PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Rye Hill in July 2012

Our Vision

‘*To be a leading, independent investigatory body,*
a model to others, that makes a significant contribution
to safer, fairer custody and offender supervision’

This is the investigation report into the death of a man who was found dead in his cell at HMP Rye Hill in July 2012. A post-mortem examination was unable to determine a cause of death. He was 56 years old. I offer my condolences to his family and friends.

A clinical reviewer was appointed to review the man's clinical care in custody. Rye Hill cooperated fully with the investigation.

The man suffered from both diabetes and asthma. While in prison, his conditions were appropriately managed with medication. The clinical review concludes that the treatment he received in prison for these conditions was equivalent to that which could have been expected in the community.

The man was found unresponsive in his cell one morning in July 2012. It was evident that he had been dead for some time, so no attempt to resuscitate him was made. He was formally pronounced dead at 7.20am by the prison doctor.

After the man's death, it was noted that insulin medication, which he self-administered by injection, was missing. Empty insulin pen cartridges were found in his rubbish bin. Although the post-mortem examination into his death was inconclusive and the cause of death was not able to be ascertained, the pathologist considered that his death was probably caused from either an asthmatic attack, possibly brought on from anxiety, or from an overuse of insulin, thus an overdose could not be excluded. I am sorry that the need to wait for the post-mortem report has delayed the issue of this report.

The man was described as a private man who kept things to himself. Although he told prison doctors that he experienced stress and sleeplessness about a court confiscation order, he never mentioned this to wing staff. Other than occasional medication to help him sleep, he declined offers of additional healthcare support, including from the prison's mental health team. There was no indication that he was at risk of harming himself.

Circumstantial evidence would suggest that the man overdosed on insulin, whether intentionally or unintentionally. However, the pathologist found that the cause of death could not be ascertained with any certainty and he did not rule out a severe asthma attack. Whatever the cause, I am satisfied that he received an appropriate standard of healthcare treatment Rye Hill and that staff there could not reasonably have foreseen or prevented his sudden death.

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 2013**

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SUMMARY

1. The man absconded to Spain in 2001 and was repatriated to the United Kingdom in November 2010, to face drugs charges. When he arrived at HMP High Down, he told healthcare staff that he suffered from diabetes, for which he was prescribed insulin, and asthma. Over the following years in prison, he received appropriate treatment for both conditions.

2. The man later transferred to HMP Bullingdon and then to HMP Rye Hill on 17 April 2012. On several occasions he told healthcare staff that, although he was coping with his sentence and life in prison, he was concerned that his family home was at risk because he faced a confiscation order. He declined medication or mental health support to help reduce his stress but was sometimes prescribed short courses of medication to help him sleep. He did not say anything or exhibit any signs to suggest that he was at risk of harming himself.

3. In July, the man was issued with a new month's supply of insulin as usual. That evening he was locked in his cell at 7.30pm. At 5.35 the next morning he was seen, apparently collapsed on the floor of his cell. Officers immediately went in and summoned emergency healthcare assistance. It was evident that he had been dead for some time and any attempts to resuscitate him would be futile. Six used insulin pens were later found in his rubbish bin.

4. The clinical reviewer concludes that the care the man received for his diabetes and asthma was equivalent to the care he could have expected to receive in the community. Apart from his reported stress, which sometimes disturbed his sleep, there was no sign that he was at any risk of harming himself.

5. The post-mortem report does not provide a certain cause of death, which could have been the result of an asthmatic attack, possibly brought on by anxiety, or an overdose of insulin.

6. We do not consider that the circumstances of the man's death were either foreseeable or preventable by prison staff. Our report makes one recommendation about the need to ensure that family members' concerns are recorded and acted on.

THE INVESTIGATION PROCESS

7. An investigator visited Rye Hill, on behalf of the lead investigator, on 17 July to carry out preliminary enquiries. She met members of the prison's staff and spoke to a prisoner who knew the man.

