PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man at HMP Rye Hill in April 2011

Report by the Prisons and Probation Ombudsman for England and Wales

November 2012

This is the report of an investigation following the death of a man in April 2011 at HMP Rye Hill. He was 31 years old[1]. Two post-mortem investigations were held, the second at the request of his family. The first gave the cause of death as a pulmonary thromboemboli (blood clot causing blockage in lung). The second concluded that the cause of death was multiple pulmonary emboli and thrombosis of venous malformation of the right thigh. Despite the differing clinical views of the exact cause of death, both show that it was from natural causes. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. A clinical reviewer from the Primary Care Trust (PCT) carried out a clinical review. It is a concern that Rye Hill was not able to supply all the expected documentation for the investigation. I apologise for the delay issuing this report.

The man had routine health assessments when he arrived at Rye Hill in March 2011, which did not indicate any ongoing medical problems. On 14 April, he complained of chest pains, but a medical assessment found nothing of concern. On 20 April, he missed a healthcare appointment because he was segregated pending a disciplinary hearing. A few days later, at approximately 9.10am, he collapsed on the wing. He was initially conscious and staff did not immediately realise his condition was life threatening. However, his condition deteriorated quickly and he was pronounced dead at 10.04am.

This case raises a number of concerns. First, it was inappropriate that the man should have been refused access to a healthcare appointment because he had been segregated, possibly unlawfully, and that, while segregated, he was denied a meal for misbehaviour. Second, the emergency response to his collapse was poorly managed, recording of key events was weak and some medical staff appeared to lack up to date training. Finally, it is disappointing that not all relevant evidence was made available to my investigator.

Despite these failings, the investigation does not conclude that the man's death could reasonably have been foreseen or prevented. He did not present with any symptoms which suggested he was at imminent risk of collapse and there was no indication that he was unwell in the days before his death. Nevertheless, the report makes a number of recommendations and it is important that Rye Hill ensures that lessons are learned for the future.

This 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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **November 2012**

[1] Some doubt was subsequently raised about the man's identity. See paragraph 14.

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SUMMARY

1. The man received an eight year sentence on 12 June 2009 for a serious sexual offence. He transferred to HMP Rye Hill on 17 March 2011 from HMP Pentonville. Upon his arrival, he underwent two routine healthcare screenings. No ongoing medical conditions were identified. On his second day, he asked to be moved to the vulnerable prisoners' wing.

2. On 14 April 2011, the man complained of chest pains and wing staff asked the Clinical Manager, who was already on the unit, to see him. He told the nurse he had shoulder pain and was advised to have a hot bath and to keep his shoulder moving. No medication was given and no record was made in his medical records by the nurse. Wing staff had also logged the complaint with the healthcare department that morning and he was seen by another nurse in the afternoon. He complained of shortness of breath, headaches, aches and being stressed. The nurse took a full set of observations but found nothing of concern. A follow-up appointment was not considered necessary. On 15 April he received paracetamol for shoulder pain.

3. During routine cell checks on 20 April, the man was asked to remove a poster from the back cell wall as this contravened security rules. He did not comply and became abusive to staff. He was charged with disciplinary offences and required to attend an adjudication (disciplinary hearing) the next day. Because of concern about his behaviour a prison manager incorrectly decided to segregate him in his cell under Prison Rule 53(4) until the hearing. During his segregation he missed a healthcare appointment and was denied an evening meal. The following day he spoke to a prison chaplain, who encouraged him to write his complaints down rather than protest to staff directly. (A complaint letter was found in his cell after his death detailing these concerns.) His adjudication was adjourned for 14 days so he could get legal advice. He received paracetamol for shoulder pain on 21 April.

4. On 23 April, he again spoke with the chaplain, and played pool with an officer. Prison staff described him as much more amenable. He did not raise any concerns with them about feeling unwell.

5. The next morning, at approximately 9.10am, the man collapsed, although he was initially conscious and responsive. A non-life-threatening emergency code was called by wing staff and a nurse responded almost immediately. Another nurse was later requested to bring the emergency bag. The nurses attempted to examine him and ascertain what was wrong. An ambulance was called at 9.30am, although one of the nurses believed she asked for one to be called earlier. He then stopped breathing and staff performed cardiopulmonary resuscitation (CPR) until paramedics arrived and took over. He was pronounced dead at 10.04am.

6. We make eleven recommendations covering the use of rule 53(4) and its implications, ensuring missed healthcare appointments are followed up, healthcare staff training and about emergency procedures. One relates to the need to inform families promptly of a death in custody and finally there is one

about the failure to provide the investigator with all the relevant documentation.

THE INVESTIGATION PROCESS

7. The investigator visited Rye Hill on 3 May 2011 and met with the Head of Safer Custody. She returned to the prison on three subsequent occasions. During the initial visit, she was shown the cell that the man had occupied and the place where he had collapsed. She found a number of documents in his cell – a letter of complaint, a wall diary and adjudication documents – and made copies of these. Notices were issued to staff and prisoners telling them of the investigation and offering them the opportunity to speak to the investigator. No-one came forward as a result. Feedback about the findings of the investigation was given to the Director and the Head of Safer Custody.

8. Documentation relating to the man was made available to the investigator, but his wing history sheets (which should record the main events about a prisoner during their time in prison and routine staff observations) could not be found then or subsequently. A copy of the family liaison log was not provided, despite a number of requests. CCTV footage for 20 and 21 April 2011 was requested but was unavailable, although footage of his collapse was provided. The investigator listened to recorded telephone conversations he made while at Rye Hill. The Independent Monitoring Board provided a copy of an application he had made to them.

