Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Reid, a prisoner at HMP Rye Hill, on 11 January 2021

A report by the Prisons and Probation Ombudsman

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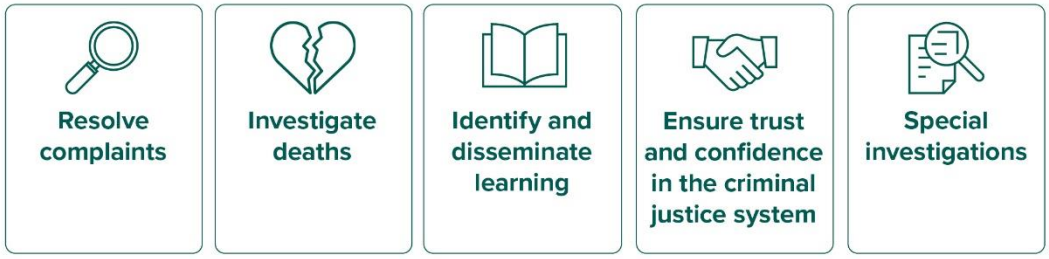
OUR VISION

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

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 David Reid died of heart failure caused by heart disease on 11 January 2021 at HMP Rye Hill. He was 63 years old. I offer my condolences to his family and friends.

The clinical reviewer found that the care that Mr Reid received for his heart disease at Rye Hill was not equivalent to that which he could have expected to receive in the community.

Mr Reid took medication to reduce his blood pressure. The clinical reviewer found that medication changes made by prison GPs to reduce the swelling in his legs appear to have contributed to poor control of his blood pressure. The clinical reviewer also found that prisoners with long-term conditions were not monitored sufficiently because of a lack of trained specialist nurses, there was no recall system in place to monitor prisoners with long-term conditions, and there was a lack of continuity of care because Mr Reid was seen by a number of different GPs.

We are also concerned that the officer who carried out the morning roll count and the two officers who unlocked Mr Reid's cell door for breakfast and medication failed to obtain a response from him in line with Rye Hill's local instructions. While we do not know whether the delay in finding Mr Reid affected the outcome for him, it is critical that prison staff carry out welfare checks correctly as early intervention can save lives.

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

Sue McAllister CB
Prisons and Probation Ombudsman **September 2021**

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Summary

Events

1. In 2013, Mr David Reid was sentenced to 16 years in prison for sex offences. On 24 April 2019, he was transferred to HMP Rye Hill.

2. Mr Reid was obese and had hypertension (high blood pressure) and paranoid schizophrenia.

3. In May, a consultant psychiatrist arranged for Mr Reid to have an ECG and blood tests as he was prescribed antipsychotic medication (which can cause side effects). In June, a prison GP reviewed the blood test results and found that Mr Reid's Vitamin D and folic acid levels were very low, his blood sugar level was raised, and his kidney function and creatinine kinase levels (CK, an enzyme, which can indicate muscle damage or inflammation of the heart muscle) were abnormal.

4. On 15 January 2020, a prison GP replaced Mr Reid's blood pressure medication with a different medication because he had swollen legs.

5. On 19 March, a prison GP reviewed blood test results which showed that Mr Reid still had low levels of Vitamin D and folic acid and raised CK levels. The prison GP stopped Mr Reid's medication for cardiovascular disease because it can cause high CK levels, and prescribed Vitamin D and folic acid.

6. On 16 April, a prison GP increased Mr Reid's blood pressure medication. On 13 May, further blood test results showed that Mr Reid had low potassium levels and that his cholesterol level had increased.

7. On 8 June, a nurse found that Mr Reid had very high blood pressure. The prison practice nurse, a primary care specialist, arranged for Mr Reid to have an ECG. A prison GP said that the ECG showed changes. He did not explain what these changes were or refer Mr Reid to a specialist clinic.