8. Notices about the investigation were posted in the prison informing staff and prisoners of the investigation, inviting those with any relevant information to contact the investigator. No one came forward.

9. The lead investigator visited the prison to conduct a number of interviews. He reviewed the man's prison records and spoke to a prisoner who had known him and occupied a neighbouring cell. He gave verbal feedback to managers at Rye Hill about the preliminary findings of the investigation.

10. The local PCT appointed a clinical reviewer to review the man's clinical care in prison. She reviewed all relevant medical and prison documentation relating to him and conducted a number of interviews with staff at the prison. The investigator also liaised with a DC from Northamptonshire Police.

11. HM Coroner for the Northamptonshire District was informed of the investigation and provided the results of the post-mortem examination. The Coroner has been sent a copy of this report.

12. One of our family liaison officers contacted the man's daughter to tell her about the investigation. We have aimed to cover the following points which his daughter has asked that the investigation address:

    - She said that she had visited her father towards the end of June and was deeply concerned about the way he was presenting and contacted the prison that evening about her concerns.

    - She asked how and when her father was found.

13. As we were unable to conclude the investigation until toxicology results and the post-mortem report were available, the investigation was suspended for some time. We regret the consequent delay in issuing this report.

HMP RYE HILL

14. HMP Rye Hill is a category B training prison, privately managed by G4S Care and Justice Services. It holds up to 625 sentenced adult male prisoners serving sentences of at least four years. Around 20 percent of prisoners at Rye Hill are serving life sentences.

15. G4S provide 24 hour healthcare services, including an eight bed inpatient unit. There are a number of nurse-led clinics and doctors, dentists and other specialists run regular clinics, including diabetes clinics at the prison.

Her Majesty's Inspectorate of Prisons

16. HM Inspectorate of Prisons last inspected Rye Hill in June 2011. The inspection report noted that relationships between staff and prisoners were generally good and that an effective safer custody team proactively managed and took a generally caring approach to those at risk of suicide and self-harm. Healthcare was judged to have improved from a standard that had previously raised concerns. Inspectors reported that the prison provided a decent, safe and secure environment but more needed to be done to tackle offending behaviour and prepare men for release.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that prisoners are treated fairly and decently. In its 2012 annual report, the IMB noted that the prison had maintained a stable and safe environment for prisoners and operated with respect and fairness towards them during the year. The IMB reported that there had been some difficulties recruiting and retaining nurses. A new doctor had been appointed who had cleared waiting lists.

Previous deaths at Rye Hill

18. Since 2011, there have been four deaths from natural causes at Rye Hill and no self-inflicted deaths. There is no similarity of issues between the circumstances of the man's death and the other deaths we investigated.

KEY EVENTS

19. The man absconded to Spain in 2001, before his trial on charges of supplying drugs. In November 2010, he was arrested and returned to the United Kingdom. He was taken to HMP High Down where, at an initial health screen, it was noted that he was diabetic. He said he had not received any treatment for his condition in Spain. After referrals for further tests he was formally diagnosed with the disease and was prescribed insulin. (Insulin is a hormone made naturally in the body. It helps to control the level of sugars in the blood. People with diabetes are unable to make the insulin naturally and it is often injected.) During his time in prison his diabetes was regularly assessed and monitored.

20. The man said he also suffered from asthma. Following a number of tests, including X-rays, he was diagnosed with chronic obstructive pulmonary disorder (COPD) for which he was prescribed a salbutamol inhaler. He was frequently offered smoking cessation advice, which he declined. (COPD is an umbrella term for people with bronchitis or emphysema. It is usually caused by smoking and most often leads to shortness of breath. Salbutamol is used to alleviate the symptoms by opening up the air passages in the lung so air can flow to the lungs more easily. It relieves coughing, wheezing and shortness of breath.)