9. The coroner's officer provided the investigator with copies of the post-mortem reports. She liaised with the investigating police officer from the local constabulary, who provided her with copies of their statements.

10. The local Primary Care Trust (PCT) commissioned a clinical reviewer to undertake an independent clinical review into the quality of the healthcare the man received at Rye Hill. He was provided with copies of relevant medical and prison documentation relating to the man. She conducted joint interviews with the investigator with three medical staff and two prison staff. A doctor from HMP Wellingborough, who assisted the clinical reviewer, was also present for some of the interviews with healthcare staff. The investigator attended a review meeting conducted by the clinical reviewer.

11. During the investigation, the investigator had access to a large number of complaint letters that the man wrote throughout his time in custody. He had sent three letters to the Ombudsman's complaints department in December 2009, February 2010 and January 2011, none of which related to his time at Rye Hill. None of these were investigated further by this office as he had not exhausted the internal complaints procedure at each prison.

12. The complaint letter found in his cell at the time of his death concerned:

- not being allowed to attend chapel
- not being allowed to attend his doctor's appointment
- not being given his evening meal

13. One of the Ombudsman's family liaison officers contacted the man's family shortly after his death. He had several telephone conversations with the

man's partner and his two brothers but, as he attempted to arrange a visit to the family with the investigator, the family stopped all contact. He wrote to the family on two further occasions but received no response.

14. At a late stage in the investigation some doubt was raised about the man's true identity. A suggestion was made that it was not the named individual who died, but one of his brothers. At the time of issue of this report this was being investigated by the police and immigration authorities.

15. We are sorry that this report has been delayed as a result of a back log of cases in the office that we are striving to clear.

16. The family received a copy of the draft report as part of the consultation period. Having considered the investigation findings, his family indicated to my family liaison officer that due to continuing issues with legal aid assistance they did not feel able to disclose their comments ahead of the report being finalised without the input of a legal representative. They therefore decided not to comment at this time choosing instead to pursue matters at the inquest hearing.

17. A copy of the draft report was sent to G4S and the responses to the recommendations are repeated verbatim in the recommendations section.

HMP RYE HILL

18. HMP Rye Hill is a Category B prison near Rugby that holds up to 664 prisoners, all of whom must have received a sentence of at least four years, with a minimum of 18 months left to serve. It is privately run by G4S Justice Services. Two private companies provide the primary health services.

HM Inspectorate of Prisons (HMIP)

19. HMIP carried out an announced inspection of Rye Hill in July 2011. The Chief Inspector commented in the introduction to the report that:

> "For prisoners serving their sentence at Rye Hill, many of whom have committed serious offences, the prison gets some of the basics right. It provides a decent, safe and secure environment, and some important areas such as health care continue to improve."

20. The report notes that in relation to healthcare:

> "A senior nurse was responsible for health care, supported by an able practice manager. There was an adequate number of clinical staff. There had been changes to the continuity of senior leadership and an over-reliance on agency nursing in the recent past. A revised staffing model had been introduced and was to be reviewed in July 2011. There were more mental health nurses and an increased number of nurse-led activities. An in-house bank of staff had been created which had reduced the use of agency staff.
>
> "Resuscitation equipment was sited in the health centre and in the two wing-based medication rooms. It was subject to recorded weekly checks and included oxygen and automated external defibrillators."

Independent Monitoring Board (IMB)

21. Each prison in England and Wales has an IMB responsible for monitoring day-to-day life in the prison to help ensure that proper standards of care and decency are maintained. The most recent annual report 2010-2011 published by the IMB for Rye Hill includes the following comment:

> "The Board believes that the progress reported in the previous year has been maintained and that the prison has been stable and safe where offenders are treated with respect. There are signs that routine good practice is better monitored and better embedded by Rye Hill management. This has tended to improve stability and clarity of expectations on staff."

Previous deaths in custody

22. The Ombudsman has investigated 17 deaths at Rye Hill since being given responsibility for all such investigations in 2004. Thirteen of those deaths were from natural causes. There are no direct similarities between these deaths and that of the man's.

KEY EVENTS

23. On 12 June 2009, the man received an eight year sentence for a serious offence. He spent time in a number of prisons before being transferred to HMP Rye Hill on 17 March 2011.

24. A Healthcare Assistant (HCA) completed the man's reception healthscreen (FRHS). He told her that he was generally fit and well, although he wanted to see a counsellor to discuss post traumatic stress disorder which he said he suffered from. He also said he had been in hospital for mental health issues, but could not remember when or where. He said he was not currently prescribed any medication. The HCA told the investigator she referred him for counselling, but there is no record of this in his file.

25. The man was assessed as high risk on the cell sharing risk assessment (CSRA) document. The HCA observed his behaviour in reception and recorded that he had a:

> "Long history of bad behaviour in prison, bad attitude upon entering the prison to reception staff, states does not cell share and has harmed others. Due to size and attitude could be a risk to others".

26. The man was initially placed on the induction wing, the Farley unit. However, the next day he asked for vulnerable prisoner (VP) status and moved to the vulnerable prisoners' wing (a wing that accommodates prisoners separately from the rest of the prison population, either due to the nature of their offence, bullying from other individuals or at their own request). During his first days there, he met his personal officer (a named officer who should introduce themselves to the prisoner, speak regularly with the prisoner and make entries in their wing history sheets). The personal officer told our investigator that when he introduced himself he told her "I don't like to talk, I like to fight". She said she thought they would have had a lot more issues with him than they did, because of his comment.

27. On 22 March, a nurse completed a secondary health screen with the man. She told our investigator he laughed and joked and was a "very bubbly person", although when he spoke about his family he became emotional. She took his blood pressure, which she said indicated he was fit and healthy.

