

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

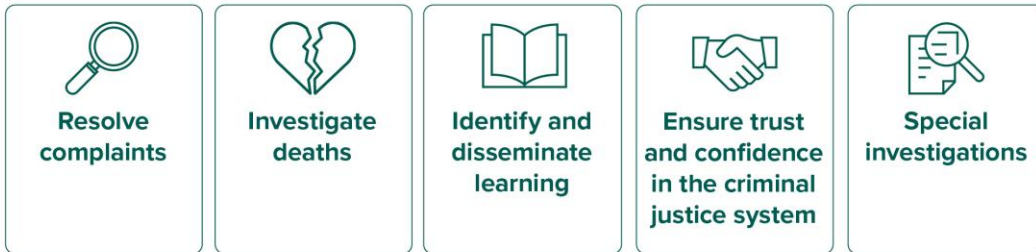
# **Independent investigation into the death of Mr Colin Richell, a prisoner at HMP Rye Hill, on 25 October 2021**

**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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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 Colin Richell died in hospital of pneumonia on 25 October 2021, while a prisoner at HMP Rye Hill. He was 80 years old. I offer my condolences to his family and friends.

The clinical reviewer concluded that the care Mr Richell received at HMP Rye Hill was partially equivalent to that which he could have expected to receive in the community. She found that his care was not equivalent from July 2021 to his death. By July 2021, Mr Richell had dementia and Parkinson's disease and needed 24-hour care. He could not get out of bed safely, was often confused and needed help with basic tasks.

By September, Mr Richell could not hold a beaker of water unaided and was not aware he was in prison. Despite his social care needs and the efforts of healthcare staff at Rye Hill, he remained at the prison and at risk. Eventually his health deteriorated and on 7 October, he was taken to hospital, where he later died.

The clinical reviewer raised concerns about the number of missed clinical follow-ups and healthcare reviews, issues with Mr Richell's long-term conditions and palliative care, and head injury assessments.

I am concerned that despite the efforts of staff at Rye Hill, some of the key processes (such as special leave and compassionate leave applications) that might have allowed Mr Richell to move to a facility that could provide 24-hour care were not progressed or not progressed with sufficient urgency.

However, the issue of equivalent social care in prisons is wider than one case at one prison. Rye Hill, like a number of prisons across England and Wales, exclusively holds men convicted of sexual offences, many of whom are older and serving long sentences. The likelihood of an increasingly aged prison population means that the importance of effective prison-based social care will continue to grow. We invite HM Prison Service to consider pathways for providing 24-hour social care in prisons to support individual prisons such as Rye Hill.

I am disappointed to find that several recommendations I raise in this report have been made previously in other investigations at Rye Hill. It is of particular concern that the action plans for recommendations made relating to compassionate leave applications, long-term health condition care planning and palliative care planning have not been embedded. The Director and the Head of Healthcare will need to pay particular attention to these repeated 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.

**Kimberley Bingham**  
**Acting Prisons and Probation Ombudsman**

**May 2023**

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# Summary

## Events

1. On 25 March 2015, Mr Colin Richell was sentenced to 16 years imprisonment for sexual offences. He was 73 years old. On 12 June, he transferred to HMP Rye Hill.
2. By mid-2020, prison staff were concerned about Mr Richell's memory and that he was increasingly confused. In December, he was diagnosed with Lewy Body dementia.
3. In July 2021, a nurse saw Mr Richell and reviewed his dementia pathway. She completed an Addenbrookes Cognitive Examination (ACE-III) and a mini mental state examination (MMSE). The results showed that he had moderate dementia and significant cognitive impairment. Healthcare staff referred him to an old age psychiatrist.
4. A few weeks later, the prison's multi-disciplinary team (MDT) met. They agreed that Mr Richell's needs could not be met at Rye Hill because he needed 24-hour social care and was only receiving four social care visits each day. They agreed to start the process for applying for early release on compassionate grounds (ERCG) on Mr Richell's behalf.
5. The prison contacted Northampton Adult Social Services (NASS) to see if his care package could be increased. NASS advised that they could not increase his social care package as he was in prison. They recommended that the prison find alternative accommodation such as a hospital. They advised there was nothing further they could do.
6. On 30 September, the MDT met with the regional NHS commissioner. The MDT reviewed the progress in transferring Mr Richell to a more suitable environment that could meet his care needs. However, all the prisons had advised that they either did not have a bed space or they could not meet his social care needs.
7. On 7 October, Mr Richell appeared dehydrated and had low oxygen saturation levels. He was taken to hospital.
8. At around 2.54am on 25 October, Mr Richell died in hospital.