21. On 2 February 2011, the man transferred to HMP Bullingdon. During a health screen he was re-prescribed his insulin medication. A risk assessment determined that he was able to keep and administer his medication himself. His diabetes and COPD continued to be monitored and assessed.

22. On 6 May, the man told the prison doctor that he was not sleeping well and was stressed about the charges he was facing. The doctor prescribed promethazine for five days to try and correct his sleeping patterns and noted that if symptoms persisted he was to be assessed for possible depression. (Promethazine is an antihistamine, which is occasionally used to treat insomnia.)

23. Prison staff described the man as polite and courteous. They noted he worked hard on the wing and was helpful to staff. On 4 July, he was sentenced to 16 years imprisonment for supplying drugs.

24. At the beginning of August, the man told healthcare staff that for several days he had felt down, lacked energy, had difficulty sleeping and lacked concentration. He said he did not have any thoughts of self-harm but complained of insomnia, due to stress about his financial situation. The doctor prescribed five days of zopiclone. (Zopiclone is a sleeping tablet used for a short period of time to help with sleeping difficulties. The body can become dependent on the drug if taken for longer periods.)

25. In September, the man told the prison doctor that he was having problems sleeping again. He said that after his conviction he now faced a confiscation order which put at risk his family home. The doctor prescribed promethazine for a further five days.

26. In October, the man again reported to the prison doctor that he was feeling stressed and had difficulty sleeping, because of worry about the confiscation order. He said that, once he knew the court's decision about this, he would be

able to sleep better. He asked the doctor for zopiclone, saying that the promethazine did not work. The doctor explained the risks of becoming dependent on zopiclone, but as he was experiencing a period of short-term stress, she prescribed some for five nights. The doctor requested a further chest X-ray in relation to his COPD, but noted that he rarely used his inhaler. He declined help with giving up smoking. The results of the X-ray showed that his condition remained consistent with the diagnosis of COPD.

27. A risk assessment interview was carried out on 12 January 2012, during which the man said he was coping with custodial life but the confiscation order was causing him some stress. He said that this had led him to worry about his family and the security of their home where his wife and children lived. It was noted that he had had no previous psychiatric intervention in the community or in prison, and had expressed no thoughts of suicide or self-harm.

28. On 21 February, a doctor noted that the man continued to worry about the confiscation order, about which he was expecting a hearing in April. He told the doctor that he woke in the night with sweats and wrote letters to occupy himself before disposing of them. The doctor discussed with him a number of methods to distract himself. He declined any medication to assist with his mood and anxieties, but he accepted five days of zopiclone to help him sleep. On 28 March, he again reported that he felt stressed and unable to sleep. He was given another course of zopiclone.

29. On 11 April, a doctor noted that, due to his upcoming court case, the man was not sleeping well and that this was stress related. The doctor noted that several courses of zopiclone had previously been prescribed. Due to the risk of dependency, the doctor prescribed promethazine for five days.

30. The man transferred to HMP Rye Hill on 17 April 2012, as a progressive move. His routine health screen on arrival noted that he was receiving insulin for his diabetes and that he was asthmatic, but that there were no other health concerns.

31. At a first night induction interview, the man nominated his partner and one of his daughters as his next of kin. The officer noted that he had one outstanding court appearance in July with regard to a confiscation order, which he intended to appeal. He said he had no drug or alcohol issues and had never self-harmed or attempted to take his own life. He said he was concerned about being at Rye Hill because of the distance from his family. He did not mention any other concerns.

32. On 22 April, an entry in the man's wing history sheet noted that he was fairly quiet around staff since his arrival on the wing and that he stayed mostly in his cell with his cell mate. A few days later he was given a single cell and moved to the enhanced level of the incentives and earned privileges scheme which allowed him some extra prison privileges.

33. A doctor saw the man on 26 April. He told the doctor about the confiscation order and asked for zopiclone to help him sleep. The doctor prescribed three nights of zopiclone and noted that he should be reviewed again if he continued to struggle.

