

**Investigation into the death of a man at Bassetlaw Hospital
whilst in the custody of HMP Ranby
in February 2010**

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

August 2010

The man died at 7.15pm having suffered a heart attack in Bassetlaw Hospital while in the custody of HMP Ranby. He was 50 years old. I offer my sincere sympathy and condolences to those touched by the death of the man.

The investigation was carried out on my behalf by my investigator. A clinical review of the man's healthcare was undertaken by two clinical reviewers on behalf of Bassetlaw Primary Care Trust. I am grateful for their review. I would also like to thank the Governor of Ranby and her staff for their co-operation and assistance.

The man had been in custody for under a year. He had not complained to staff of any serious medical issues and none were identified during his initial healthscreen assessments. On 22 February 2010, the man became involved in an altercation in the welding workshop. Staff intervened and separated the prisoners. However, the man collapsed shortly afterwards. The post-mortem report confirmed that his collapse was not directly related to the fight. He was taken to hospital but died later that day.

There do not appear to have been any signs that the man was in danger of collapsing and I find no fault in the response of Ranby healthcare staff. This was an unexpected event that I do not believe could reasonably have been prevented. I make one recommendation in this report regarding the collection of next of kin details.

The version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Jane Webb
Acting Prisons and Probation Ombudsman

August 2010

CONTENTS

Summary

The investigation process

HMP Ranby

Key findings

Issues

Recommendations

SUMMARY

The man was remanded into HMP Hull on 29 May 2009. The initial healthscreen did not reveal anything of concern. The man was transferred to HMP Leeds and then to HMP Ranby in December 2009. No significant medical history was identified at his first reception health screen. He told staff he was a smoker and did not raise any concerns about his physical or mental health. He was located on an ordinary wing and allocated work in the welding workshop. He did not report any significant concerns about his health in the following eight months.

On 22 February 2010, the man was involved in a brief fight with another prisoner in the welding workshop. After officers ended the fight, the man became unwell and was taken to the healthcare centre. Staff telephoned for an ambulance as they were concerned about his health. He was taken to Bassetlaw Hospital. Hospital staff undertook a series of tests on him. They declared the man fit to leave the hospital but, as he was preparing to go, he collapsed suffering from a heart attack. Despite attempts to resuscitate him, he died at 7.15pm. Prison staff visited the man's mother the next morning to inform her of his death. The report contains one recommendation regarding obtaining accurate next of kin details.

THE INVESTIGATION PROCESS

1. One of the office's investigators opened the investigation on 26 February on behalf of the investigator appointed to consider the circumstances of the man's death. She met senior prison managers and took copies of the documentation relating to the man. Notices of the investigation were issued to staff and prisoners, inviting those who wished to provide information regarding the man's death to make themselves known to the investigator. No-one came forward in response to the notices.
2. The investigator wrote to the Chief Executive of Bassetlaw Primary Care Trust (PCT) to commission a clinical review. Bassetlaw PCT asked two clinical reviewers to carry out a review of the care received by the man whilst at HMP Ranby. The two clinical reviewers received a copy of the relevant medical documents upon which they based their findings. The clinical review can be found at the first annex to this investigation report. I am grateful for their timely review.
3. One of my family liaison officers contacted the man's family at the beginning of the investigation. She explained the investigation and offered them the opportunity to raise any questions or concerns they would like addressed during the investigation. My investigator and another family liaison officer, visited the man's family on 24 June. They discussed the investigation process and answered the initial questions that the man's family had concerning his death.
4. The Ombudsman's investigation was initially suspended because Nottinghamshire Police were investigating the death. Having concluded their enquiries, the police confirmed that there was no criminal matter to pursue with regard to the man's death. The Ombudsman's office was able to continue the investigation. My investigator met Nottinghamshire police officers to discuss the case and was provided with the evidence collected as part of their investigation.

HMP RANBY

5. HMP Ranby is a category C male adult training prison in North Nottinghamshire. It contains prisoners who cannot be trusted in open conditions but who are unlikely to try to escape. There are 11 residential wings, of which four are on the 'open' side of the prison. It has an operational capacity of 1,098. The prison does not have a hospital wing and does not provide 24 hour healthcare.

Independent Monitoring Board

6. Each prison has its own Independent Monitoring Board (IMB) made up of volunteers from the community. The Board's role is to ensure that the prison is properly run and that prisoners are treated fairly. Each Board produces an annual report for the Secretary of State. The most recent report from the Ranby IMB covers the period from 1 April 2008 – 31 March 2009. The board commented positively on the progress in the education and skills facilities at the prison, and noted how many prisoners are able to gain qualifications to help their prospects once released.

