Investigation into the Death in Custody of a man in custody at HMP Rye Hill on 29 October 2005

Report by the Prisons and Probation Ombudsman for England and Wales

July 2006

This is the report of an investigation into the circumstances of the death of a man who was 59 and a prisoner at HMP Rye Hill. He died in hospital on 29 October 2005.

In the autumn of 2005, the man who died had been diagnosed with Squamous Cell Carcenoma. This is a particularly aggressive form of cancer. The prognosis was that the man could not be treated effectively with radiotherapy and he had months to live. Following this diagnosis, his health deteriorated very quickly.

I extend my condolences to the family of the man who died and to all those touched by his death.

This investigation was led by two of my Fatal Incident Investigators. My investigators and I would like to thank the Director and his staff at Rye Hill for their assistance and co-operation. A doctor from Daventry and South Northamptonshire Primary Care Trust carried out a clinical review of the care the man received during his time in custody, for which I am also grateful.

I conclude that the clinical care the man received was appropriate and commend the actions of the healthcare manager. However, my investigation has also revealed a number of flaws in Rye Hill's procedures which the Director will wish to address.

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

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Summary

The man who died was sentenced to eight years for supplying Class A drugs on 1 November 2004. He was imprisoned at HMP Rye Hill and, up until he complained of a persistent cough in July 2005, was in reasonably good health.

In early August 2005, the man was seen by the prison doctor and was found to have a swelling on the right side of his neck. It was also noted that his chest infection had not cleared and he was suffering drastic weight loss. The man was referred to an outside hospital for a chest x-ray. However, the clinical review says that he had to wait an unreasonable and unexplained length of time before an appointment was established, although it notes that the length of time would not have affected the final outcome. A biopsy was taken of the lymph node in mid September. Results of this biopsy confirmed extensive secondary cancers. He was given months to live. This caused him considerable distress and he seemed to deteriorate rapidly.

During early October, the man was finding it difficult to swallow and was having difficulty breathing. He was provided with a wheelchair and was given numerous opportunities to move to the healthcare unit for constant care and observation. However, he chose to stay on the wing with his friends. It was only on the night before his death that he decided to spend the night in the healthcare unit where oxygen was provided.

On the morning of 29 October, the man's condition deteriorated significantly. He was taken by ambulance to a local Hospital. After examination, a doctor explained the man's situation to him and a decision was taken not to escalate his treatment further and not to resuscitate in case of cardiac arrest, due to his extensive and incurable cancer. The man agreed and understood this decision. In the meantime, his family were contacted and were at his bedside when he passed away. They are distraught by his death and have raised questions over the level of care he received whilst at Rye Hill.

The clinical review concludes that the man received a reasonable and appropriate level of care whilst in prison.

During the investigation, it was said that arrangements had been discussed regarding an early release for the man on compassionate grounds. However, we are unable to verify this as there is no documentation to support it. Rye Hill's doctor had raised the question of transferring him during September. However, this does not appear to have been explored any further.

Investigation Process

Notices were sent to HMP Rye Hill on 31 October 2005 to inform staff and prisoners of the investigation. My investigators visited Rye Hill on 24 November. The Director and his staff produced the man's prison and medical records for examination. My investigators spoke with healthcare staff and with two prisoners who knew the man.

A Family Liaison Officer from my office contacted the man's eldest son and offered a meeting to discuss the purpose of the investigation and any issues the family would like explored. The meeting took place on 18 November 2005. The family raised concerns over:

- the care and treatment the man received during his time at HMP Rye Hill, particularly over the timeliness of his diagnosis and level of appropriate care; and
- the presence of escort staff and use of restraints during his last hours. The family felt that this was excessive and insensitive.

During the course of the meeting, it was agreed my office would address these concerns within the report.

The man's eldest son subsequently raised further concerns over the return of his father's possessions. As late as 15 February 2006, Rye Hill still had possession of the man's property. My investigators followed this up by letter to the Director of Rye Hill asking that he take the appropriate action to release the property.

My investigators contacted Her Majesty's Coroner to inform him of the nature and the scope of my investigation. An inquest was held on 8 December. The man's death was recorded as occurring from natural causes.

