Investigation into the circumstances surrounding the death of a prisoner at HMP Rye Hill, at University Hospital (Coventry) on 26 October 2007

Report by the Prisons and Probation Ombudsman for England and Wales

February 2010

This is the report of an investigation into the circumstances of the death of a prisoner on 26 October 2007 at the University Hospital (Coventry). The man had been released on licence from HMP Rye Hill on 25 October, the day before his death. He was 57 years old.

My colleagues and I would like to extend our condolences to the man's family, his friends and all those touched by his death.

The Coroner's direction was that no post mortem examination or inquest was to take place. This is of course a matter for the Coroner but I have to say that, contrary to what may have been believed, the man remained a prisoner at the time of his death. A Notification to the Registrar by the Coroner indicates that he died of natural causes, namely acute renal failure and pancreatic carcinoma with metastases.

One of my investigators led the investigation on my behalf. An independent review of the man's medical care in prison was conducted by an independent clinical investigator. I am most grateful for her assistance. I would also like to thank the management and staff at HMP Rye Hill for their co-operation during the course of this investigation. I must apologise for the delay in completing this report.

Although his family has expressed concerns about his treatment the man appears to have received responsive and appropriate medical care throughout his time at Rye Hill. The independent clinical investigator points out in her clinical review that pancreatic cancer is a very difficult malignancy to identify. Given this difficulty in diagnosis, I conclude that the man's death could not have been prevented. I make eight recommendations relating to clinical matters, dietary provision and family liaison.

Stephen Shaw CBE
Prisons and Probation Ombudsman **February 2010**

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SUMMARY

The man who is the subject of this report, a prisoner at HMP Rye Hill, died of pancreatic cancer on 26 October 2007 at University Hospital (Coventry). He was 57 years old and was serving a twelve year sentence imposed in September 2005. He was in good health when first received into HMP Bedford. He transferred to Rye Hill in early October 2005.

On reception, the man was anxious about being in prison and asked to be segregated from other prisoners. However, he was not considered to be at risk of harming himself. He was seen by a support counsellor on a regular basis and was consistently reported by staff as presenting little in the way of problems. He remained fit and well reporting only minor medical complaints until December 2006 when he was treated for indigestion. Several days later, he complained of similar symptoms and was given further medication.

Between May and September 2007, the man complained of abdominal pain. An initial diagnosis of irritable bowel syndrome was made for which he was prescribed medication. In June 2007, the prison doctor referred him to the gastroenterology department of the local hospital. The abdominal pain persisted and he was given pain relief as well as additional medication for indigestion. Staff also noticed that he had a yellowish colour to his skin. On 1 August, the man reported a urinary obstruction and drugs to treat prostate problems were prescribed.

In early September, the man had abdominal cramps and diarrhoea for a period of a week. He was prescribed medication and a follow up was made to the earlier gastroenterology referral. Three days later on 7 September, the man had a constant aching pain in his abdomen and diarrhoea. He was not eating or drinking much and his eyes and skin looked yellow. The prison doctor sent him to the local hospital accident and emergency department but he was discharged back to Rye Hill the same evening. No hospital discharge letter is available, and therefore the medical opinion is unclear. The man told the prison doctor on his return that the hospital doctor had said that there was nothing to worry about. He remained unwell and a diet to reduce his fat intake was advised. After several complaints by the man about the supply and inadequacy of his meals and an intervention by the Director, his diet was adjusted.

As a result of his observations, the prison doctor considered that the man might be exhibiting signs of cancer. On 13 September, therefore, he made a two week referral to the cancer clinic asking for the man to be seen earlier than the appointment booked for 3 October. His condition was monitored and on 19 September he was again treated for abdominal pain. Later the same evening, wing staff reported to healthcare staff that he was crying in pain. The nurse spoke to the duty doctor who sent him for admission to the local hospital.

While the man was in hospital, healthcare staff at Rye Hill were frustrated in their attempts to gain information about his condition because hospital staff were reluctant to share what they knew. Escort staff reported to Rye Hill that he had undergone exploratory scans and on 25 September they reported that they had learned there was a blockage between his liver and gallbladder. The following day a specialist

Hepatic, Pancreatic, Biliary (HPB) nurse told Rye Hill healthcare staff that the man had an inoperable pancreatic cancer that had also spread to his liver. Over the next two weeks, tests were carried out and plans made for palliative treatment. The HPB nurse told healthcare staff that the man's life expectancy was about six to nine months and that he was not aware of this. The HPB nurse also said that an email had been sent to the Director at Rye Hill to enable her to make decisions about a possible early release on compassionate grounds.

The ward staff nurse told healthcare staff on 21 October that the man was very poorly and his life expectancy was now being measured in days and weeks. Hospital staff told his family of the prognosis and he signed a "do not resuscitate" form. The duty Director authorised the removal of handcuffs from him and escorting staff remained at the hospital but outside his room.

The man's condition continued to deteriorate and Rye Hill applied for his release on compassionate grounds. Following confirmation of his terminal condition and life expectancy on 24 October, he was released on temporary licence by the Director of Rye Hill from 1.00pm on 25 October until midday on 29 October. Sadly the man died at about 11.30am on 26 October before Ministerial authority was secured for his release on compassionate grounds. His family was with him when he died.

Following the man's death, the Coroner took the view that a post mortem and inquest was not necessary and informed the Registrar that his death could be registered.

The man's property was returned to his daughter at a meeting with Rye Hill's Director on 27 October. His family has raised a number of concerns about aspects of his care and the prison's actions after his death.

I make eight recommendations and am pleased to note that G4S have fully accepted them all. Three are about record keeping, two about communication between healthcare and hospital staff. Two relate to the appropriateness and provision of special diets for prisoners, and the last is about prompt payment of funeral expenses.

THE INVESTIGATION PROCESS

1. My investigator visited HMP Rye Hill on 5 November 2007. He was given a full briefing about the circumstances surrounding the man's death by the Head of Safer Custody, and the Deputy Controller. He was unable to speak to members of the staff associations or the Independent Monitoring Board as they were unavailable.

2. Invitations were extended to staff and prisoners, inviting anyone who might have information relating to the man who died to make themself known to the investigator. One prisoner took up the invitation and was formally interviewed. Another, a wing representative, wrote to the investigator outlining his concerns about the man's treatment. He was also interviewed. The investigator also met relevant prison staff. There was no police involvement in the investigation of the man's death.