34. Healthcare staff completed a secondary health screen on 2 May. It was noted that he appeared fit and well, had no concerns over his physical health, that his mental state was stable and he had no history of self-harm.

35. On the morning of 3 May, the man collapsed at work. He told a nurse that he had suddenly felt faint and had had to hold on to something to stop himself falling down. Although he had hit his forehead, the nurse noted that he was alert and orientated and that there were no visible injuries. His blood sugar levels were low and he was given food, after which he felt better. The nurse advised him that he should eat a proper breakfast and a snack mid- morning. The nurse liaised with the prison's kitchen to ensure that he was receiving a diabetic food pack.

36. A doctor saw the man the next day and discussed how best to manage his diabetes and the need to judge his insulin dosages, taking into account his activities. The doctor assessed him as not suitable to work in the prison's workshops but that he was able to carry out lighter work.

37. On 6 May, a Prison Custody Officer (PCO) wrote in the man's wing history sheet that he was "Polite and compliant, currently on restricted work due to having a (Hypo) diabetic low sugar level while working in industries, respectful to staff and locks up on time". On 12 May, a PCO wrote that he worked well on the unit and that he expressed no concerns.

38. On 25 May, the man saw his solicitor about his ongoing confiscation proceedings. Later that day, his solicitor wrote to him responding to allegations he had made at their meeting, including an allegation he had made that his solicitors were working for the police and the Serious Organised Crime Agency. His solicitor expressed her concern about his mental state. She wrote, "… I now take the view that you are under such stress that you should actually seek medical attention". As the correspondence was written under legal privilege, staff at Rye Hill were unaware of its contents and it does not appear that the solicitor raised any concerns directly with staff at the prison.

39. The next day, a PCO noted in the man's record that again no concerns had been raised and that he remained polite and compliant. On 28 May, his partner sent an e-mail message to him via the prison. She told him that she was pleased she would be seeing him shortly and asked if he was still feeling "up and down". She told him to ask the doctor for citalopram, an anti-depressant, to keep him calm. She said she, "… can't bear to see you like this, you are worrying the life out of me. I do wish you were nearer home so that I could see you more often". She ended the e-mail by asking that he make sure that he made the booking for her visit. She, and other family members, visited him on 31 May.

40. On 2 June, a PCO wrote in the man's wing history sheets, "Working well as wing cleaner on bins and sinks, he seemed a little quiet the past week, could benefit with a move to a quieter part of the unit". Several days later on 9 June, a PCO noted that he continued to work on the unit and that there were no concerns.

41. On 10 June, the man had a visit from his daughters and other family members. His daughter told our family liaison officer that, during their visit, he appeared paranoid and vague, and made little eye contact. She described his behaviour as "weird". She said she believed this could have been as a result of low sugar

levels and phoned the prison that evening to express her concerns about this. She said she spoke to a manager, but could not recall who this was. She said that she asked that her father should be seen by a doctor as an emergency. She was told that unless her father specifically asked for help there was nothing the prison could do. She also said that her father's partner had also contacted the prison with concerns about his health. The investigator was unable to find any record at the prison about these calls.

42. On 16 June, a PCO recorded that the man continued to be polite and respectful to staff, and other prisoners, and was working well on the unit. On 23 June, it was noted that he was polite and complied with the prison regime, was a good unit cleaner and again was respectful to others. On 19 June, he moved to a single cell on a quieter part of the unit. His brother and sister in-law visited him that afternoon. On 21 June, his partner and members of her family visited him.

43. On 27 June, the man's solicitor visited him. The next day his application to appeal his original conviction was formally rejected. The last entry to be made in his wing history sheets was on 30 June, by a PCO. The officer noted that there were no concerns, no changes, nothing to report and that he had had a quiet week.