A doctor from Daventry and South Northamptonshire Primary Care Trust conducted a clinical review into the medical care and treatment of the man whilst in the custody of Rye Hill.

My investigators also contacted the police. The police investigation has not highlighted any third party involvement or any criminal negligence issues.

The man who died

The man was born in London in 1945. He was 59 years of age when he died. He had a close-knit family of four children and an ex-wife, with whom he remained in constant contact until his death. At the time of his arrest, he had been living with his partner.

The man had a history of convictions for a variety of offences dating back to 1963. His most recent offence was for the supply of class A drugs in September 2004. He was held in remand at HMP Woodhill until 1 November 2004, when at Crown Court he was sentenced to eight years imprisonment. The man was transferred into the custody of Rye Hill on 22 November 2004.

During his time at Rye Hill, and short stay at Woodhill, the man had enhanced prisoner status and worked as a cleaner. Although he earned these privileges, there were a number of occasions where he received warnings for supplying drugs within the prison, receiving drugs from visitors for distribution, and possession of a mobile phone. However, he was not described as a discipline problem.

On 15 June 2005, the Court of Appeal reduced the man's sentence from eight years to six years.

The man was a life long heavy smoker.

HMP Rye Hill

HMP Rye Hill is a relatively new prison run by Global Solutions Ltd (GSL). It opened in 2001 as a category B training prison for adult male prisoners serving sentences of four years or more. Rye Hill has an eight bed in-patient healthcare centre which is included in the certified normal accommodation of 600 prisoners.

Davies unit, like the other housing units, has 72 cells. It was on Davies unit that the man who died spent his sentence.

The regime at Rye Hill is relaxed and informal. Association is available throughout the day, either at work or on the accommodation units. Work is available to most prisoners.

Healthcare in Rye Hill is delivered by contract from Primecare FMS. A local general practitioner provides a surgery daily during the week. Out of hours medical cover, including the weekends, is provided by the local practice. Nursing care is provided on a 24 hour basis.

In 2003, Her Majesty's Chief Inspector of Prisons carried out an inspection of Rye Hill which highlighted some concerns regarding the recruitment of "staff with far less experience of prison that the long-term prisoners in their care". It was felt this compromised the safety and security on the wings. The prison undertook to establish more effective management and support systems. An unannounced inspection of Rye Hill in April 2005 found that the Inspectorate's concerns had not been addressed. Concerns for safety still remained and race relations need considerable development. However, there had been improvements in activity and resettlement.

Since September 2004, there have been 12 deaths at Rye Hill, including that of this man. Of these, nine were classified as natural cause deaths. Each death has been investigated by my office. There are no recommendations arising from these investigations that are pertinent to this report.

Events leading up to the man's death

Along with other prisoners from Rye Hill, the man who died was transferred to Woodhill on 29 April 2005 as the result of a murder enquiry at the prison. During his first health screen on reception at Woodhill he stated that he was fit and well. On returning to Rye Hill on 23 June, it was noted that he had no health concerns.

On 25 July, the man complained of a persistent cough. He was examined by the prison doctor who diagnosed him with a chest infection and prescribed oral antibiotics with a view to re-examining him on 8 August. The doctor noted that the man was suffering considerable weight loss.

The doctor saw the man again on 8 August. During the consultation, the doctor noted a swelling in the right side of the man's neck. His chest infection had not cleared so the doctor wanted him to have an x-ray at an outside hospital. In the meantime, further antibiotics were prescribed.

The man received his chest x-ray on 8 September at hospital. Results of this x-ray were available on 13 September. The results showed that he had cancer and it was spreading. They also showed the possibility of tuberculosis. The man was re-examined by the doctor and it was noted that he had developed a definite lymph gland in the right-hand side of his neck. The man said this had appeared over the last ten days. The doctor contacted the oncology department at a local Hospital. He stated that the man was experiencing significant weight loss and shortness of breath. The doctor followed up on his contact with the oncology department by letter on 21 September to confirm that an assessment of a biopsy of the man's lymph gland would take place.

