Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr William Richardson a prisoner at HMP Wakefield on 13 February 2019

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 William Richardson died on 13 February 2019 from cancer of the oesophagus at HMP Wakefield. He was 81 years old. I offer my condolences to Mr Richardson's family and friends.

I am satisfied that the standard of care that Mr Richardson received at HMP Wakefield was equivalent to that which he could have expected to receive in the community.

I commend the prison for the efforts it made to enable Mr Richardson's family to spend time with him before he died.

I am concerned, however, that it is not clear that decisions to use restraints on Mr Richardson when he was taken to hospital between May and October 2018, took account of his age and mobility.

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 **February 2020**

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Summary

Events

1. On 7 August 2014, Mr William Richardson was sentenced to 16 years in prison for sexual offences. On 6 November, he was moved to HMP Wakefield.

2. On 9 April 2018, Mr Richardson went to see a prison nurse as he was concerned about a lump under his right ear which had been there for six weeks. The nurse thought the lump was a cyst but referred Mr Richardson to hospital for an ultrasound scan to check.

3. On 8 June, following two scans and a biopsy, the hospital told the prison that Mr Richardson needed to be referred to an ear, nose and throat specialist under the suspected cancer referral pathway. The prison made the referral immediately.

4. On 7 August, Mr Richardson was told that he had oesophageal cancer and in October, he was told it was terminal. Mr Richardson was looked after in the palliative care suite at Wakefield for the next four months. His condition gradually deteriorated and he died on 13 February 2019.

Findings

5. The clinical reviewer is satisfied that the healthcare Mr Richardson received at Wakefield was equivalent to that which he could have expected to receive in the community.

6. However, the clinical reviewer considered that the lump under Mr Richardson's right ear warranted a referral under the suspected cancer pathway. This might have resulted in an earlier diagnosis for Mr Richardson, although the clinical reviewer could not say whether this would have affected the eventual outcome.

7. Between May and October 2018, Mr Richardson was escorted to hospital on numerous occasions and was restrained. We are not satisfied that Mr Richardson's age and health was taken into account when decisions about restraints were made.

8. We found that the prison's family liaison officer (FLO) kept in regular contact with Mr Richardson's family during his illness. However, shortly after Mr Richardson died, the FLO took leave but did not hand over the FLO duties to another member of staff. This meant that Mr Richardson's family were not adequately supported before his funeral.

9. We commend Wakefield for making considerable efforts to enable Mr Richardson's family to spend as much time as possible with him in the period before he died.

Recommendations

- The Head of Healthcare should ensure that clinical staff are aware of the relevant guidance on recognising and referring prisoners who have suspected cancer.

- 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
    - assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time; and
    - risk assessments record the consideration that has been given to the prisoner's health and mobility.
- The Governor should ensure that when a family liaison officer takes leave, they hand over their FLO responsibilities to another suitable member of staff and inform the family of the new contact details.
- The Governor and the Head of Healthcare should review arrangements for family members to spend time with dying prisoners, taking account of the views of Mr Richardson's family and prison and healthcare staff, and the experience of other long-term and high security prisons.

The Investigation Process

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

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

12. NHS England commissioned an independent clinical reviewer to review Mr Richardson's clinical care at the prison.

13. We informed HM Coroner for West Yorkshire of the investigation. We have sent the coroner a copy of this report.

14. One of the Ombudsman's family liaison officers contacted Mr Richardson's daughter to explain the investigation and to ask if the family had any matters they wanted the investigation to consider.

15. The family told us that they thought the quality of family liaison was poor. They said that the prison's family liaison officer was not always helpful in dealing with their queries, and that they were sometimes made to feel like they were being a nuisance. They were particularly concerned that despite being told that they would be supported in making funeral arrangements, there was no contact from the FLO for several weeks after Mr Richardson died.

16. 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.

17. Mr Richardson's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

18. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Wakefield

19. HMP Wakefield is a high security prison which holds up to 750 men. There are four main residential wings, a healthcare centre, a segregation unit and a close supervision centre (a small unit aiming to provide a supportive, safe, structured and consistent environment for some of the most challenging offenders).

20. Care UK provides the healthcare provision at Wakefield. They provide primary healthcare services during normal working hours and overnight, and weekend care in the inpatient unit for prisoners with physical health problems. There is a dedicated palliative care suite in the healthcare unit.