28. The nurse said he asked her a few days later to clarify if he was up-to-date with his hepatitis B immunisation. She confirmed he was and said he, seemed fine. She said he never indicated to her that he had any problems.

29. On the morning of 14 April, the man's personal officer said he complained twice of chest pains. The Clinical Manager was already on the wing and was asked to see him. The officer said she also referred him to the healthcare department. In interview, the Clinical Manager said he went to his cell as chest pain had been mentioned, but he told him he had a pain in his shoulder, not chest pain. He said he thought he had just pulled a muscle in the gym. The Manager advised him to keep it moving and to have a hot bath to try and

reduce some of the inflammation. (It is not clear how he was expected to implement this advice as Rye Hill does not have baths on the wings.) The Manager asked him if he wanted pain relief but he declined. He said he told wing staff the man had shoulder pain, but he did not document the consultation in his medical records because he just wanted some advice and did not ask for, or receive treatment.

30. A nurse examined the man that afternoon in healthcare at 3.34pm and recorded that he complained of shortness of breath, headaches, general aching and stress. She carried out a full set of observations including taking his blood pressure, temperature, pulse, his saturations (oxygen saturation measures the capacity of blood in transporting oxygen to parts of the body from the lung) and everything was within normal limits. She recorded the results in his medical records.

31. The nurse said he appeared anxious and, although he was not specific about the reason, she thought it was caused by issues on the wing rather than his health. She advised him to see his personal officer. She found him intimidating because of his body language and he raised his voice. She noted in his medical record that she would advise against female staff seeing him alone in the future. The investigator asked if this had inhibited her from doing a complete assessment but she said this had not been the case, and she had completed a full set of observations. Because the results were normal she did not consider there was any need to refer him to the doctor.

32. On his wall diary on 14 April, the man wrote 'I had a problem in breathing plus my back is paining me'. On 15 April, he complained of shoulder pain to the triage nurse and was given "1g para" (1 gram of paracetamol). (In such circumstances when non-prescription medication is given out at the treatment hatch in response to a usually minor medical complaint, it is recorded on a form known as the over the counter medication form. The details would not be recorded in the prisoners' individual medical records.)

33. The man made his last telephone call to his partner on 18 April at 4.30pm and they spoke for 30 minutes. The conversation was of a general nature and he did not mention the doctor or that he was feeling unwell.

34. At 8.50am, on 20 April, a manager, who was working an extra shift as a PCO, locked the man in his cell for the roll count (a physical count of all prisoners undertaken at various times in the day.) She asked him to remove posters from the cell back wall. (For security reasons, prisoners are not allowed to put posters on the back wall of the cell.) She said that he responded by asking if she had anything against his religion. (She told the investigator she was not aware it was a religious picture.) She explained to him that the reason was not about religion, but security, and asked him to put it on the picture board on the side wall.

35. As she attempted to close the door, she said the man tried to keep it open by pulling it. She said he was not aggressive but wanted to continue challenging her about the poster being religious. She locked the door and later conducted

the roll check with his personal officer. When they checked his cell for the count, he asked her what her role was at the prison. She explained and asked him again to remove the poster again. As she walked away from the cell she said he called her “a fucking lesbian”. She said she warned him about his behaviour but he continued shouting. She placed him on two disciplinary charges for using threatening, abusive or insulting words of behaviour and disobeying a lawful order (by failing to removing the poster.) This meant he would need to attend a disciplinary hearing, known as an adjudication.

36. At 9.13am, the man rang his cell bell and told his personal officer that he wanted to go to the chapel, and she unlocked his cell. When he left his cell, he went to the office and again started to challenge the manager about the poster. At this point, another prison manager came onto the wing to undertake routine daily management checks. She observed the interaction between them and described his behaviour as aggressive. She intervened to ask why he was unlocked. The first manager explained it was so he could go to the chapel. The second manager advised him to wait by the gate and he left the office. She said he was then aggressive towards her and she felt quite threatened. She said as he swore at her she decided she would not allow him to go to the chapel and returned him to his cell.

37. The second manager contacted the duty Director that day, to explain what had happened. The Director discussed the incident in more detail with wing staff and then decided to speak to the man. She said initially he was very polite and but when she explained why he had to take the poster off the wall he became aggressive and hostile. She asked him if she could remove the poster and she said he said she could do what she liked. She removed the poster but said he was starting to get more aggressive and said he did not understand why other people had not asked him to remove it in the past. (The prison appears to have accepted there was an inconsistency of approach and the duty Director told the investigator that a new system of duty director checks was subsequently introduced.)

38. The duty Director said that as she left the cell, the man grabbed her arm, and the second manager helped extricate her from the cell. She told him that she was giving him a formal behaviour warning. The second manager told our investigator that following a discussion with all the staff involved a decision was made to segregate him under Prison Rule 53(4) due to the level of his aggression. (Prison Rule 53(4) says ‘A prisoner who is charged with an offence against discipline may be kept apart from other prisoners pending the governor’s first inquiry’. Prisoners can be moved to the segregation unit or remain on their wing but stay in their cell.) There is no evidence that he had had a segregation health screen at this stage.

39. The man had a healthcare appointment that day at 11.00am. According to the healthcare diary, he was due to see a nurse for ‘general check up: pains’. His personal officer told our investigator that someone from the healthcare department telephoned the wing for him and she told them he was subject to Rule 53(4) and could not attend his appointment. She was not aware of what

the appointment was for but thought he had mentioned it earlier in the morning. No further action was taken by healthcare staff or wing staff to rearrange the appointment or to see him in his cell.

