

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Albert Richardson, a prisoner at HMP Oakwood, on 25 January 2022

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



© Crown copyright, 2024

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 Albert Richardson died on 25 January 2022 of lung cancer at HMP Oakwood. He was 82 years old. I offer my condolences to his family and friends.

The clinical reviewer concluded that the care Mr Richardson received at HMP Oakwood was of a good standard and equivalent to that which he could have expected to receive in the community.

The clinical reviewer was concerned that prison staff commenced CPR even though Mr Richardson had a Do Not Attempt Cardiopulmonary Resuscitation order in place and displayed signs of rigor mortis.

I am concerned that the prison restrained Mr Richardson on his last visit to hospital on 20 January 2022, five days before he died. Given his age and ill health. I consider that this was unnecessary and inappropriate. The use of restraints should be based on the risk that a person presents at the time.

I have made a recommendation about the inappropriate use of restraints at Oakwood twice in the past two years and it is disappointing that I am having to highlight the same concerns in this report.

I am also concerned about the events that took place prior to and during the emergency response. I have been unable to answer some key questions about the actions of the Prison Custody Officer who found Mr Richardson unresponsive in his cell on 25 January. The prison is conducting a disciplinary investigation into his actions. The Prison Director should provide me with the outcome of the investigation and a copy of the investigation report.

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

March 2023

Contents

Summary	1
The Investigation Process.....	3
Background Information.....	4
Key Events.....	5
Findings	7

Summary

Events

1. On 27 November 2020, Mr Albert Richardson was sentenced to three years in prison for sexual offences. He transferred to HMP Oakwood on 21 December 2020.
2. Mr Richardson had several pre-existing medical conditions, including anxiety and depression, angina and chronic obstructive pulmonary disease.
3. On 18 November, Mr Richardson was diagnosed with a rare form of lung cancer. He was told a month later that he had less than three months to live. He signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Order on 16 December.

2022

4. At 2.00am on 25 January, a Prison Custody Officer (PCO) checked on Mr Richardson and saw him sitting in his wheelchair in the toilet area of his cell. The PCO checked him again at 5.15am and found him in the same position. The PCO radioed another officer for help.
5. The PCO entered Mr Richardson's cell and checked for signs of life but found none. He radioed a medical emergency code and started cardiopulmonary resuscitation (CPR).
6. At 5.55am, a paramedic arrived at Mr Richardson's cell. At 6.02am she instructed staff to stop CPR as Mr Richardson was dead.

Findings

7. The clinical reviewer concluded that the clinical care Mr Richardson received at HMP Oakwood was of a good standard and equivalent to that which he could have expected to receive in the community.
8. She did, however, make a recommendation about the inappropriate use of CPR as Mr Richardson had a DNACPR order in place and there were signs that he had been dead for some time.
9. We are concerned that despite his advanced ill health, on his last trip to hospital on 20 January 2022, Mr Richardson was restrained using single handcuffs and an escort chain.
10. We were unable to interview the PCO who found Mr Richardson unresponsive in his cell on 25 January as he was absent from work due to ill health during the course of this investigation. The prison is conducting a disciplinary investigation into his actions. It is important that the prison fully disclose the outcome of disciplinary investigation once the matter is concluded to assure the Ombudsman that all matters of concern were fully addressed.

Recommendations

- The Prison Director and the Head of Healthcare should ensure that:
 - there are adequate processes in place to ensure prison staff are aware of those prisoners who have DNACPR instructions in place; and
 - staff are aware of the circumstances in which resuscitation is inappropriate, using the 'Guidance to support the decision-making process of when not to perform Cardiopulmonary Resuscitation in prisons and IRCs'.
- The Prison Director should write to the Ombudsman with the outcome of the disciplinary investigation into the actions of PCO A and provide a copy of the report.
- The Prison Director 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 assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.
- The Prison Director should write to the Ombudsman and tell her what further steps they will take to ensure ill prisoners are not inappropriately restrained in the future.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Oakwood informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
12. The investigator obtained copies of relevant extracts from Mr Richardson's prison and medical records.
13. The investigator interviewed two members of staff via video link.
14. NHS England commissioned an independent clinical reviewer to review Mr Richardson's clinical care at the prison. The clinical reviewer jointly interviewed one member of staff with the investigator.
15. We informed HM Coroner for Staffordshire of the investigation. The Coroner provided us with the cause of death. No post-mortem was carried out. We have sent the coroner a copy of this report.
16. We contacted Mr Richardson's next of kin to explain the investigation and to ask if she had any matters, she wanted the investigation to consider. She did not respond to our letter.