44. On 28 June, a doctor saw the man, who again complained that he was not sleeping well and was anxious about his confiscation order hearing, which he said was now due in November. The doctor had a "long chat" with him and noted in the medical record that he did not want to be referred to the prison's mental health team. The doctor prescribed a further three nights of zopiclone.

45. On 11 July, the prison's pharmacist renewed the man's regular prescription of insulin on 11 July, to last for 28 days as usual. This was in accordance with his regular prescription of insulin medication.

46. A PCO told the investigator that the man worked well on the wing, was never a problem and mixed well with other prisoners, and was polite and quiet. He said that in the time he had known him he had never talked about any physical ailments or of what was happening in his private life or about forthcoming court cases.

47. The man's personal officer said he was a quiet and compliant prisoner and would often pass the time of day with him. The PCO said that he gave no indication that he was stressed but, as with other prisoners, sometimes appeared "up and down". He said that in the days before his death, he was not aware of any problems, but added that he never talked about confiscation orders or any other legal matters. When asked if he showed any signs of stress in the days leading up to his death, the PCO said that he got the impression that he had spent a long time in prison and seemed experienced with prison life.

48. A prisoner, with whom the man was friends, occupied a neighbouring cell. The prisoner told the investigator that, although he did not know him outside prison, they had a number of mutual contacts. He described him as someone who was friendly, funny and trying to do the best he could while he was in prison. He said that, although prison was a shock to him, he had accepted his sentence. However, the prisoner said that he was stressed about his confiscation order,

adding that he would sometimes pace up and down and was often on the phone to his solicitor about it. The prisoner said the man had been angry after a recent legal visit and stressed by some of the comments that had been made. However, the prisoner said he was a private man who kept the details such as this and other issues to himself. In the days before his death, the prisoner noticed nothing strange about his behaviour.

49. The prisoner said he knew the man had diabetes and that he had previously told him that he was receiving the best treatment that he had ever received for his condition. He said that he never complained about his diabetes and that, in the days before his death, he made no complaint about his general health.

50. The man used the telephone frequently to keep in touch with friends and relatives and to speak to his solicitor. In the days leading to his death he made numerous telephone calls. On the morning of 11 July, he made two short calls to his partner and five to his solicitor. These were for very short times so it would appear that he either left a short message or hung up when there was no one there. The last call he made was to his partner at 2.28pm.

Events leading up to the incident

51. The man's personal officer told the investigator that no particular issues or concerns were raised by any of the prisoners on the wing on the evening and night before he was found. He said that when he locked him in his cell it was just like any other day. He said if he had had any concerns about him he would have talked to him to check he was okay. Other officers who were working on the wing that night also described it as quiet.

52. At approximately 7.30pm, prisoners were locked in their cells for the night. A prisoner told the investigator that he said good night to the man as normal and that he would see him in the morning. Although he told the investigator he had heard no unusual noises that night, in a statement to the police the prisoner said he had heard loud banging on a cell wall, but could not be sure where it was coming from. He said he also heard what sounded like a snoring type of noise from the man's cell, which stopped at about 10.30pm. He said he heard nothing further.

53. At approximately 5.35am, during a routine roll check to ensure all prisoners were present, a PCO looked into the man's cell and saw he was lying flat on his back on the cell floor. He did not respond when he called his name so the PCO immediately requested help by calling an emergency code one alarm. This notified colleagues of a life-threatening situation and the need for the emergency response nurse to attend. He was joined by another PCO who was nearby. The officers immediately used an emergency key to go into the cell.

54. The officers checked the man for signs of life, including a pulse, but could find none. They noticed a "purple mottling" to the back of his arm and that he looked grey. Rigor mortis had set in so they decided not to attempt resuscitation. One PCO told the investigator that it was obvious that he was dead. Other officers and the emergency response nurse arrived quickly at the cell. The nurse also could not find any signs of life and agreed that he had died and that resuscitation would not be possible. An ambulance had been called and paramedics

confirmed death at 6.05am.