40. At lunchtime, the first manager went with another colleague to the man's cell to collect his plate as he liked to use his own. She said he told her that he had a doctor's appointment. She said she was aware of this appointment and told him he was not going and it would be no problem to reschedule the appointment. She said he did not report to her that he was feeling unwell and his main concern was about going to chapel.

41. A prison chaplain was asked by wing staff to see the man in his cell that morning as he had wanted to go to the chapel but was subject to Rule 53 (4). They had a conversation through the cell door observation flap.

42. The investigator interviewed a prisoner, who said he saw the man that day and spoke to him at his cell door. He said the man told him the staff had refused to let him see the doctor. He said the man was due to see the doctor because of a problem with his stomach and said he had problems breathing and sometimes got heartburn.

43. PCO A, who was not a regular staff member on the vulnerable prisoners' wing, took the man's dinner to his cell at 4.30pm. He opened the observation hatch and asked him to stand at the back of the cell while he opened the door. He refused to do this and the PCO said he asked him three times, but he became more irate and started swearing. He explained to him that it was normal procedure to ask prisoners to stand at the back of the cell and that he needed to calm down. He closed the observation hatch, returned the meal to the servery and explained to staff why he had not given him his meal.

44. The man pressed his cell bell and PCO B responded. She knew him and said he said "you can't starve me of food". She explained to him that he had not complied with the rules and had been abusive and aggressive. She said he made a joke out of it and appeared fine. She was aware he had food in his cell which he had bought previously. (Prisoners are able to buy some food items through the prison shop.)

45. Cell bell records show that the man rang his cell bell a total of 17 times that day, the last at 10.04pm. His personal officer noted in the staff observation book "busy shift, he is on call button a lot".

46. The following day, 21 April, the man rang his cell bell three times in the morning. He attended his adjudication hearing where he declined to enter a plea and asked for legal assistance. The adjudicator, a prison manager, heard the evidence and adjourned it for 14 days. He said the man did not speak very much during the hearing.

47. A prison chaplain saw the man twice that day after the adjudication. He told our investigator he saw him regularly and knew he had problems with staff. He had told him that he might be overbearing in his interactions with staff. He

explained that he had not seen the doctor. (The chaplain said when he had seen him the previous week, he had told him he had chest pains. On that occasion, he had offered to ring the doctor but he explained that he had already put in an application for an appointment.) The chaplain said he had advised him to write a complaint about missing the appointment.

48. The over the counter medication record on 21 April shows the man was given "1g para" (1 gram of paracetamol). It notes the complaint was "shoulder pain". PCO B said she saw him later that day. They had a pleasant conversation and he appeared fine. A manager also saw him and described him as "like a different character" and was "one of the first to be locked up with no issues".

49. Although we do not have the man's history sheet, from the records provided to the investigator, he had no significant interactions with staff on 22 April, and he did not have any contact with healthcare staff. He wrote an application to the IMB dated 22 April, in which he asked to see 'the manager' of the IMB and referred to:

> "… how some of the prison officers have started treating me on this wing and the way they behave towards me, which is very very filthy attitude and behaviour."

50. On 23 April, the chaplain saw him in his office and said he looked OK and always looked healthy. That same day, his personal officer played pool with him, after he asked her for a game, and she said she had no concerns about him. There is no record that he reported feeling unwell to staff.

51. A prisoner saw the man the next morning when he greeted him. He said he seemed to be OK, but looked as if he had just woken up because his eyes were not fully open. He said the man sat in a chair:

> "… and then the next minute I just heard him like wheezing and he went into a seizure…[I] went over to him and pulled him down off the chair onto the floor…He's quite a big lad but I know the recovery position, so like I had to use quite a lot of effort and turned him over, but I couldn't fully get him on his side. So eventually I got him onto his, he was like half on his side, stomach like…I put his neck back so I could clear his airways…and I shouted to a member of staff. And that's when they came running up."

52. Prisoners alerted staff to the incident. The man's personal officer said he:

> " … was on the floor and he was foaming at the mouth. So we called a code straightaway, called a Code 2 emergency (which indicates a non-life-threatening incident which requires healthcare intervention) he was still breathing, his eyes were open and he was still like responding".

The duty record for that day notes the Code 2 was called at 9.12am.

53. A PCO also responded and described the man as "speaking incoherently…he was breathing, he was semi-conscious". While they waited for healthcare to respond to the emergency code, the PCO said they asked him what had happened but he was unable to explain. He said he then rolled onto his front so he was up on his elbows and able partially to support his own weight. The PCO described him as looking very confused.

54. From this point the CCTV camera recorded the incident. Nurse A was carrying the emergency radio for healthcare and responded when she heard the emergency code. She went straight to the wing as she was nearby. She had been on her way to another wing and did not have the emergency equipment with her. She said the man's breathing was very fast and he did not look a very good colour. She said she spoke to a manager who was present and they agreed to call paramedics as she did not like the way he looked. She thought this was within a minute or two of her arrival. In addition to requesting paramedics, she believed she had asked the manager to call for the other nurse on duty to bring the emergency bag.

55. The CCTV shows the manager using his radio at 9.13am. However, during his interview, he could not recall what this was for. There was no corresponding entry on the control log, which should record all radio calls made in the prison.

56. Nurse B, said she had not heard the Code 2 but was contacted over the radio to tell her she was required on the wing. She said she was told to "get the bag". She collected the green bag from healthcare (the green bag contains equipment for healthcare staff to be able to do basic monitoring and observations on a prisoner and is used for non-life-threatening medical incidents). The CCTV shows her arriving at 9.18am. She said she saw the man "hitting out…we did try to speak to him but to me he wasn't making any sense".