3. A Coroner's Officer at Coventry, wrote to the investigator on 20 November to inform him of the Coroner's view that a post mortem and inquest were unnecessary. The Coroner had agreed for the hospital to issue a Medical Cause of Death Certificate and he also issued a Form "A" certificate informing the Registrar that the man's death could be registered.

4. One of my Family Liaison Officers (FLO) wrote to the man's daughter and spoke to her twice by telephone. During those conversations the man's daughter spoke of her concerns. These were principally about the treatment given to her father at Rye Hill, but also about restraints used while he was in outside hospital and how Rye Hill treated her after his death. My FLO explained that an independent clinical review would consider the standard of medical care the man received in prison and the circumstances surrounding her father's death.

5. Rye Hill provided incomplete copies of the man's prison and medical records. An independent review of his medical care in prison was commissioned from an independent clinical investigator. This was received in May 2009.

6. On 21 May 2009 my investigator telephoned the Coroner's Officer to advise him that tha man who died had not been released on compassionate grounds prior to his death and had remained a prisoner released on temporary licence. The investigator confirmed this information by email. No response has been received to date and this remains a matter for the Coroner. It is possible that the release on temporary licence for compassionate reasons was misinterpreted as early release on compassionate grounds under the provisions of the Crime (Sentences) Act 1997.

HMP RYE HILL

7. HMP Rye Hill is a category B training prison opened in 2001 and run by G4S on behalf of the Prison Service. Rye Hill holds up to 660 sentenced adult male prisoners, serving over four years imprisonment, in cellular accommodation.

8. At the time of the death of the man who is the subject of this report, healthcare at Rye Hill was provided by Primecare Forensic Medical. Daily medical services are provided by a full-time doctor and qualified nursing staff. Medical staff are based in an eight bed unit comprising four single in-patient rooms and a four bedded dormitory. The healthcare centre provides a 24 hour healthcare service. Sudden illnesses and treatments are managed by clinical staff.

9. HM Chief Inspector of Prisons carried out an unannounced full inspection of Rye Hill in June 2007. She highlighted in her report several matters which are of relevance to this investigation:

> "Health services were commissioned from Primecare Forensic Medical. Due to significant staffing issues, prisoners received only a basic health service. Some essential services, such as counselling and chiropody, had been reduced, and there was no consistent management of prisoners with long-term illnesses. Pharmacy services were inadequate. Mental health provision met the essential needs of patients, but there was no mental health in-reach support, although there were well developed plans to introduce a team later in the year. Relationships between health services and the rest of the prison were fraught. There were significant problems with the cancellation of NHS appointments, and the responsibility for the delivery of secondary and tertiary care within the local NHS economy appeared blurred. Although there were no formal links with the Northamptonshire Primary Care Trust (PCT), the head of healthcare and PCT lead commissioning manager had established sound working relationships and the PCT provided support where necessary."

13. Amongst HM Chief Inspector of Prisons recommendations were the following:

> (4.58) Primecare should seek the assistance of the Northamptonshire PCT to ensure that the provision of secondary and tertiary NHS care locally offers equity of care for prisoners.
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> (4.83) All completed prescriptions should be faxed through to the pharmacy so that patient medication records can be completed.
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> (4.89) The pharmacy should be required to provide at least a next-day service for the delivery of medications.

14. Including the man who is the subject of this report, I have investigated 14 deaths in custody at Rye Hill since I was given responsibility for all such investigations in 2004. Ten of those deaths were from natural causes.

KEY EVENTS

Leading up to 26 October 2007

15. The man who died was convicted and remanded into custody at HMP Bedford on 27 September 2005. He returned to court the following day and was sentenced to 12 years imprisonment. During his first reception health screen the man was deemed to be fit and well. He was not thought to be at risk of self-harm and was regarded as suitable to share a cell. However, he asked to be segregated from other prisoners because of the nature of his offences. He was located on F wing under the provisions of Prison Rule 45 for his own safety.

16. The man was interviewed on 29 and 30 September as part of Bedford's initial reception procedure. He was designated a category B prisoner. His offending behaviour needs and restrictions were identified and he was recommended for transfer to HMP Parkhurst. He also began the process of appealing against his conviction and sentence.

17. The man transferred to HMP Rye Hill on 7 October as a result of overcrowding at Bedford. When he arrived at Rye Hill, medical staff assessed him and classified him as being fit for heavy work. A completed "Transfer in Checklist" records that he was not on medication and that he did not know his community doctor. He had no substance misuse issues or mental health problems. He was a smoker. An in-possession medication assessment was started but not completed and no decision on this was recorded. A new admissions risk assessment was completed and indicated that the man was anxious about being in prison. Although he wanted to see a registered mental nurse or counsellor, he did not want to see a doctor. He was not at risk of harming either himself or others and was not worried about his safety, although it is recorded in his Record of Events that by 11 October he had seen Listeners (prisoner volunteers trained by the Samaritans to support others through low periods) on two occasions. He also read and understood the Rye Hill healthcare medication policy which he signed. The man was seen by a support counsellor on 12 October.

18. The man who later died was noted on 17 October to need continued monitoring due to his emotional state. On 24 October he was prescribed Phenergan 25mg (a brand of medicine used as a short term sedative) nightly for three nights to treat his insomnia. A Prison Custody Officer (PCO) became his personal officer on 11 November and on 18 November he had a second support visit with a counsellor.

19. During routine monitoring of recorded telephone calls at 3.50am on 9 January 2006, a night duty PCO raised concerns with the night duty nurse about the man, reporting that during a call he was tearful and possibly depressed. The nurse contacted the counselling team and requested a visit for him as soon as possible. He was assessed for counselling on 22 January and contracted to receive ten counselling sessions starting on 1 February.

20. His personal officer consistently reported the man as presenting few problems to staff and on 30 January 2006 he was granted enhanced 1 status under the Incentives and Earned Privileges Scheme (IEP). He later applied for enhanced 2

status on 9 April and this was granted on 1 May. His personal officer again reported him as a quiet, polite man who never failed to attend for work and presented no problems to staff.

21. The man who died missed one counselling session on 17 February but continued for a further 10 sessions concluding on 23 July. After completing this he was seen at monthly intervals for support counselling until mid-November. The man made complaints about missing property on 14 May and again on 4 June which were resolved through the prison complaints procedure.

22. The man had other minor medical complaints and saw a podiatrist and an optician in October and November. He was issued with spectacles and had a further appointment in December. His sentence plan review report was completed on 9 November.