8. On 16 June, blood test results showed that Mr Reid had kidney disease. On 14 July, the consultant psychiatrist stopped prescribing olanzapine (an antipsychotic drug) because Mr Reid's CK level remained high.

9. On 6 August, blood test results showed that Mr Reid's CK levels were higher. A prison GP stopped prescribing blood pressure medication because of the risk of affecting his kidney function. On 25 August, a prison GP prescribed a diuretic for his swollen legs.

10. On 4 November, Mr Reid still had high blood pressure and a prison GP re-prescribed a blood pressure medication. Further blood tests showed that Mr Reid's kidney function had worsened. Further test results on 20 December showed that Mr Reid's CK levels and kidney function were still abnormal but had improved.

11. At 7.15am on 11 January, a Prison Custody Officer (PCO) carried out a roll count and saw Mr Reid lying in his bed, apparently asleep. Other PCOs unlocked Mr Reid's cell door at 7.48am for breakfast and 8.14am for medication and saw him apparently asleep and did not wake him.

12. At about 8.35am, a PCO opened Mr Reid's cell door for exercise. He appeared to be asleep and did not respond when called and shaken. At 8.40am, a PCO radioed a medical emergency code. Mr Reid had no pulse and was not breathing. Staff started chest compressions. A nurse gave him oxygen and used a defibrillator which advised no shockable rhythm.

13. At 9.00am, ambulance paramedics arrived and at 9.17am, they pronounced that Mr Reid had died.

Findings

Clinical care

14. The clinical reviewer found that the care that Mr Reid received at Rye Hill in relation to his cardiovascular disease was not of the required standard and was not equivalent to that which he could have expected to receive in the community.

15. The clinical reviewer found that changes that prison GPs made to Mr Reid's blood pressure medication to reduce the swelling in his legs contributed to the poor control of his blood pressure. Mr Reid also had low levels of Vitamin D and folic acid, which was not treated until eleven months after he arrived at Rye Hill.

16. There are five GPs who work five sessions a week at Rye Hill, a GP will work the same day in the week every week. The clinical reviewer considered that this might have contributed to a lack of continuity of care.

17. Rye Hill does not have a specialist nurse to monitor and manage chronic diseases.

Unlock procedures

18. On 11 January, when staff carried out a morning roll check and later unlocked Mr Reid's cell for breakfast and for medication, they should have checked him physically and tried to obtain a response from him in line with local policy.

Recommendations

- The Head of Healthcare should ensure there is a system in place for GPs to follow-up and action abnormal blood test results and blood pressure readings.

- The Head of Healthcare should ensure that there is a system in place for prisoners with chronic disease to be monitored and assessed effectively.

- The HMPPS Executive Director for Custodial Contracts should write to the Ombudsman setting out what he has done to satisfy himself that healthcare services at Rye Hill, including the contract for GP services, meet the needs of the prison's population.

- The Director should ensure that when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner by obtaining a response in line with local instructions.

- The Director should share this report with PCO A and PCO B and ensure that a senior manager discusses the Ombudsman's findings with them.

The Investigation Process

19. 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. No one responded.

20. The investigator obtained copies of relevant extracts from Mr Reid's prison and medical records.

21. The investigator interviewed two members of staff by video on 23 February.

22. NHS England commissioned a clinical reviewer to review Mr Reid's clinical care at the prison. The investigator and clinical reviewer jointly interviewed five members of staff by video between 16 February and 23 February.

23. We informed HM Coroner for Northamptonshire of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

24. The Ombudsman's family liaison officer wrote to Mr Reid's brother to explain our investigation. He asked if Mr Reid was ill, and about the medication and treatment he was receiving and the emergency response. We have addressed these issues in this report.

25. We shared the initial report with the prison service. There was one factual inaccuracy in the report.

26. Mr Reid's brother received a copy of the initial report. He raised a number of questions that did not impact on the factual inaccuracy of this report. We have provided clarification by way of separate correspondence to him.

