

**A death in custody at
HMP Rye Hill in September 2004**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

April 2005

This is the report of an investigation into the circumstances of the death in September 2004 of a life sentence prisoner at HMP Rye Hill. The man died as a result of a blockage in a coronary artery.

I would like to extend our condolences to the man's family for their loss. I would like to thank the Director in charge of HMP Rye Hill, and his staff for their help.

**Stephen Shaw CBE
Prisons and Probation Ombudsman**

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Summary

The man had suffered from anxiety and depression for many years for which he received a great deal of attention in the early years of his imprisonment. Although he smoked, his clinical records give no indication that he had any problems with his physical health.

In the early hours of the morning on 2 September 2004, the man rang his cell call bell and asked the night officer for some paracetamol as he had stomach pain. He did not ask to see a nurse. Later that morning, he was found to be dead.

The man's cause of death, as determined at post mortem, was acute thrombotic and atheromatous coronary artery occlusion (blockage in a coronary artery). His death could not have been anticipated and was not connected to the fact that he was in prison or to the level of care that he received there.

This report makes two recommendations in relation to Healthcare services. These are in relation to the issuing of medication by non-clinicians and to the provision of age related medical check-ups for long term prisoners.

Investigation process

My practice in cases of deaths from apparently natural causes is to conduct an initial review to determine the extent of investigation required.

My investigator visited Rye Hill on 6 September 2004 when he spoke informally with the Duty Director and other staff. He also spoke to four prisoners. The investigator was given copies of all relevant records including medical records. The investigator subsequently spoke by telephone to one of the prison's night officers.

The investigator met a representative of the Independent Monitoring Board (IMB), who said that the IMB had been informed promptly and appropriately about the man's death and she had no concerns to bring to the PPO's attention.

We contacted the man's mother by telephone and letter. She replied by letter and explained that she had kept in touch with her son by visiting him at prison each fortnight. She had visited her son on 1 September, the day before his death. He had been extremely tired that day, although he had not complained about being in any pain. The man's mother added that she understood that at some point after her visit her son had reported to staff that he was feeling unwell. She asked the PPO to investigate whether there had been any failure or delay in treating her son.

Another of my staff, a trained nurse, carried out a clinical review of the man's care and treatment. No formal interviews with staff were conducted. This report is based upon a thorough review of all relevant paperwork and upon the clinical review.

HMP Rye Hill

HMP Rye Hill was opened in early 2001 as a purpose built category B training prison. It has a 660-bed capacity, predominantly made up of single cells. Rye Hill is a privately managed prison which is run by Global Solutions Ltd (GSL).

GSL's stated aims include the creation of a constructive prison regime through the provision of education, work and other programmes to best prepare people for re-integration into mainstream society.

The prison regime is based on a minimum of 35 hours per week purposeful activity including work, training and education (including physical education) and offending behaviour programmes, all of which are linked to a system of earned incentives and privileges.

Healthcare services at Rye Hill are provided by Primecare Forensic Medical, which is a private healthcare provider. The Healthcare Centre is staffed 24 hours per day by qualified nurses and healthcare assistants who are supported by visiting specialists, including doctors, dentists and psychiatrists. The Healthcare unit has eight in-patient beds.

The Events Leading up to the Man's Death

The man's medical records from the time of his imprisonment show that during health screening on various occasions he reported experiencing feelings of anxiety dating back many years and taking medication for the condition, also for many years. The man was a regular user of Healthcare services. The majority of these consultations related to his anxiety state. Other consultations were to report minor complaints such as headaches, colds and muscle injuries. The man's last consultation with a Healthcare doctor before his death was in June 2004 when his complaint was about a minor eye injury, possibly caused by a foreign body in the eye.

The man's mother visited him on 1 September 2004 and, in a letter to the PPO, she wrote to say that her son was feeling extremely tired that day, although he had not been in any pain. The man did not mention any concerns to Healthcare staff.

At around 3.30am on the morning of 2 September, the man pressed his cell call button. When the night duty officer responded to the call, the man said that he had stomach pain and wanted some paracetamol. He did not report being in severe pain, nor did he ask to see a nurse. The night duty officer gave the man two paracetamol tablets and she watched him take the tablets with a cup of water.

Following standard practice at Rye Hill, cell doors were unlocked at 7.20am on the morning of 2 September. Again in keeping with the prison's standard practice, prisoners were not roused at that point in time; instead prison officers merely satisfied themselves that each cell was occupied. A little after 8.30am, another prisoner, a friend of the man's, visited his cell and found him lying in bed and seemingly dead. The prisoner alerted staff at about 8.40am and they went immediately to the man's cell when, on checking for presence of a pulse, found none. Healthcare staff then arrived at the scene and confirmed that there were no detectable signs of life. At about 9.05am, first paramedics and then a doctor arrived. At 9.14am, the man was formally pronounced dead.

