# Investigation into the death of a man , formerly a prisoner at HMP Rye Hill, in hospital on 10 November 2006

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

**November 2007**

This is the report of an investigation into the circumstances surrounding the death of a man who died on 10 November 2006 in hospital . He had been diagnosed with terminal cancer in September 2006 while at HMP Rye Hill, and had been in hospital since 18 August 2006. On 12 October, the Parole Board granted him early release on compassionate grounds. He was officially released on 7 November and was no longer in custody when he died. He was aged 60.

The man had not had any contact with his family for some eight years before his death. According to their wishes, they have had sight of this report and an opportunity to comment on my findings.

The investigation was led by one of my investigators. One of my family liaison officers spoke by telephone with the man's daughter.

An independent review into the man's medical care was undertaken by a practising GP. I am most grateful to him for his assistance. I am also grateful to the liaison officer at HMP Rye Hill for her co-operation with this investigation. I make one recommendation and highlight an area of good practice.

This version of my report is published in anonymous form on my website. All names and the background section on the man have been removed. The annexes have not been published.

**Stephen Shaw CBE**
**Prisons and Probation Ombudsman** **November 2007**

**CONTENTS**

## SUMMARY

The man was sentenced to ten years imprisonment in August 2000. He was then 54 years of age. He was transferred to HMP Rye Hill in March 2001.

Maintaining he was innocent of the offences for which he had received his sentence, the man undertook no offending behaviour courses in relation to them. He was refused parole in 2005 and June 2006 on the grounds that his risk of re-offending could not be managed in the community.

The man had a history of poor health in prison, including heart disease and asthma. In June 2006, he began complaining of a cough and chest pain. He was originally treated with antibiotics for bronchitis but his symptoms persisted. On 12 July 2006, he was referred to hospital for blood tests and a chest X-ray.

The man's condition continued to worsen but the result of his chest X-ray, which was received on 26 July, was negative. On 14 August, the prison's Medical Officer (MO) referred the man back to the consultant chest physician but this referral was overtaken by his admission to hospital on 18 August after his condition deteriorated. The man was eventually diagnosed with lung cancer in late September 2006. The cancer had already spread to his liver, adrenal gland and bones.

The man applied for and was granted early release on compassionate grounds on 12 October 2006. He remained too ill to be released to a hospice in his home area and was released on consecutive temporary licences between 12 October and 7 November. On 7 November, he was released early on compassionate grounds to St Cross Hospital in Rugby with the condition that his home probation officer should provide him with accommodation in his home area should he become well enough to leave hospital. The man died in hospital on 10 November.

The clinical review judges that the man received a high standard of care in his last illness, and that the provision of chronic disease management and the assessment and management of new conditions at Rye Hill is good.

I make a single recommendation and highlight one area of good practice.

## THE INVESTIGATION PROCESS

1. I was notified of the man's death on 23 November 2006, some two weeks after he died. The man had been released on compassionate licence on 7 November and staff at Rye Hill did not realise that his death would be within my remit to investigate. In fact I have discretion to investigate deaths within a short period after release and decided to exercise this discretion in this case. Notices were issued to staff and prisoners at Rye Hill telling them that an investigation would be taking place, and inviting those who wished to see the investigator to make themselves known. The Coroner was contacted. Although the man's death was registered it was not reported to the Coroner at the time and no Post Mortem was performed.

2. My Deputy Ombudsman visited Rye Hill on 27 November 2006. She collected copies of the man's Inmate Medical Record (IMR) and his core prison record including applications for his early release on compassionate grounds. My investigator in this case was later provided with the man's wing and education record.

3. A clinical review of the man's medical care was undertaken by a GP. Rye Hill is a private sector prison and there is no formal agreement for the provision of clinical reviews by the relevant Primary Care Trust. Before identifying a clinical reviewer, my office must apply for funding to undertake the review from the Department of Health. In this case the reviewer was not appointed until 26 March 2007. It was agreed that his review would focus on the man's general clinical care in Rye Hill as well as his diagnosis with terminal cancer.

4. One of my family liaison officers contacted the man's daughter by telephone. She asked for a copy of my report.

**HMP RYE HILL**

5. HMP Rye Hill opened in early 2001 as a purpose built training prison. It is operated by the private firm GSL and accepts adult male prisoners aged over 21 years. Rye Hill offers several courses designed to address offending behaviour and a variety of daytime and evening education classes. There are two mainstream workshops devoted to welding, packing and electronic assembly. There is an eight bed in-patient healthcare centre staffed by a full time doctor and nursing staff.