23. The man reported to a prison doctor on 15 December 2006 that he had suffered from "bad indigestion last night and today". The doctor noted that this was the first episode and prescribed Peptac liquid 500ml which was given in-possession.

24. Three days later, on 18 December the man attended the healthcare centre with a minor head injury. He explained he had banged his head on the underside of a telephone box. He had not lost consciousness and the medical staff recorded that his pupils were equal and reactive. The small laceration was cleaned but did not warrant dressing. He was given paracetamol for a headache and advised to return in the event of any problems arising from the wound.

25. An entry on the man's Prescription and Administration Record Chart at 7.30pm on 19 December records that he reported special sick with stomach pain for which he was given paracetamol (1g) and ibuprofen (200mg). (Special sick allows a prisoner to gain medical attention during the day or night without a scheduled medical appointment.) An entry in his medical record for the following day records that Peptac was not helping his indigestion. A trial of omeprazole for 28 days was prescribed in-possession to be taken once per day, and was re-prescribed after this period.

26. A note on the man's Continuous Clinical Record dated 21 May 2007 records that he complained of abdominal cramps but that he was not constipated. On examination, his abdomen was soft and not tender, his bowel sounds were normal and there were no obvious lumps. His weight was recorded at 108kg. A possible diagnosis of irritable bowel syndrome (IBS) was made and Colofac was prescribed at a rate of 135 mg three times daily to combat the symptoms. The Colofac prescription was dispensed four days later in the man's possession. He was also re-prescribed omeprazole for a further three 28 day periods, but received only enough for 28 days at a time.

27. On 13 June, after the man complained that he was still in pain a prison doctor wrote a letter of referral to the Gastroenterology department outlining the man's history of peri-umbilical (in the region of the navel) pain and his current medication. The doctor requested a consultation for him and an endoscopy (an internal examination of the body using a tube and optical device).

28. The following day, a sentence plan report was completed for the man. His personal officer noticed in late July or early August that his skin was a yellowish colour but she was aware at the time that he was awaiting tests to be undertaken at an outside hospital. She told my investigator that some weeks later he appeared more yellow than before. The man told her that he was in pain and had been given paracetamol but that he did not want to make a fuss. As a result of that conversation his personal officer went with him to Medications where she asked healthcare staff to give him something stronger than paracetamol as his stomach remained painful. There is no record of the response to this request.

29. On 1 August the man complained of a urinary obstruction and the doctor asked for a Prostate Specific Antigen (PSA) test. (This is a test that may indicate the presence of prostate cancer.) The note indicates that Proscar (a drug that inhibits the growth of the prostate) and Cardura (a drug used to relax the muscles in the prostate gland allowing the flow of urine) were dispensed as a 28 day course in-possession on 4 August.

30. The man attended a Sentence Planning Board on 24 August with his offender manager and offender supervisor. Due to his denial of the offences and his appeal against conviction, he was not eligible to undertake the Sex Offenders Treatment Programme (SOTP) nor the Enhanced Thinking Skills (ETS) course, as the two courses are linked. However, sentence plan targets were set and a review of those targets was to take place after the outcome of the appeal was known.

31. The man reported on 4 September that he had suffered from abdominal cramps for the previous week and from diarrhoea since the previous Saturday, four days earlier. He was prescribed loperamide and Buscopan (10mg) and a note was made to follow up the referral to the gastroenterology department.

32. An untimed and unsigned entry in the medical record shows that the man's eyes and skin looked yellow when he attended the medication hatch on 7 September. He complained of a constant aching pain in his abdomen and changes in his stools. He also said that he was not eating or drinking much but had no nausea or vomiting. The author of the note recorded the man's physical observations and the results of a urine test. The note concludes that the doctor was to be contacted. A nurse recorded at 7.50pm the same evening that she had spoken to the prison doctor who would attend later in the evening. The doctor examined the man and at 8.15pm he was taken from Rye Hill to the Accident and Emergency (A&E) Department of University Hospital (Coventry).

33. Although the man's Continuous Clinical Record indicates that he was taken to hospital on the evening of 7 September, his movements record shows that he was taken out to hospital on 8 September and returned to Rye Hill the same day. As there was no hospital discharge letter, the timing of the admission and medical opinion could not be confirmed by my investigator. The prison doctor remembers a conversation with the man who died following his return in which he told the doctor that the hospital doctors had said there was "nothing to worry about, it was probably gallstones and that they would pass". The prison doctor said he felt at this stage that

the man might have been exhibiting signs of cancer but his colleagues at the hospital disagreed. The prison doctor decided to "keep an eye" on the man's condition.

34. In any event the man was back at Rye Hill on 10 September and a Primecare sick note confirmed that he was unfit for work owing to diarrhoea. (Similar notes were completed for the following two days.) On 11 September the prison doctor completed a special diet sheet identifying that he should not eat fatty foods and specified cold meat, salad and breakfast cereal. Undated supplements to the diet sheet were subsequently added and signed. They include the words "cheese also" and next to the doctor's entry "breakfast cereal" the words "x2 daily until further notice". The doctor also recorded on 11 September that the man was still suffering from stomach pain and "Nothing done when sent to hospital. Awaiting gastro appointment. States paracetamol reliefs (sic) pain." The doctor found on examination that the man was still jaundiced and noted that his urine was to be tested daily. The man continued to be monitored. His weight was recorded at 104 kg and an appended note said that he had lost 4 kg since 21 May 2007.

35. A signed note on 13 September in the Continuous Clinical Record that a "2 wk ref faxed to Booking Centre" indicated that an NHS two week referral document completed by the prison doctor had been sent to the hospital. (This is the referral form used when a doctor considers that the patient has clinical indications of a new malignancy.). The doctor wrote on the form that the man had an appointment for 3 October but he would like him to be seen earlier if possible. Two copies of this form were filed. One of them had an additional unsigned, undated note reading "Rec'd by post 17.09.07" and a further similar note on the form reads, "Appt 27.09.07 – 1410 - Endoscopy Unit".

36. The man's family were seen by a representative of Rye Hill's healthcare department on 15 September to discuss his physical health (a note was made of the meeting but the signature of the note taker is unclear). The man's daughter recalled to my investigator that this meeting took place in the visits room at Rye Hill and the representative was a nurse from the healthcare centre. The Rye Hill representative explained his treatment but the man's daughter was unhappy with the explanations. The tone of the interview deteriorated and it finally broke down. Later the same evening the man was examined by the medical officer who requested a liver function test to assess him for a fat free diet.