## Findings

9. The clinical reviewer concluded that the care Mr Richell received at HMP Rye Hill was partially equivalent to that which he could have expected to receive in the community.
10. She found that Mr Richell needed 24-hour care and if he had been in the community, he would have been offered care home placements to meet his needs. This was not immediately available to him because of the difficulties in releasing him. This meant he did not receive the same level of care, and despite the efforts of healthcare staff and carers at HMP Rye Hill, his needs were not met.

11. The clinical reviewer found that there were delays and omissions at Rye Hill in considering all release options and the use of bed watch for Mr Richell, which would have increased the likelihood of his care needs being met. There were also systemic issues that impacted Mr Richell's care. She noted that with a growing elderly population, HMPPS needs to consider how best to provide 24-hour care for prisoners who cannot be easily or quickly released.
12. There was no staff debrief following Mr Richell's death, which is not in line with prison policy.

## Recommendations

- HM Prison Service should reflect on the disparity in care services in prison and the community and ensure that in cases where a prisoner has been assessed as requiring 24-hour care but cannot be released into community care, there is a clear pathway to meet those needs in prison.
- The Head of Healthcare should:
  - arrange a reflective case review for all healthcare staff to identify the learning from Mr Richell's case. This should include the significant number of failed onward referrals, follow up clinical actions and appointments; and
  - conduct an internal audit to ensure the learning from Mr Richell's case has been embedded and improvements have been made to clinical monitoring and follow up.
- The Head of Healthcare should develop a process to ensure that end of life discussions and care planning are held at an early stage with prisoners with complex and deteriorating conditions, and fully documented in the medical record.
- The Head of Healthcare should ensure that all prisoners with a long-term condition have regularly reviewed personalised care plans, in accordance with the relevant NICE guidelines.
- The Director and the Head of Healthcare should ensure that applications for early release on compassionate grounds are progressed and all required documentation provided to the MoJ in a timely manner.
- The Director and the Head of Healthcare should ensure that, where a prisoner requires 24-hour care and this cannot be met in the prison, all options for facilitating this care, including Release on Temporary Licence (RoTL) and use of bedwatch are progressed, and that actions completed and issues identified are documented.
- The Director and Head of Healthcare should ensure that after all deaths in custody:
  - a hot debrief is held, in line with PSI 02/2018;
  - a senior member of staff acts as the debriefer and a member of the care team attends;

- all staff directly involved in the incident, including healthcare staff, are invited; and
- consideration is given to whether any staff not directly involved in an emergency response, but who provided care, may need support and debriefing.

## The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Rye Hill informing them of the investigation and asking anyone with relevant information to contact him. A prisoner wrote to him about issues that were outside the remit of our investigation. The investigator responded to his letter in writing and advised him accordingly.
14. The investigator obtained copies of relevant extracts from Mr Richell's prison and medical records.
15. NHS England commissioned an independent clinical reviewer to review Mr Richell's clinical care at the prison.
16. The initial report was shared with HM Prison and Probation Services (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.
17. We informed HM Coroner for Warwickshire of the investigation. The Coroner gave us the cause of death; no post-mortem report was completed. We have sent the Coroner a copy of this report.
18. The Ombudsman's family liaison officer wrote to Mr Richell's 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 to our letter.

## Background Information

### HMP Rye Hill

19. HMP Rye Hill is a medium security prison for up to 664 men convicted of sexual offences. It is located near Rugby and is operated by G4S under contract from the Ministry of Justice.
20. G4S Healthcare provides healthcare services. There is no inpatient facility at Rye Hill but there is 24-hour healthcare provision, with one nurse on duty at night.

