

**Prisons &
Probation**

Ombudsman
Independent Investigations

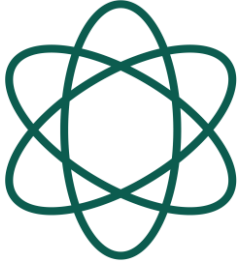
Independent investigation into the death of Mr James Reilly, a prisoner at HMP Stoke Heath, on 26 September 2022

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

OGI

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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 James Reilly died in hospital from a variceal bleed (the bleeding of blood vessels in the gastrointestinal tract) on 26 September while a prisoner at HMP Stoke Heath. This was caused by alcohol liver disease. He also had type 2 diabetes which contributed to but did not cause his death. He was 60 years old. I offer my condolences to his family and friends.

The clinical reviewer concluded that the clinical care that Mr Reilly received at Stoke Heath was partially equivalent to that which he could have expected to receive in the community. Mr Reilly did not have a care plan in place to manage his symptoms of fluid retention and cellulitis in his legs which were caused by his liver cirrhosis.

I am concerned that when Mr Reilly went to hospital as a medical emergency on 25 September, he was restrained with an escort chain despite having mobility issues, using a wheelchair and vomiting blood. I am particularly troubled that he remained restrained in hospital, even during an anaesthetic and endoscopy and that it was only when Mr Reilly's health deteriorated to a point that it was life-threatening that prison staff agreed to remove his escort chain.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman

May 2023

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Summary

Events

1. In August 2014, Mr James Reilly was sentenced to 15 years in prison for robbery. In July 2018, he was transferred to HMP Stoke Heath. Mr Reilly had type 2 diabetes and liver cirrhosis caused by a history of alcohol misuse.
2. On 30 May 2022, Mr Reilly went to hospital for a venogram (a test that shows the veins) of his left leg because he said that it was painful and swollen. A prison GP noted that the hospital had diagnosed him with frailty, type 2 diabetes and long-term liver damage caused by alcohol misuse.
3. On 4 June, a nurse reviewed Mr Reilly because he was in pain and his legs were swollen. Mr Reilly was sent to hospital but returned with no change in his treatment. Hospital staff said that he had cellulitis (a bacterial skin infection) caused by his chronic liver disease.
4. On 22 June, a prison GP referred Mr Reilly to the hospital's gastroenterology department for unexplained weight loss. This was done under the NHS suspected cancer pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks. He was seen on 11 July.
5. On 16 July, a nurse sent Mr Reilly to hospital because he had a swollen testicle. He returned to Stoke Heath with medicine to treat excess fluid in the body. The hospital discharge letter noted that he had a diagnosis of alcoholic cirrhosis of the liver. Mr Reilly was given a wheelchair because of his swollen legs.
6. On 4 August, Mr Reilly went to hospital for a gastroscopy (a test to check inside the throat, oesophagus and stomach).
7. On 17 September, a nurse saw Mr Reilly because he was vomiting blood. The nurse arranged for an ambulance, and he was admitted to hospital. Hospital staff carried out another gastroscopy and endoscopy to rule out an upper gastric bleed. On 22 September, Mr Reilly had an ultrasound scan and hospital staff found that he had lesions on his liver. Mr Reilly returned to Stoke Heath on 23 September.

Events of 25 September

8. At about 12.35pm on 25 September, Mr Reilly pressed his cell bell in distress. An officer saw blood on the cell floor and radioed a medical emergency code red (used for severe blood loss). Officers opened the door and saw a large amount of blood and blood clots around the toilet and the walls of the cell.
9. At 12.37pm, a control room operator telephoned for an ambulance. The ambulance service did not prioritise the response.
10. Two nurses went to Mr Reilly's cell. Mr Reilly told them that he was dizzy. He walked out of his cell and sat in his wheelchair outside. Mr Reilly had low blood pressure, a high pulse rate and normal blood oxygen saturation. Prison staff raised his feet. Mr Reilly vomited a significant amount of dark red blood.

11. At 2.00pm, ambulance paramedics arrived at Stoke Heath and took Mr Reilly to hospital. Mr Reilly was restrained with an escort chain on his way to the hospital. He remained restrained in hospital, including during an anaesthetic and endoscopy.
12. After his procedure, Mr Reilly's condition deteriorated, and he haemorrhaged. It was only then, when hospital staff indicated that the situation was life-threatening, that prison escort staff removed the restraint. Hospital staff then placed Mr Reilly in a coma, but he died the next day.

Findings

Clinical care

13. The clinical reviewer found that the clinical care that Mr Reilly received at HMP Stoke Heath was partially equivalent to that which he could have expected to receive in the community. Mr Reilly did not have a care plan in place to manage his symptoms of fluid retention and cellulitis in his legs which were caused by liver cirrhosis. The clinical reviewer has made three recommendations, which do not directly relate to Mr Reilly's death but which the Head of Healthcare will need to address.