57. According to the CCTV, the chaplain arrived a minute after Nurse B. He said that when the man saw him:

> "He opened his eyes, feeling hot and said that he could not breathe… one nurse was trying to … take blood samples, his pulse, and the other one … actually trying to get his pulse also".

58. The CCTV footage shows that the chaplain moved behind the man. He said the man was "squeezing my hand and his hand was cold". He then started to fan him with his papers and "all the while he was talking but sluggish".

59. Nurse A said in interview:

> "I was trying to do his sats [oxygen saturations], trying to do a blood pressure but he was very agitated and his arms were kind of waving around and I couldn't get a reading on because we couldn't keep him still long enough to do that and it just seemed to be stressing him out more as well".

60. Nurse B said he was "… really clammy … he was saying 'I can't breathe, move away, move away, I can't breathe'". She said she "… checked his pupils, they weren't dilated, they were pinpoint". She said during her interview:

> "It did enter my head he's taken something. Because previously he had told me that, a long time ago he did say to me he had misused drugs … at first I thought he might be having a hypo (low blood sugar levels). So I said to the staff because we didn't have any sugary content drink I said just to get me anything".

61. Nurse B said the man was given a sip of water "… and it just drooled out of him". She did more tests and said "I knew that he wasn't a hypo … his breathing was laboured and he was that clammy, he was agitated so that's why I automatically said get the oxygen".

62. At 9.25am, the CCTV shows the manager using his radio again but, in interview, he could not recall why he did so. Again there is no record of this in the control log. The CCTV shows Nurse B next to the man and Nurse A getting equipment from the green bag. The chaplain is standing at the side of the man, fanning him with his papers. He then left at 9.31am.

63. The manager used his radio again at 9.31am. The control log notes he called for an ambulance at 9.30am. Both Nurse A and the manager said in interview the man was still breathing at the point an ambulance was requested. The chaplain told our investigator that he heard the manager call for an ambulance. However, the CCTV shows him using his radio only once when the chaplain was there, at 9.25am.

64. The CCTV footage then shows the officers and nurses moving the man from a seating position to lying on the floor at 9.33am. Nurse A said:

> " … [His] eyes started to roll. So we knew he was going off then so we've got him flat on the floor. At first we kept him sat upright because he was struggling with his breathing, we tried to keep him upright as much as we can to try and assist his breathing…with eyes rolling we got him flat because we knew we were going to end up having to do CPR."

65. Nurse B left at that point to get oxygen and the other emergency bag (which included full resuscitation equipment) from healthcare. She said in her interview that the man was still breathing at that point. According to Nurse A's entry in his medical record:

> "I started by doing a sternum rub which started his breathing for about 4-5 breaths then breathing ceased again. I checked his mouth which was clear. I then looked down the line of his body to observe any rising of his chest but there was none. I felt for a pulse but none was present. We then commenced 30 chest compressions followed by 2 breaths."

66. The CCTV footage shows the manager running from the scene at 9.34am. At 9.36am, Nurse B returned with the oxygen and emergency bag. Another prison manager also arrived at the scene as she said she received a telephone call from the first manager not long after the emergency code had been called. He asked her to assist the staff on the wing while they waited for the ambulance. She told the investigator she assisted in the resuscitation attempt by doing the rescue breaths.

67. Nurse B said that when she returned, she saw the man "wasn't breathing and said to 'get the oxygen on him now'". Chest compressions continued and she checked for a pulse which she said was "very, very, very slight but I lost it after a minute".

68. At 9.36am, the control log notes the first manager called a Code 1 emergency (this is used to indicate a life threatening incident or a prisoner not breathing). It was explained to the investigator that this was because the situation had changed from the man "being conscious still making some kind of communication with staff to all communication being lost and he's really seriously ill".

69. CPR was continued until paramedics arrived at 9.44am. At 10.04am, the paramedics confirmed that he had died.

After the man's death

70. The prison's family liaison officers (FLO) left the prison at approximately 4.30pm, six and a half hours after the man had died to go to inform his family of his death. The investigator was told that the delay was caused by one of the FLOs not arriving at the prison until early afternoon and there being different contact details for the next of kin. They went to the man's partner's home to break the news. The chaplain prayed with the family and told them he would hold a memorial service for the man at the prison, to which they would be invited.

71. The Director posted notices in the prison informing staff and prisoners of the man's death. Prisoners were reminded that the chaplaincy team and Listeners were available, if they needed any additional support. (Listeners are prisoner volunteers trained by the Samaritans to offer confidential support.) All prisoners being monitored as at risk of suicide or self-harm were reviewed after the death.

72. Rye Hill's duty Director that day held a hot debrief with the PCOs and Nurse A immediately after the man's death. (A hot debrief is a meeting held after an incident with those involved to gain an account of what happened and to offer support). No notes of this meeting were taken. Nurse B told the investigator that she had heard about the debrief but she did not attend as she was on duty and could not get to it.

73. Most of the staff who were involved told our investigator they were offered support by the care team that day. The duty Director told the investigator a critical debrief was held on 28 April by the prison's employee support service. She said staff told them they had support from the care team. Prisoners on the wing were spoken to by staff.

74. A 'significant event analysis' report was prepared after the man's death. The report said "as part of the commitment of G4S to learning lessons and continuous improvement this Untoward Incident report has identified risk areas for immediate action". However, it concluded there were "no recommendations to make in this case with regard to lessons that could be learnt".

ISSUES

Cause of death

75. The first post-mortem report notes:

> "The immediate cause of death in this case has been pulmonary thromboembolism. Such emboli occur as result of clots forming in the deep veins of the legs, so called deep leg thrombosis. When the clots break up they travel through the venous system via the right side of the heart and lodge in the pulmonary arteries. If large they cause collapse and death. This would be consistent with the man's sudden collapse. Deep vein thrombosis are more common in individuals with clotting disorder or have been generally immobile. There would not appear to be a history of immobility in this case and no identified history of clotting disorder. However it is well recognised that in a minority of cases such deep vein thrombosis can occur spontaneously without obvious precipitating cause and this case would appear to fall into that category".

