

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alan Richardson on 18 April 2021, following his release from HMP Littlehey

A report by the Prisons and Probation Ombudsman

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



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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. Since 6 September 2021, the PPO has been investigating post-release deaths that occur within 14 days of the prisoner's release.
3. If my office is to best assist HM Prisons and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.
4. Mr Alan Richardson died on 18 April 2021, four days after his release from HMP Littlehey. He was 62 years old. The cause of Mr Richardson's death was a lack of oxygen to the brain caused by a cardiac arrest and heart disease.
5. The clinical reviewer concluded that, for the reasons summarised below, the clinical care that Mr Richardson received at Littlehey was not equivalent to that which he could have expected to receive in the community.
6. Cambridgeshire's integrated healthcare policy on discharge from prison is that prisoners on supervised medication should be seen by a member of the healthcare team on the day of release; and those who are unable to travel independently due to medical needs should be escorted. The clinical reviewer found that the policy was not adhered to in Mr Richardson's case.
7. Additionally, despite Mr Richardson's health conditions and mental impairment, he did not receive a pre-release health assessment. The clinical reviewer considered that the reason for this should have been recorded.

The Investigation Process

8. HMPPS notified us of Mr Richardson's death on 20 April 2021.
9. The initial investigator issued notices to staff and residents at Brighton Approved Premises informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
10. The investigator obtained relevant extracts from Mr Richardson's probation service records. Another investigator completed the later stages of the investigation.
11. NHS England commissioned an independent clinical reviewer to review Mr Richardson's clinical care at the prison.
12. We informed HM Coroner for Brighton & Hove of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
13. The Ombudsman's family liaison officer contacted Mr Richardson's sister to explain the investigation. She did not raise any issues for the investigation to consider.
14. We sent a copy of our report to Mr Richardson's sister. She made no comments.
15. The initial report was shared with HMPPS, who reported no factual inaccuracies.

Background Information

HMP Littlehey

16. HMP Littlehey is a medium security prison housing approximately 1,200 men. A high proportion have been convicted of sexual offences.
17. Northamptonshire Healthcare NHS Foundation Trust provides healthcare services at the prison. The prison's healthcare centre is open every day and there is a range of nurse-led clinics. A local practice delivers GP services.

Brighton Approved Premises

18. Approved premises provide accommodation for offenders released from prison on licence and those directed there by the courts as a condition of bail or community orders. Their purpose is to provide an enhanced level of residential supervision in the community, for the purpose of risk management, as well as a supportive and structured environment. Residents are responsible for their own healthcare and are expected to register with a GP.
19. Brighton Approved Premises is one of around 100 approved premises in England and Wales. It accommodates up to 18 adult male residents. There have been no recent deaths at the approved premises.

HM Inspectorate of Prisons

20. The most recent full inspection of HMP Littlehey was in August 2019 (a short scrutiny visit took place in June 2020.) Inspectors noted that although it was not a resettlement prison, Littlehey released about 30 prisoners a month and, at the time of the inspection, the prison had only recently introduced a community rehabilitation company (CRC) to provide specialist release planning. The offender supervisors responsible for the interim arrangements did not have the necessary expertise to adequately meet prisoners' resettlement needs.
21. Inspectors reported weaknesses in rehabilitation and release planning. They found that the levels of regular, meaningful contact between offender supervisors and prisoners varied, and their work was mainly reactive. However, discharge arrangements on the day of release were satisfactory. Staff ensured that prisoners understood their licence conditions, as well as where and when to report.
22. Inspectors found that medical records were informative and included prisoners' involvement in their care. Clinical audit reports showed that learning points were acted on. Prisoners were seen by healthcare staff before their release, they received a supply of medication and information was shared for GPs to provide ongoing care.

Key Events

23. Mr Alan Richardson was remanded to HMP Elmley on 19 October 2013. He was later convicted of robbery and sexual assault. On 15 December 2013, Mr Richardson was sentenced to four years and eight months in prison, with an extended supervision period of three years.
24. Having transferred between several prisons, Mr Richardson was released from HMP Dartmoor on 25 November 2016. He was expected to report to his probation office that day but failed to do so, therefore his licence was revoked, and he was recalled to prison. He later said that he could not find the probation office.
25. On 1 December, Mr Richardson was taken to HMP Elmley, and he transferred to HMP Littlehey on 22 March 2017.
26. When he was remanded to prison, Mr Richardson told healthcare staff that he had had a stroke and a heart attack in 2011, while in the community. In October 2019, an echocardiogram (ECG) revealed that he had heart failure, but he had no symptoms. In December, he was diagnosed with heart disease and medication was prescribed.
27. On 2 January 2020, Mr Richardson had a CT scan, due to concerns about his memory. The scan showed evidence of several past strokes (of which he had been unaware) and he was referred to the memory service at Addenbrooke's Hospital. Mr Richardson was seen in June 2020. (A further appointment was scheduled for March 2021, but there is no evidence that this took place.)