37. At about this time the man made an undated formal complaint to the Director. He complained that since the special diet had been requested on 10 September he had received no meals on the following two days. He had one that complied on the evening of 13 September, and again at lunchtime on 14 September when a bag of shredded cabbage and lettuce was provided. No special diet was supplied on the evening of 14 September until complaints were made by the man and fellow prisoners on his behalf. On that evening, he was advised by the unit manager that the situation would be resolved by Sunday (15 September).

38. On the following day (16 September 2007), the man was reviewed in the healthcare centre. Records show that he remained jaundiced and that he had problems with the diet from the kitchen specifying lettuce leaf, tomatoes and cheese. It was also recorded that the kitchen should be contacted for a more balanced and

attractive meal. The man was prescribed a nightly course of the sedative (Zopiclone) for three days to aid his sleep pattern. The doctor's note reads "ring for Zopiclone 7.8grams" and he was encouraged to drink. He was also noted to be apyrexial (meaning there was an absence of fever).

39. The Director of Rye Hill responded on 17 September to a formal complaint from the man about his diet. She said that she had established that he was on a fat free diet, which did not mean that he was only to eat salads and that the kitchen would now supply tuna, lean meat etc.

40. The man's condition was monitored daily, and on 19 September he again had abdominal pain and constipation for which the duty doctor prescribed appropriate medication. At 8.30pm that evening a fellow prisoner, reported to the man's personal officer that the man was in pain. She went to see the man then telephoned healthcare and told the duty nurse that he was crying in pain. The nurse in turn spoke to the prison doctor briefing him on the man's medical history since 7 September. The doctor decided there was little more Rye Hill could do for the man and that he should be admitted to hospital. The duty nurse made the arrangements and he was admitted to the University Hospital at 2.00am on 20 September, under escort. He was to be assessed by the surgical team the following morning. No bedwatch log or other escort documentation was made available during this investigation. The man's prescription chart on 19 September records the first dose of Zopiclone, prescribed on 16 September, as not being administered as the patient was absent.

41. The man's clinical record shows that, after his admission to hospital, Rye Hill healthcare staff were frustrated in their attempts to gain first hand information about his medical status because hospital staff were reluctant to disclose what they knew. It is evident from the clinical record that escort staff were able to tell Rye Hill that the man had ultrasound and computerised tomography (CT) scans and that, dependent on the outcome, an operation on his liver was possible and which would have required him to stay in hospital for seven to ten days. On 25 September, the escort staff reported that there was a blockage between the man's liver and gallbladder and that a specialist would be seeing him later on that day.

42. A specialist Hepatic, Pancreatic, Biliary (HPB) nurse, telephoned the duty nurse at 9.30 on 26 September to discuss the man's post hospital discharge treatment. The HPB nurse told her that his CT scan showed a probable cancer at the head of the pancreas with liver metastases (the spread of malignant tumours from the site of its origin). She also said that the cancer was inoperable but that the man would probably have chemotherapy on a weekly basis. She added that she would send an information pack about pancreatic cancers to the healthcare centre. Following the HPB nurses' contact with healthcare staff at Rye Hill, it was left to the prison escort staff at 3.40pm to relay information back to Rye Hill about an operation to insert a catheter and the reasons for its subsequent failure.

43. No further substantive information is available until a note dated 1 October 2007 in response to an enquiry to the hospital, which said "poorly and will be having surgery on Wednesday 3 October". A note dated 2 October records that the man was stable, in pain and jaundiced. On 3 October at 12.30pm, the duty nurse

attempted to contact the hospital ward but the telephone was continually engaged. When another nurse telephoned at 10.30am on 4 October, the man was in theatre.

44. A member of healthcare staff contacted the ward on 5 October and was told that the man was doing well, was taking food and fluids, and would be seen later by his consultant. At 3.40pm the same day the HPB nurse telephoned Rye Hill. She updated the duty nurse on the man's progress and the proposed plan of action. This included a possible biopsy of the lesions on his liver, but was dependent on the outcome of cytology tests (the microscopic examination of cells) of his pancreas. In any event, he would not be discharged from hospital in the near future. Following the tests the man was to see an oncologist with regard to palliative chemotherapy (this does not cure the disease but gives relief from the symptoms) which would be administered weekly as an out-patient. The HPB nurse also gave a life expectancy prognosis of about six to nine months which, she said, the man was not aware of. The HPB nurse concluded the conversation by telling the duty nurse that an email had been sent to Rye Hill's Director, to enable her to make a decision about early release on compassionate grounds.

45. Rye Hill healthcare staff continued to contact the ward to monitor the man's progress. They were told on 10 October that he was now taking Oramorph (a morphine based painkiller taken orally) at two hourly intervals, and was confused and disorientated. He remained in hospital and underwent a liver biopsy on 16 October after which he was described as feeling "rough". On 17 October, he was subject to an oesophagogastroduodenoscopy (OGD) – an examination of the upper alimentary tract using an optical instrument. Later in the day, a member of Rye Hill healthcare staff telephoned the ward and was told by the ward sister that the man was suffering from clostridium difficile (known as C. diff - a complication of antibiotic therapy) which was being treated with antibiotics, and that he was due to receive a blood transfusion. The ward sister indicated that the man might be discharged the following week.

46. A multi-disciplinary team meeting took place on 19 October in which the man's condition was discussed and consideration given to his needs when he returned to Rye Hill. During a telephone conversation with the ward staff nurse on 21 October, a prison healthcare staff member was told that the man was very poorly and his life expectancy was now being measured in days and weeks. Medical staff had told the man's family his prognosis and the duty Director authorised the removal of all restraints. Escorting staff remained at the hospital, but because he was suffering from C. diff they were relocated outside his room.

47. The man's condition continued to deteriorate during 22 October. Rye Hill began the process of gaining authority from the Secretary of State for his release on compassionate grounds under the provisions of section 10(1) of the Crime (Sentences) Act 1997:

> "10(1) The Secretary of State may at any time release a prisoner if he is satisfied that exceptional circumstances exist which justify the prisoner's release on compassionate grounds."