Use of restraints

14. Mr Reilly was restrained on 25 September when he was taken to hospital as a medical emergency after he had lost a considerable amount of blood and despite being a wheelchair user. The restraints were only removed when hospital staff explained Mr Reilly was in a life-threatening condition.

Recommendations

- The Head of Healthcare at Stoke Heath should ensure that care plans are created for prisoners with symptoms and complications related to long-term conditions or chronic disease.
- 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 that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Investigation Process

15. The investigator issued notices to staff and prisoners at HMP Stoke Heath informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
16. The investigator obtained copies of relevant extracts from Mr Reilly's prison and medical records.
17. NHS England commissioned a clinical reviewer to review Mr Reilly's clinical care at the prison.
18. We informed HM Coroner for Shropshire of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
19. The Ombudsman's family liaison officer wrote to Mr Reilly's sister to explain our investigation. She had no specific questions and did not want a copy of the report.
20. We shared the initial report with the Prison Service. There were no factual inaccuracies.

Background Information

HMP Stoke Heath

21. HMP Stoke Heath is a medium secure prison in Shropshire that holds up to 782 adults and young adult men on eight residential wings. Healthcare is provided by Shropshire Community Health NHS Trust.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Stoke Heath was in November 2018. Inspectors reported that all healthcare staff were trained to provide basic life support, and resuscitation equipment was appropriate. Inspectors found that patients with long-term conditions were well supported by appropriately skilled nurse practitioners. Evidence-based care planning was used, and additional specialist support was provided as required.

Independent Monitoring Board

23. 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 April 2022, the IMB reported that healthcare staff responded to the increase in demand for services following the pandemic. Access to routine GP services was very good. The IMB was frustrated that the healthcare building had a decommissioned inpatient facility. They noted that if this was refurbished and reinstated, it would be of substantial benefit as a regional resource.

Previous deaths at HMP Stoke Heath

24. In the two years before Mr Reilly's death, four prisoners died from natural causes at Stoke Heath, two of which were as a result of COVID-19. There were also two self-inflicted deaths in the same period. There are no significant similarities between our findings in this investigation and those of the other deaths.

Key Events

25. In August 2014, Mr James Reilly was sentenced to 15 years in prison for robbery. On 31 July 2018, he was transferred to HMP Stoke Heath.
26. Mr Reilly had type 2 diabetes and liver cirrhosis caused by a history of alcohol misuse.
27. On 23 January 2019, a healthcare administrator completed a diabetes care plan for Mr Reilly. Healthcare staff frequently reviewed the care plan and offered Mr Reilly dietary advice and support. Mr Reilly had regular blood tests to check his blood sugar levels and healthcare staff frequently weighed him and recorded his weight in his medical records.
28. On 30 May 2022, Mr Reilly went to hospital for a venogram of his left leg because he said that it was painful and swollen. The following day, a prison GP noted that the hospital had diagnosed him with frailty and confirmed the diagnoses of type 2 diabetes and long-term liver damage caused by alcohol misuse.
29. On 4 June, a nurse reviewed Mr Reilly who was in a lot of pain. The swelling had increased in both of his legs, particularly the left leg. She discussed Mr Reilly with a prison GP, who decided that he should go to hospital. Mr Reilly was sent to hospital later that day and returned with no change in his treatment. The GP noted that the hospital said that he had cellulitis caused by chronic liver disease. The clinical reviewer found no record that healthcare staff created a care plan to manage his fluid retention or cellulitis. However, healthcare staff frequently monitored the swelling and pain in Mr Reilly's legs.
30. On 22 June, a prison GP referred Mr Reilly to the hospital's gastroenterology department for unexplained weight loss. This was under the NHS suspected cancer pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks. The hospital saw him for this appointment on 11 July, after which hospital staff said that they needed to keep him under review and carry out further investigations and treatment with the gastroenterology team.
31. On 16 July, a nurse sent Mr Reilly to hospital because he had a swollen testicle. Mr Reilly was discharged to Stoke Heath with furosemide (a medicine used to treat excess fluid in the body). The hospital discharge letter noted that he had a diagnosis of alcoholic cirrhosis of the liver. That day, a nurse noted that Mr Reilly was given a wheelchair because of his swollen legs.
32. On 4 August, Mr Reilly went to hospital for a gastroscopy, following his appointment on 11 July. Hospital staff told Mr Reilly that he needed to stay in hospital for further tests, but he refused and returned to Stoke Heath. The following day, Mr Reilly went back to hospital, where he stayed until 11 August.
33. On 17 September, Mr Reilly told a nurse that he had vomited blood that morning and that it had been getting worse. He was taken to hospital by ambulance and admitted as an inpatient. Hospital staff carried out a gastroscopy and an endoscopy to rule out an upper gastric bleed. On 22 September, Mr Reilly had an ultrasound scan. When a nurse telephoned the hospital, hospital staff told her that he had lesions on his liver. Mr Reilly returned to Stoke Heath on 23 September.

We found no evidence that the hospital provided the prison with instructions about how to care for Mr Reilly.