### HM Inspectorate of Prisons

21. The most recent inspection of HMP Rye Hill was an unannounced inspection in September 2019. Inspectors found that health services were reasonably good overall. Partnership working between the prison and health providers had improved since the previous inspection, and strong leadership had driven recent improvements in the delivery of primary care. Inspectors also found that healthcare staff monitored prisoners with long-term health conditions reasonably well. However, they also found that too many healthcare staff had not completed mandatory training.
22. HMIP also conducted a Short Scrutiny Visit of Rye Hill in June 2020 to report on the treatment and conditions of prisoners during the COVID-19 pandemic. They found that the prison had adopted clear plans to manage the pandemic at the start of the lockdown, identifying those who were most vulnerable so they could protect them and limit the spread of the virus. Health and safety protocols were in place and the prison remained calm, well ordered and safe. Most healthcare clinics had been suspended but managers had implemented a triage system to ensure that urgent cases were dealt with appropriately.

### 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 annual report for the year to 31 March 2021, the IMB reported that prisoners' health was well provided for during the COVID-19 pandemic, with continued access to healthcare on a par with that provided to the community.
24. In their most recent report to 31 March 2022, the IMB reported that;  
  
"The difficulties surrounding appropriate arrangements for end-of-life care and compassionate release, imposed by current HMPPS facilities and procedures, impact HMP Rye Hill disproportionately because of the higher-than-average age profile of the prisoners held. The current procedures do not seem to facilitate humane treatment of these prisoners."

## Previous deaths at HMP Rye Hill

25. Mr Richell was the fifteenth prisoner to die at Rye Hill since October 2019. All previous deaths were from natural causes.
26. In our previous investigations into the deaths of two prisoners at Rye Hill in 2019, we made recommendations about monitoring prisoners' long-term health condition(s). The prison accepted our recommendation and reported that all care plans had been reviewed, a care plan template had been created on the clinical electronic records system, a nurse had been allocated to review long-term conditions care planning and staff had received refresher training.
27. We previously found that an application for release on compassionate grounds was not progressed as speedily as it should have. We made a recommendation which the prison accepted. The prison said that compassionate release applications were identified and reviewed regularly through the Vulnerable Adults meeting and the healthcare team.
28. In another investigation in 2020, we found that a staff debrief was not carried out. In their action plan, the prison reported that notices had been sent to staff to remind them to attend debriefs and that debriefs would be held at the first available opportunity.
29. It is disappointing that we are having to raise similar issues and make the same recommendations in this report.

## Key Events

30. On 25 March 2015, Mr Colin Richell was sentenced to 16 years imprisonment for sexual offences. He was 73 years old. Mr Richell was sent to HMP Pentonville. On 12 June, he transferred to HMP Rye Hill.
31. Mr Richell had several pre-existing medical conditions including hypertension (high blood pressure), rheumatoid arthritis, Parkinson's disease (a progressive brain disorder) and high cholesterol. He received a range of medication to manage his conditions. During his time in prison, he fell several times and by 2020, he was assessed as a high risk of falls. He was also being managed by the old age psychiatry services.

### 2020

32. By 2020, Mr Richell was living in a disabled cell and received social care visits from Northampton Adult Social Services (NASS – local authorities are responsible for providing social care to prisoners). Prison and healthcare staff were concerned about his memory and levels of confusion. A series of tests to assess his memory and cognitive function indicated that he had mild to moderate dementia. In December, he was diagnosed with Lewy Body dementia (a common form of dementia). He was later discharged from the old age psychiatry services because his mental health was stable.
33. On 16 October, a prison GP saw Mr Richell. Mr Richell's carers told nurses that Mr Richell had been passing blood from his rectum. The GP made a two week wait referral (used for suspected cancer) for a lower gastro-intestinal (GI) hospital appointment. Although a healthcare administrator noted in Mr Richell's medical records that healthcare staff had referred him, there is no evidence that an appointment was ever made and the original referral could not be found.

### 2021

34. On 4 January 2021, Mr Richell's carers again told nursing staff that Mr Richell was passing blood from his rectum. Nursing staff booked a GP appointment for Mr Richell and collected a faeces sample. However, this sample was not usable and another sample was needed. There is no evidence that healthcare staff asked for or obtained a new sample. A week later, healthcare staff referred Mr Richell for a colorectal surgery appointment. The appointment was re-arranged and cancelled on several occasions due to a breakdown in communication between prison healthcare and security staff. The appointment was never re-booked.
35. Through January, Mr Richell fell on several occasions. Staff did not witness these falls but found him on the floor. On 21 January, healthcare staff opened a Falls Risk Assessment (FRA) which they reviewed monthly. They referred him to the physiotherapy service, and he saw a physiotherapist regularly. Staff also arranged for safety aids to prevent further falls including grab rails for his toilet, a walking frame and a bed side rail (although this was fitted on the wall side of the bed).
36. In March, the prison's multi-disciplinary team (MDT) met and reviewed Mr Richell's health. They agreed that he needed a higher level of support and observation and that he would have hourly welfare checks throughout the day and night.

