart into a regular rhythm and to reduce the level of sedation, his condition failed to improve.
34. On 23 November, hospital staff stopped active treatment and at 1.05pm, a doctor declared that Mr Lilley had died.

Contact with Mr Lilley's family

35. On 19 November, at 10am, the prison appointed an officer as family liaison officer. He phoned Mr Lilley's son and daughter, his named next of kin, and arranged to meet them at Doncaster Royal Infirmary to introduce himself and to offer support.
36. On 23 November, a prison manager informed the family liaison officer of Mr Lilley's deteriorating condition and he went to the hospital to provide support to Mr Lilley's family.
37. The family liaison officer provided ongoing support to Mr Lilley's family and attended his funeral on 10 December with a prison manager. The prison contributed towards the cost, in line with national policy.

Support for prisoners and staff

38. After Mr Lilley's death, the prison manager debriefed the staff present at the hospital to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
39. The prison posted notices informing other prisoners of Mr Lilley'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 Lilley's death.

Post-mortem report

40. The post-mortem report found that Mr Lilley died of heart disease caused by coronary artery atheroma (a build-up of fatty deposits on the walls of the arteries around the heart). Diabetes was given as a contributory factor.

Findings

Clinical care

41. Mr Lilley had diabetes and heart disease. Healthcare staff monitored and reviewed him frequently, doctors prescribed appropriate medication and prison staff facilitated hospital appointments, when required.
42. The clinical reviewer considered that healthcare staff managed Mr Lilley's diabetes well, conducted appropriate heart disease related investigations and monitored his conditions at regular MDT meetings. She concluded that Mr Lilley received a good standard of care and treatment in prison that was equivalent to that which he could have expected to have received in the community. We are satisfied that Mr Lilley received appropriate clinical care at Doncaster.

Restraints, security and escorts

43. 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.
44. When Mr Lilley was taken to hospital on 17 November, a prison manager authorised two officers to escort him using a single pair of handcuffs. The risk assessment states that Mr Lilley presented a low risk of escape and a low risk of harm to the public. The medical section was not completed. In the authorising manager's section, the prison manager recorded that Mr Lilley was a category B prisoner and he authorised a single handcuff due to his age and medical condition. (The standard level of restraint for a category B prisoner in good health is a double handcuff - when the prisoner has his hands handcuffed in front of him and then has one wrist attached to a prison officer by an additional set of handcuffs.)
45. While we acknowledge that the prison manager authorised a lower level of restraint for Mr Lilley due to his age and medical condition, we consider that the use of single pair of handcuffs was still unjustified. Mr Lilley was 73 years old and was having a suspected heart attack when he was taken to hospital. We are particularly concerned that the medical section of the escort risk assessment was not completed. This meant that there was no input from healthcare staff on Mr Lilley's current medical condition and how that affected his risk of escape.

46. 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, in all cases:

- **healthcare staff complete the medical section of the escort risk assessment to say whether the prisoner's current medical condition affects their mobility and risk of escape; and**
- **authorising managers show that they have taken this information into account when assessing a prisoner's current level of risk.**

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