Background Information

HMP Oakwood

17. HMP Oakwood is managed by G4S and is one of the largest prisons in England and Wales, providing places for around 2,100 male prisoners.
18. Practice Plus Group provides the healthcare services, which include a daily GP clinic and some specialist services. Healthcare staff are on site from 7.00am-8.00pm Monday to Friday, and 7.30am-5.30pm on weekends and Bank Holidays. Outside of these hours, the prison has access to the community out of hours GP service.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Oakwood was in May 2021. Inspectors reported that healthcare services were effectively governed and well-led and patients were well informed. The prison had a collaborative Dying Well in Prison Charter which inspectors thought was positive.

Independent Monitoring Board

20. 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 March 2021, the IMB reported that health needs of the prison population were met and were at least equivalent to that offered in the community. Healthcare staff maintained their presence throughout the pandemic, providing a high level of medical care and support to prisoners.

Previous deaths at HMP Oakwood

21. Mr Richardson was the eleventh prisoner to die at HMP Oakwood since January 2020. Of the previous deaths, eight were from natural causes and two were drug related.
22. In our previous investigations into the deaths of two prisoners at Oakwood in February 2021, we made a recommendation about the inappropriate use of restraints. The prison accepted our recommendation and said that in October 2021, they had reviewed the escort risk assessment process, given refresher training to all clinical staff and communicated the message to prison staff through multiple means.
23. It is disappointing that we are having to highlight the same concerns in this report, yet again. The Prison Director must tell us what further steps they will take to ensure ill prisoners are not inappropriately restrained in the future.

Key Events

24. On 27 November 2020, Mr Albert Richardson was sentenced to three years in prison for sexual offences. He transferred to HMP Oakwood on 21 December.
25. Mr Richardson had several pre-existing medical conditions including anxiety, depression, angina, and chronic obstructive pulmonary disease. When he arrived at Oakwood, his initial health screening was completed properly, and all relevant medications were prescribed.
26. On 4 June 2021, a prison GP saw Mr Richardson as he was experiencing breathlessness, persistent excess fluid on his lungs and weight loss. He was taken to hospital and admitted for further investigation. He remained in hospital until 15 June.
27. On 6 July, Mr Richardson attended an outpatient appointment. He was told that he might have lung cancer. On 25 October, he went to hospital and had a lung biopsy taken. The results of the biopsy showed that Mr Richardson had biphasic malignant pleural mesothelioma (a rare cancer that develops in the thin membrane that lines the lungs and chest cavity).
28. On 14 December, Mr Richardson went to an outpatient appointment and was told that it was likely he had less than three months to live, and that chemotherapy would not be an appropriate form of treatment due to his fragility.
29. On 16 December, the prison started a palliative care plan for Mr Richardson. Mr Richardson's preferred place of care was HMP Oakwood, and he declined the opportunity to move to a hospice or the Complex Care Unit at HMP Stafford. Mr Richardson also agreed to a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order, meaning that, in the event his heart or breathing stopped he would not be resuscitated.
30. The prison started an application for Mr Richardson's early release on compassionate grounds.

2022

31. On 18 January, Mr Richardson's application for early release on compassionate grounds was refused. This decision was fully explained to him.
32. At 2.00am on 25 January, Prison Custody Officer (PCO) A checked on Mr Richardson and saw him sitting in his wheelchair in the cell toilet area. In his written statement, PCO A said that numerous prisoners sleep in their chair, so he presumed this was normal for Mr Richardson.
33. At 5.15am, PCO A checked on Mr Richardson again and found him in the same position. In his statement he said that he tried to get Mr Richardson's attention to tell him to get back into bed where he would be more comfortable, but Mr Richardson did not respond.
34. At about 5.22am, PCO B received a call over the radio from PCO A. PCO B called PCO A back on a private line. In his written statement, PCO B said that PCO A asked if 'I would mind popping over as he had an old man on the floor in a cell on

Ash house block.... At this time I did not think it was a matter of urgency as this is something that happened often on Ash house block with elderly residents’.