48. The prison also contacted the man's consultant at the hospital to confirm his condition so that the application for early release on compassionate grounds could be progressed. A further request for a report of his prognosis was made early on 24 October. The man's consultant, wrote to the prison doctor at Rye Hill that day confirming that he had pancreatic cancer, had deteriorated rapidly, and was unlikely to survive for more than a short time.

49. The prison doctor completed an "Immediate early release on compassionate grounds. Compassionate medical condition report" on 25 October. His assessment of the man's condition, after discussion with the consultant, was that he was terminally ill and unlikely to leave hospital, and he doubted that he would survive another week. A member of Rye Hill staff also confirmed the man's condition and was told by the ward Staff Nurse that his death was imminent.

50. Following the consultant's confirmation of his terminal condition and life expectancy on 24 October, and the completion of the compassionate medical condition report by the prison doctor, the Director released the man on temporary licence from 1.00pm on 25 October. The licence was to expire at midday on 29 October.

51. Determined efforts were made by Rye Hill staff to complete the release on compassionate grounds but the man died before Ministerial authority was given. He died at about 11.30am on 26 October. His family was with him.

After the man's death

52. Ward staff at the University Hospital informed Rye Hill at 1.10pm that the man had died. The Rye Hill death in custody contingency plan was activated but the process was modified because the man's death was the result of a long term serious illness, was not unexpected, and had happened in an outside hospital.

53. Having been told that the man had been released before his death, the Coroner decided not to hold a post mortem or inquest. The Coroner issued a Medical Cause of Death Certificate and a Form "A" certificate informing the Registrar that the man's death could be registered.

54. The day after the man died, a staff member told the prisoners wing representative, of his death and a notice informing the other prisoners was published. The wing representative organised a collection and card for the family of the man who died.

55. The man's property was returned to his daughter following a meeting with Rye Hill's Director at Rye Hill on 27 October. Arrangements were made to return the money remaining in her father's account at the prison and a verbal offer of assistance with funeral expenses was made. The Director sent a letter of condolence to the man's wife on 29 October, in which she invited contact with her and offered to see her either at her home or the prison. The Director also confirmed the offer of a financial contribution and asked the family to let her know the funeral date so that representatives of Rye Hill could attend to pay their respects.

56. The file copy of the letter of condolence has a hand written note indicating that a cheque was being sent by the prison on 8 November 2007 with the proceeds of a collection from prisoners added to it. A second reminder letter dated 1 March 2008 from the funeral directors to the man's wife for payment of the outstanding funeral costs was forwarded for the attention of the Director. A post-it note indicating that a cheque was issued for that amount on 6 May 2008 was appended to the letter. No reason for the delay in settling this account has been given.

ISSUES CONSIDERED DURING THE INVESTIGATION

Delivery of medical services

57. In the report of her unannounced full inspection of Rye Hill in June 2007, HM Chief Inspector of Prisons noted that:

> "Pharmacy services were inadequate."
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> "Relationships between health services and the rest of the prison were fraught. There were significant problems with the cancellation of NHS appointments, and the responsibility for the delivery of secondary and tertiary care within the local NHS economy appeared blurred. Although there were no formal links with the Northamptonshire Primary Care Trust (PCT), the head of healthcare and PCT lead commissioning manager had established sound working relationships and the PCT provided support where necessary."

58. During this investigation into the man's death, another prisoner raised concerns about the delivery of medical services at Rye Hill. These are outlined later in this report. Similarly, my investigator judged that there was a lack of accountability in terms of local NHS responsibility for prisons run by the private sector. Throughout, it has been evident that meaningful communications between Rye Hill healthcare staff and hospital staff was poor, with the notable exception of the contact between the HPB nurse at University Hospital and the duty nurse at Rye Hill. At times, it was left to escort staff to provide prison healthcare staff with information either from their own observations or after they had asked ward staff.

59. Since the man's death a former Deputy Ombudsman in my office has been appointed Head of Medical Services at G4S. In response to enquiries by the clinical reviewer regarding the areas highlighted the G4S Head of Medical Services provided a written update on current clinical provision. She said that Rye Hill is part of Northamptonshire Teaching Primary Care Trust, with a jointly signed partnership agreement. Regular partnership board meetings are held.

60. The G4S Head of Medical Services further explained that Leicestershire Partnership Trust (NHS) (hereafter LPT) is now the prison's pharmacy provider. There is also an on site pharmacy technician, supported by fortnightly visits by the pharmacist from LPT to review compliance and audit stock levels. The number of offenders who manage their medications independently by having them in-possession has increased, and the Head of Medical Services considers this has reduced the pressure on the other treatment times. Medication is ordered and delivered the same day from LPT. They are also actively promoting self-management of medication by encouraging offenders to apply for a repeat prescription and holding pharmacy clinics.

61. Commenting on communication the G4S Head of Medical Services said that there was good representation of healthcare on various prison committees and working groups as well as clear evidence of good partnership working both internally and externally. She added that healthcare now attend the daily briefing and the healthcare manager is a member of Rye Hill's Senior Management Team. She

considers this has helped to improve communication between healthcare and the wider establishment.

62. In a further communication with the clinical reviewer the G4S Head of Medical Services said:

> "We have met with Coventry and Warwick Hospital [i.e. University Hospital (Coventry)] to discuss improving communication. The information sharing protocol deals with internal and external communication. We have a clear avenue of complaint if we do not receive the information we need via the director of nursing and the clinical governance manager. We would also raise any SUI [serious untoward incident] investigation if the lack of information posed a serious risk to health and or life as we have in another establishment."

63. I am conscious that a great deal of time has elapsed since the man's death and, in the light of the changes highlighted in the G4S Head of Medical Services responses, I make no formal recommendations in this area.

Medical Care

64. When the man who later died reported sick with indigestion on 15 December 2006, the initial prescription drug did not help and another medication was prescribed five days later. According to the clinical notes the man did not go to the doctor again for about five months. In May 2007, he complained of abdominal cramps. A diagnosis of possible irritable bowel syndrome was made and suitable medication prescribed. By June, the man was still experiencing peri-umbilical pain and the prison doctor referred him to a gastroenterologist. During August the man experienced further related symptoms and was examined by the prison doctor.

65. The man who died continued to experience abdominal cramps and diarrhoea. His medication was changed and a note made to follow up the previous referral to gastroenterology. By 7 September the man appeared jaundiced and had a constant ache in his abdomen. He was referred to the prison doctor who advised that he required hospital treatment and he was taken to A&E at the University Hospital. It seems from the clinical notes that the man was discharged from hospital having received no treatment. There is no evidence on file of a discharge letter from the hospital. The doctor at Rye Hill considered that the man might have been exhibiting signs of cancer but his colleagues at the hospital disagreed. Later, on 13 September, he completed a two week referral form. This form is used when the referring doctor considers that the patient has clinical indications of a new malignancy.

