Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Storey, a prisoner at HMP Leeds, on 17 April 2022

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

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 John Storey died of cancer at Wheatfields Hospice on 17 April 2022, while a prisoner at HMP Leeds. He was 77 years old. We offer our condolences to Mr Storey's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Storey received at Leeds was equivalent to that which he could have expected to receive in the community. The clinical reviewer made two recommendations to the Head of Healthcare regarding matters not directly affecting Mr Storey's death. She identified that the nurse completing the escort risk assessment documentation was not properly trained. We are concerned that the decision to restrain Mr Storey when he was taken to hospital was not justified given his advanced age and poor mobility.

5. We are also concerned that an application for compassionate release was not progressed in a timely manner.

Recommendations

- **The Governor and the 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 information 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 Governor and Head of Healthcare should ensure that applications for compassionate release are progressed in a timely manner and submitted as promptly as possible.**

The Investigation Process

6. The PPO investigator obtained copies of relevant extracts from Mr Storey's prison and medical records. She investigated the non-clinical issues relating to Mr Storey's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

7. NHS England commissioned an independent clinical reviewer, to review Mr Storey's clinical care at Leeds. The independent clinical reviewer and a supporting independent clinical reviewer conducted one joint interview with the investigator on Microsoft Teams on 4 July 2022.

8. We informed HM Coroner for Wakefield of the investigation. The Coroner gave us the results of the doctor's opinion of the cause of death. We have sent the Coroner a copy of this report.

9. The PPO family liaison office wrote to Mr Storey's wife to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.

10. We shared the initial report with the Prison Service. There were no factual inaccuracies and the action plan has been appended to this report.

Previous deaths at HMP Leeds

11. Mr Storey was the 24th prisoner to die at Leeds since April 2020. There has been one death since Mr Storey's. Of the previous deaths, fifteen were from natural causes, seven were self-inflicted and one is awaiting classification.

12. Following recommendations we made in a previous investigation, in February 2022 Leeds agreed to remind all staff who authorise the use of restraints to consider the impact that a prisoner's health and level of mobility would have on the risk the prisoner presents at the time.

Key Events

13. On 26 July 2021, Mr John Storey was convicted of sex offences and later sentenced on 18 October 2021 to four years in prison. He was sent to HMP Leeds.

14. Mr Storey had several health concerns, including a history of ischaemic heart disease (IHD, the narrowing of the blood vessels to the heart), type 2 diabetes (a condition that causes too much sugar in the blood), chronic obstructive pulmonary disease (COPD, a lung disease), pulmonary fibrosis (scarring of the lung tissues) and ongoing bowel problems. Mr Storey also had some mobility difficulties that required him to use a wheelchair and required help with personal care and daily living activities.

15. On 11 November, a prison GP assessed Mr Storey as he was feeling unwell. The prison GP performed a chest examination and sent a sputum (mucus that is coughed up) sample to the laboratory to be examined for infection.

16. On 12 November, a prison GP reviewed Mr Storey because of continuing low blood pressure results. The prison GP requested an electrocardiogram (ECG, a simple test to check the heart) and bloods to be taken.

17. On 15 November, the prison GP reviewed Mr Storey and requested a chest x-ray to be carried out as a precaution.

18. On 10 December, Mr Storey attended St James' Hospital for the chest x-ray. The results of this were returned on 14 December, which suggested that he needed further investigations for cancer.

19. On 20 December, Mr Storey attended hospital for a colonoscopy, a chest CT scan and respiratory clinic appointment.

20. On 29 December, Mr Storey attended a respiratory appointment at the hospital. The respiratory consultant told him that he had lung cancer.

21. On 20 January 2022, Mr Storey attended a respiratory appointment at the hospital and was told that his cancer was terminal. A nurse noted that Mr Storey had been told he only had a few months left to live.

22. On 21 January, Mr Storey said that he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect. The same day, healthcare staff began an end-of-life care plan.

23. On 9 February, local hospice staff visited Mr Storey. Healthcare staff remained in contact with the hospice for advice over the coming months.

