

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Barlow, a prisoner at HMP Risle, on 20 December 2020

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 John Barlow died in hospital from heart failure on 20 December 2020, while a prisoner at HMP Risley. He was 81 years old. I offer my condolences to Mr Barlow's family and friends.

Mr Barlow had ongoing health conditions and was regularly seen by healthcare staff. Appropriate care plans were in place and when Mr Barlow's health deteriorated, he was sent quickly to hospital.

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

I make no recommendations.

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 2021

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Summary

Events

1. On 28 September 2018, Mr John Barlow was sentenced to five years in prison for sexual offences. On 23 July 2020, he was moved to HMP Risley.
2. Mr Barlow had several long-term health conditions including high blood pressure, diabetes and an underactive thyroid. He was prescribed appropriate medication for these conditions.
3. On 17 December, prisoners at Risley were tested for COVID-19. Mr Barlow tested positive, although he did not have any symptoms and he appeared to be well.
4. On 19 December, Mr Barlow's carers were concerned that he was not responding to them as he usually would. A nurse came to assess Mr Barlow and said that his oxygen levels were low and that he needed to go to hospital. Mr Barlow was admitted to hospital that day and over the next 24 hours his health deteriorated. He died at 9.00pm on 20 December.
5. A hospital doctor gave the cause of death as congestive heart failure caused by hypertensive heart disease.

Findings

6. We are satisfied that Mr Barlow received appropriate care and treatment for his health conditions. The clinical reviewer considered that the standard of care Mr Barlow received was equivalent to that he could have expected to receive in the community.
7. We make no recommendations.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Risley informing them of the investigation and asking anyone with relevant information to contact her. No one responded
9. The investigator obtained copies of relevant extracts from Mr Barlow's prison and medical records.
10. NHS England commissioned a clinical reviewer to review Mr Barlow's clinical care at the prison.
11. We informed HM Coroner for Cheshire of the investigation. The coroner gave us the cause of death. We have sent the coroner a copy of this report.
12. One of the Ombudsman's family liaison officers contacted Mr Barlow's nominated next of kin, a friend, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond.
13. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Risley

14. HMP Risley is a medium security training prison which holds over 1,000 convicted men. Bridgewater Community Healthcare NHS Trust provides healthcare services in the prison. Greater Manchester West Mental Health Foundation Trust provide mental health services. Substance misuse services are provided by Change, Grow, Live (CGL). There is 24-hour healthcare cover.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Risley was a scrutiny visit in November 2020. Inspectors found strong leadership and a motivated management team, with a clear vision and sense of purpose. The management team had worked well, in partnership with health care staff and Public Health England, to control an outbreak of COVID in the prison at the start of the pandemic and to contain a later outbreak on G Wing in September. Prisoners who were considered clinically at risk were offered the opportunity to move to a designated shielding unit on B Wing.
16. Inspectors were concerned that the regime restrictions often presented prisoners with an unacceptable choice, between attending their health care, dental and substance misuse appointments or taking a shower and exercise during their very limited time out of cell.

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 31 March 2020, the IMB reported that prisoners' health and wellbeing needs were, in the main, being addressed. Initial health screenings for new arrivals were undertaken promptly by a registered nurse and immediate healthcare needs were identified, including mental health and substance misuse.
18. The Board reported that the healthcare building was clean and well equipped, and regular clinics were held for GP appointments, dental services, optometry, physiotherapy and mental health issues. Waiting lists for GP, dental, optometry and other services were within national timescales; however, the Board noted that, in certain circumstances, appointments were cancelled/missed owing to staff shortages at busy times.

Previous deaths at HMP Risley

19. Mr Barlow was the 12th prisoner to die at Risley since December 2018. Of the previous deaths, seven were from natural causes, three were self-inflicted and one was a homicide.

Key Events

20. On 28 September 2018, Mr John Barlow, was sentenced to five years in prison for sexual offences. He was sent to HMP Forest Bank.
21. On 23 July 2020, Mr Barlow was moved to HMP Risley. He had several long-term health issues, including high blood pressure, diabetes, and an underactive thyroid. Mr Barlow had also previously had a stroke. He was prescribed regular medication for these conditions and was seen regularly by healthcare staff.
22. On 10 August, Mr Barlow was told that because of his underlying health conditions he was at risk of becoming seriously ill if he caught COVID-19. He was offered a shielding regime, but he refused and signed a disclaimer to confirm that he did not want to shield.
23. On 20 August, a nurse saw Mr Barlow because a recent blood test showed that he had hyperkalaemia (abnormally high potassium levels which can cause an abnormal heart rhythm). The nurse said that Mr Barlow needed to go to hospital for treatment, so she called an ambulance and Mr Barlow was taken to hospital.
24. Mr Barlow was treated in hospital for hyperkalaemia and returned to prison the following day. Mr Barlow was told to increase his fluid intake, and the blood tests were to be repeated in two days to check that the potassium levels had returned to normal. On 23 August, staff noted that Mr Barlow's potassium levels had returned to normal.
25. On 17 December, the prison completed mass testing of prisoners for COVID-19. Mr Barlow tested positive, but he did not have any symptoms and appeared to be well.
26. On 19 December, Mr Barlow's carers were concerned that Mr Barlow was unwell. He was not responding as he usually would, and his speech appeared to be slurred. They called the landing officer. He called the control room to ask for a nurse to come and see Mr Barlow. The nurse attended and said that Mr Barlow's oxygen levels were low, so he needed to go to hospital.
27. Mr Barlow was taken to hospital where he was admitted. Over the next 24 hours, Mr Barlow's health rapidly deteriorated and on 20 December at 9.00pm he died.

Contact with Mr Barlow's next of kin

28. On 20 December 2020, the prison appointed an officer as the family liaison officer (FLO). Mr Barlow's friend was listed as his next of kin. The FLO tried to contact him to tell him that Mr Barlow was very unwell in hospital. However, the telephone number that he found for Mr Barlow's next of kin was incorrect. Later that day, a prison manager found a contact number and, when Mr Barlow died, the duty governor informed his next of kin by telephone.
29. The prison paid for Mr Barlow's funeral in line with national guidelines. The funeral took place on 12 January.

Support for prisoners and staff

30. The prison told the investigator that the escorting officers on the bed watch when Mr Barlow died were offered support from the care team.
31. The prison posted notices informing other prisoners of Mr Barlow's death and offering support.

Cause of death

32. No post-mortem examination was carried out as the coroner accepted the cause of death provided by a hospital doctor. The doctor gave Mr Barlow's cause of death as congestive heart failure caused by hypertensive heart disease.

Findings

Clinical Care

33. Mr Barlow had several long-term health conditions including high blood pressure, diabetes and an underactive thyroid. Mr Barlow was seen regularly by healthcare staff, who made sure that all care plans were in place. When Mr Barlow's health deteriorated, staff sent him to hospital.
34. The clinical reviewer considered that the standard of care Mr Barlow received was equivalent to that which he could have expected to receive in the community. He made two recommendations but as neither were linked to Mr Barlow's death, we have not included them in this report.
35. We make no recommendations.

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