Pre-release planning

28. Cambridgeshire has a reablement team in the Specialist and Secured Services Directorate. It provides intensive support to help increase independence for people who have medical, or other problems and are due for release from prison.
29. In October 2020, a member of the reablement team asked the pharmacist at Littlehey for information on Mr Richardson's medical history and medication. The information was to be used in a referral to Brighton and Hove Social Care Department, for adult social care (Mr Richardson wanted to be released to the Brighton area). The pharmacist told him about Mr Richardson's memory problems, including the discovery of 18 months of medication that he had forgotten to take. As a result of this, he then had to take his medication under supervision. The reablement team requested more detailed clinical information on 12 February.
30. On 16 March 2021, a community offender manager (probation officer) at Folkestone Probation Office informed a Resettlement Case Administrator at Littlehey that Mr Richardson was due to be released and would need help with several matters, including travel from the prison to approved premises. (We were not able to establish when the referral to Brighton AP was made but, clearly, he was accepted as suitable and given a place on release.) She mentioned that he did not realise the impact of his memory loss on his ability to do things and they should try to avoid a repeat of him being recalled to prison for breaching the licence condition on reporting after his release.

31. On 17 March, a Resettlement Responsible Officer held a resettlement review. Mr Richardson told her that due to his memory loss, he did not feel able to travel to the approved premises independently. She was aware that he had previously been recalled due to confusion and failing to report to probation on release. She asked healthcare and the mental health in-reach team for further details of his memory problems, medication and support received. She also asked for a taxi to be booked to take Mr Richardson to the approved premises. A GP at the prison provided the information on 24 March.
32. Further meetings were held to discuss post-release support for Mr Richardson, as he was estranged from his family and had no friends. He signed a form to request support in the community from the St Vincent de Paul Society, a charity. It was agreed to refer him to adult social care after his release.
33. Healthcare staff shared a patient summary, information on referrals to other agencies and outstanding appointments with Mr Richardson, the Resettlement Responsible Officer and Brighton Approved Premises. The information about Mr Richardson's poor memory and medication needs was shared with a range of service providers who would be supporting him on his release. Before he left the prison, a healthcare administrator delivered his discharge medication to prison reception staff.

Post-release

34. On 14 April 2021, Mr Richardson was released on licence from Littlehey. His licence conditions included reporting to Brighton Approved Premises, without delay. He was due to live at the approved premises until 19 May and his licence was due to expire on 18 June. A prison administrator booked a taxi, giving the company the address and postcode of the approved premises. Mr Richardson left the prison at 9.30am.
35. Mr Richardson was expected to arrive at the approved premises by 2.00pm. As he was not there by 4.00pm, his offender manager asked approved premises staff to consider asking the local police to find and guide him to the building. She felt it was likely that he was lost and confused, rather than deliberately avoiding reporting. Therefore, staff agreed to give him more time and if he did not arrive by 11.00pm, they would request an emergency out of hours recall to prison.
36. Mr Richardson arrived at Brighton Approved Premises just after 7.00pm. Two residential workers were on duty. One residential worker welcomed him, and he signed the approved premises' rules. They intended to complete the remaining induction the next day.
37. When asked, Mr Richardson could not account for his whereabouts in the previous six hours. Due to his rambling explanation, the residential workers thought he might have been drinking alcohol. They checked his bags, but nothing was found.

Circumstances of Mr Richardson's death

38. A residential worker showed Mr Richardson to his room on the fourth floor. When they went into the room, Mr Richardson sat on a chair and immediately had a

seizure. The residential worker went back downstairs and asked his colleague to call the ambulance service. The ambulance was requested at 7.22pm.