24. On 24 February, prison and healthcare staff held a multi-disciplinary meeting to review and discuss prisoners identified as having reduced mobility or receiving palliative care. The meeting was to consider the risk each prisoner posed to security in the case of an escort outside of the prison. The meeting confirmed that Mr Storey should not be restrained during escorts due to being a wheelchair user.

25. At 2pm on 8 March, the prison GP saw Mr Storey because an Healthcare Assistant (HCA) reported that he was drowsy and unresponsive during a welfare check. The prison GP believed that Mr Storey was suffering from opioid toxicity from his pain medication, and he administered a drug to counteract the effects. He asked healthcare staff to monitor Mr Storey every two hours and said that he may be at the end of his life.

26. At around 4.50pm, an HCA completed a welfare check on Mr Storey and again found him unresponsive. She asked a nurse to review Mr Storey, who confirmed that he did not respond to voice or stimuli. The nurse did not call an emergency response due to the do not resuscitate order that was in place. The nurse called the prison GP to review Mr Storey.

27. At around 5.15pm, the prison GP reviewed Mr Storey. Mr Storey responded and complained of pain in his abdomen. The prison GP asked the nurse to arrange admission to hospital for treatment and requested that healthcare staff review him hourly in the meantime.

28. The nurse asked the control room to request an ambulance. The ambulance service advised it would be a four hour wait.

29. Before Mr Storey was admitted to St James' Hospital, prison staff completed an escort risk assessment. The nurse completed the medical section and did not object to the use of restraints. He noted that Mr Storey's condition did not restrict his ability to escape but wrote that he had very poor mobility and was receiving palliative care. A Custodial Manager (CM) found an old security risk assessment document for Mr Storey on the computer system. The risk assessment stated that Mr Storey should be restrained using 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.) The CM read the risk assessment out to the Head of Reducing Reoffending, who authorised that Mr Storey should be restrained with an escort chain and escorted by two members of prison staff. When Mr Storey went to hospital he remained restrained until 9.00am the following morning, when the Head of Business Assurance, authorised that the restraints be removed. She said that they should be replaced when returning to the establishment.

30. On 18 March, the Offender Management Unit (OMU) at Leeds began an application for compassionate release for Mr Storey.

31. On 5 April, the Head of Offender Management, emailed the application for compassionate release to, the Head of Healthcare, to request that she ask the hospital consultant to complete it.

32. On 6 April and 12 April, the Head of Offender Management, emailed the Head of Healthcare again to follow up on the compassionate release application request.

33. On 12 April, Mr Storey was transferred from hospital to Wheatfields Hospice for symptom management at the end of his life. He remained unrestrained and escorted by two prison officers during the journey and on arrival at the hospice.

34. On 13 April, the Head of Healthcare replied to the Head of Offender Management's, email stating that as Mr Storey had transferred to a hospice, the hospice consultant

would now have to complete the consultant's sections of the compassionate release application and was doing it that day. The Head of Healthcare said that the hospice consultant did not feel his death was imminent, so they had some time. The application was never completed.

35. At 8.05pm on 17 April, hospice staff confirmed that Mr Storey had died.

Post-mortem report

36. The Coroner accepted the cause of death provided by a hospice doctor and did not request that a post-mortem examination was carried out. The doctor gave Mr Storey's cause of death as metastatic lung cancer with retroperitoneal and psoas muscle metastases (a lung cancer which had spread to a muscle in the abdominal cavity). Pulmonary fibrosis, chronic obstructive pulmonary disease and ischaemic heart disease were also listed as contributory factors.

Non-Clinical Findings

Restraints, security and escorts

37. 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. It said 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. It found that using handcuffs or other restraints on terminally ill or seriously ill prisoners was inhumane, unless justified by security considerations.

38. Mr Storey was restrained during the escort to hospital in the early hours of 9 March. The following morning the risk assessment was reviewed and the decision was made to remove the restraints.

39. Mr Storey was a category C prisoner and a wheelchair user. He had chronic lung disease, terminal cancer, his health had deteriorated and he had been unresponsive in prison. Mr Storey was being sent to hospital due to a possible bowel obstruction and it was considered that he may be at the end of his life. It is clear that the authorising officer did not take these factors into account when he authorised that Mr Storey should be restrained. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances.