66. The man who died had lost 5.2kg in weight between May and mid-September and continued to feel unwell. On 19 September, the unit staff contacted healthcare to inform them that he was in a lot of pain. The man was admitted to University Hospital and was seen by the surgical team the following day. After investigations, he was diagnosed with incurable pancreatic cancer that had spread to other organs in his body and was considered inoperable. The man's condition was managed by

the hospital but he continued to deteriorate and he died at around 11.30am on 26 October.

67. The National Institute for Health and Clinical Excellence (NICE) guidelines for pancreatic cancer included the following passages:

> "It is very difficult to diagnose pancreatic cancer as the pancreas is so deep within the body and symptoms vary depending on the exact location of the tumour in the pancreas and which cells or function of the pancreas is affected by the tumour or cancer.
>
> "Unfortunately there are frequently no symptoms at all at the very early stages. The tumour may have grown significantly before it causes any obvious recognised symptoms.
>
> "Unfortunately the symptoms of pancreatic cancer can also be quite vague and non specific i.e. may be caused by many other more common and less serious conditions. Diagnosis can be delayed as the GP or specialist tries to rule out other causes such as hepatitis, gall stones, irritable bowel syndrome and stress."

68. The clinical reviewer concludes that:

> "The man's overall care was of a standard which could reasonably be expected had he been in the community. However, the delay in him being admitted to hospital following his initial presentation and particularly when he became jaundiced resulted in a delay in the man receiving specialist investigations. This may have delayed the diagnosis and subsequent treatment. The lack of discharge summary following the man's initial referral to hospital on 7 September makes it impossible to assess the hospital staff's conclusion at this stage. However, the prison healthcare staff had requested a specialist opinion and they made attempts to ensure this occurred.
>
> "The clinical notes indicate a caring and thorough approach to the care the man received during his time at Rye Hill."

I endorse that view.

69. Although the man received an appropriate level of care during his illness, some shortcomings have been identified by the clinical reviewer. She has made several recommendations, and these also reflect some of comments and recommendations made by HM Inspector of Prisons in her report of the June 2007 inspection at Rye Hill. I have modified some of the clinical reviewer's recommendations as follows:

G4S should ensure that a discharge summary is filed in the patient's clinical notes when he returns to prison from hospital. If a discharge summary is not received, the hospital must be contacted for a hand-over and a discharge summary requested. A verbal hand-over should be documented in the patient's clinical notes.

G4S should ensure that the standard of record keeping meets Nursing and Midwifery Council guidelines and is consistent with all current professional guidance. Medical record entries should be clearly written with a date, time, name, position and signature of the author. It should include the accurate completion of medication prescription charts, copies of all referral letters and the results of tests carried out.

G4S should ensure that referrals to specialist medical practitioners are followed up in a timely manner if appointments are not received within an acceptable timeframe, particularly when a patient continues to experience the symptoms or to develop new ones.

G4S should ensure that in cases where a special diet is prescribed the patient is referred to a dietician or advice sought from an appropriately qualified professional.

G4S should ensure that the new Information Sharing Protocol is widely distributed amongst both hospital and Rye Hill staff. This will support effective communication between both entities.

Family issues

70. The man's daughter spoke to one of my Family Liaison Officers, during February 2008. She and the family felt that her father had been seriously ill for about six months, and that he had been in pain and was jaundiced for over a month before he died. She had a number of concerns mostly about the healthcare given to her father. As a weekly visitor, she said she had seen the deterioration in his health.

71. The family felt that they always had to push for the man to be seen and given treatment. His daughter said she had made an issue of his health during a visit about a month before he died, and a nurse came to the visits room and explained that he had gallstones. The family have a number of questions about the failure to offer tests to establish the cause of the pain and reason for his jaundiced appearance. They said they were told that the healthcare unit at Rye Hill was understaffed and various tests such as a daily blood test could not be done.

72. It is self-evidently distressing for families to see a loved family member who is obviously unwell and in prison, and a natural reaction to believe that not enough is being done to help. However, in this man's case his illness was an extremely difficult one to diagnose as is evidenced by the extract from the NICE guidelines reproduced above. Rye Hill staff reacted appropriately to his symptoms and healthcare staff asked for a specialist opinion via a gastroenterology referral. There was some delay, but the appointment was followed up the next time the man presented with relevant symptoms. (I have made a recommendation relating to this in the Medical Care section above.)

73. As soon as the man became jaundiced on 7 September, Rye Hill healthcare staff arranged admission to University Hospital. The absence of a discharge summary following his return to prison from hospital means that the conclusion or

diagnosis of the medical staff is unknown. However the prison doctor recalls a conversation with the man who later died following his return from hospital in which the man said that the hospital doctors had told him that it was probably gallstones and nothing to worry about. The prison doctor, who considered that the man might have been exhibiting signs of cancer, wrote to the hospital but the doctors there disagreed. He later wrote to University Hospital regarding the man's condition. The clinical reviewer has made efforts to trace that letter with University Hospital but it has not been found and there is no copy in the prison records. Again, I have made a relevant recommendation above regarding the maintenance of patient records.

74. On 13 September 2007, the prison doctor attempted to speed up the specialist assessment by completing a two-week referral form to the cancer clinic. When the man presented six days later with associated symptoms, prison healthcare staff immediately arranged for his admission to outside hospital.

75. The view of the man's family is that there was a general lack of care for him. He had been advised not to eat the usual food available on the wing due to his health problems. However, he was then not provided with any other option and his family believe that a special diet should have been provided. He apparently ate very little during this time.

76. Following the doctor's advice to reduce the fat content of the man's meals, the prison caterers gave him a much more restricted diet consisting mainly of salads. There does, however, appear to have been a failure in that the new diet was supplied sporadically until the Director intervened as a result of the formal complaint made by the man.

77. I am concerned that the man who later died, already suffering from a painful stomach condition, found himself in a position where he needed a change of diet to alleviate some of his problems yet the prison was initially unable to provide this. It was undoubtedly frustrating for him to report the failure to wing staff to be told that he must wait a few more days before action was taken. I have made a recommendation above regarding the consultation of a dietician or other qualified person when a special diet is advised by the doctor. I make a further related recommendation:

The Director should ensure that catering and accommodation unit staff are aware of their responsibilities to ensure that appropriate diets are supplied promptly and in accordance with medical and religious requirements.