Interviews with Prisoners and Staff

When my investigator visited Rye Hill, he was told that a prisoner had reported that the man pressed his cell call button at 6.30am, but when the night officer went to his cell she told him to wait for the day staff to come on duty later that morning. My investigator spoke separately to four prisoners about this report.

The prisoner who made the report that the man had called for assistance at 6.30am was located in a different prison wing to the man's. This prisoner made his report after hearing a rumour that the man had been told to wait for the day staff to come on duty.

Two of the prisoners, one of whom was in one of the cells adjoining the man's, had heard the rumour, but they had not personally witnessed the incident and they knew nothing about the rumour's origin.

The fourth prisoner was in the other cell adjoining the man's cell. This prisoner said that he had woken at some point on 2 September and had overheard a conversation between the man and the night officer. The night officer asked the man whether he had a headache, to which the man replied that he did not have a headache, he had a stomach-ache. The prisoner heard no further conversation as he fell back to sleep. The prisoner thought that this conversation might have occurred at around 6.30am, but he could not say why he thought that.

The Duty Director told the investigator that night officers are required to respond immediately when call bells are sounded. If the prisoner wants pain relief for a straightforward ailment, such as a stomach-ache or headache, the night officer is able to give out soluble paracetamol. When the ailment requires clinical assessment, a Healthcare nurse should be summoned. Healthcare is staffed 24 hours a day. No record is kept of call bells being sounded.

The night officer who gave the man paracetamol at 3.30am said that that was the only call for assistance that he made that night. If he had sounded his call bell again, for instance at 6.30am, she would have responded to that call too.

After the Man's Death

On the morning of the man's death, the prison's head of residence, accompanied by one of the prison chaplains, visited the man's mother to inform her of her son's death. The prison staff spent approximately 30 minutes with the man's mother and passed to her as much information as was known at that stage. When they left, the man's mother was left in the company of the warden at the residential care unit where she lived.

Rye Hill notified the Prison Service's National Operations Unit of the man's death and statements were taken from staff involved.

On arrival at the prison by my investigator, all the necessary information had been gathered together for the purposes of the investigation. Arrangements were made for the investigator to speak to relevant members of staff.

Level of Compliance with Prison Service Requirements

Standards of clinical care in prison are intended to mirror those available in the outside community. The clinical aspects of the man's care are described in the independent clinical review which indicates that that the man's health was not compromised as a direct consequence of his being in prison.

The post-incident response by Rye Hill was fully compliant with Prison Service instructions and policies on managing a death in custody.

Findings

The man had been in prison since October 1996. He was a reasonably frequent user of Healthcare services during his eight years in custody, the last three years of which he spent at Rye Hill. Typically, his consultations were for treatment of anxiety, and otherwise for comparatively minor physical ailments.

At about 3.30am on 2 September 2004, the man rang his call bell and asked the night officer for paracetamol as he had stomach pain. The night officer gave him two paracetamol tablets, which she watched him consume with water. The night officer's action, in issuing the man paracetamol, was in accordance with standard practice at the prison. At around 8.30am the following morning the man was found dead.

Later that day, a rumour circulated around the prison that the man had called for assistance on a second occasion that morning, this time at 6.30am, when he was told to wait for the day staff to come on duty. Rye Hill keeps no records of call bells being sounded, however prisoners were interviewed and it was found that there was no substance to the rumour. What seems to have happened was that a prisoner in an adjoining cell woke to hear part of the conversation that occurred at 3.30am. The prisoner did not remain awake to hear the conclusion of the conversation and he later wrongly estimated that it had occurred at 6.30am.

While not finding fault with the night officer in giving the man paracetamol in the early hours of 2 September – the night officer was, after all, following standard procedures – the clinical review, has pointed out the potential problem of such a practice. The problem is that a prisoner might self diagnose and request analgesia, when the early intervention of a Healthcare nurse might result in the identification of symptoms indicating a more serious illness.

There were no early warnings that the man was about to suffer a heart attack. However, the clinical review has also pointed out that, as the man had a history of alcohol misuse and benzodiazepine dependence, he might have benefited from pro-active health monitoring. The prison will also wish to note the toxicologist's findings that the man had used both heroin and cannabis in the period shortly before his death.

Conclusions

The care that the man received at Rye Hill was probably at least as good as it would have been in the outside community. There were no early warnings that he was about to suffer a heart attack.

Recommendations

Local

HMP Rye Hill should consider reviewing the circumstances under which non-clinical staff are able to issue paracetamol to prisoners.

National

Consideration should be given to devising a policy for regular medical checks for long sentenced prisoners with reference to the checks being age appropriate.