76. The author adds that the man had complained of 'some chest discomfort around two weeks prior to his death' and notes:

> "Although small non-fatal emboli can cause chest discomfort, there is no evidence of anything other than acute thromboemboli (ie there were no organising emboli or pulmonary infarction. On balance of probability it is therefore my view this episode was not related to pulmonary thromboembolism".

77. The second post-mortem, requested by the man's family, gives the cause of death to be "multiple pulmonary emboli and thrombosis of venous malformation of right thigh". The examination confirmed:

> "It appears, from the appearance of the arteries within the lung this is not a 'one off' process because some emboli are showing healing changes with scar tissue formation and some vessels appear to show complete resolution. Putting this in the context of a complaint of shortness of breath on 14th April 2011, it would seem reasonable to conclude that he was at that time suffering from the effects of an early pulmonary embolism. Whether this complaint was managed adequately or not is not a matter for a pathologist but, rather, for a doctor".

78. The pathologist notes the muscle from the man's right thigh appeared "essentially normal" with "no sign of recent or organising injury including bruising and scarring". He said that overall "the appearances suggest a venous malformation with evidence of recent and old thrombosis".

79. The second pathologist concludes:

> "I think that the underlying cause for the man's pulmonary embolism was the vascular malformation in his right leg which had thrombosed - a

recognised complication - and embolised. That process of embolisation has been ongoing for some time - a process probably measured in months at least rather than days and weeks. I could find no evidence of significant injury."

Clinical care

80. Nurse A saw the man on 14 April, and said he was anxious but thought this was more to do with concerns he had on the wing rather than any health issues. She did a full set of observations and the clinical reviewer concludes she responded appropriately as he had not presented with specific symptoms suggestive of embolisation. In the light of the clinical reviewer's findings, we are satisfied that the nurse's assessment and treatment of him on 14 April was appropriate.

81. The man had a healthcare appointment booked for "general check up: pains" on 20 April. The chaplain saw him on 21 April and he told him he had put in an application to see the doctor in relation to chest pains the week before. Copies of applications are not retained by the healthcare department so it is not clear what he requested, or whether this appointment was requested before he was seen by the nurse on 14 April.

82. When healthcare staff contacted the wing on 20 April, about the man's appointment they were informed he was subject to Prison Rule 53(4) and would not be allowed out of his cell to attend. In the complaint letter found after his death he said he had told the prison manager about the appointment. She said during her interview he did not appear unwell at that time and told him it would be rescheduled. The manager said he did not mention it to her that day, and if he had "he would have been allowed to attend". Whether or not he mentioned the appointment again to the manager, it was the prison's responsibility to get him to his healthcare appointment. He was not given another date as she suggested.

83. Regardless of whether the man appeared unwell or not, his being subject to Rule 53(4) (which is discussed below) should not have hindered him keeping his appointment. Alternatively, a member of healthcare could have attended him in his cell. The practice at Rye Hill, as mentioned by numerous staff in their interviews, was that a prisoner cannot come out of their cell if subject to Prison Rule 53(4). This is not a requirement of the rule. Having denied him the opportunity to see healthcare at this time, we are concerned that there was no follow up either that day or subsequently. We cannot know whether a further healthcare appointment on 20 April or later would have identified any underlying concerns. The clinical reviewer suggests this is unlikely, as he displayed no obvious symptoms, and an embolism is very difficult to detect. Nevertheless it is a concern that he missed the appointment. .

The Director should ensure that prisoners do not miss healthcare appointments while segregated for any reason.

The Head of Healthcare should ensure that any missed healthcare appointments are followed up and rescheduled as necessary.

Record-keeping

84. The Clinical Manager saw the man in his cell earlier on 14 April. When he spoke to him he said he had shoulder pain and thought he may have pulled a muscle. The Manager advised him to have a hot bath and asked him if he needed pain relief but he said he declined. He said he did not document this interaction in his medical records as he saw it as informal advice and did not treat him. The clinical reviewer notes:

> "All contact with inmates relating to health concerns must be documented. Residual concern remains that some inmate symptoms that did not elicit clinical interventions went unrecorded."

The Head of Healthcare should ensure that all interactions with prisoners in relation to their health concerns are documented in the prisoner's medical records.

The management of Rule 53(4)

85. The man was segregated under Prison Rule 53(4) on 20 April, pending an adjudication hearing. The purpose of Rule 53(4) is to keep prisoners separate from others until the hearing, and its use is justified only where the reasons for the segregation relate to the investigation, such as where there is the possibility of collusion or intimidation of witnesses. It is evident from the facts that he was segregated 'due to his aggression' rather than for a reason directly related to the adjudication. In effect, he appears to have been punished before his adjudication. If the manager believed that he needed to be segregated because his behaviour was a threat to the good order of the prison, then this should have been done under Prison Rule 45. Prison Service Instruction 47/2011, which sets out the prison discipline procedures, also requires an "Initial Segregation Health Screen" to be completed and taken into account before segregation is agreed. This was not done. Segregation is the most extreme form of imprisonment and these procedures are in place to protect prisoners.

86. The misuse of segregation in this way was further compounded by the man being denied the opportunity to attend his healthcare appointment (discussed above) and the refusal to provide him with a meal because of his behaviour. This was unacceptable. As well as missing his usual prison regime he was also denied the opportunity to attend the chapel.