6. Since 2004, I have investigated 13 deaths at Rye Hill. Nine of these deaths were the result of natural causes.

## THE EVENTS LEADING UP TO THE MAN'S DEATH

7. A full account of the man's medical history in prison is contained in the clinical review annexed to this report [not published with this version on the website], but it is apparent that he did not enjoy good health. On reception at Rye Hill he was noted to have a history of heart attacks, angina and asthma. Between March 2001 and August 2006, he was admitted to hospital on ten occasions for reasons relating to his heart complaint.

8. On 22 June 2006, the Parole Board refused the man's application for parole on the grounds that his risk of re-offending could not be managed in the community.

9. In June 2006, the man developed a cough and chest pain. On 22 June, he saw the prison's medical officer (MO), and was prescribed antibiotics. The man was a life long smoker and asthmatic and his symptoms were not therefore considered unusual. He saw the doctor again on 28 June and complained of chest and back pain and vomiting.

10. The man saw the MO on three further occasions on 30 June, 1 July and 3 July 2006. He complained of chest pain and pain with cough. No further medicine was prescribed as there were no further symptoms of infection. The clinical reviewer said in his clinical review that this is the standard approach to treating a patient with bronchitis.

11. On 11 July, the man complained that he was "in agony". He saw the MO on 12 July and the doctor became concerned that the man was losing weight. He was weighed and a number of hospital tests, including blood tests and a chest X-ray, were ordered. On 24 July, the MO was concerned that the man was developing signs in his finger nails of serious lung disease. On 26 July, the result of his chest X-ray was received and was normal. The man's other test results were not received at this time.

12. The man was seen again by the MO on 27 and 31 July and 3 and 14 August. His condition was described as declining and he was given more antibiotics pending his test results. On 14 August, the MO referred the man again to the consultant chest physician at the hospital. On 18 August, before the referral appointment had taken place, the man was admitted to the hospital for investigation because his condition had considerably worsened.

13. The man was escorted at the hospital by two prisoner custody officers (PCOs). Because of the nature of his offences, he was initially handcuffed to one of the officers. Following a risk assessment on 15 September, it was judged that his risk had lowered; restraints were removed and he was escorted by a single PCO until the Parole Board agreed his early release on 12 October.

14. A diagnosis remained elusive for some weeks but in late September tests revealed that the man was suffering from metastatic bronchial carcinoma (lung cancer). The tests showed that the cancer had already spread to his liver, adrenal gland and bones. He was told he had between two and six months left

to live. On 26 September, he began a course of palliative radiotherapy in an attempt to reduce his pain.

15. Following confirmation that he was terminally ill, the man asked Rye Hill to apply for early release on compassionate grounds. The man's application was supervised by the prisoner records supervisor. The man had passed his parole eligibility date (PED – the date on which a prisoner sentenced to more than four years becomes eligible for release on parole licence) and the decision to release him on compassionate grounds was therefore the responsibility of the Parole Board. The records supervisor requested reports from medical and probation staff as required by Prison Service Order (PSO) 6000 in support of the man's application.

16. The reports were received and collated by 10 October and faxed to the Parole Board. On 12 October, the Parole Board granted the man early release on compassionate grounds. The Parole Board directed the man to reside at an address agreed by his supervising probation officer. The man was too ill to live independently and it was envisaged that he would transfer to a hospice in his home area.

17. A place in a hospice in his home area was found but the man remained too unwell to be released there. He was therefore released to the hospital on a succession of temporary licences between 12 October and 7 November. Eventually, as his condition deteriorated rapidly, Rye Hill became concerned that the man would die while technically in custody despite having being released on compassionate grounds. On 7 November, he was released to the hospital with the condition that his probation officer would place him in suitable accommodation in his home area should he become well enough to leave hospital. He died on 10 November.

18. The prison contacted the man's family when it became apparent that his death was imminent. The chaplain also informed the man's family of his death. A memorial service was held in the prison on 13 December 2006.

## ISSUES CONSIDERED DURING THE INVESTIGATION

### *The man's general clinical care*

19. The clinical reviewer concludes that the general standard of medical record keeping was good. He comments that entries were legible, appropriate and chronological, although the lack of a printed name meant it was hard to see which member of staff had made the entries. Consultations appeared to be of a high standard with appropriate action plans. Referrals to secondary care were also appropriate and timely.

20. The reviewer is critical of the filing of the man's medical records. He found the Inmate Medical Record (IMR) to be "cluttered" with various administrative documents mingled with clinical information.

21. The reviewer argues that prisons who take on the long term medical care of prisoners would benefit from obtaining information from the medical notes of the prisoner's GP. He says:

    "In this case in particular it may have been helpful to establish what heart conditions occurred in 1982 and 1987 given that eventually coronary angiography performed at Walsgrave on 29/11/05 demonstrated no evidence of ischaemic heart disease. This finding putting into doubt the assumption that the majority of the man's 46 attacks in prison were due to angina."