37. On 26 April, a mental health nurse saw Mr Richell because staff were concerned about his memory. She completed a mental health risk assessment and found he was at risk of self-neglect and exploitation due his cognitive decline. The mental health nurse created a mental health care plan. She reviewed the care plan and saw Mr Richell regularly.
38. On 7 July, a nurse saw Mr Richell and reviewed his dementia pathway. Test results showed that he had a significant cognitive impairment, and he was re-referred to the old age psychiatry service.
39. On 16 July, a prison GP saw Mr Richell to discuss his wishes in the event he stopped breathing or had a heart attack. Mr Richell became upset. The prison GP assessed that Mr Richell wanted to be resuscitated despite the low chance of success. He referred this issue to the MDT.
40. On 20 July, a nurse saw Mr Richell. She noted he was coughing when eating and drinking. She assessed that he needed a referral to speech and language therapy (SALT). Healthcare staff contacted a hospital occupational therapist (OT) who advised that they would make a referral. There is no evidence that the appointment was made or that healthcare staff followed it up.
41. The next day, a prison GP saw Mr Richell. The prison GP noted that Mr Richell could not get out of bed unaided and that he was suffering from recurring urinary tract infections (UTIs). The prison GP requested that healthcare staff complete urgent blood tests due to concerns about possible heart failure. There is no evidence that healthcare staff took the blood samples.
42. The same day, the MDT met. They agreed that Mr Richell's needs could not be met at Rye Hill because he was receiving four social care visits each day and needed 24-hour social care. The MDT asked the prison safer custody team to contact NASS to see if his care package could be increased and separately, for safer custody to begin completing early release on compassionate grounds (ERCG) paperwork.
43. Around the same time, prison staff were concerned that Mr Richell's carers were not seeing him at the right time. This left Mr Richell unattended for long periods of time and healthcare staff did not have the capacity to cover for the carers. On 29 July and 3 August, the prison raised safeguarding referrals to NASS about Mr Richell's social care package.
44. On 5 August, NASS reviewed Mr Richell's care package. They assessed that he needed 24-hour care that could not be provided in a prison setting. They concluded that they had no community pathways for serving prisoners. This was fed back to staff at Rye Hill.
45. On 9 August, a prison GP saw Mr Richell. He recorded his significant concerns about Mr Richell remaining at Rye Hill. He noted that an immediate plan was needed to reduce the risk of Mr Richell suffering significant injury. The prison GP's concerns and the conclusions of NASS were escalated to the head of healthcare, and the head of safer custody.

46. Through mid-August, staff at the prison explored options for moving Mr Richell out of Rye Hill. This included transferring Mr Richell to a secure mental health unit. This was correctly assessed to be an inappropriate pathway as his needs were physical and social and he did not need psychiatric treatment.
47. The prison submitted the ERCG paperwork to the Ministry of Justice (MoJ). MoJ sent the application back to the prison because it was incomplete as there was no consultant opinion on Mr Richell's prognosis and they asked that one be provided.
48. On 22 August and 29 August, Mr Richell suffered falls in his cell. Following the first fall he was reviewed by OT. She assessed that Mr Richell was at severe risk of injury as he was prone to getting out of bed unaided and was liable to fall. Following his second fall, healthcare staff assessed Mr Richell needed to be reviewed by a GP, but this did not happen.
49. On 1 September, NASS wrote to Rye Hill advising that they could not increase his social care package as he was in prison. They recommended that the prison should find alternative accommodation such as a hospital. They advised there was nothing further they could do.
50. Mr Richell suffered further falls on 4 and 11 September. Following the fall on 11 September, a nurse assessed him and concluded that he was not safe to get out of bed and was increasingly confused.
51. On 15 September, the Head of Healthcare organised an MDT for 27 September and invited a regional NHS commissioner. The same day, a member of the healthcare team contacted Mr Richell's neurologist. Staff were concerned that he was rapidly deteriorating, and he needed to be reviewed. A message was left with the neurology service, but it appears the call was not returned, and healthcare did not follow this up.
52. On 21 September, staff had to help Mr Richell lift or hold a beaker of water to drink, as he could no longer do it himself. This was escalated to the Head of Healthcare.
53. On the 23 September 2021, a GP documented that Mr Richell's blood levels needed to be checked. He advised that if the levels were raised he would need to refer Mr Richell to hospital for exploration of heart failure, and that an electrocardiogram (ECG, used to assess the electrical output of the heart) should be considered.
54. On 27 September, the MDT met without the regional NHS commissioner. The MDT agreed that Mr Richell would have hourly observations and placed on a support book (a framework where prison staff are responsible for providing increased support and regular observations to a prisoner), which would be reviewed daily by managers. Healthcare staff would also complete daily welfare checks, twice weekly body maps, weekly weighing and a food and diet chart.
55. On 30 September, a prison GP reviewed Mr Richell's blood test results. He concluded that Mr Richell had increased B-type natriuretic peptide (BNP) levels, which indicated Mr Richell had an irregular heartbeat. The prison GP considered that Mr Richell was too frail to go to hospital for further investigations and that anticoagulant (blood thinning) medication was too high a risk. The prison GP also