39. An ambulance arrived at the approved premises around two minutes after the call. When the paramedics reached Mr Richardson's room at approximately 7.26pm, he was slumped in a chair and was not breathing. They placed him on the floor and performed cardiopulmonary resuscitation. They used a defibrillator which gave two shocks. Another ambulance crew and the fire brigade arrived shortly afterwards.
40. The residential workers contacted the on-call senior manager and the manager of the approved premises, who arrived during the emergency.
41. At 9.04pm, the paramedics took Mr Richardson to Royal Surrey County Hospital, where he was admitted to the intensive care unit, sedated and placed on a ventilator. Approved premises staff obtained updates on Mr Richardson's condition.
42. Mr Richardson died at 8.30pm on 18 April. The next day, the Probation Service informed HMPPS of his death.

Support for staff

43. Probation managers checked the wellbeing of approved premises staff and offered trauma counselling the day after Mr Richardson's death.

Contact with Mr Richardson's Family

44. On 19 April, the manager of the approved premises tried to trace Mr Richardson's mother, his next of kin. The next day, the police visited the address listed in his prison (NOMIS) record, but she no longer lived there, so the enquiries continued.
45. On 19 May, the hospital's bereavement service gave the police the contact details for Mr Richardson's sister, and they were passed to the manager of the approved premises. Mr Richardson's sister had asked the hospital to arrange for Mr Richardson to be cremated and no funeral service was held.

Post-mortem report

46. A post-mortem examination was conducted. The coroner concluded that the cause of Mr Richardson's death was a hypoxic ischaemic brain injury (a lack of oxygen to the brain) due to cardiac arrest and ischaemic heart disease, which had been caused by coronary artery atheroma (a build-up of fatty deposits on the walls of the arteries around the heart).

Findings

Arrangements for Mr Richardson's release

47. The clinical reviewer concluded that although Mr Richardson's long-term health conditions were monitored appropriately at Littlehey, his clinical care overall was not equivalent to that which he could have expected to receive in the community. She found significant omissions in the handling of the clinical aspects of Mr Richardson's release and some of the expected procedures in Cambridgeshire's guidance on discharge from prison were not followed.

Head of Healthcare to Note

Pre-release health assessment and medication

48. *Specialist and Secured Services Directorate Cambridgeshire; Integrated Healthcare Service Provision* sets out the guidelines for the release/discharge of people in prison in the region. The guidance states that if there is a discharge clinic, prisoners should be given the opportunity to book a pre-release assessment. In addition, *National Institute for Health and Care Excellence (NICE) guidance 57 Physical Health of People in Prison*, indicates that those with complex health needs should have a pre-release health assessment, led by primary care and overseen by a multidisciplinary team.
49. The clinical reviewer noted that despite Mr Richardson's health conditions and memory impairment, he had not been regarded as having complex medical needs. As the healthcare department is responsible for ensuring continuity of care, she considered that the reason for not conducting a pre-release health assessment should have been documented.
50. The deputy head of healthcare said that due to the COVID-19 pandemic, the relevant clinics had been suspended and had not been reinstated at the time of Mr Richardson's release.
51. Another requirement in the protocol is that a healthcare professional should see prisoners on supervised medication in reception and ensure that there is two weeks' supply of medication. Although Mr Richardson's medications were delivered to reception, there was no discussion with healthcare staff.
52. We agree with the clinical reviewer's view that if a prisoner with chronic health conditions is not offered a pre-release health assessment, the rationale for the decision is recorded and that those receiving supervised medication should be spoken to by a member of healthcare on the day of their release and their medication checked, in line with Cambridgeshire's integrated healthcare policy.

Mr Richardson's travel arrangements

53. The guidance also advises that if a prisoner is unable to travel unassisted due to health problems, transport should be provided and, if necessary, they should be assisted by a healthcare professional.

54. Mr Richardson had expressed concern about travelling on his own to the approved premises. The prison administrator gave the taxi company the full address and postcode to get an estimate of the fare, but it was unclear what instructions were passed to the driver. Mr Richardson was reportedly dropped off at the sea front.
55. As Mr Richardson's memory problems had directly led to a recall following a previous release from prison, we agree with the clinical reviewer that the prison should have arranged for him to be escorted. However, we recognise that staff responsible for the transport arrangements could not have foreseen that he would not be taken to the specified address.
56. As the weaknesses identified in the investigation were not directly linked to Mr Richardson's cause of death, we make no formal recommendations. However, the Head of Healthcare will need to address these deficiencies, which are set out in more detail in the clinical review report.

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