HM Inspectorate of Prisons

21. The last inspection at Wakefield was in June 2018. Inspectors noted that health services were good overall, but some parts of the healthcare environment required improvement. Primary care services were very good and had an appropriate emphasis on the care of patients with long-term conditions.

Independent Monitoring Board

22. 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 April 2018, the IMB reported that 2017-2018 saw the first complete year with healthcare provided by Care UK. The major challenges required in bringing together the previous separate nursing teams into a collective one was well in hand, and integration remained positive.

23. The Board reported that end of life care continued to be of a very high standard. It was pleased to report that the palliative care suite had recently been redecorated and upgraded and was a credit to all those involved in the planning and successful operation of this facility.

Previous deaths at HMP Wakefield

24. Mr Richardson was the 12th prisoner to die at HMP Wakefield since January 2017. Nine deaths were from natural causes and two were self-inflicted. There have been two deaths since Mr Richardson's death, both were from natural causes. There were no similarities between the circumstances of Mr Richardson's death and the previous deaths at the prison.

Findings

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

25. On 7 August 2014, Mr William Richardson was sentenced to 16 years in prison for sexual offences. He was sent to HMP Durham. On 6 November, he was moved to HMP Wakefield.

26. Apart from problems with his hearing, Mr Richardson was generally fit and well.

27. On 9 April 2018, a nurse saw Mr Richardson who was complaining of a lump under his right ear, which had been there for six weeks. The nurse noted that the lump was tender to touch but did not appear to be infected. He thought that the lump was a cyst (a type of non-cancerous fluid-filled bump on the skin) but thought it appropriate to refer Mr Richardson for an ultrasound scan (a procedure that uses high-frequency sound waves to create an image of part of the inside of the body) to check.

28. On 10 May, Mr Richardson had an ultrasound scan of his neck which showed a mass in front of his right ear. A hospital consultant recommended a further scan by a specialist head and neck sonographer (a specialist health professional who performs ultrasound examinations).

29. On 4 June, Mr Richardson had a further ultrasound scan of his neck. He also had a biopsy taken from the cyst.

30. On 8 June, the hospital told the prison healthcare team that the biopsy sample was suspicious and that Mr Richardson should be referred using the suspected cancer referral pathway (for an appointment in two weeks) to an ear, nose and throat (ENT) specialist. Prison healthcare staff made an urgent referral.

31. Over the next two months Mr Richardson had further ultrasound scans and biopsies. On 7 August, Mr Richardson was told that he had oesophageal cancer (the oesophagus is the long tube that carries food from the throat to the stomach).

32. On 13 August, Mr Richardson was reviewed by two hospital consultants. They told him that surgery and radiotherapy (treatment where radiation is used to kill cancer cells) was the best treatment but in his case, due to nerve, muscle and blood vessel involvement, surgery would be extensive and would leave him with very poor function. They advised radiotherapy only, to which Mr Richardson agreed.

33. On 10 September, the prison healthcare team were told that a further scan had identified a possible malignant tumour in his lower oesophagus. Mr Richardson was referred for an urgent endoscopy (a procedure in which an instrument is put into the body to give a view of its internal parts and allow a biopsy to be taken). Later that day records show that a nurse saw Mr Richardson to explain this information. Mr Richardson was offered support and was noted to have taken the news well.

34. On 21 September, Mr Richardson had the endoscopy. On 2 October, the hospital told the prison healthcare team that the primary source of cancer was the oesophagus. It was therefore considered that radiotherapy would not be appropriate and was cancelled. The healthcare team were told that a further oncology appointment would be arranged. A nurse explained this to Mr Richardson and he understood that his condition was terminal.

Mr Richardson's clinical care

35. On 5 October, the hospital told the healthcare team that a two-week course of palliative radiotherapy (intended to relieve symptoms but not curative) had been arranged to help Mr Richardson's pain. It was started on 8 October.

36. On 18 October, a hospital consultant reviewed Mr Richardson and considered that there had been a deterioration in his condition. It was agreed that he was not fit to continue the course of palliative radiotherapy and was instead a candidate for end of life care. He was discharged from the hospital and prison healthcare staff began end of life care.

37. On 10 October, Mr Richardson said he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect.

38. Over the next four months Mr Richardson was seen daily in accordance with his care plans. Staff made every effort to provide Mr Richardson with appropriate pain relief and records reflect accurate assessments of his pain. This meant that there was no delay in responding to any pain or discomfort Mr Richardson felt in the last days of his life. The clinical reviewer considers that this approach ensured that his comfort and dignity were maintained throughout. His condition gradually deteriorated and Mr Richardson died on 13 February 2019.