noted that Mr Richell knew his date of birth and who the monarch was but was “clearly demented”, and was not aware he was in prison.

56. The Head of Healthcare, a GP and nursing staff discussed his care. They noted that Mr Richell did not have a Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) order. They agreed that he would not be suitable for resuscitation, but he should be admitted to hospital for treatment that could not be provided at Rye Hill. There is no evidence that healthcare staff assessed Mr Richell’s mental capacity (to see if he could make decisions for himself) or that they asked him about the DNACPR order.
57. The same day, the MDT met with the regional NHS commissioner. The MDT reviewed the progress in transferring Mr Richell to a more suitable environment that would meet his care needs. The Head of Safer Custody contacted several prisons with 24-hour healthcare units to see if Mr Richell could be moved to one of them. However, all the prisons advised that they either did not have a bed space or they could not meet his social care needs.
58. At around 6.45am on 7 October, a nurse saw Mr Richell. He was dehydrated and had trouble swallowing his medication. The nurse passed this to the day staff coming on duty so Mr Richell could be reviewed.
59. At around 10.30am, a nurse saw Mr Richell. He appeared sleepy and his lips were dry. She assessed him and his oxygen saturation was below normal. She also completed a NEWS-2 assessment (a standardised tool that measures clinical deterioration in adults) and he scored two, which meant that he needed to be reviewed. She booked an appointment for Mr Richell to see a GP.
60. Around 10.50am, the nurse re-assessed Mr Richell. His NEWS-2 score was now three and his oxygen saturation levels were still below normal. At 12.10pm, Mr Richell was taken to hospital. He was escorted by prison officers and was not restrained, in line with his physical health and assessed level of risk.
61. The hospital diagnosed Mr Richell with pneumonia.
62. While in hospital, Mr Richell’s condition deteriorated. He was completely immobile and bedbound, he could not feed himself, and was not able to lift his arms and legs. On 18 October, he was transferred to St Cross Hospital, Rugby for treatment and care.
63. On 22 October, Rye Hill staff contacted the MoJ for an update on Mr Richell’s ERCG. The case manager advised that they were waiting for the specialist consultant report to advise on Mr Richell’s condition and prognosis before the ERCG could be progressed. This report had been asked for previously but not provided by a specialist consultant. The ERCG application made no further progress prior to Mr Richell’s death.
64. The same day, Mr Richell’s health deteriorated further and he was treated for sepsis.
65. At 2.54am on 25 October, Mr Richell died in hospital.

## **Contact with Mr Richell's family**

66. Following Mr Richell's death, a Family Liaison Officer (FLO) rang his next of kin, a friend. Over the following days, the FLO provided support and information.
67. Mr Richell's funeral was held on 26 November 2021. The prison offered to contribute to the cost of the funeral in line with prison policy.

## **Support for prisoners and staff**

68. No staff debrief was held following Mr Richell's death.
69. The prison posted notices informing other prisoners of Richell'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 Richell's death.