During this period, the healthcare manager was in contact by letter and telephone with the man's eldest son to keep him informed of his father's condition and treatment. In addition to offering support to his son, the healthcare manager, a trained counsellor, offered support and reassurance to the man throughout this difficult time. They had a good rapport and she was able to have frank conversations with the man, which he appreciated. She made it clear that he had the opportunity to be relocated to the healthcare unit to receive constant care and observation should he wish to.

An ultrasound was performed on the man's abdomen on 22 September. On the same day, his youngest son requested a visit with his father through his solicitors. At this time the man's son was on remand in custody. A letter was sent via the solicitors to the Director at Rye Hill requesting information about the man's medical condition to support his son's application for bail. Bail was not granted. My investigators spoke with the Director at Rye Hill to find out whether the prison had been formally contacted about arranging an inter-prison visit. Rye Hill has no documentary record to confirm whether an application for visiting was received or processed. However, there are records of frequent inter-prison telephone calls between the man and his son.

On 27 September, the doctor wrote to the consultant oncologist at the hospital asking for further help to manage the man's deteriorating health. In his letter, the

doctor referred to the likelihood of the man moving to a prison nearer London. From reading the man's prison and medical records, the possibility of a transfer does not appear to have been explored any further.

On 29 September, a biopsy was performed on of the lymph gland which had developed on the right-hand side of the man's neck. During this time the man was finding it difficult to swallow food. Every effort was made by the prison to ensure that he received soft or pureed food to aid ingestion. He was provided with nutritional supplement drinks called Ensure.

On 14 October, test results of the biopsy confirmed that the lymph node was cancerous. The man was reviewed at hospital. His medical record indicates that his health was deteriorating and that at this stage only supportive care could be offered. The man was described as very low in mood due to his illness and records indicate that he seemed to be giving up the fight.

At this stage, the man's eldest son had asked the prison whether it was possible to move his father to a prison closer to home. The wing manager told the family that the prison would try to arrange this but that it would take some time to put into place. During the investigation, whilst staff have referred to plans for a transfer or early release, no documentation has been made available for examination despite several attempts to obtain this. Unfortunately the wing manager has been unavailable for comment during the course of this investigation.

The man attended hospital on 24 October. The location of the primary source of cancer was still was not clear. However, it was suspected that the man had entered a terminal phase. He was unable to walk without assistance and was experiencing difficulty in breathing. He was provided with a wheelchair and fellow prisoners helped him with it. Healthcare provided him with a nebuliser for use in his cell. The man was also given the opportunity to be located within healthcare, both during the day and night, for closer observation and access to oxygen. He chose to stay on the wing to be with fellow prisoners. Staff and prisoners described the man as being 'Old School'. He felt that moving to healthcare was a last resort. Indeed, he felt the care and attention he received on his wing was preferable as he was amongst friends.

On 28 October, a prisoner contacted the man's eldest son by telephone. He advised him that his father's health was deteriorating rapidly and suggested that the family should travel to Rye Hill as quickly as possible. The man chose to sleep in healthcare rather than in his cell that night. At 8:30pm, he was given oxygen to aid his breathing. His oxygen levels were between 82-93%. The prison doctor was contacted for further advice. He prescribed diazepam if required to help him sleep. At 00:30am, the man was given 10mg of diazepam as he was restless and having difficulty sleeping. During the course of the night, he was continually checked on by healthcare staff who reported that he was settled and sleeping.

The man's condition worsened during the early hours of Saturday 29 October. At 7:40am, he was experiencing difficulty breathing. The doctor was informed and he advised that an ambulance be called to take him to hospital. Although an ambulance was immediately called for, at 8:05am the healthcare staff had to contact the

communications room to find out when it was likely to arrive. The communications room said they had not been told the ambulance was needed urgently, so they had not requested a 'blue light' response. Ambulance control was immediately contacted and the status of the responding vehicle was appropriately elevated.

The ambulance arrived at 8:20am and the man was taken to hospital at 8:45am. Two prison custody officers (PCOs) escorted him to the hospital on bedwatch duty. At this stage, the man was handcuffed in compliance with the local security and operating procedures. He arrived at hospital at approximately 9:15am. The healthcare manager contacted his eldest son to tell him that the man had been taken to hospital.