78. The man's family are concerned that he was offered very little in the way of pain relief until his personal officer insisted that he should be given further medication. The family are aware that other prisoners on the man's wing were also worried that he did not appear to be getting the right sort of attention. Their main question is why he was left for so long without proper treatment. They understand that it was only when his personal officer became concerned when she returned to work that an ambulance was called. The man was immediately put on morphine which suggests to his family that he needed that level of treatment.

79. The man was admitted to hospital during the night of 19/20 September 2007, after complaining of abdominal pain during the evening. The man's personal officer

told my investigator that, although she could not remember the date, some days before being admitted to hospital he had told her that he was in pain and was using paracetamol but that he did not want to make a fuss. As a result of that conversation, she went with him to Medications and asked healthcare staff to give him something stronger. The clinical records show that at 7.45pm on 15 September he was seen by a doctor and prescribed Ibuprofen, another common pain killer, four times daily for five days. The man's personal officer remembers that some days later, on 19 September, she saw the man and he was obviously in pain. She reported the matter to healthcare staff and, because they were aware of his history, they arranged for him to be admitted to UHCW Hospital.

80. The clinical reviewer has found no cause for concern over the management of the man's pain during his illness which at the time had not been fully diagnosed. She judges that healthcare staff were reactive to his needs as he presented with them.

81. The man's family consider that his condition should have been diagnosed sooner and want to know if earlier treatment or intervention would have prevented his death.

82. The clinical reviewer points out in the conclusion of her review that pancreatic cancer is a notoriously difficult malignancy to identify and, because the man initially presented with symptoms spasmodically, his clinical history was sketchy. The weight of evidence suggests that it would have been difficult to secure an earlier diagnosis as a number of other possible illnesses had to be eliminated first.

83. The prison doctor referred the man to the gastroenterology clinic on 13 June 2007 and an appointment was later received for 3 October. Following the man's admission and discharge from hospital on 7 September, hospital doctors disagreed with the prison doctor's concerns that the man was suffering from cancer. The prison doctor subsequently sent a two week referral form to the hospital pointing out that the man had an appointment for 3 October but that he would like him to be seen earlier if possible. The man was admitted to hospital during the early hours of 20 September, and a few days later a diagnosis was made of inoperable pancreatic cancer that had spread to other organs. It seems that the prison doctor made every effort to get the man examined by specialists at the hospital in a timely manner. It is unlikely that his death could have been prevented.

Use of restraints

84. The man's daughter told this investigation that she had found the level of restraints used in hospital to have been quite shocking. Both her father's wrists had been handcuffed, and he had been under a two person escort up until four days before he died when it had been reduced to one. She recognised, however, that one of the escort staff members had been particularly helpful. Similarly, the prison chaplain had visited the man daily, and the family considered he had been very kind to them all.

85. The level of restraint required for a bedwatch is determined by a prison risk assessment. Such assessments are made whenever a prisoner attends hospital for

either inpatient or outpatient treatment and take account of factors such as the location of the ward, possible escape routes and the prisoner's offence. Guidance on risk assessments is given in the Prison Service National Security Framework (NSF). The NSF indicates that there is a presumption that, unless the risk assessment states otherwise, prisoners should not be restrained during treatment or medical examination.

86. No risk assessment documents or bedwatch logs are available to indicate how and when decisions were made on the level of restraint used. The only reference is from an entry in the Continuous Clinical Record on 21 October that indicates that all restraints were removed and escort staff were relocated outside the man's hospital room. The lack of supporting documentation makes it impossible to assess whether the level of restraint was appropriate throughout the man's stay in hospital. However, given the incapacity resulting from the serious nature of his illness, the level of discomfort he endured, and the consequent improbability of him attempting to effect an escape, I would question whether handcuffing was necessary. Regrettably, this is a matter I have had to comment on all too often.

The Director should ensure that all relevant documents, such as risk assessments, are retained and properly filed in the prison record and are available for inspection.

87. After the man's death, his daughter expressed concern about how the family were treated by the prison. She said that when she visited Rye Hill to collect her father's belongings she had felt humiliated when a member of prison staff had burst into the room and removed her handbag in an insulting and rude manner. She said she had found the incident very upsetting. She was also upset that they had been told that the Director and another representative of Rye Hill would go to the funeral but no one from the prison had actually attended, and this absence had never been explained.

88. The residential manager of Beaumont Wing at the time of the man's death spoke to the man's daughter during her visit to Rye Hill. My investigator has discovered that the wing manager was aware of the incident involving the removal of her handbag whilst she waited to see the Director. After the man's daughter left the prison the wing manager spoke to the staff member involved and gave advice about handling such sensitive situations appropriately. It is regrettable that the actions of an individual staff member resulted in upsetting a visitor in such circumstances. Nevertheless, it is commendable that the situation was raised at the time with the person involved and appropriate advice given. I note, however, that the outcome was never communicated to the man's daughter.

89. The Director indicated in her letter of condolence that the prison would contribute to the funeral costs and send representatives to the funeral. However, as the man's daughter has said, no one from the prison in fact attended. The Director's recollection is that there was either some confusion about the date of the funeral or no date was forthcoming. Whatever the case, it is clearly regrettable that the commitment given by the Director was not carried through in practice.

90. The funeral directors sent two reminders to the man's wife requesting payment of the outstanding funeral costs which were forwarded to the Director. It appears that a cheque to settle the bill was issued on 6 May 2008. It is extremely regrettable that further distress was caused to the man's family as a result of non payment of the account. No reason for the delay in settlement of this account has been given.

The Director should ensure that funeral expenses are settled promptly to avoid additional anxiety to families coming to terms with their loss. An apology should also be sent to the man's wife, should this not have happened already.

Concerns raised by the man's friends

91. A fellow prisoner and friend of the man who died at Rye Hill, in interview with my investigator, described the man as having diarrhoea after eating. He said that, as a consequence the man was put on a diet of salads that did not arrive at the same time as the normal meals and had to be collected separately later. He was of the opinion that the man was not receiving a balanced diet. I have explored the issue of the man's diet earlier in this report and have made recommendations relevant to the issues raised.