Background Information

HM Prison Rye Hill

27. HMP Rye Hill is run by G4S and holds over 600 men convicted of sex offences. About 20% of the prisoners are aged 60 or over. G4S Forensic and Medical Services provide primary, physical and mental health services. The prison does not have an inpatient facility.

HM Inspectorate of Prisons

28. The most recent inspection of HMP Rye Hill was in September 2019. Inspectors noted that the prison held a complex mix of sex offenders who posed a high risk of harm to the public.

29. At the previous inspection in 2015, inspectors said that the quality of healthcare services was the weakest area of the prison. In 2019, they found improvements in most healthcare areas previously identified as underperforming, and that strong leadership had driven improvements in primary care services. They found that long-term conditions were reasonably well managed, appointment times to see doctors were reasonable and social care provision was good. Inspectors found that there were still healthcare staff shortages, but these were better managed, with well-integrated agency staff. However, there were still some gaps in the mandatory training of healthcare staff, and IT problems impacted disproportionately on healthcare delivery.

Independent Monitoring Board

30. 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 31 March 2020, the IMB reported that the prison was a safe environment for the current population. They said that healthcare provision and access to hospital appointments had improved during the year but there remained physical constraints on the facilities for disabled and elderly prisoners, with only a small number of cells sized for wheelchair access and hospital-style beds.

Previous deaths at HMP Rye Hill

31. In the two years before Mr Reid's death, there were twelve deaths from natural causes (two of which were related to COVID-19) at Rye Hill. There have been two deaths from natural causes (both related to COVID-19) since Mr Reid's death.

32. In our investigation into a death at Rye Hill in December 2020, we identified several serious shortcomings in the prisoner's healthcare, including a lack of clinical leadership and oversight. In our investigations into two other deaths (in February and April 2020) we also found that the healthcare the prisoners received was not equivalent to that they could have expected in the community.

Key Events

33. In 2013, Mr David Reid was remanded into custody and sentenced to 16 years in prison for sex offences. On 24 April 2019, he was transferred to HMP Rye Hill.

34. On 24 April, a nurse carried out Mr Reid's initial health screen. She noted that he had high blood pressure and had had a stroke in 2009, and that he had a long history of paranoid schizophrenia. A mental health nurse carried out a mental health assessment and planned for him to see the inreach mental health team.

35. On 25 April, a Healthcare Assistant (HCA) carried out Mr Reid's second health screen. She noted that Mr Reid had high blood pressure and was obese.

36. On 7 May, a consultant forensic psychiatrist saw Mr Reid and asked for an ECG and blood tests as part of the routine monitoring process for people prescribed antipsychotic medication (which can cause serious side effects).

37. On 14 June, a prison GP reviewed the blood test results and found that Mr Reid's CK level was grossly abnormal, his kidney function was slightly abnormal, his Vitamin D and folic acid levels were very low, and his blood sugar level was slightly raised.

38. On 15 January 2020, a prison GP reviewed a wound on Mr Reid's leg and noted that his legs were swollen. He stopped Mr Reid's lercanidipine (for high blood pressure) and prescribed him indapamide (another blood pressure medication). He did not take Mr Reid's blood pressure.

39. On 19 March, a prison GP reviewed a further set of blood test results for Mr Reid and found that he still had low levels of Vitamin D and folic acid and raised CK levels. He stopped Mr Reid's atorvastatin (medication for cardiovascular disease) because of the risk of it causing high CK levels. He prescribed Vitamin D and folic acid.

40. On 16 April, a prison GP saw Mr Reid and noted that he had high blood pressure and increased his doxazosin (a blood pressure medication). On 13 May, he reviewed further blood test results. They showed that Mr Reid had a low potassium level (which can cause muscle cramps and abnormal heart rhythms) and an increased cholesterol level. His kidney function was within the normal range.