The man was examined by the Medical Registrar. He found that he was tachypnoeic, tachycardic and hypothermic. He was also in severe type 2 respiratory failure. Treatment commenced with a nebuliser, intravenous fluids and steroids and controlled oxygen therapy. The man was not in pain. The Registrar spoke with the man about his condition and explained that a decision had been made not to escalate the treatment further and not to resuscitate in case of cardiac arrest, due to his extensive and incurable cancer. The man agreed and understood this decision.

The bedwatch log indicates that at 10:20am, one of the PCOs contacted the prison enquiring about compassionate release. The log indicates that at 2:02pm the man's condition further deteriorated. The Duty Director decided that the restraints were no longer appropriate and at 3.20pm, the wing manager PCOs at the hospital to remove the restraints. The man's son and daughter were at his bedside.

During the course of the afternoon, it was apparent that the man had deteriorated to such a level that he was no longer aware of his surroundings. His son and daughter were very distressed. They were informed that his condition was unlikely to improve. The decision was made not to resuscitate.

At 4:33pm, the man stopped breathing. He was pronounced dead at 4:49pm. One of the PCOs contacted the prison control room at 5:04pm to notify them of the man's death. The prison's death in custody contingency plan was put in motion.

Events following the man's death

A letter was sent from the prison to the man's family offering condolences and assistance with the cost of the funeral.

My investigators were told by prisoners close to the man that they were notified of his death in a sensitive and compassionate manner. Officers told them privately, before issuing an official notification to the prison as a whole.

The funeral took place on Friday 11 November. No representatives from the prison attended at the request of the family. Instead a memorial service was held at the prison. Staff and prisoners sent wreaths and cards to the family offering their deepest sympathy.

On 18 November, my family liaison officer and two investigators met with the man's eldest son. The family have raised concerns in respect of the timely diagnosis of his illness and have sought assurances that he received an appropriate level of care and treatment whilst in prison. The family have also raised concerns regarding the presence of escort staff and use of restraints during his last hours. They questioned the appropriateness of this level of security.

There was a delay of approximately five months before the man's property, which included items of sentimental value, was returned to his family. This caused undue stress and required prompting by the man's eldest son and a letter from my office before the prison complied with his request. The son arranged with the Head of Operations, to collect the property from Rye Hill. He stated that on arrival he had to wait several hours before he was met at the prison gate by a member of staff. He feels that he was treated disrespectfully. The Head of Operations has provided a written response. He states that a date and time was arranged and he contacted Admissions, asking that all relevant items were made ready for collection. He is unaware of any problems with the collection of the items other than the comment made by the son to my investigator.

Clinical Review

The clinical review indicates that the man's care and treatment was satisfactory. The man had a particularly aggressive form of cancer that had spread rapidly by the time he came to the attention of clinicians. The clinical review determines that his condition was such that only palliative support treatment could be given. This would not have necessarily prolonged his life. The review concludes that the man deteriorated quicker than anyone could have expected. Nothing else could have been done to improve his care.

The clinical review highlights an issue with respect to the length of time taken before the man received his chest x-ray. Healthcare staff at Rye Hill stated that it is not unusual for patients to have to wait for two to three weeks for an escort to leave prison and attend an outside hospital. Escorts are often booked up well in advance. Unfortunately, the escort booking list is not always available to healthcare staff. Therefore the length of waiting list is not necessarily known.

The Director should review the system for booking escorts to outside hospital appointments. Healthcare staff should have access to the bookings sheet so they are able to assess the waiting list. There should be a mechanism for identifying urgent appointments and making sure they are prioritised.

However, it should be noted that this issue was not pertinent to this man's situation. At the time he presented himself to medical staff with a cough in early August, the doctor recorded a suspicion of a swelling on the man's neck. The presence of this swelling indicates that secondary cancer had already spread significantly and would have been inoperable. Both the chest x-ray and ultrasound of his liver confirm this.