Her Majesty's Chief Inspector of Prisons

7. Her Majesty's Chief Inspector of Prisons undertook an announced inspection of Ranby from 12 – 16 March 2007. Her report said that healthcare facilities offered a reasonable service. It also described the educational and vocational training facilities as "good quality".

Other deaths at Ranby

8. In the last five years, Ranby has only experienced one other death due to natural causes. The death, which occurred in October 2009, was also due to a cardiac arrest.

KEY FINDINGS

9. The man was born in September 1959 in North Yorkshire. He had convictions for violent behaviour and had previously been released from custody in 2001.
10. He was remanded into HMP Hull on 20 May 2009, following a court appearance at York Crown Court, for failing to surrender to bail for an alleged offence of grievous bodily harm in 2004. A first reception health screen document was completed by a nurse. He told the nurse that he was not worried about his physical health other than an abscess on his tonsils which had been removed six years previously. It had left a permanent tickle in his throat and some sinus discharge. He was concerned that the abscess may have returned. It was also noted that he smoked, had used cocaine approximately a year before and was a social user of alcohol. The man's blood pressure was recorded at 110/70, (an average reading is 130/80 but 110/70 is considered an ideal reading), and his pulse rate measured 76 beats per minutes, (an average is between 60 -100). He was not taking any prescribed medication.
11. As part of the reception process, an officer conducted a cell sharing risk assessment. This seeks to establish the level of risk a prisoner presents to a cellmate. It contains a number of questions that are put to the prisoner. No issues were noted and the man was assessed as being of low risk of attacking a cellmate.
12. The following day the man was examined by the doctor. The doctor wrote that the man had fallen from a ladder 18 months previously causing on-going pain and restricted movement to his right knee and arm. The man also told the doctor about his throat problems and his concerns that a second abscess might be forming. On examination, his blood pressure reading was 118/84. The doctor referred the man for remedial exercise in the prison gym to help his knee and arm pain.
13. On 11 June, the man was seen on the wing with swelling to the right side of his face and pain in his mouth. A nurse prescribed pain relief and he was seen by the dentist that afternoon. He was diagnosed as having a tooth infection and was prescribed antibiotics. The man was given Ibuprofen for pain relief to ease shoulder pain when he seen by a second doctor on 27 July.
14. The man was transferred to HMP Leeds in October and subsequently sentenced to four years in prison by Leeds Crown Court. He moved to HMP Ranby on 30 December. Upon his arrival at Ranby, The man was again assessed as low risk on the cell sharing risk assessment. At his first reception health screen no significant medical history was identified. The man told staff that he was a smoker and he did not raise any concerns about his physical or mental health. He was located on an ordinary wing and allocated work in the welding workshop.

15. The man had no further significant contact with healthcare whilst he was at Ranby. He attended a training course in welding, sheet metal work and general engineering. This course led to a NVQ qualification. The morning shift was from 8am to 11.30am and the afternoon shift lasted from 2.00pm to 4.30pm.
16. The man did not go to work on the morning of 22 February 2010 as he said that he felt unwell. He attended work in the afternoon although he later said that he had still felt unwell. The man did not bring this to the attention of staff. Shortly after the start of the session, at approximately 2.15pm, he became involved in a dispute with another prisoner in workshop 13. The other prisoner claimed that he asked the man if he could use the station that the man was working at as it had a light that he needed. The man refused and the two began to push each other. They fell to the floor before they were separated by staff. The other prisoner complained that the man had head-butted him.
17. The healthcare department received a call from Workshop 13 advising that the man had knee pain and could not walk. A wheelchair was sent to collect the man with a healthcare support worker. During the move from the workshop to healthcare, his condition deteriorated. Upon arrival at healthcare, he was found to be in a collapsed state, and cold and clammy. A second nurse examined him and noted that his blood pressure was low at 90/60, with an exceedingly weak pulse. He had a Glasgow Coma Score (GCS) of five. (The GCS is a reliable, objective way of recording the conscious state of a person. A score of five would indicate that the patient was responsive to pain when touched.) The nurse administered oxygen therapy and carried out an electrocardiograph (ECG) which indicated the man's had an abnormal heart rate. (An ECG measures the heart rate and rhythm.) The man then became more responsive and complained of tightness in his chest, pain and tingling in his arms with further pain going to his neck. At this point it was decided to transfer him to hospital so an ambulance was requested. A paramedic arrived within 10 minutes and placed an intravenous cannula (tube) in the man arm to provide him with fluids.
18. The man was taken to Bassetlaw Hospital at approximately 3.30pm. This was later than intended as the first ambulance broke down. The ambulance notes recorded that his blood pressure remained low. Two officers escorted the man using a single-cuff chain. (This is a restraint made from 1.8 metres of chain with one cuff attached to the prisoner and the other cuff to an officer.) the man was examined by doctors when he arrived at the hospital at approximately 4.05pm. He had a blood test, followed by an X-ray at approximately 4.15pm. At 4.30pm, officers accompanied the man to the x-ray department and then returned to the accident and emergency department. At 4.50pm the two officers were relieved of their duties and two other officers took over responsibility for the escort.
19. The result of the blood test was normal and the hospital subsequently permitted the man to return to the prison. At approximately 6.50pm as he

