Investigation into the death of a man at HMP Rye Hill on 21 November 2004

Prisons and Probation Ombudsman for England and Wales

March 2006

In the early hours of 21 November 2004, the man was taken ill in his cell at HMP Rye Hill. He complained of chest pains and was taken to St Cross Hospital for treatment. Shortly after 8.00am, he suffered a serious cardiac arrest and was pronounced dead at 8.45am. He was 48 years old.

The man had a history of heart problems and was on regular medication for his condition.

This investigation was carried out on my behalf by one of my investigators. A clinical review was conducted. I am grateful to the then Director of Rye Hill and his staff for their co-operation throughout the investigation. I regret the long delay in issuing this report.

The man had not given the name of anyone as his next of kin and, poignantly, no members of his family have been found.

Stephen Shaw CBE
Prisons and Probation Ombudsman **March 2006**

SUMMARY

The man was a 48 year old single man serving a long sentence for serious sexual offences. He had an extensive criminal history and had spent several years of his life in Europe where he had also offended. He had no contact with any family members and few friends in this country.

Whilst on the continent, the man had developed serious heart problems. He had undergone a heart valve replacement shortly before returning to England and committing the offences for which he was imprisoned. Throughout his sentence, he received treatment for his condition and had to take regular medication to maintain the fragile state of his health. There is some evidence to indicate that he was not diligent in adhering to his prescribed treatment regime, although he was generally cooperative and compliant when reminded of it.

In the early hours of 21 November 2004, the man rang his cell bell in HMP Rye Hill and alerted staff to the fact that he was suffering severe chest pains. The duty nurse attended and examined him. After consultation with the duty doctor, arrangements were made for him to be taken by ambulance to the local hospital. During the course of the next few hours, his condition grew steadily worse and shortly after 8.00am he suffered a fatal cardiac arrest.

INVESTIGATION METHODOLOGY

1. My office was contacted following the man's death and a formal investigation was initiated. I appointed as my investigator. At the same time, a police investigation was opened on the instructions of the Coroner. The purpose of the police investigation was to determine if there were any suspicious circumstances surrounding the death of the man and to assist the Coroner's inquest.

2. In order to ensure that the police inquiries were not hampered or compromised in any way, no formal interviews or detailed discussions were carried out by the investigator until after the police inquiries had concluded. This took a considerable length of time due to a long delay in obtaining a full medical report from the prison.

3. A review of all the available documentation relating to the man was examined. At the end of March 2005, the final medical report was received by the police and their investigation formally concluded. There were no suspicious circumstances identified. Copies of all the interviews and information obtained by the police were made available to the investigator.

4. The post-mortem established that the man had died from a myocardial infarction (heart attack). This investigation is therefore concerned primarily with the medical care the man received during his time in prison. A clinical review of the care and treatment of the man has been conducted by an experienced clinician appointed by my office.

HMP RYE HILL

5. HMP Rye Hill is a purpose-built category B adult training prison, opened in 2001 and run by a private company, GSL, on a contract with the Home Office. The certified normal accommodation is 600, but this can be increased to a maximum operating capacity (maximum crowded capacity) of 664 if needed.

6. All the prisoners are male, serving over four years and there is capacity to hold up to 120 life sentence prisoners.

7. In the four years after the prison opened there were nine deaths in custody in addition to that of the man. There were no deaths in 2001, four in 2002, three in 2003 and two other deaths in 2004. The investigations found no serious shortcomings and made only minor recommendations regarding procedures.

8. The last Standards Audit report were satisfied with the procedures and plans for dealing with prisoners at risk and for handling deaths in custody.

KEY EVENTS

9. On the night of 20 November 2004, two Prison Custody Officers were on duty in Andrews Wing. Shortly before 1.30am, there was a call from one of the cells. Both the officers were in the wing office at the time, together with a third officer from another wing. He had been on the unit to carry out some administrative tasks. One of the officers went to answer the call, which is known to have been made by the man.

10. When he arrived at the cell, the officer opened the door flap and saw the man standing by the door. He told the officer that he was suffering from chest pains. He also said they had been going on for about half an hour, but had been so severe that he could not get off the bed to ring his bell. Eventually they had eased sufficiently to allow him to call for help. The officer went back to the office and called the Healthcare Centre, asking the duty nurse to attend. He then contacted the Night Manager, informing him of the situation and requesting his attendance.

11. On receiving the call, the nurse contacted the Communications Centre asking for an officer to collect him and take him to the wing. This is normal procedure at Rye Hill during the night when only identified officers carry keys. The nurse then gathered together his equipment and within a few minutes the Night Manager arrived. Together they went to Andrews Unit, arriving five to ten minutes after the initial call had been made.

12. The Night Manager had to contact the Duty Director for permission to open the cell. This too is normal procedure at Rye Hill although, in life-threatening situations, officers are instructed to open the cell immediately. The nurse, Night Manager and officers entered the man's cell where they found him sitting on his bed. He complained of pains down the left side of his body and seemed to be short of breath. The nurse was aware of the man's medical condition and checked his blood pressure, pulse and heart rate. She then asked him when he had last used the GTN spray that he had been given to assist him with his heart problem. The man said that he had used it only about ten minutes earlier. However, when the nurse asked him to use it again, the man had to search for it. He eventually found it in a cardboard box under several other items.

13. The man used the spray as instructed by the nurse, who then re-checked blood pressure, pulse and heart rate. On both occasions, these were within normal limits. However, the nurse was concerned about the man’s condition, suspecting that he might have suffered an angina attack. She informed the man and the other staff that she would contact the Duty Medical Officer for advice. Everyone then left the cell. The nurse spoke to the Duty Medical Officer who instructed thattThe man should be taken to the outside hospital for assessment and treatment.