41. On 8 June, a nurse reviewed Mr Reid's physical health and found that Mr Reid's blood pressure was very high. The following day, a nurse, the prison practice nurse, saw that Mr Reid's blood pressure was still very high. She arranged for Mr Reid to have an ECG and gave him health and lifestyle advice. There is no record of the ECG in Mr Reid's medical records, but a prison GP said that it was carried out and showed changes which he said that he should have taken more notice of. The GP said that because Mr Reid did not have chest pain or shortness of breath, he did not refer him to a chest pain clinic.

42. On 16 June, a prison GP reviewed more blood test results which showed that Mr Reid had stage three kidney disease (which indicated mild to moderate kidney damage). On 14 July, the consultant forensic psychiatrist stopped Mr Reid's olanzapine (an antipsychotic drug) because his CK levels remained high.

43. On 6 August, a prison GP noted that Mr Reid's CK levels were higher despite having stopped taking olanzapine. His kidney function had improved, and the GP noted that no further action was needed in relation to his kidney function. The GP told the investigator that he would not normally refer a patient to a kidney specialist in these circumstances as there was no specific treatment for the condition.

44. On 21 August, Mr Reid refused to talk to a prison GP about his kidney function. The GP stopped prescribing indapamide because it could have affected his kidney function.

45. On 25 August, Mr Reid saw a prison GP because he had a minor skin lesion. The GP noted that his legs were slightly swollen, so he prescribed furosemide (a diuretic) for two weeks.

46. On 4 September, an assistant practitioner, and Mr Reid's mental health worker, spoke to him about healthy eating. He reviewed the items Mr Reid was ordering from the prison shop and found that he was ordering large amounts of sugar and many vapes.

47. On 4 November, a prison GP saw Mr Reid after he bit his tongue, and it was slow to heal. Mr Reid still had high blood pressure and he re-prescribed Indapamide.

48. On 11 November, a prison GP noted that Mr Reid's kidney function had worsened and that he should make an appointment with a GP.

49. On 11 December, healthcare staff held a multidisciplinary team meeting in which they discussed Mr Reid's kidney function. They decided that he needed more blood tests. On 20 December, a prison GP reviewed the blood test results which showed that Mr Reid's CK levels and kidney function were abnormal but had improved.

50. On 5 January, a prison GP told Mr Reid that his blood test results were stable.

51. On 6 January 2021, a First Line Manager (FLM) moved Mr Reid to a cell closer to the wing office because he was concerned that he was possibly being bullied.

Events of 11 January 2021

52. At 7.15am on 11 January, PCO A carried out a roll count and saw Mr Reid lying in his bed, apparently asleep.

53. At about 7.48am, PCO B unlocked Mr Reid's cell door to ask if he wanted breakfast. She said that Mr Reid was lying face down on his bed, she could see the rise and fall of his quilt and believed that she could hear breathing (groaning) sounds. She said that she did not wake him because Mr Reid was a challenging prisoner who was sometimes abusive and aggressive towards staff.

54. At about 8.14am, a PCO unlocked Mr Reid's cell door for him to collect his medication. In his prison statement, he said that Mr Reid appeared to be asleep and so he did not wake him. (On 19 January, the PCO resigned from G4S and was not interviewed as part of the investigation.)

55. At about 8.35am, PCO C opened Mr Reid's cell door to ask him if he wanted to exercise. Mr Reid did not respond, and she entered the cell and walked over to

him. She saw that he was lying on his front, with his head turned to the left on his pillow. He had bedding over him, and he appeared to be asleep. She called his name but got no response. PCO B, who was nearby, went into the cell. PCO C shook Mr Reid and touched his back which was warm. She said that she could see movement from his back and believed that he was breathing.

56. PCO B called to the FLM, who was in the unit office near the cell. The FLM went into the cell and shook Mr Reid but got no response and said that he heard a gurgling sound. He noticed that Mr Reid's body felt warm and that his T-shirt was soaking wet with sweat.

