

**Investigation into the circumstances surrounding the death of
a prisoner at HMP Rye Hill on 9 May 2004**

Prisons and Probation Ombudsman for England and Wales

May 2005

This is the report of an investigation into the circumstances surrounding the death of a prisoner at HMP Rye Hill on 9 May 2004. At the time of his death, he was serving a sentence of seven and a half years. A post-mortem was performed and concluded that his death was due to a chronic coronary disease.

Since 1 April 2004, the Prison and Probation Ombudsman's office has been responsible for investigating all deaths of prisoners in custody, including those due to natural causes. I must apologise for the long delay in completing this report.

I offer my condolences to the family of the man who died. I would like to thank the Director of Rye Hill and his staff for their co-operation with the investigation.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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Summary

The subject of this report was 48 years old when he died on 9 May 2004. At the time of his death, he was serving a seven and a half year sentence at HMP Rye Hill. Rye Hill is a privately managed medium security prison in Warwickshire, and was opened in 2001.

Before his death, the man appeared to be in reasonable health, although it had been noted that he was overweight, breathless and showed signs of early heart disease. He complained of chest pains the day before he died, was given medication for suspected angina and a referral was made for a cardiology appointment at his local hospital. Unfortunately, he was found dead in his cell before the appointment could be arranged.

The report makes one recommendation in relation to healthcare services at HMP Rye Hill and two in relation to the complaints process.

Investigative Process

My investigators visited Rye Hill on 13 May 2004. They spoke to the Senior Controller. The Senior Controller is a Home Office official whose role is to monitor the performance of Global Solutions, who run Rye Hill, and to impose penalties if the contract is breached. They also spoke to, the Deputy Controller, Head of Health Care, Head of Tactical Service, and to two prisoners.

A Notice of Investigation, Notice to Staff and Notice to Prisoners were issued explaining the purpose of the investigation and inviting contributions. Six prisoners contacted us to express their views about health care at Rye Hill. No responses were received from staff.

A clinical review of the man who died's health care whilst in prison was carried out by Daventry and South Northants Primary Care Trust and forms part of this report as an annex.

No formal interviews with staff were conducted. This report is based on a review of the relevant documentation, including the man's clinical records.

One of the man's daughters and his mother were contacted as part of the investigation. They chose not to respond to an offer to be involved in the investigation process.

The inquest into the man's death took place on 13 October 2004. A finding of death by natural causes was recorded.

The deceased

He was 48 years old when he died on 9 May 2004. He had five children and was divorced. He was imprisoned on 3 March 2000 for sexual offences, but had already been in prison since September 1999 having been remanded in custody on other charges. He was serving a sentence of seven and a half years. He went first to HMP Nottingham then, on conviction, to HMP Blakenhurst. He was moved to HMP Birmingham in September 2000 and to Rye Hill on 28 February 2002. He remained at Rye Hill until his death. According to his friends at Rye Hill he was an affable, likeable, placid person.

HMP Rye Hill

Rye Hill is a privately managed medium security prison in Warwickshire. It was opened in 2001.

The health of the man who died

On reception to Nottingham, he was assessed as having a history of depression, anxiety and panic attacks but no history of significant past physical health problems. He did not have a history of illegal drug use but his Inmate Medical Record (IMR) does record heavy alcohol intake before he was imprisoned and he had taken an overdose just before entering custody. His IMR states he admitted to feeling suicidal and that he had suffered breakdowns in 1967 and 1995. His father had had a triple heart by-pass in 1995 and died in 2002, shortly after the subject of the report arrived at Rye Hill on 28 February 2002.

The man suffered from obesity, high cholesterol, hypertension and depression. He continued to be treated for depression whilst in custody. He first reported a problem of chest tightness in September 1999 which was treated as indigestion. On 8 March 2002, health care staff were called to his unit after he experienced pain in his chest. He was not observed to be short of breath or clammy and said he had had a similar pain before which resolved itself. He was advised to contact the Health Care Centre again if his condition did not improve. During the rest of 2002 and 2003, he suffered intermittently from chest pains and breathlessness. His chest pain was attributed to panic, and breathing problems attributed to stress. In October 2003, he reported chest pain attributed to a panic attack. In December 2003, he again reported chest pain. He was prescribed a number of medications including Ibuprofen, Gaviscon, Transxasin, Atenolol, Statins and Beta Blockers.

On 20 March 2004, he underwent a mental health assessment. It was noted that he was experiencing weight problems, high blood pressure and high cholesterol. A follow up psychiatric review on 22 April referred to the man as suffering from panic attacks but said that these were under control.

Events leading up to the man's death

On 8 May 2004 at about 11:15 in the morning, Health Care staff were asked to see the man on Andrews wing. An entry in his IMR afterwards stated that he had complained of a "constant and dull" pain in his chest but, although he said he could not take a breath in, he did not appear to be struggling with his breathing. The man said that he had experienced similar episodes over the previous weeks but he had not mentioned them to staff as they had resolved themselves. He was taken from Andrews wing to the Health Care Centre in a wheelchair for observation. He was seen by a doctor who diagnosed angina and prescribed the man with GTN spray to have in his possession and use when he felt the symptoms returning. The doctor drafted a letter to be sent to the local hospital, requesting an appointment with a cardiologist as he felt that the man's health warranted further investigation.