Findings and Conclusions

Once it had been established that the man was terminally ill, the prison were approached by his family requesting that he be moved to an establishment closer to London. There is no available documentation to suggest that this possibility was explored.

The prison states that they had begun to compile a case for compassionate release during the last week of the man's life. A compassionate release is a lengthy process that requires compiling prison, probation and medical records to support an application, which is then submitted to the Home Secretary for approval. At the time when the prison began making enquiries regarding this form of release, it was believed that there would be time to process the application. During the course of this investigation, the prison was unable to provide any documentation to support the claim that arrangements were in hand. The Head of operations, who is said to have initiated the process, has been unavailable for comment during the course of this investigation and no other member of staff has been able to clarify this issue. The lack of documentation leads me to conclude that no formal steps were taken to obtain compassionate release.

The Director should ensure that staff keep comprehensive paper trails of all steps undertaken to make applications for compassionate release, as they are required to do.

My investigators enquired about any applications made for release on temporary licence (ROTL). The Records Unit at Rye Hill confirmed that no applications had been received for ROTL.

No-one could have predicted that the man would have deteriorated as quickly as he did. On talking to my investigators, staff commented that given the uncertainty of the severity of his situation it was difficult to hold a ROTL board in advance, because they did not know when he would be admitted to hospital.

Although I do not believe the miscommunication in defining the level of emergency on requesting an ambulance for the man would have altered the outcome, I do find it of concern. Staff should make it clear what the situation is when requesting the communications room call emergency services. Likewise, the communications room should seek to clarify with the person who has made the request if they are unsure of the situation.

The Director should remind staff of the importance of communicating clearly the severity and urgency of a situation on requesting that emergency services be called.

During those last few weeks, the man received an appropriate and reasonable level of care and attention from the prison. The man was also supported by his friends on the wing.

The healthcare manager maintained sensitive and appropriate contact with the man's family during the final months of his life and immediately after his death.

The Director should commend the healthcare manager for the sensitive care and support she gave the man after he was diagnosed with cancer. She also maintained frequent contact with his next of kin during the month prior to his death, providing support and reassurance explaining his father's condition.

Since the man's death there remain unresolved issues over arranging a visit to the prison and the return of his property, which include items of sentimental value. I am disappointed that there has been an unreasonable delay in returning the man's property to his family, which has caused undue anxiety and upset.

The Director should ask staff to ensure that the property of a person who has died in custody is returned to the next of kin within a reasonable time frame so not to cause undue distress.

Recommendations

1. **The Director should review the system for booking escorts to outside hospital appointments. Healthcare staff should have access to the bookings sheet so they are able to assess the waiting list. There should be a mechanism for identifying urgent appointments and making sure they are prioritised.**

2. **The Director should ensure that staff keep comprehensive paper trails of all steps undertaken to make applications for compassionate release, as they are required to do.**

3. **The Director should remind staff of the importance of communicating clearly the severity and urgency of a situation on requesting that emergency services be called.**

4. **The Director should commend the healthcare manager for the sensitive care and support she gave the man after he was diagnosed with cancer. She also maintained frequent contact with his next of kin during the month prior to his death, providing support and reassurance explaining his father's condition.**

5. **The Director should ask staff to ensure that the property of a person who has died in custody is returned to the next of kin within a reasonable time frame so not to cause undue distress.**

Response to the report

The Prison Service has accepted the recommendations put forward in this report.

Actions to be taken for each recommendation are:

1. A new policy has been put in place for booking escorts to outside hospital appointments. A “medal of clinical importance” (gold, silver and bronze) has also been established to identify and prioritise urgent appointments.

2. The Head of Offender Management has introduced an administrative procedure to better record all steps taken during applications made for compassionate release.

3. The Head of Operations has issued a notice to relevant staff reminding them of the importance in clearly communicating the severity and urgency of a situation on summoning emergency services.

4. The Director has written to the Healthcare Manager in appropriate terms for her sensitive care and support given to the man after his diagnosis.

5. The Director has issued a notice to managers asking them to ensure that all property belonging to a prisoner who has died in custody is returned to the next of kin within a reasonable time frame.