

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Clive Oliver, a prisoner at HMP Lincoln, on 31 December 2019

**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*



© Crown copyright 2020

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](https://nationalarchives.gov.uk/doc/open-government-licence/version/3) or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: [psi@nationalarchives.gsi.gov.uk](mailto:psi@nationalarchives.gsi.gov.uk).

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

## Summary

1. 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.
2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Clive Oliver died of prostate cancer which had spread to other parts of his body on 31 December 2019 at HMP Lincoln. He was 71 years old. We offer our condolences to his family and friends.
4. The clinical reviewer concluded that the clinical care that Mr Oliver received at Lincoln was of a good standard and equivalent to that which he could have expected to receive in the community. She made a number of recommendations about clinical issues which are not directly related to Mr Oliver's death but which the Head of Healthcare will need to address.
5. We are concerned that in the weeks before his death, prison managers were not consistent in assessing whether Mr Oliver should be restrained when he went to hospital for oncology treatment. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances. Mr Oliver was restrained on 27 November and 23 December but not on 11 December. On each occasion, security staff assessed Mr Oliver as posing a low risk of escape. He was 71 years old and had been diagnosed with cancer which a prison manager noted to be in a palliative stage on 11 December. We are therefore concerned that he was restrained on 23 December, a week before he died.

## Recommendations

- The Governor 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.

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

## Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Oliver's clinical care at HMP Lincoln. The clinical review is attached to this report at Annex 1.
7. We have investigated the non-clinical issues in Mr Oliver's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

8. The Ombudsman's family liaison officer wrote to Mr Oliver's next of kin to explain the investigation. She did not respond.
9. We shared the initial report with the Prison Service. There were no factual inaccuracies and their action plan has been appended to this report.

#### **Previous deaths at Lincoln**

10. Mr Oliver was the fourth prisoner to die at Lincoln since December 2017. Two of the previous deaths were self-inflicted and the other was drug-related. There were no significant similarities between the circumstances of Mr Oliver's death and the previous deaths.

## Key Events

11. On 8 October 2019, Mr Clive Oliver was convicted of sex offences and was sentenced to three years in prison on 3 November 2019. On 13 November, he was sent to HMP Lincoln, where he told a nurse at his initial health screen that he had prostate cancer which had spread to other parts of his body.
12. On 27 November, Mr Oliver went to hospital for cancer treatment as an outpatient. A nurse completed the medical section of his escort risk assessment and noted that although Mr Oliver had cancer, he was fully mobile. A security officer assessed Mr Oliver as posing a low level of risk, including a low level of escape, and recommended that he should be restrained. The Head of Reducing Re-offending authorised that Mr Oliver should be restrained with a single cuff.
13. On 11 December, Mr Oliver had another outpatient appointment at hospital. A nurse completed the medical section of his escort risk assessment and noted that Mr Oliver was unsteady on his feet and needed a wheelchair for long distances. The Head of Security and Intelligence said that Mr Oliver should not be restrained “due to his palliative condition and lack of ability to escape due to his medical condition and health”.
14. On 23 December, Mr Oliver went to hospital for a routine outpatient appointment. A nurse completed the medical section of his escort risk assessment and noted that Mr Oliver was not fully mobile, was unsteady on his feet and required a wheelchair for longer distances. The Head of Operations authorised that Mr Oliver should be restrained with an escort chain.
15. Hospital staff decided that Mr Oliver should stay in hospital. Prison staff reviewed the level of restraints and the Head of Security and Intelligence decided that Mr Oliver should be restrained with an escort chain for movement around the hospital but did not need to be restrained when in bed on a ward. On 24 December, the Governor authorised that Mr Oliver should not be restrained because he had limited mobility and was very ill.
16. On 31 December, Mr Oliver died in hospital of prostate cancer which had spread to other parts of his body.

## Findings on non-clinical issues

### Use of restraints

17. When prisoners travel outside of prison, staff complete a risk assessment to determine the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public which must be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on prisoners’ security risk, taking into account factors such as their health and mobility.
18. 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 he has a serious medical condition. The judgment indicated that medical opinion about a prisoner’s ability to escape must be considered as part of the assessment process and kept under review as circumstances change. The judgement found that using handcuffs or

other restraints on terminally ill or seriously ill prisoners was inhumane, unless justified by security considerations.

19. Mr Oliver was a 71-year old Category C prisoner with terminal prostate cancer. He had limited mobility and sometimes used a wheelchair. We are concerned that Mr Oliver was restrained with a single cuff on 27 November, despite his cancer diagnosis, age and low level of risk. We acknowledge that Mr Oliver was not restrained when he went to hospital on 11 December but have seen no evidence to justify why he was then restrained on 23 December. Mr Oliver had terminal cancer, was not fully mobile and remained at a low risk of escape. We are concerned that the decision-making process was not consistent and that he was restrained given his poor health, mobility and age. We make the following recommendation:

**The Governor 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.**

**Caroline Mills  
Assistant Ombudsman**

**May 2020**

## **Annexes**

1. Clinical review

### **Additional documents**

2. Prison action plan