55. A doctor attended at 7.20am and formally certified the man's death. After his death, police removed six empty insulin pens from the rubbish bin. The doctor told the clinical reviewer that he thought a possible cause of death might have been an insulin overdose.

56. The prison family liaison officer, accompanied by the prison chaplain, broke the news of the man's death to his partner. His daughter was abroad on holiday so there was a delay in informing her of her father's death. A memorial service was held at the prison and was attended by a number of prisoners and staff, as well as his sister and partner. The prison made a full contribution towards the funeral expenses.

Post-mortem examination

57. A post-mortem examination was conducted. In the light of his investigations, the pathologist considered that the man's death might have been caused by an asthmatic attack, brought on by anxiety, or from the overuse of insulin. He was unable to exclude either one of these possibilities over the other and concluded that the cause of death should therefore be recorded as unascertained.

ISSUES

Cause of death

58. The-post mortem examination into the man's death was unable to establish the cause of his death with any certainty. The pathologist's view was that it could have been caused by either an asthmatic attack or from an overdose of insulin.

59. After the man's death, empty insulin injection pens were recovered from the rubbish bin in his cell. He had been issued a new supply of insulin the previous day to last a month. There was no unused insulin recovered from his cell so it seems that he might have injected the month's supply. In his post-mortem report, the pathologist concludes that if he had injected this level of insulin it would have been a level of overdose which could have resulted in coma. His death could have been the result of an overdose of insulin but if so, we do not know whether he intentionally injected the insulin to take his own life, or if he inadvertently overused it for another reason, such as in the belief that it would alleviate a particular symptom or pain.

Treatment of asthma and COPD

60. In her clinical review, the clinical reviewer comments on the management of the man's asthma and chest condition. She reports that, during his time in custody, he presented to healthcare staff on a number of occasions with shortness of breath and coughing. She says that he was appropriately referred for X-rays and other tests and that these showed he was suffering from chronic obstructive pulmonary disease (COPD).

61. The clinical reviewer notes that after he was diagnosed with COPD the man was given a salbutamol inhaler which he used when experiencing shortness of breath. She notes that he was frequently offered smoking cessation advice, but said he felt unable to give up due to stress about his court case. She reports that there is little evidence in his medical records that he was prone to worsening of shortness of breath when anxious. There was therefore no reason why, in the time before his sudden death, healthcare staff would have been alerted to a risk of a severe asthma attack or of a need to change his treatment or monitor him more closely.

Treatment of insomnia and anxiety

62. After his conviction in July 2011, it was frequently recorded in the man's medical record that he was stressed and worried about the confiscation order against him, which he believed might lead to his family losing their home. He often mentioned this to prison doctors as a worry which caused him difficulty sleeping. He did not share these concerns with other prison staff, including officers on his wing. Although another prisoner, as a friend, was aware that he was stressed about the confiscation order, he said the man did not discuss the details of his concerns with him.

63. In her clinical review the clinical reviewer notes that the man was initially prescribed a mild sedative to try and establish better sleeping patterns but on some occasions he was prescribed a stronger sedative. Although he often

requested strong sedatives, doctors explained to him that they would not be prescribed frequently because of the risk that he would become dependent on them. When he was offered medication such as anti-depressants to help alleviate his stress, he declined. He also refused any interventions from the prison's mental health team.

64. The clinical reviewer asked a prison doctor specifically how he assessed the man's mental state. The doctor said his level of anxiety about the confiscation order was not unusual in the circumstances. The doctor said he did not observe any indication that he had reached a level of stress which needed specialist intervention. In her clinical review the clinical reviewer says that his:

> "… anxiety was not considered to be out of line with any other prisoner in the same situation. He was offered referral to a mental health practitioner but declined this. The treatment of his sleep problems was in line with practice which is to avoid long tern medication which can cause dependence and not actually help to relieve the problem."