## **Post-mortem report**

70. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Richell's cause of death as aspiration pneumonia (a lung infection caused by inhaling oral or gastric contents). Mr Richell also had advanced dementia, Parkinson's disease and lymphoproliferative disease (an autoimmune disorder) which did not cause but contributed to his death.

## Findings

71. The clinical reviewer concluded that the care that Mr Richell received at HMP Rye Hill was partially equivalent to that which he could have expected to receive in the community.
72. She found that Mr Richell needed 24-hour care, and if he were in the community, he would have been offered care home placements to meet his needs. This was not immediately available to him because of the difficulties in releasing him. This meant he did not receive the same level of care, and despite the efforts of healthcare staff and carers at HMP Rye Hill, his needs were not met.

## Clinical Findings

### Care Pathway

73. The clinical reviewer found that once Mr Richell was identified as requiring 24-hour care in July 2021, his social care needs were not met at HMP Rye Hill because Rye Hill has no inpatient facility. In August 2021, NASS formally assessed him as needing 24-hour social care, and the local authority said that this could not be provided in prison.
74. The clinical reviewer also found that there were apparent delays and omissions at Rye Hill in considering all release options including the use of bed watch (when prison officers supervise a prisoner in hospital for extended periods) for Mr Richell, which would have increased the likelihood of his care needs being met.
75. She also found that there were systemic issues that impacted Mr Richell's care. She noted that with an increasing elderly population, HMPPS needed to consider how best to provide 24-hour care for prisoners who cannot be easily or quickly released. The issue of disparity in providing social care within a prison setting has been previously set out in the HM Inspectorate of Prisons' 2018 thematic report of social care in prisons. The clinical reviewer assessed that the issues went beyond a single case in a single prison. We recommend:

**HM Prison Service should reflect on the disparity in care services in prison and the community and ensure that in cases where a prisoner has been assessed as requiring 24-hour care but cannot be released into community care, there is a clear pathway to meet those needs in prison.**

### Clinical follow-up and monitoring

76. The clinical reviewer found that through 2021, there were numerous instances where the healthcare team did not follow up referrals with external agencies, and incidences of referrals not being made when recommended.
77. Of significant concern were the omissions relating to Mr Richell's colorectal surgery appointment (although incidental in relation to his death), and the significant number of clinical activities recommended and required by prison healthcare staff (for

example arranging blood tests and GP appointments), that were not actioned or completed.

78. The clinical reviewer found that the underlying cause of these issues was that staff were not using the clinical systems effectively. We recommend:

**The Head of Healthcare should:**

- **arrange a reflective case review for all healthcare staff to identify the learning from Mr Richell's case. This should include the significant number of failed onward referrals, follow up clinical actions and appointments; and**
- **conduct an internal audit to ensure the learning from Mr Richell's case has been embedded and improvements have been made to clinical monitoring and follow up.**

**End of Life care**

79. The clinical reviewer found that given Mr Richell's deteriorating condition, age and circumstances it would have been helpful to have had earlier discussions with him about his end of life care wishes, including discussions about advanced decisions (decisions a patient can make to refuse a specific type of treatment in the future).
80. Mr Richell's views on resuscitation were discussed with him in July 2021, and he was very clear he wanted to be resuscitated in the event of a cardiac arrest. This was not then documented formally on a DNACPR form.
81. In September 2021, the MDT concluded that Mr Richell should not be resuscitated if his heart stopped and a DNACPR form was completed. There was no evidence that Mr Richell's previous wishes were taken into consideration, or that his mental capacity was assessed at the time.
82. The clinical reviewer was unable to obtain a copy of the DNACPR form because it accompanied Mr Richell to hospital with him on the 7 October 2021. Any clinical paper documents should be uploaded to a prisoner's file in the event of the paper copy being mislaid. We recommend:

**The Head of Healthcare should develop a process to ensure that end of life discussions and care planning are held at an early stage with prisoners with complex and deteriorating conditions, and fully documented in the medical record.**

**Long Term Condition Care Planning**

83. The clinical reviewer found that Mr Richell was reviewed regularly by various members of the healthcare team which included regular long term conditions reviews. However, his formal care plans had not been updated since June 2020. Information about his care was detailed in Mr Richell's daily notes, but this information should have been contained in an easily referenced personalised care plan. We recommend:

**The Head of Healthcare should ensure that all prisoners with a long-term condition have regularly reviewed personalised care plans, in accordance with the relevant NICE guidelines.**

84. The clinical reviewer has made several other recommendations about manual handling aids and the use of Glasgow scoring system which we do not repeat in this report but which the Head of Healthcare will need to address.