35. At 5.29am, PCO B collected the cell key from the First Line Manager (FLM) who was Oscar 1 (the Officer in charge of the prison during the night). In his statement, PCO B said he then called PCO A to confirm it was a ‘lift and grab’, PCO A said yes.
36. At approximately 5.33am, PCO A and PCO B arrived at Mr Richardson’s cell and opened the door. PCO B explained in his statement and in interview, that Mr Richardson was not on the floor but sat on his toilet chair, slouched to the left side. PCO B shouted hello to try and get a response from Mr Richardson and when that failed, he touched his right arm to try and wake him. PCO A tried to feel for a pulse but could not find one.
37. At approximately 5.34am PCO A radioed a code blue (indicating a prisoner is unconscious or having difficulty breathing) and the control room called an ambulance. PCO A and PCO B moved Mr Richardson onto the floor and PCO A started CPR. It was difficult for the PCOs to get Mr Richardson onto the floor as his body was stiff, indicating that rigor mortis had set in.
38. PCO C and the FLM arrived at the cell. Both officers helped perform CPR. There was some confusion over where to find the nearest defibrillator. PCO B located one on another wing, which was brought over by another PCO.
39. At 5.55am, a paramedic arrived at Mr Richardson’s cell. At 6.02am, she instructed staff to stop CPR as Mr Richardson had died.

Contact with Mr Richardson’s family

40. On 15 December 2021, the prison appointed a Family Liaison Officer (FLO). The FLO maintained regular contact with Mr Richardson’s next of kin, his wife.
41. On 25 January, the FLO contacted Mr Richardson’s wife by telephone to break the news of his death. He offered his condolences and explained what would happen next.
42. Mr Richardson’s funeral was held on 4 March 2022. In line with Prison Service instructions, the prison contributed towards the cost of the funeral.

Cause of death

43. The Coroner gave Mr Richardson’s cause of death as malignant pleural mesothelioma.
44. The inquest, held on 1 August 2022, concluded that Mr Richardson died from an industrial disease.

Findings

Clinical care and emergency response

45. The clinical reviewer concluded that the care Mr Richardson received at Oakwood was equivalent to that which he could have expected to receive in the community. Mr Richardson was managed with compassion and cared for by confident, competent staff during his time at Oakwood.
46. She did, however, identify some areas of concern.
47. Guidance to support the decision making process about when not to perform Cardiopulmonary Resuscitation in prisons and immigration removal centres (IRC) states that 'CPR must be started on all patients who are found not breathing and/or pulseless UNLESS certain conditions exist....In the prison estate, the primary judgement that needs to be made is whether rigor mortis is present...The ERC guidelines state that in such cases, a non-clinician might make a diagnosis of death but is not certifying death. CPR that has no chance of success in terms of survival is pointless and may violate the right for dignity in death.'
48. Staff should not have attempted to resuscitate Mr Richardson when he was found unresponsive in his cell. Mr Richardson's body was stiff when the PCOs moved him to carry out CPR, which was a strong indication that rigor mortis had set in. Rigor mortis generally starts to occur on average 2-4 hours after death.
49. A nurse said that Oakwood has a protocol in place that in the event of a prisoner dying (who is dying or has a DNACPR in place) resuscitation is initiated until advised otherwise by a competent member of staff. She was concerned that should Mr Richardson die when there was no healthcare on site, CPR would be carried out against his wishes.
50. Healthcare staff are on site from 7am-8pm Monday to Friday and 7.30am-5.30pm on weekends and Bank Holidays. Outside of these hours, the prison is able to access a community out of hours GP service.
51. On 17 December, a nurse received confirmation from the Prison Director that if Mr Richardson was found unresponsive overnight, resuscitation would not be attempted.
52. PCO A started CPR on Mr Richardson. We have not been able to interview PCO A as part of this investigation; he is suspended from his post and on long term leave due to ill health. It is therefore not clear exactly whether PCO A knew that Mr Richardson had a DNACPR in place.
53. PCO B worked on another wing and therefore could not reasonably have been expected to know about Mr Richardson's DNACPR. The FLM (Oscar 1) did know about Mr Richardson's DNACPR, however he was not the first officer to arrive at the cell and was not aware of the circumstances under which CPR was initiated. The FLM said because of this, he was not comfortable with the decision to stop CPR without knowing all the facts.
54. A nurse told the clinical reviewer that there is now a process in place which ensures that all custodial staff are aware of all prisoners who have a DNACPR in place.