1. She goes on to conclude that:

> "Healthcare staff offered a good standard of treatment and care to him and whatever the cause of his death it would be difficult to identify any preventive measures that could have been taken."

Treatment of the man's diabetes

65. The clinical reviewer is satisfied that healthcare staff carried out the required actions to help improve the control of the man's blood sugar levels and to assist him in the prevention of and detection of the complications of diabetes. She reports that advice and actions, including patient education on testing and injecting insulin, dietary advice, dealing with symptoms of low blood sugar, smoking cessation advice, regular physical examinations, such as blood pressure checks, eye screening, impact on heart circulation and kidney function test were all well documented. She concludes that his diabetic management was consistent with NHS guidelines for managing insulin dependent diabetes.

66. She notes that the man received supplies of insulin to keep in his cell and injected the insulin himself, as he would have been expected to do in the community. She notes that this self-administration maintained a satisfactory level of control of his diabetes. She says he recognised when his blood sugar was low and knew when to raise his sugar levels. She considered that allowing him to keep supplies of insulin to administer himself was consistent with how he would have been treated in the community. One of the prison doctors said that this was usual practice and that the prisoners with diabetes would be expected to self-treat unless they had severe physical or learning disabilities which would preclude effective administration. She concludes that it would have been inappropriate for health care staff to have withdrawn his insulin. We are satisfied that there was no reason to consider that he should not be allowed to hold his own stocks of insulin to administer himself.

67. The clinical reviewer concludes that, as with the man's asthma / COPD, the treatments, referrals for investigations and care for his diabetes was at least

equal to that he would have expected to receive in the community. She noted that the control of his diabetes and checking for complications was better than before he went to prison.

68. In conclusion, the clinical reviewer reports that the general approach and standard of clinical care offered during the man's time in custody was good. She cites that consultations with medical staff were well documented, including prescribing and administration charts. As well as good treatment for COPD and diabetes, he was seen by the prison dentist and received appropriate medicine for minor ailments.

Logging family concerns

69. The man's daughter said after her visit on 10 June, she telephoned the prison to express her concerns about his health and asked that he should see a doctor urgently. She could not recall who she spoke to. She said that she was told that, unless he himself specifically asked to see a doctor, there was nothing the prison could do.

70. The investigator made enquiries with the prison about what actions should be taken by staff when relatives telephone in with concerns. Rye Hill said that the switchboard operator should log any concerns expressed by a family member about a prisoner, complete a form and send it to the unit manager for action, copying the concern to the prison's safer custody department. They said that the manager working at the prison would sign the log, if any such calls had been received on a particular day. During the evening, the calls to the prison are directed to the prison's communications room. There are no records of any calls about the man being logged at any time in June.

71. It is regrettable that there is no record of any call and there is nothing in the healthcare records to suggest that his family's concerns about his health were passed on. However, even if the systems failed, a doctor saw the man on 28 June. The doctor noted in the record that they had spoken for some time and it is apparent that he used the opportunity to talk about his anxieties and troubles. At that appointment, he was offered further support from the prison's mental health team but declined. Nevertheless, a family's concerns about the state of a prisoner's health are important and ought to be handled sensitively and recorded so that any necessary action is taken. We make the following recommendation:

    The Governor should ensure that telephone calls from families expressing concern about the well-being of a prisoner are logged and dealt with appropriately.

RECOMMENDATION

1. The Governor should ensure that telephone calls from families expressing concern about the well-being of a prisoner are logged and dealt with appropriately.

ACTION PLAN: The Man – HMP Rye Hill

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Governor should ensure that telephone calls from families expressing concern about the well-being of a prisoner are logged and dealt with appropriately.	Accepted	An instruction will be issued to staff All logged concerns are copied to the Duty Manager, Duty Director and Safe Custody Team to ensure that appropriate follow up action is taken.	Complete	A Notice to staff, issue number 1885 (Offender Well-Being Warning Form) was published on 25th July 2013