

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Donald Cassidy a prisoner at HMP Risley on 17 September 2021

**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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## 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 Donald Cassidy died on 17 September 2021 of heart failure caused by heart disease while a prisoner at HMP Risley. He was 86 years old. I offer my condolences to Mr Cassidy's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Cassidy received at HMP Risley was equivalent to that he could have expected to receive in the community. She considered that his care was of a good standard and that his rapid health deterioration in June 2020 was managed well.
5. We did not identify any non-clinical issues of concern and make no recommendations.

## The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Cassidy's clinical care at HMP Risley.
7. The PPO investigator has investigated non-clinical issues, including Mr Cassidy's location, management of COVID-19, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. The PPO family liaison officer wrote to Mr Cassidy's next of kin to explain the investigation. Mr Cassidy's family received a copy of the draft report. They did not make any comments.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies

### Previous deaths at HMP Risley

10. There were ten deaths at Risley in the two years before Mr Cassidy's death. Seven of the previous deaths were from natural causes (two of which were related to COVID-19) and three of these deaths were self-inflicted.
11. There are no significant similarities between our findings in this investigation and those of the other deaths.

## Key Events

12. On 23 June 2015, Mr Cassidy was sentenced to 16 years custody for sexual offences. He was sent to HMP Altcourse and then transferred to HMP Risley on 25 September 2015.
13. Mr Cassidy had several health conditions including hypertension, high cholesterol, atrial fibrillation (a heart condition which causes an irregular heartbeat) and a combination of dementia and Alzheimer's. These conditions were managed by medication.
14. On 7 July 2020, Mr Cassidy had a routine medical review with a prison GP. He noted that Mr Cassidy's health had deteriorated significantly over the past five years. The doctor arranged for Mr Cassidy's medication to be administered by healthcare staff, rather than him looking after his own medication. Healthcare staff also arranged a social care assessment which was appropriately reviewed.
15. On 17 December, Mr Cassidy tested positive for COVID-19. He said he felt well and had no symptoms. He isolated until 27 December. He developed symptoms on 29 December and was admitted to Warrington District General Hospital where he was treated for COVID-19 and a pleural effusion (excess fluid between the layers on the outside of the lungs). Mr Cassidy had a chest X-Ray which showed a possible mass on his lung, so was referred for a CT scan.
16. Mr Cassidy returned to Risley on 31 December. On 22 January 2021, Mr Cassidy told a prison GP that he did not want to go back to hospital for any treatment. He also said that he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect.
17. Mr Cassidy was referred to a palliative care consultant on 27 January. Mr Cassidy said that he wanted to remain at Risley until his last few days, when he would like to transfer to St Rocco's Hospice as his preferred place of death. Healthcare staff assessed that Mr Cassidy had capacity to make this decision.
18. Mr Cassidy refused to attend three CT scans which had been booked for 20 April, 17 May, and 22 June to further investigate the suspected mass on his lungs.
19. On 30 July, the prison GP applied for Mr Cassidy's early release on compassionate grounds, and he was referred to St Rocco's Hospice to accommodate him for end of life care.
20. On 17 September, Mr Cassidy's health had deteriorated significantly, and a doctor went to Risley to arrange his transfer to the hospice. The transfer to St Rocco's was cancelled on the same day as Mr Cassidy was too weak to be moved.
21. Mr Cassidy died in his cell on 17 September at 1.45pm. His carers and wing buddies were with him when he died as he had requested.

## **Post-mortem report**

22. The post-mortem report concluded that Mr Cassidy died of congestive cardiac failure caused by ischemic hypertensive heart disease. He also had carcinoma of the prostate, which did not cause but contributed to his death.

**Karen Johnson**  
**Assistant Ombudsman**

**March 2022**

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