Healthcare staff update senior managers daily with this information. We make the following recommendation:

The Prison Director and the Head of Healthcare should ensure that.

- **there are adequate processes in place to ensure prison staff are aware of those prisoners who have DNACPR instructions in place; and**
- **staff are aware of the circumstances in which resuscitation is inappropriate, using the Guidance to support the decision-making process of when not to perform Cardiopulmonary Resuscitation in prisons and IRCs’.**

Restraints, security, and escorts

55. 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.
56. 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 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.
57. On 20 January 2022, Mr Richardson went to hospital for the last time. According to the prison escort record (PER), he was restrained using a single handcuff and escort chain. Healthcare staff had completed the PER and stated, ‘does not require cuffing...palliative patients...end of life care’. Mr Richardson was assessed as a medium risk of harm to the public and hospital staff and a low risk of escape.
58. We question whether Mr Richardson should have been restrained given his ill health and age. The PER records one incident in June 2021 where Mr Richardson was inappropriate towards a minor while on a hospital escort. However, this incident had happened eight months before and Mr Richardson had been out on several hospital escorts since (the last two without being restrained) with no issues. Given his fragility at this time, his risk could have been effectively managed by the two escorting PCOs accompanying him. The investigator asked the Head of Security to comment on why the decision was made to restrain Mr Richardson, but they did not respond.
59. In a previous investigation into two deaths at Oakwood in February 2021, we were concerned about the inappropriate use of restraints. It is disappointing that we are having to highlight similar concerns in this report and are having to repeat our recommendation. The Prison Director must tell us what further steps they will take to ensure ill prisoners are not inappropriately restrained in the future.
60. We make the following recommendations:

The Prison Director 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 assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Prison Director should write to the Ombudsman and tell her what further steps he will take to ensure ill prisoners are not inappropriately restrained in the future.

61. In response to this recommendation the Prison Director wrote as requested to the Ombudsman and said:

‘All managers undertaking the completion of risk assessment have been verbally briefed by the Director and Head of Healthcare, to remind them that all relevant information is to be taken into consideration including previous risk assessments, changes in health, the age of the person, their mobility, and their current risk at this time. This must be fully recorded on the risk assessment.

If there are any concerns or questions these must be directed to the Director or Deputy Director, who will make the decision on the cuffing arrangements and the staffing requirements of the escort.

The Head of Security will maintain a database of prisoners who have previously been risk assessed as requiring no cuffs, this will be accessible for those completing the risk assessment to help them in their decision making.’

Actions of PCO A

62. The prison has undertaken a disciplinary investigation into PCO A’s actions. There are unanswered questions such as why he did not help or take further actions when he saw Mr Richardson on the toilet at 2am, why he did not call an emergency code immediately when he found Mr Richardson unresponsive at 5.22am and why he did not enter Mr Richardson’s cell immediately to help him. Also, it is not clear whether PCO A undertook the hourly checks on Mr Richardson, as the care plan paperwork from that shift is missing. It is also unclear whether PCO A knew that Mr Richardson had a DNACPR in place.
63. The prison has not yet concluded the disciplinary investigation. Therefore, we make the following recommendation:

The Prison Director should write to the Ombudsman with the outcome of the disciplinary investigation into the actions of PCO A and provide a copy of the report.

**Prisons &
Probation**

Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100