57. At 8.40am, PCO B radioed a medical emergency code blue (which indicates that a prisoner is unconscious or having difficulty breathing and triggers the control room to call an ambulance immediately).

58. The FLM checked Mr Reid's neck for a pulse and found that his neck was cold. Mr Reid had no pulse and was not breathing. The officers turned Mr Reid onto his back and the FLM saw that his nose was squashed, and blood was coming out of his mouth. He started chest compressions.

59. A nurse went to Mr Reid's cell in response to the code blue. Staff moved Mr Reid from the bed to the floor. The nurse tried to insert an airway device into Mr Reid's throat but was not able to because it was rigid. He inserted a nasal airway device instead and gave him oxygen with a bag. He used a defibrillator which advised no shockable rhythm. Staff moved Mr Reid from the cell to the landing.

60. At 9.00am, ambulance paramedics arrived and took over resuscitation but, at 9.17am, they pronounced that Mr Reid had died.

Contact with Mr Reid's family

61. On 11 January, the Head of Safer Custody appointed a safer custody manager as the family liaison officer. They telephoned Mr Reid's brother (in line with national instructions on managing the risk of COVID-19 in prisons) to tell him that Mr Reid had died and offered their condolences.

62. Mr Reid's funeral took place on 5 February. The prison contributed to its cost in line with national instructions.

Support for prisoners and staff

63. After Mr Reid's death, the Director debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

64. The prison posted notices informing other prisoners of Mr Reid'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 Reid's death.

Post-mortem report

65. A post-mortem examination established that Mr Reid had died of heart failure (acute left ventricular heart disease) as a result of ischaemic and hypertensive heart disease (heart disease caused by narrowed heart arteries and high blood pressure).

Findings

Clinical care

66. The clinical reviewer found that the care that Mr Reid received at Rye Hill in relation to his mental illness was of the required standard and was equivalent to that which he would have expected to receive in the community.

67. However, she found that the care that Mr Reid received at Rye Hill for cardiovascular disease was not of the required standard and was not equivalent to that which he could have expected to receive in the community.

68. The consultant forensic psychiatrist asked for a number of additional blood tests, including to assess Vitamin D, folic acid and CK levels. The clinical reviewer noted that it was good practice that he told prison GPs that these blood test results were abnormal, and that Mr Reid needed treatment when he realised that vitamins had not been prescribed.

High blood pressure

69. The clinical reviewer found that the medication that Mr Reid was prescribed to reduce his blood pressure was ineffective. She noted that the changes made by prison GPs to his blood pressure medication to reduce the swelling in his legs appear to have contributed to poor control of his blood pressure. She found that insufficient care was taken to review the previous medication changes. She noted that some of the high blood pressure readings were not followed up. She also noted that, with the benefit of hindsight, there was evidence of ischaemic heart disease on the ECG taken in June 2020, but no action was taken in the absence of chest pain.

70. We make the following recommendation:

    The Head of Healthcare should ensure that there is a system in place for GPs to follow-up and action abnormal blood test results and blood pressure readings.

Continuity of care

71. Mr Reid had taken antipsychotic medication for many years. The clinical reviewer noted that antipsychotic medication is linked to heart disease (as it can increase blood cholesterol levels) and to a very high risk of developing diabetes. Mr Reid was at additional risk of developing these conditions because of his age, ethnicity (Caribbean background), smoking and obesity. Mr Reid had taken atorvastatin to reduce his cholesterol, but a prison GP stopped his prescription in March 2020. This did not make any difference to his CK level and only a marginal difference to his cholesterol level.

72. Mr Reid was deficient in Vitamin D and folic acid, but this was not treated until eleven months after his arrival at Rye Hill.

73. The clinical reviewer said that the monitoring and actioning of abnormal test results depended on the attention of the GPs, each of whom worked in the prison for one session each week. The clinical reviewer said that this may have led to a lack of continuity of care.