40. The nurse was unable to attend for interview however he answered questions that the investigator and clinical reviewer put to him by email. The nurse stated that he did not object to the use of restraints as Mr Storey was conscious, alert and independently mobile, and did not suffer from limb injuries. He said that he had received training to complete risk assessments by peers at a previous prison but had never heard of the Graham Judgement (the high court judgment made in 2007). We understand that the nurse not received training on completing escort risk assessments at Leeds.

41. In interview, the CM said that she could see from the security risk assessment stored on the computer system that Mr Storey had been discussed in the multi-disciplinary meetings regarding the use of restraints and that a decision had been made to use the escort chain. She did not realise at the time that this was an old assessment. She said that she was mindful that Mr Storey was in a wheelchair and that the medical risk assessment noted poor mobility but said that based on the stored security risk assessment that she found she supported the use of the escort chain as he was presenting as 'quite spritely'. The CM said that she knew that the risk assessment was to be reviewed the next day. Therefore, based on his presentation, she discussed the risk assessment she found with the Head of Reducing Reoffending, and they made the decision to restrain Mr Storey. There is

no written record of the involvement of the Head of Reducing Reoffending, in the decision within the escort records.

42. It is positive that Leeds have been holding multi-disciplinary meetings to discuss those prisoners who have reduced mobility and/or palliative care needs in relation to the use of restraints. Following the multi-disciplinary meeting, the risk assessments are updated to note the decisions made in that meeting and we acknowledge that on this occasion an old risk assessment was used in error. Leeds have confirmed that this process has already been rectified and all authorising governors are aware of where to find the most up to date risk assessments.

43. However we are concerned that this system of deciding the level of restraints in advance may reduce the confidence of authorising officers to make dynamic decisions when completing the escort paperwork. It is important that the medical staff at Leeds provide a full and clear picture of the prisoner's medical conditions and feel confident to object to the use of restraints where their use would be inhumane. It is also important that authorising governors feel confident to make a dynamic decision on the day regardless of previous decisions made by other staff, and that they take into account the health condition of the prisoner at the time of the escort.

44. We refer Leeds back to their action plan of February 2022 where they agreed to remind staff of their responsibilities to consider the current health of a prisoner and ask that they consider whether they need to take further actions to ensure this is consistently considered.

45. The clinical reviewer made a recommendation within her report of Mr Storey's healthcare at Leeds. She said that the Head of Healthcare should review the knowledge and skills of all healthcare staff who contribute to the risk assessments on the personal escort record documents and their understanding of the Graham Judgement. We ask Leeds to consider this recommendation when considering their future actions.

46. We make the following recommendation:

The Governor and the 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 information 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.**

Compassionate release

47. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months, can be permanently released from custody before their sentence has expired. A clear

medical opinion of life expectancy is required. The criteria for early release are set out in the Early Release on Compassionate Grounds Policy Framework. Among the criteria is that the risk of reoffending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of HM Prison and Probation Service (HMPPS).

48. In March 2022, prison staff started an application for Mr Storey to be released on compassionate grounds. Compassionate release applications can take some time because there are several different agencies that need to be a part of the process.

49. We are concerned that a compassionate release application was never submitted despite the poor prognosis being given to Mr Storey in January. It is disappointing to see that Leeds did not begin the application until March, after Mr Storey had been sent to hospital believed to be at the end of his life. While we appreciate that compassionate release can be a lengthy process, at this stage Mr Storey was in hospital with an extremely poor prognosis. It was clear that the time that Mr Storey had remaining was very limited and therefore we would expect to see that the application was progressed quickly. It was not completed before Mr Storey died. We make the following recommendation:

The Governor and Head of Healthcare should ensure that applications for compassionate release are progressed in a timely manner and submitted as promptly as possible.

Mark Judd
Acting Assistant Prisons and Probation Ombudsman
September 2022

Annexes

1. Clinical review

Transcripts of interviews with:

2. Ms Julia Portrey, custodial manager

3. Action plan

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