began to fasten his shoes, the man collapsed onto the hospital floor. Hospital staff immediately responded and the third officer removed the restraint. Despite the efforts by hospital staff, the man died at 7.15pm.

20. A senior prison officer was appointed as family liaison officer that evening. The man had not nominated a next of kin, and the prison confirmed that he had not received any visits from a family member since arriving at Ranby. His telephone account indicated that he had spoken to his mother the previous day. The police liaison officer was able to find an address for the man's mother.
21. The prison family liaison officer noted that if staff left the prison immediately to break the news of the man's death to his family, it might be as late as midnight before they arrived at their destination. (This was due to the distance and location of the man's mother's home.) Therefore, it was decided to travel early the next morning. The prison family liaison officer and the prison governor broke the news to the man's mum and, due to her distress, telephoned her daughter to come and be with her. The family liaison officer explained what would happen next, and offered to contribute to the costs of the funeral.
22. A notice was issued to prisoners informing them of the death of the man. I understand that the care team was available to any staff who required their support, and the Governor and Duty Governor met with the escort officers on their return from the hospital.
23. The man's property was returned to his family on 5 March. Prison staff attended the funeral, provided a wreath and conducted a memorial service for the man inside the prison. The man's family told the investigator that they were very grateful for all the support they received from the prison following his death.

ISSUES

Clinical care

24. The man had very little contact with healthcare services while in prison. No significant medical history or concerns were raised during his initial healthscreen interviews in the prisons he entered. Although the man's collapse followed an altercation in the workshop, the post-mortem report said that he died as a consequence of a thrombotic occlusion of his left coronary artery. This resulted in him having a heart attack. The pathologist said that the collapse of the man appeared to be a coincidental event rather than an event directly linked to the fight in the workshop. The pathologist was of the opinion that a thrombus cannot form and be associated with an argument or fight, so the two events were not directly linked.
25. The clinical review described the clinical care received by the man as equitable to what he would have received had he been in the community. The care received by the man prior to his collapse was described as satisfactory. The clinical review went on to say the care provided on the day of the man's death was equitable to what he would have received in the community. The assessment and actions were described as comprehensive and commendable.
26. I understand that the clinical reviewer asks some further questions regarding the treatment the man received at Bassetlaw Hospital. However, his time at hospital is outside the Ombudsman's Terms of Reference. However, I understand that a serious untoward incident investigation is to be undertaken by the PCT to consider this aspect further.

Next of kin details

27. Next of kin details are recorded when a prisoner arrives at a prison, and I consider it important that staff attempt to gather full information. The lack of an address for the man's family was one of the factors in the decision to break the news the following morning.

The Governor should remind reception staff to record the full address and telephone number of the next of kin for all new receptions into prison. If it is not possible to attain accurate details on reception, efforts should be made to obtain them as soon as possible.

Liaison with the man's family

28. PSO 2710 (Follow-up to a death in custody) says that the news should be broken as soon as possible. The prison took the decision to travel up early the following morning to avoid reaching the man's mother's house late at night. Although it is nearly always best to break the news as quickly as possible, I understand why the prison took the decision they did. The man's family were very grateful that the prison did so as they confirmed that their

mother would have been distressed had prison staff arrived at her home late at night.

RECOMMENDATIONS

1. The Governor should remind reception staff to record the full address and telephone number of the next of kin for all new receptions into prison. If it is not possible to attain accurate details on reception, efforts should be made to obtain them as soon as possible.

The National Offender Management Service accepted this recommendation:

“Reception managers and staff instructed to ensure that all F2050 page 2 details are routinely and comprehensively completed.
Head of Residence to conduct ad hoc spot checks to ensure compliance.
LSS amended to include this recommendation.”