74. The clinical reviewer also noted that Rye Hill did not have a specialist nurse to monitor and manage chronic diseases. The Head of Healthcare said that since Mr Reid's death, the medical records of all prisoners had been reviewed and registers of those with chronic illnesses created. She said that plans to start chronic disease clinics in 2020 had been affected by the COVID-19 pandemic. We make the following recommendation:

The Head of Healthcare should ensure that there is a system in place for prisoners with chronic disease to be assessed and monitored effectively.

75. This is now the fourth death we have investigated at Rye Hill in the last 18 months where we have found that the healthcare the prisoner received was not equivalent to the care they could have expected to receive in the community (the other deaths occurring in February, March and April 2020). This is obviously a concern and we, therefore, make the following recommendation:

The HMPPS Executive Director for Custodial Contracts should write to the Ombudsman setting out what he has done to satisfy himself that healthcare services at Rye Hill, including the contract for GP services, meet the needs of the prison's population.

Unlock procedure

76. A PCO saw Mr Reid apparently asleep in bed at the 7.15am roll check, and two other PCOs had seen him apparently asleep when they unlocked his cell at 7.48am for breakfast and at 8.14am for medication. However, when Mr Reid was found unresponsive in his cell at about 8.35am, the nurse found that his throat was rigid, which suggests that rigor mortis was already present (indicating that Mr Reid had probably been dead for at least two hours when he was found).

77. On 29 January 2020, the Director issued a staff notice about welfare checks when prisoners are unlocked, highlighting the importance of staff completing a welfare check on each prisoner at the time of unlock, ensuring a positive response is received to ensure that prisoners are well, and emphasising the need to take immediate action if there are concerns.

78. On 12 January 2021, the Director issued another staff notice about the process to follow when carrying out a roll check or observing a prisoner. It said that staff should confirm the physical presence of prisoners and obtain a positive response from them to demonstrate their wellbeing on every occasion that a roll check is conducted, or a cell door is opened. It also said that prisoners are not permitted to display signs outside their cell indicating that they do not want to have breakfast or to leave their cell.

79. The primary purpose of a roll check is to confirm that all prisoners are present and correctly accounted for. However, roll checks are also an opportunity to check on prisoners' well-being and to identify any obvious signs that a prisoner may be ill or

dead. Roll checks may be carried out very early in the morning and, where that is the case, we do not consider that it is reasonable for staff to wake prisoners up and obtain a response from them to confirm that they are alive. If a prisoner is in bed covered by bedding during a roll check, we consider that it is reasonable for staff to assume that he is asleep, unless he is lying in an obviously awkward position. However, we note that the Director's notice of January 2021 says that staff at Rye Hill are expected to obtain a positive response from each prisoner every time a roll check is conducted.

80. Prison Service Instruction 75/2011 on residential services says that:

"Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight … but staff unlocking them have not noticed that the prisoner had died. This is not acceptable...

"…there needs to be clearly understood systems in place for staff to assure themselves of the wellbeing of prisoners during or shortly after unlock ...Where prisoners are not necessarily expected to leave their cell, staff will need to check on their wellbeing, for example, by obtaining a response during the unlock process."

81. PCO A, who carried out the 7.15am roll check, PCO B, who unlocked Mr Reid's cell door at 7.48am and the PCO who unlocked Mr Reid's cell door at 8.14am, all thought that Mr Reid was asleep and did not wake him. None of them followed local policy and obtained a response from Mr Reid to confirm his well-being.

82. We cannot know whether earlier intervention would have affected the outcome for Mr Reid, but there were a number of missed opportunities to identify Mr Reid's condition earlier. We make the following recommendations:

The Director should ensure that when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner by obtaining a response in line with local instructions.

The Director should share this report with PCO A and PCO B and ensure that a senior manager discusses the Ombudsman's findings with them.

Inquest

83. The inquest into Mr Reid's death concluded on 10 September 2024, with a verdict of natural causes.

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