92. The man's friend, fellow prisoner and wing representative also referred to the occasion that the man was taken to an outside hospital during the evening and returned to Rye Hill later that same night. He said the man had told him the following morning that the hospital had wanted to admit him but that, because of staffing limitations, Rye Hill had refused to let him stay.

93. Another prisoner and friend of the man who died wrote to my investigator on 18 December 2007, raising a similar concern. He said that the man had complained to him that, having spent several days as an inpatient at University Hospital, prison management at Rye Hill had persuaded the hospital to discharge him because the prison could not supply bedwatch staff.

94. The wing representative's concerns appear to refer to the man's admission and discharge from hospital on 7 September 2007 for which there is no discharge letter. There is no supporting evidence to show that Rye Hill actively discouraged admission to hospital or brought about the man's discharge from hospital because of staff shortages. Evidence from the prison doctor seems to indicate that hospital staff took the decision that he did not require admission. A discharge summary would have clarified this issue and I have made a recommendation about the need to obtain such a summary.

95. The second friend also wrote that the man had complained to him that healthcare staff did not always give him the medication prescribed and explained that the prison healthcare provider had a contract with a pharmacy in Liverpool and, as a consequence, any drugs prescribed at Rye Hill that are not in stock are ordered from Liverpool. He said this resulted in delays of between two days and two weeks before the drugs were dispensed.

96. Issues regarding the performance of the pharmacy at Rye Hill were highlighted by HM Inspector of Prisons report of 2007 and were raised in the course of this

investigation with G4S's Head of Medical Services. Her response is outlined earlier in this report, and I judge that the issues raised regarding the specific pharmacy services appear to have been addressed by the prison.

Early release on compassionate grounds

97. The man who died was very ill and on 21 October 2007 had signed a "not for resuscitation" form. His life expectancy prognosis was short and his family had been told of his condition by hospital staff. Rye Hill staff were also aware of the terminal nature of his illness, and on 22 October began the process of consideration for early release on compassionate grounds under the provisions of the Crime (Sentences) Act 1997. Following confirmation of his terminal condition by his consultant on 24 October, and the completion of a medical condition report by the prison doctor the man was released on temporary licence by the Director.

98. I consider that determined efforts were made by Rye Hill staff to complete the release on compassionate grounds promptly, but sadly the man died before a decision was made. It is evident that staff reacted to and took account of all the circumstances surrounding the man's situation. He remained in prison custody but the Director of Rye Hill made the best judgement she could by releasing him on temporary licence

CONCLUSION

99. The man who later died was in good health when he entered prison in September 2005, and remained so until December 2006. A long period followed during which he was treated for a number of symptoms linked to his digestive system. Prison healthcare staff requested a specialist opinion for the man and there was a delay in following up the initial referral.

100. The man's symptoms worsened until he spent a brief spell in hospital in early September 2007. Prison healthcare staff attempted to speed up the specialist assessment by submitting a two-week referral, and when he further presented with associated symptoms they immediately arranged for his admission to hospital where he remained. From that point the man's health deteriorated rapidly. A diagnosis of inoperable pancreatic cancer was made and he died on 26 October 2007.

101. Overall, I conclude (in line with the clinical reviewer) that the care the man received at Rye Hill was of a standard that could reasonably be expected had he been in the community. The clinical notes - whilst they may be criticised on some grounds - indicate a responsive and appropriate approach to the problems with which the man presented during his time at Rye Hill.

RECOMMENDATIONS and RESPONSES

1. G4S should ensure that a discharge summary is filed in the patient's clinical notes when he returns to prison from hospital. If a discharge summary is not received, the hospital must be contacted for a hand-over and a discharge summary requested. A verbal hand-over should be documented in the patient's clinical notes.

G4S fully accepted this recommendation and responded that:

"We will ensure that the discharge summary is filed in the clinical notes and will contact the hospital if no discharge summary is received."

The action was completed and is ongoing

2. G4S should ensure that the standard of record keeping meets Nursing and Midwifery Council guidelines and is consistent with all current professional guidance. Medical record entries should be clearly written with a date, time, name, position and signature of the author. It should include the accurate completion of medication prescription charts, copies of all referral letters and the results of tests carried out.

G4S fully accepted this recommendation and responded that:

"Medical record keeping requirements will be communicated to all nursing staff. A quarterly audit of record keeping will be undertaken by the Care and justice Head of Medical Services."

The action was completed and is ongoing

3. G4S should ensure that referrals to specialist medical practitioners are followed up in a timely manner if appointments are not received within an acceptable timeframe, particularly when a patient continues to experience the symptoms or to develop new ones.

G4S fully accepted this recommendation and responded in two parts:

1. "Health Care Administrator will ensure the timely referral of specialist appointments."

   This action was completed and is ongoing

2. "Installation of System One in the New Year will assist."

   This action is due to be completed by April 2010.

4. G4S should ensure that in cases where a special diet is prescribed the patient is referred to a dietician or advice sought from an appropriately qualified professional.

G4S fully accepted this recommendation and responded that:

“Specialist advice is now sought in such cases.”

The action was completed and is ongoing

5. G4S should ensure that the new Information Sharing Protocol is widely distributed amongst both hospital and Rye Hill staff. This will support effective communication between both entities.

G4S fully accepted this recommendation and responded that:

“The information sharing protocol is available to all staff on the Rye Hill common drive”

The action was completed and is ongoing

6. The Director should ensure that catering and accommodation unit staff are aware of their responsibilities to ensure that appropriate diets are supplied promptly and in accordance with medical and religious requirements.

G4S fully accepted this recommendation and responded that:

“Regular meetings now take place between the Head of Health Care and the Catering Manager to review medical diets and to ensure that the appropriate food is provided.”

The action was completed and is ongoing

7. The Director should ensure that all relevant documents, such as risk assessments are retained and properly filed in the prison record and are available for inspection.

G4S fully accepted this recommendation and responded that:

“All risk assessments and other relevant documents are now retained and filed.”

The action was completed and is ongoing

8. The Director should ensure that funeral expenses are settled promptly to avoid additional anxiety to families coming to terms with their loss. An apology should also be sent to the man’s wife, should this not have happened already.

G4S fully accepted this recommendation and responded in two parts:

1. “A cheque for £3275.50 was raised following receipt of the undertaker’s bill. Due to accounting complications, the cheque was held up and eventually overlooked.”

2. “A letter of apology has been sent to the man’s wife.”

Both actions have been completed.