The Director should ensure prisoners are segregated under Prison Rule 53(4) only when there is a significant risk of collusion or intimidation in the period before the opening of a disciplinary hearing, and that an initial segregation healthscreen is completed and taken into account.

The Director should ensure that prisoners are not denied meals under any circumstances.

The emergency response

87. A 'Code 2' was called when officers initially found the man. Nurse A, who was the healthcare emergency response nurse that day, responded quickly as she was near to the unit. She did not have any emergency equipment with her. Nurse Jones said during her interview that, from a healthcare perspective, she was satisfied the correct code was called as his condition was not assessed as life threatening when he first collapsed. Nevertheless, she also said that within a minute or two or arriving at the scene she asked that the other nurse on duty be called and that she should bring the emergency bag. This would suggest a Code 1 should have been called at that stage. When Nurse B arrived she brought only the green bag to do basic monitoring. It was not until 9.36am that the emergency bag and oxygen were brought. This would appear to be about twenty minutes after Nurse A says she requested it.

88. It is unclear at what point Nurse A asked for an ambulance to be called. She said it was after a "minute or two" of arriving at the scene and then said she thought the "maximum it could have been 10 minutes before I had the conversation with the manager about getting the paramedics". She said during her interview she might have requested it after she had completed the observations on the man, which would have been when Nurse B arrived with the green emergency bag at 9.18am. Nurse B said in interview she asked for an ambulance to be called but did not know whether she was "the first one to say it". She said the ambulance was called when he was "sitting up and responding" and it was "within four, five minutes" of her arriving on the scene.

89. According to the control log, the manager asked for the ambulance at 9.30am which was 18 minutes after Nurse A arrived at the cell and 12 minutes after Nurse B. He said he radioed for one in response to Nurse A asking for an ambulance but, during his interview, he could not recall the exact time. The CCTV shows he made three calls on his radio and during his interview he said:

> "One of them was definitely to contact comms and to ask them to get hold of the duty director and to tell him to make his way to the command suite because the incident had become serious."

90. He said "One of them was to call the Code 1" and "one of them would have been to call the ambulance". He said he called the ambulance before he called a Code 1, but could not remember whether he had asked for the duty director to be informed first. However, the Code 1 call did not go out until 9.36am, which was after both nurses had arrived, the emergency equipment had been brought, and also after an ambulance had been called. It is therefore difficult to see what the purpose of the belated Code 1 call was at that stage.

91. The chaplain said he heard the manager call for an ambulance, although the CCTV shows he only used his radio once when the chaplain was at the scene (9.25am) and the control log lists that ambulance as requested at 9.30am. Both the nurses and the manager said the man was still breathing when the ambulance was requested.

92. The CCTV footage during the emergency response shows some staff laughing while the man was being treated. In interview, staff said it was in relation to the chaplain fanning him when he said he was hot. He was in a sitting position and still responsive and at that point the situation was not regarded as life threatening. While the actions of staff were inappropriate and unprofessional, we accept they did not consider it was a very grave situation at that point and acted appropriately once his condition worsened.

93. The clinical review notes that the man "had suffered from a sudden-onset clinical condition, whose course would inexorably and unavoidably have taken his life, regardless of life-saving intervention including mouth-to-mouth and other resuscitation efforts lasting 20 to 30 minutes, in the prison setting". While we note the clinical reviewer does not believe that anything could have been done to save him at that stage, this was not known at the time. We are concerned that there was confusion and delay in the emergency response – both in getting emergency equipment to the scene and in calling an ambulance. In other cases a quicker and better managed response could save a life. From the interviewees' accounts and CCTV footage, it is not possible to determine at what stage the ambulance was requested by the nurses, and how long it took for the request to be passed to the control room to be acted on. Faced with his deteriorating condition, it would seem an ambulance should have been called much earlier, even though the clinical reviewer makes it clear that this would not have altered the outcome. The failure of the control room to monitor all radio calls during the emergency did not help establish a clear picture of events.

The Director should ensure that all staff are reminded and understand they should call an ambulance as quickly as possible in a medical emergency.

The Director should ensure that during emergencies all radio requests are recorded in the control room log.

94. The clinical review notes there is no evidence that G4S conducted a robust internal investigation. The investigator has read the 'Significant event reporting" document completed by G4S after the man's death and it is surprising that it concluded that there were no lessons to be learnt. We are concerned that the report does not assess the incident thoroughly and that the staff involved were not asked to go through the events in any detail. We believe a more detailed significant event report from G4S, using all available resources, including the CCTV footage, would have assisted in both exploring any lessons to be learnt and in supporting staff. Overall, it is evident that the response to the emergency was poorly coordinated.

The Director should ensure that there are well understood, and practiced, contingency arrangements to deal with emergency situations, which set out clear roles and responsibilities for prison and healthcare staff.

Staff training

95. The clinical review notes "Neither of the nurses who attended the deceased during his last illness had received refresher BLS (Basic Life Support) training in the prison setting". Our investigation found that the evidence suggests this would not have made a difference to the outcome for the man. However the clinical review notes "Basic Life Support training, the content and quality of delivery within the context of a prison setting could benefit from a review".

96. The investigator asked the Clinical Manager to provide dates for when Nurses A and B completed their BLS refresher training. He provided a form which said Nurse B was trained on 20 April 2011 (four days before the man's death) and Nurse A had training on 6 May 2011. This information did not correspond with what the nurses told the investigator. Nurse A said that, although she had received training, it was not on that day but over a year earlier when she first started work at the prison. Nurse B said she had not had any training since arriving at Rye Hill. Our investigator highlighted this discrepancy to the Director. We agree with the clinical review that "gaps appear to exist in the co-ordination and documentation of workforce development and training needs, and this requires attention".