The man returned to Andrews wing and spoke to a fellow prisoner on the wing about how he was feeling. According to that prisoner, the man said that he was feeling some "niggling" pains down his left arm and was holding his chest shortly before they were locked in their respective cells at 8:30pm. They continued to talk in their adjacent cells through the ventilation pipes. The prisoner on his wing was concerned that the man should seek help if he continued to feel ill, but the man did not want to draw attention to himself and thought it was too much bother to ring his cell bell. He did agree that he would ask to see the doctor again if he still felt unwell.

The cell of the man who is the subject of this report was unlocked by a residential unit officer at 8:30am. My investigators were told by Rye Hill that it is not the practice for staff to enter prisoners' cells after the door is unlocked, particularly on weekends, so that prisoners may sleep until lunchtime if they wish. A prisoner on the same unit, said that the man was usually up and out of his cell shortly after being unlocked. When the man did not appear, the prisoner went into his cell at 8:40am and found the man dead in bed. He said that from the man's appearance, he seemed to have been dead for several hours. The prisoner who had been concerned about the man told the unit staff who then alerted the Health Care Centre at 08:45 am. A doctor arrived at 10:05 and pronounced the man dead at 10:10am.

Post Mortem and Inquest

A post-mortem was performed on 11 May 2004. It described evidence of heart disease including very severe atherosclerosis of the coronary arteries and gave the cause of death as acute chronic myocardial ischaemia, haemorrhage into atheromatous plaque left main coronary artery, coronary artery atheroma and old myocardial infarction of left ventricle. The inquest into the man's death took place on 13 October 2004. The jury returned a finding of death by natural causes.

Clinical Review

A clinical review into the health care the man received was carried out by a Clinical Governor from Daventry and South Northants NHS Primary Care Trust. He noted that the man had been experiencing possible symptoms of heart disease periodically since September 1999 but concluded:

"...this 48 year old died following a number of indications that he could have been developing Coronary Heart Disease. There were attempts to treat his risk factors, but these were not followed up in systematic fashion. In the 6 months leading up to his death, in retrospect, there were further indications that he may have had episodes of angina.

"The above comments have to be made in the context of a man who had anxiety problems and panic attacks, which can closely mimic the symptoms of angina.

"My recommendations would be, that risk factor data should be collected, recorded in the medical record and followed up in a more systematic way, that a formal tool for risk assessment should have been used at some stage and that a database with chronic diseases should be kept."

The clinical reviewer's comments were put to PrimeCare Forensic Medical, the health care provider at Rye Hill. Their Health Care Manager responded that the man was followed up systematically but accepted that the system needed to be developed and improved. The man had been on their Chronic Disease Register and had been reviewed at the Coronary Heart Disease clinic a month before his death.

Responses from prisoners at Rye Hill

After the man's death, a number of prisoners telephoned my office or wrote to my investigators as a result of the notices about the investigation into his death being displayed. One prisoner wrote that the man told him before his death that Health Care would not listen to him when he complained about his health problems, but "he did not want to cause any hassle" so would not put in a complaint. The prisoner said that he himself felt that Vulnerable Prisoners were treated poorly by Health Care and that he had no confidence in the nurses at Rye Hill. Two distressed-sounding prisoners telephoned to say they were concerned at the quality of care they had received after harming themselves. Worryingly, there was a consistent theme from almost all the respondents that they were concerned about the consequences of complaining. They said they had experienced pressure from staff not to make complaints, or perceived that they had been treated adversely for doing so. Several prisoners expressed concerns about a named Senior Medical Officer, whom I understand has since left Rye Hill.

Conclusion and Recommendation

Standards of clinical care in prison are intended to mirror those available in the outside community. The records of the subject of this report indicate that he was prescribed medication according to his symptoms. He suffered from anxiety problems, panic attacks and may have had episodes of angina. The deceased's family might well ask whether his coronary heart disease could reasonably have been diagnosed at an earlier stage. The man had been seen by a doctor several times whilst he was in custody, he had a family history of heart disease and he was on the register of patients with chronic disease, so Rye Hill were aware of the possibility that he had the potential to become seriously ill.

It is possible that the man might have sought treatment earlier but, as the prisoners who responded have said, he did not want to draw attention to himself. Indeed, the man who died told the health care worker who had seen him the day before his death that he had not said anything to staff about the discomfort he had been suffering because his symptoms had eased.

The NHS National Service Framework for the management of Coronary Heart Disease contains 12 standards for the prevention, diagnosis and treatment of coronary heart disease. Whilst not all of these are relevant to the man's circumstances, it is clear from the man's IMR and from the clinical review that his risk factors were not followed up systematically. By the time an appointment with a cardiologist was requested, it was too late for the subject of this report.

I recommend that policies are drawn up and implemented for the systematic management of Chronic Diseases in accordance with the National Service Frameworks, when prisoners present with associated clinical risk factors.

In October 2004, two recommendations were made by my office and accepted, by Rye Hill regarding a full review of the Complaints System at Rye Hill being undertaken and the handling of prisoners complaints. During the course of this investigation, it has become apparent that prisoners still have concerns about the Complaints System. I therefore repeat these recommendations and ask that they are addressed as a matter of urgency by Rye Hill's new management team.

Steps should be taken to ensure that staff members and management are receiving appropriate levels of training in the handling of prisoners' complaints.

A full review of the Complaints System at Rye Hill be carried out with a view to ensuring that all complaints are collected, logged and answered to an acceptable standard within approved timescales.

Annexes

- 1. Mr Phillips' Inmate Medical Record**
- 2. Rye Hill Staff Statements**
- 3. Post mortem report**
- 4. Clinical Review**
- 5. Response to Clinical Review from PrimeCare Forensic Medical**
- 6. NHS National Service Framework for Coronary Heart Disease:
Executive Summary.**