22. The reviewer judges that there is a well organised system for delivery of chronic disease management at Rye Hill. He highlights this as an area of good practice. The man received regular checks on his asthma and cardio-vascular disease as well as an annual flu jab and hepatitis B vaccination. The reviewer recommends that this good practice is built on by offering nurses the opportunity to attend prescribing courses.

23. The reviewer highlights a further area of good practice in the assessment and management of new conditions. The man saw the doctor for eight different medical complaints at Rye Hill, including allergic dermatitis, tonsilitis and knee pain. All were dealt with appropriately and the treatment of the man's frozen shoulder resulted in the prison employing a physiotherapist on a weekly basis to treat prisoners.

24. In considering the reviewer's detailed comments and recommendations about the man's clinical care at Rye Hill I make the following recommendation:

    **I recommend that within three months of the publication of this report the Director of Rye Hill initiates a review of prisoner medical records and patient care. The purpose of this review should be to find a way to ensure that medical records are organised into clear sections; separating clinical entries from hospital correspondence, investigations and immunisations. There should be a current medical summary listing established medical conditions. Non medical items should not be stored in the medical files. In addition to signing and dating entries, staff should print their names. The review should also consider asking**

**for corroboration of identified medical conditions from the prisoner's GP. The review should further consider the possibility of offering nursing staff the option of attending nurse prescribing courses to extend their role in chronic disease management.**

**[This recommendation was accepted at draft report stage and a plan put in place to monitor progress.]**

25. I also endorse the reviewer's recognition of good practice:

**Good practice: The prison and healthcare workers should be praised for their preventative health programme, chronic disease clinics and range of services offered. The healthcare delivered appears to be of a very high standard and equitable with a progressive general practice.**

***The diagnosis and management of the man's final illness***

26. In his report, the reviewer concludes that the approach of the MO to the man's condition follows the National Institute of Clinical Excellence (NICE) guidelines for the investigation of the possibility of lung cancer. It is arguable that the referral made by the MO on 14 August should have been an urgent one, but the man was admitted on 18 August and the delay did not change his prognosis. Despite a number of tests being carried out in the hospital, the man's diagnosis remained elusive until late September.

27. The reviewer concludes that:

"… the care given to the man during his last illness has been of a high standard. The recorded consultations demonstrate a high level of clinical acumen by the MO. The investigations have been appropriate, if slightly delayed. This delay has had no bearing on the outcome in this case."

***The man's early release on compassionate grounds***

28. The man applied for early release on compassionate grounds once he had received the news in late September that he was terminally ill. Reports were requested under the provisions of PSO 6000 and were sent to the Parole Board for consideration on 10 October. On 12 October, the Parole Board agreed to release the man on compassionate grounds. I consider that this process was completed efficiently and in a timely manner. Unfortunately, the man was too ill to be released to his home probation area. The terms of his release were that he reside at an address in his home area as directed by his probation officer. The problem was resolved in the short term by releasing the man on temporary licence. When it became apparent that he would almost certainly never be well enough to leave hospital, permission was given to release him to the hospital. I consider that this was the most sensible course of action in the circumstances.

***The level of escort and restraint used on the man***

29. The man was admitted to St Cross Hospital on 18 August. An initial risk assessment took into account the nature of his offences, and it was decided that he should be accompanied by two PCOs and that he should be handcuffed to one of them. On 15 September, the Director of Rye Hill made a further risk assessment. The MO informed him that the man's physical condition meant that he no longer posed a risk of escape or harm to the public. The Director decided that restraints need no longer be used and that one PCO only was needed as an escort. (The Director may wish to note that this decision does not appear to have been passed on to the escort as a management check on 17 September revealed that the man was still handcuffed to his escort.) I see too many cases of dying prisoners who remain chained long after their risk to the public has reduced, and I am pleased to see an example of an appropriate risk assessment based on medical advice.

## RECOMMENDATIONS

**I recommend that within three months of the publication of this report the Director of Rye Hill initiates a review of prisoner medical records and patient care. The purpose of this review should be to find a way to ensure that medical records are organised into clear sections; separating clinical entries from hospital correspondence, investigations and immunisations. There should be a current medical summary listing established medical conditions. Non medical items should not be stored in the medical files. In addition to signing and dating entries, staff should print their names. The review should also consider asking for corroboration of identified medical conditions from the prisoner's GP. The review should further consider the possibility of offering nursing staff the option of attending nurse prescribing courses to extend their role in chronic disease management.**

***Good practice:***

**The prison and healthcare workers should be praised for their preventative health programme, chronic disease clinics and range of services offered. The healthcare delivered appears to be of a very high standard and equitable with a progressive general practice.**