The Head of Healthcare should ensure a training needs analysis is completed for healthcare staff in relation to Basic Life Saving and that a training plan is then implemented and regularly reviewed.

Informing the next of kin

97. Staff did not leave the prison to tell the man's family of his death until six hours after he had died. In the absence of the family liaison log, the exact reason for the delay is not clear. Prison Service Order 2710 "Follow up to deaths in custody" gives clear guidance for contacting the next of kin:

> "Arrange notification to the next-of-kin and any other person reasonably nominated by the prisoner as soon as possible in a suitable manner giving an accurate factual account of what has happened."

98. Regardless of the reason for the delay, the amount of time taken to break the news of the man's death was not acceptable.

The Director should ensure that next of kin is informed as quickly as practicable after a death in the prison.

Missing evidence

Neither the man's history sheets nor the family liaison log were made available to the investigator despite many requests. It was also not possible to view all CCTV footage of the man's time at Rye Hill. According to Prison Service Order 2710 – Follow up to deaths in custody, prisons are required to "Hand over copies of all documents requested by the investigating teams". It is not acceptable that part of the investigation should have been hampered by the failure of Rye Hill to provide this evidence.

The Director should ensure that all records relating to a prisoner who dies in custody including documents, CCTV and PNOMIS entries should be secured and provided to the PPO investigator on request.

CONCLUSION

99. The man collapsed and died unexpectedly of natural causes. While the two post-mortem examinations do not entirely agree about the significance of the episode of chest pains on 14 April, we have found no evidence to suggest that staff could have predicted it. The clinical review notes that he had not presented with specific symptoms suggestive of embolisation. Nevertheless, we are concerned that he missed a healthcare appointment on 20 August, when he was inappropriately segregated. While it seems that once he collapsed, little could have been done to prevent his death, we are concerned that the emergency response was poorly coordinated and it took too long to call an ambulance.

RECOMMENDATIONS

1. The Director should ensure that prisoners do not miss healthcare appointments while segregated for any reason.

   Accepted. A notice to staff will be published reminding staff of offenders' basic entitlements and access to healthcare provision, while segregated under Rule 53.4 or G.O.O.D including access to healthcare, exercise and use of telephone.

2. The Head of Healthcare should ensure that any missed healthcare appointments are followed up and rescheduled as necessary.

   Accepted. A notice to staff will be drafted and communicated, detailing that all offenders must be given the opportunity to receive appropriate healthcare treatment. Under normal circumstances they should be allowed to attend their appointment, however if there are reasons that they cannot attend alternative arrangements should be made with the relevant E1 Residential Manager and Healthcare to ensure the offenders need is met.

3. The Head of Healthcare should ensure that all interactions with prisoners in relation to their health concerns are documented in the prisoner's medical records.

   Accepted. The Healthcare Manager will remind staff via a briefing note that all staff will be required to sign to say they understand – that all interactions with prisoners in relation to their health concerns are documented in the prisoner's medical records.

4. The Director should ensure prisoners are segregated under Prison Rule 53(4) only when there is a significant risk of collusion or intimidation in the period before the opening of a disciplinary hearing, and that an initial segregation healthscreen is completed and taken into account.

   Accepted. A briefing note will be distributed to all Duty Directors advising them of the proper course of action to follow with regard to segregating an offender on 53 (4). The briefing note will include the need to properly document reasons for segregating the prisoner and the requirements for the initial segregation health screen.

5. The Director should ensure that prisoners are not denied meals under any circumstances.

   Accepted. A notice to staff will be published reminding staff of offender's basic entitlements inclusive of meals and provisions at no time will offenders be refused meals.

6. The Director should ensure that all staff are reminded and understand they should call an ambulance as quickly as possible in a medical emergency.

Accepted. A notice to staff will be published reminding staff that they should call or request via the communications room an ambulance as quickly as possible in a medical emergency.

7. The Director should ensure that during emergencies all radio requests are recorded in the control room log.

   Accepted. The Director will ensure that during emergencies all radio requests are recorded in the control room log. A notice to staff will be drafted and distributed reminding communications room staff of the requirement to record such requests.

8. **The Director should ensure that there are well understood, and practiced, contingency arrangements to deal with emergency situations, which set out clear roles and responsibilities for prison and healthcare staff.**

   Accepted. A requirement to complete contingency planning exercise is in place and will continue to be adhered to. All contingency plans are reviewed annually, where applicable the roles of Healthcare are clearly identified within the plans. The Head of Safer Custody will ensure the responsibilities of healthcare staff and all operational staff on the specifics of individual plans are known to these staff.

9. **The Head of Healthcare should ensure a training needs analysis is completed for healthcare staff in relation to Basic Life Saving and that a training plan is then implemented and regularly reviewed.**

   Accepted. All healthcare staff who may respond to an incident are to have Immediate Life Support training on 15 August 2012. A training needs analysis will be completed by the Practice Manager reporting to the Head of Safe Custody, this plan will be reviewed on an annual basis.

10. **The Director should ensure that the next of kin is informed as quickly as practicable after a death in the prison.**

    Accepted. The FLO will be briefed at the earliest opportunity and will inform the next of kin at the earliest opportunity. Duty Directors will be reminded via a briefing note of the need to inform the family at the earliest opportunity.

11. **The Director should ensure that all records relating to a prisoner who dies in custody including documents, CCTV and PNOMIS entries should be secured and provided to the PPO investigator on request.**

    Accepted. A notice to staff reminding them of the need to provide all documentation relating to a death in custody will be written and then communicated. Information that is stored prior to the formal request will be stored in a central secure location prior to any request from the PPO.