39. The clinical reviewer is satisfied that overall Mr Richardson's clinical care at the prison was equivalent to that which he could have expected to receive in the community.

40. However, the clinical reviewer considers that when Mr Richardson saw a nurse complaining of a lump under his right ear, this should have been investigated further by using a suspected cancer referral pathway (for an appointment in two weeks). This may have resulted in an earlier diagnosis for Mr Richardson, although we cannot say whether it would have changed the eventual outcome. We make the following recommendation:

    The Head of Healthcare should ensure that clinical staff are aware of the relevant guidance on recognising and referring prisoners who have suspected cancer.

Mr Richardson's location

41. After his diagnosis, Mr Richardson was offered the opportunity to move to the prison's inpatient healthcare unit on a number of occasions but said he preferred to remain on the wing where he had friends.

42. In October 2018, when Mr Richardson's health began to deteriorate, he agreed to move to the healthcare unit and located in the palliative care suite. This

enabled staff to deliver responsive care. It also enabled Mr Richardson to have good contact with his family, including out of hours and overnight visits, and meant that family members could offer emotional and psychological support as Mr Richardson was approaching the end of his life.

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.

44. 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.

45. Between May and August 2018, Mr Richardson was taken to hospital on numerous occasions. He was escorted by two officers, using the double cuffing method. (Double cuffing is when the prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs.) Mr Richardson was an 81-year-old man. The risk assessment does not demonstrate that the authorising managers took this into consideration when completing the risk assessments, or that they considered his health or mobility.

46. Between August and October, Mr Richardson had further hospital appointments as his health was deteriorating. The risk assessment was updated and he was taken to hospital restrained by an escort chain. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.) While we acknowledge that the risk assessment had been revised, we are still not satisfied that Mr Richardson's current health was given full consideration at the time of making this decision. 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;**
    - **assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time; and**
    - **risk assessments record the consideration that has been given to the prisoner's health and mobility.**

47. Appropriately, from 5 October Mr Richardson was not restrained during any other hospital visits.

Liaison with Mr Richardson's family

48. On 24 September 2018, when Mr Richardson's condition deteriorated, the prison appointed Officer A as the family liaison officer (FLO). In January 2019, the FLO was changed to Officer B. In March, Officer B took some annual leave so a Custodial Manager (CM) took over the FLO role.

49. Mr Richardson's funeral was held on 25 March, and two representatives from the prison attended. The prison contributed to the cost of the funeral, in line with national instructions.

50. On 2 April, the prison held a memorial service in the prison chapel. Mr Richardson's family attended.

51. We are satisfied that the prison maintained regular contact with Mr Richardson's family throughout his illness. The prison also arranged extra visits, which included overnight stays when he became very ill, and enabled Mr Richardson's daughter to be with him when he died.

52. However, when Officer B took some leave very shortly after Mr Richardson died, he did not arrange a handover of the FLO duties, which meant that Mr Richardson's family were not contacted for over three weeks. This was not acceptable. We make the following recommendation:

    The Governor should ensure that where a family liaison officer (FLO) takes leave, they hand over their FLO responsibilities to another suitable member of staff and inform the family of the new contact details.

53. Mr Richardson's family have said they were sometimes made to feel as though they were being a nuisance when they spent time with Mr Richardson in the healthcare unit. Wakefield is a high security prison, which means that these extra visits were not easy to facilitate. We think the family may not appreciate that being allowed to spend so much time with Mr Richardson was an innovative step for a high security prison. We consider this was an example of good practice and commend the prison for making considerable effort to ensure that Mr Richardson's family were able to spend as much time as they could with him in the months before his death.

54. Nevertheless, we consider that there would be value in the prison identifying what worked well and what caused problems so that they can improve the experience for both families and staff in future. We recommend:

    The Governor and the Head of Healthcare should review arrangements for family members to spend time with dying prisoners, taking account of the views of Mr Richardson's family and prison and healthcare staff, and the experience of other long-term and high security prisons.

Compassionate release

55. 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.

56. On 13 December 2018, the prison submitted an application for early release on compassionate grounds. However, Mr Richardson decided not to pursue it as he did not want to be a burden on his family. Instead he asked if he could be transferred to a prison nearer home. While this request was being considered, Mr Richardson's condition got worse. His family said that HMP Wakefield was an accessible location for them so they were happy for him to remain there to receive end of life care.

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