## **Non-Clinical Findings**

### **Compassionate Release application**

85. The policy setting out how prisoners can be released on compassionate grounds (known as early release on compassionate grounds (ERCG)) was, at the time an application was made for Mr Richell, in Prison Service Order (PSO) 6000. The four tests for an application were:
- the prisoner is suffering from a terminal illness and death is likely to occur soon; or the prisoner is bedridden or similarly incapacitated; and
  - the risk of re-offending is past; and
  - there are adequate arrangements for the prisoner's care and treatment outside prison; and
  - early release will bring some significant benefit to the prisoner or his/her family.
86. All requests for ERCG are made to the Public Protection Casework Section (PPCS) of the Ministry of Justice who consider applications on behalf of the Secretary of State for Justice. The PPCS require details of the condition and prognosis, and any planned treatment for the prisoner. There must be evidence from a medical specialist (usually a consultant).
87. The initial ERCG paperwork was sent to PPCS on 17 August 2021. A further psychiatric report was sent on 31 August. On 18 August, PPCS asked for a specialist consultant report. From correspondence between the prison healthcare team and hospital doctors it appears that the hospital doctors assessed they could not provide a prognosis for his dementia and Parkinson's. However, no specialist consultant report setting out the difficulties in assessing Mr Richell's prognosis was provided to PPCS. While Mr Richell did not have a terminal diagnosis (in the way a patient with terminal cancer might), he was, by September, fully dependent on others for basic tasks (such as drinking) and could not get out of bed safely. He likely met the tests for bedridden.
88. We note that in May 2022, the policy on ERCG was updated with guidance on release for social care. This may help reduce delays and the issues that arose during Mr Richell's ERCG application.
89. We make the following recommendation.

**The Director and the Head of Healthcare should ensure that applications for early release on compassionate grounds are progressed and all required documentation provided to the MoJ in a timely manner.**

### **Use of other Special Purpose Leave (SPL) and use of escorts**

90. Special Purpose Leave (SPL) is a form of leave set out in the HM Prison Service's Release on Temporary Licence (RoTL) framework published in May 2019. In section 6.31 the policy provides for SPL on medical grounds. It states,

"SPL may be granted for offenders to attend medical out-patient appointments, or inpatient requirements".

The policy allows for SPL for an extended period for those in or requiring in-patient treatment.

91. While Mr Richell's offence and category may have made the granting of SPL more complex, section 6.25 provides a pathway towards SPL.

92. From the information provided by Rye Hill, although the prison identified SPL as an option to move Mr Richell to an environment where he could receive 24-hour care, there is no evidence it was progressed. We consider that this was an omission.

93. Similarly, it was not until mid-October that the prison considered sending Mr Richell to a care home escorted by prison officers. This was identified as a pathway out of hospital but did not progress as Mr Richell died shortly afterwards. We consider that this planning and exploration should have started at least a month earlier. We make the following recommendation.

**The Director and the Head of Healthcare should ensure that, where a prisoner requires 24-hour care and this cannot be met in the prison, all options for facilitating this care, including Release on Temporary Licence (RoTL) and use of bedwatch are progressed, and that actions completed and issues identified are documented.**

### **Staff Debrief**

94. During the investigation we asked for records of the staff debrief. We were told that no debrief had taken place contrary to policy set out in PSI 02/2018, Post-Incident Care. Given that there were staff with Mr Richell when he died and that many healthcare staff had provided significant care to him in months leading to his death, often in challenging circumstances, we consider that a debrief would have been of value to ensure staff were offered support. We make the following recommendation:

**The Director and Head of Healthcare should ensure that after all deaths in custody:**

- a hot debrief is held, in line with PSI 02/2018;
- a senior member of staff acts as the debriefer and a member of the care team attends;

- **all staff directly involved in the incident, including healthcare staff, are invited; and**
- **consideration is given to whether any staff not directly involved in an emergency response, but who provided care, may need support and debriefing.**

## **Inquest**

95. The inquest, held on 14 April 2023, concluded that Mr Richell died from natural causes.

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

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