Events of 25 September

34. At about 12.35pm on 25 September, Mr Reilly pressed his cell bell. Two officers went to his cell and asked him why he had pressed his cell bell. Mr Reilly shouted, 'Blood'. An officer saw blood on the floor of his cell and radioed a medical emergency code red and staff automatically called for an ambulance (the ambulance service operator did not prioritise the call and it took some time to arrive.). When another officer arrived at the cell, the officers opened the door and saw a large amount of blood and blood clots around the toilet and on the walls of the cell. Another officer said that Mr Reilly looked very pale, almost grey in colour, and was apologising for what had happened.
35. Two nurses went to Mr Reilly's cell. Mr Reilly told the nurse that he was dizzy. Mr Reilly walked out of his cell and sat in his wheelchair outside. Mr Reilly had low blood pressure, a high pulse rate and normal blood oxygen saturation. Prison staff raised his feet because of his low blood pressure. Mr Reilly vomited a significant amount of dark red blood.
36. At 2.00pm, ambulance paramedics arrived at Stoke Heath and took Mr Reilly to hospital. Before he left, prison staff completed an escort risk assessment, but the medical section of the form was not completed. A Custodial Manager (CM) noted that Mr Reilly posed a low risk of escape and a high risk to the public and hospital staff. The Head of Security and Intelligence authorised that he should be restrained. When Mr Reilly went to hospital, he was restrained by an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer).
37. He remained restrained in hospital, including during an anaesthetic and endoscopy procedure. When Mr Reilly came round from the anaesthetic, his health deteriorated and at around 5.45pm, he haemorrhaged. An escort officer noted in her prison statement that, 'an excessive amount of blood fell from [Mr Reilly's] mouth onto the floor, and because hospital staff told him that it was a life-threatening situation, the escort chain was removed, and he remained unrestrained'.
38. Hospital staff then placed Mr Reilly in a coma, with a view to stopping the internal bleeding. However, Mr Reilly's condition continued to deteriorate, and he died in hospital at 12.45pm on 26 September.

Contact with Mr Reilly's family

39. On 25 September, prison staff telephoned Mr Reilly's sister and told her that Mr Reilly was seriously unwell in hospital. Hospital staff updated Mr Reilly's sister on his condition. On 26 September, the Head of Safer Custody appointed a family liaison officer (FLO) and a deputy FLO. The FLO telephoned Mr Reilly's sister to explain her role as the family liaison officer. After Mr Reilly died, the FLO telephoned Mr Reilly's sister and offered her condolences. Mr Reilly's funeral took

place on 11 October. The prison contributed to its cost in line with national instructions.

Support for prisoners and staff

40. After Mr Reilly's death, the officers who were at the hospital when Mr Reilly died were offered support from the care team.
41. A governor posted notices informing prisoners of Mr Reilly's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Reilly's death.

Post-mortem report

42. There was no post-mortem examination. A renal medicine consultant said that Mr Reilly died from a variceal bleed caused by decompensated alcohol liver disease (chronic liver disease related to alcohol use). He also had type 2 diabetes which contributed to but did not cause his death.

Findings

43. The clinical reviewer found that the clinical care that Mr Reilly received at HMP Stoke Heath was partially equivalent to that which he could have expected to receive in the community.
44. The clinical reviewer was satisfied that Mr Reilly had a type 2 diabetes and liver cirrhosis care plan in place, and that Mr Reilly's care was appropriately managed by secondary care services in hospital. The clinical reviewer found that Mr Reilly was appropriately referred to specialist hepatology and gastroenterology teams.
45. However, the clinical reviewer considered that Mr Reilly should have had a care plan in place to manage the fluid retention and cellulitis in his legs which were ultimately caused by his liver cirrhosis. We make the following recommendation:

The Head of Healthcare at Stoke Heath should ensure that care plans are created for prisoners with symptoms and complications related to long-term conditions or chronic disease.

Use of restraints

46. 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 a prisoner's health and mobility.
47. 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, including 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 the 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.
48. We are concerned that Mr Reilly was restrained with an escort chain on his way to hospital on 25 September as a medical emergency. He had mobility issues, used a wheelchair, was clearly unwell and had lost a substantial amount of blood. While we acknowledge that this was an unplanned and urgent hospital visit, we consider that there was sufficient opportunity to involve healthcare staff in the assessment. Nurses were with Mr Reilly and could have given their medical opinion on his current risk considering his condition. Additionally, the ambulance did not arrive for over an hour, which gave staff more time to ensure medical input into the assessment.
49. We are particularly concerned that Mr Reilly remained restrained in hospital, including when hospital staff anaesthetised him and completed an endoscopy procedure. We are shocked that it was only when Mr Reilly haemorrhaged after his procedure and hospital staff indicated that it was a life-threatening situation (before

placing him in a coma) that escort officers removed his restraint. This was undignified and unacceptable. 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 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.

50. On 13 April 2023, at the inquest the Coroner concluded that Mr Reilly died from natural causes.

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