14. The Night Manager made arrangements for an ambulance to be called and for escorting officers to be made available. The Duty Director was then informed of the situation. Having done so, the Night Manager returned to he man's cell with the

nurse and officers to inform him and get him ready. On opening the cell again, they found the man sitting on his bed smoking a cigarette. The officers thought that he seemed a bit better, but the nurse felt that his clinical condition had not changed sufficiently that he should not attend the local hospital.

15. The man was informed that he would be going to hospital and was asked to get dressed. One member of staff fetched a wheelchair and the man was able to walk slowly down the stairs. The man was holding a hand to his chest and appeared to be in some pain and discomfort. He was taken to the Healthcare Centre at about 3am to await the arrival of the ambulance. The ambulance arrived some five minutes later and he was put onto it, escorted by the two custody officers. The ambulance left the prison at 3.15am. During the journey, one of the paramedics tried to put some electrodes on to the man's chest, at which he became quite agitated. The officers managed to calm him down and the rest of the journey passed without incident.

16. On arrival at the hospital, the man underwent several tests and clinical examination, but his condition gradually worsening. At about 5.20am, the doctors decided that he should be admitted to the Critical Care Unit. An Electro-Cardiogram (ECG) was taken at 7.45am which indicated that his condition had worsened further. At around 8.00am, he suffered a cardiac arrest from which he did not recover. The man was pronounced dead at 8.45am.

FINDINGS AND CONCLUSIONS

17. The man had a long history of offending behaviour. He had spent a considerable length of time travelling and living in other European countries. He apparently had no contact with any family members and did not list anyone as his next of kin. Despite many efforts, no family members have been found.

18. The man had a history of heart problems, dating back several years. In 2003, whilst living in Italy, he underwent an aortic valve replacement operation. When he returned to England, he continued to receive medication and regular treatment for this heart condition.

19. During the course of his sentence he behaved well and gave no cause for concern. He generally followed the advice and treatment regime prescribed for him, although he may have been a little lax in adhering to it at times.

20. There had been no noticeable deterioration in the man's state of health just prior to him becoming seriously ill. A routine appointment had been made for him to go to outside hospital for examination, but he died before this appointment was due.

21. The man rang his cell call bell at about 1.30am on the morning of 21 November and told the officer that he had severe chest pains. These had apparently been going on for about 30 minutes, but he had been in too much pain to get to his bell earlier. The officer called for the duty nurse to attend and informed the Night Manager who also attended.

22. The nurse had to wait for someone to take her to the wing, since she is not allowed to carry keys. Although not critical in the man's case, the inevitable delay could have potentially serious consequences. The present practice whereby the nurse must wait for a designated officer to get her from the Healthcare Centre to a cell may create a delay which could prove crucial in saving life.

    Rye Hill's procedures for dealing with medical emergencies at night should be reviewed to ensure that there is no unnecessary delay in the nurse attending a prisoner in his cell.

23. When the nurse got into the cell to examine the man, she formed the opinion that he might have suffered an angina attack. She asked him about the GTN spray which he had been prescribed and he said that he had used it only ten minutes earlier. However, when she asked him to use it again he had some difficulty finding it. It seems entirely possible that he had not in fact used the spray at all.

24. The nurse was sufficiently concerned about him that she decided to speak to the duty doctor. She called him from the wing office at about 2am. The man was locked up in his cell whilst she did so. No member of staff stayed with him during this time. Although there was no clinical need for someone to monitor the man continually, it is surprising that no-one stayed with him to offer reassurance. Leaving a sick and worried prisoner alone in his cell is likely to increase the stress and concern, and may exacerbate the situation. In this case, a prisoner with a serious heart condition, complaining of chest pains, was left unattended and decided to smoke a cigarette. Clearly, this was not in the man's best interests, and the presence of an officer might have prevented him from making his condition worse.

    The director should draw my comments on this matter to the attention of his senior colleagues.

25. The doctor instructed that the man should be taken to outside hospital. The Night Manager prepared the documentation and arranged for the two wing officers to accompany the man. One of the officers went with the nurse to tell the man and they found him sitting on his bed smoking. Although the officer thought he seemed a little brighter, the nurse correctly felt that his clinical condition had not improved. The man got dressed and walked slowly down the stairs to a wheelchair that had been brought from healthcare. He was then wheeled to the Healthcare Centre to wait for the ambulance.

26. In an emergency, the Night Manager can arrange transfer to hospital without seeking prior permission from the duty director. In non-emergency situations, as with the man, prior permission must be obtained. This meant that there was a period of one and a quarter hours from the time the doctor ordered the transfer to hospital to the ambulance arriving at the prison. It seems illogical that there should be a difference when a medical instruction has been given that requires a prisoner to be transferred to secondary care services. Furthermore, the joint guidance from the Prison Service and Department of Health, issued in March 2004, highlights the need to ensure that a protocol exists to ensure immediate access to hospital treatment.

    Rye Hill's procedure for summoning emergency medical assistance should be reviewed and an appropriate protocol drawn up to maximise patient care.

27. The ambulance left the prison about 3.15am, arriving at St Cross Hospital about fifteen minutes later. At the hospital, the man was immediately examined and underwent treatment. It appeared that his condition was deteriorating and he was admitted to the Critical Care Unit. He died just after 8.00am that morning..

Additional recommendations from the clinical review:

All Healthcare staff should be reminded of the requirements of accurate and contemporaneous record keeping in accordance with the requirements of the GMC and NMC.

A local policy should be developed and implemented for the management of prisoners who refuse to comply with prescribed treatment.