PRISONS AND PROBATION OMBUDSMAN for England and Wales

Independent Investigations

Investigation into the death of a man in January 2012 in University Hospital Coventry, while a prisoner at HMP Rye Hill

Report by the Prisons and Probation Ombudsman for England and Wales

February 2013

This is the report of an investigation into the death of a man. He died in University Hospital Coventry, having been taken there after collapsing in his cell. A post mortem showed that he died of a pneumothorax (collapsed lung) and Chronic Obstructive Pulmonary disease (COPD). I extend my condolences to his family and friends.

The investigation was carried out by one of my investigators. A clinical reviewer was commissioned to undertake a review of the man's clinical care. HMP Rye Hill co-operated with the investigation. I apologise for the delay in issuing this report.

The man was an elderly man who suffered from ill-health. He had ongoing contact with the healthcare department in Rye Hill. In December 2011, he spent some time in hospital and, on return to Rye Hill, was located in a large cell in the healthcare centre. During the early hours of 20 January, he developed trouble breathing and collapsed. Staff tried to resuscitate him while an ambulance was called. He died later in hospital.

The clinical reviewer concludes that the man's healthcare in prison was at least equivalent to that which he could have expected in the community. Although the family did not express any dissatisfaction, we note that Rye Hill struggled to ensure that a trained family liaison officer was always available and we are disappointed that the full costs of the funeral were not met, as these fell below the recommended maximum contribution in the National Offender Management Service's national guidance. Nevertheless, we have no significant criticism of the care and sensitivity with which the man was treated at Rye Hill.

I am pleased to see that the National Offender Management Service has accepted three of the recommendations in this report, but it disappointing that one has been rejected.

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.

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Prisons and Probation Ombudsman **February 2013**

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SUMMARY

1. In September 2010, the man was convicted of serious offences and sentenced to 13 years imprisonment. He was sent to HMP Wandsworth.

2. The man had some health problems. He walked with the aid of a stick, there was mention in his pre-sentence Offender Assessment System (OASys) report of possible Alzheimer's disease and he had previously been under the care of a cardiologist. In prison, he was prescribed the medication he had been receiving in the community. In April 2011, the man was diagnosed with Chronic Obstructive Pulmonary Disease (COPD – a term covering conditions which lead to problems getting air into the lungs).

3. In November 2011, the man was transferred to Rye Hill. He was initially housed on a normal wing. In early December, he saw the prison doctor, complaining of shortness of breath. The doctor noted that he had been diagnosed with COPD and decided that he needed hospital treatment. He was taken to hospital in an ambulance.

4. The man returned to prison on 14 December. He needed a constant supply of oxygen. The prison obtained the necessary equipment and gave the man a room in Rye Hill's healthcare centre as an in-patient. He was assessed daily, with nursing staff available 24 hours a day.

5. During the night of 12 January 2012, another prisoner in the healthcare centre caused a disturbance. The man became upset by the noise, and staff noticed that his heartbeat was irregular and he was wheezing. He was given medication and continued to be assessed over the coming days.

6. In the early morning of 20 January, the man was again disturbed by noise from a nearby cell. He pressed the emergency call bell, and a nurse asked him if he would like his nebuliser (a device used to allow a patient to take medication as a mist, which is inhaled into the lungs.) The man said he would. The nurse went to collect the nebuliser, but when she returned she found that the man had collapsed. Staff went into the cell, and tried to resuscitate him. An ambulance was called. A first response paramedic arrived within 10 minutes, and with staff continued to provide first aid until an ambulance and more paramedics arrived. They then transferred the man to the ambulance and he was taken to University Hospital Coventry. He was pronounced dead at 3.10am.

7. This report makes four recommendations. These concern location of the constant supervision cell, risk assessments for prisoners in hospital, the availability of trained family liaison officers and contributions to funeral costs. The National Offender Management Service has accepted three recommendations, but has rejected the recommendation about the location of the constant supervision cell.

THE INVESTIGATION PROCESS

8. This office was informed of the man's death on 20 January 2012. The investigator issued notices to staff and prisoners informing them of the investigation and inviting anyone with relevant information to contact him. No further information was received.

9. The investigator visited the prison on 25 January. The prison provided him with the man's prison record, including his medical records. He spoke to staff who knew the man and to the Vice Chair of the Independent Monitoring Board. He was shown around the prison, including the man's cell.

10. A clinical reviewer was commissioned to carry out a clinical review of the man's care and treatment while in custody. The investigator and the clinical reviewer conducted joint interviews of staff.

11. Rye Hill is a private prison, managed by G4S. A National Offender Management Service-employed Controller ensures that the prison is run in accordance with the contract. The investigator spoke to the controller and the deputy controller. In line with contingency procedures, the deputy controller had been informed of the man's death at the time. They had no particular concerns over the man's treatment.

12. The investigator interviewed five members of staff in person and one former member of staff by telephone. As printouts of cell call bell records were not available, He viewed the records for the man's cell on the 19 and 20 January on the security department's computer records. It is G4S policy for the duty manager in Rye Hill to wear a small camcorder on their uniform, so that they are able to record any significant incidents. The night manager on 20 January used her camcorder and he was able to view the footage. He provided feedback to the Director at Rye Hill during the investigation. Unfortunately, the prison had difficulty in arranging dates for the interviews which led to a delay in the production of this report.

13. The investigator wrote to HM Coroner to inform her this investigation and to request a copy of the post mortem report. This investigation report will be sent to the Coroner to assist her enquiries.

14. One of this office's Family Liaison Officers contacted the man's wife to explain our investigation and offer the opportunity to raise any concerns. The family did not raise any specific issues that they wanted the report to address, nor did they make any comments in response to the draft report.

HMP RYE HILL

15. HMP Rye Hill is a purpose-built prison near Rugby in Warwickshire. It is run by G4S. It accepts prisoners serving sentences of at least four years, with a year or more left to serve. It is a Category B prison, meaning that although the prisoners do not require the highest level of security, escape must be made very difficult.

16. The healthcare centre contains five cells. Four of these are individual cells and the fifth, cell five, is a larger room which can accommodate two beds. There is 24 hour nursing cover in the prison.

Previous deaths at Rye Hill

17. Since the Ombudsman's office took over responsibility for investigating deaths in prison custody in 2004, there have been 18 deaths at Rye Hill including that of the man. 12 of these were deaths due to natural causes. There have since been a further two deaths. There are no recommendations from previous investigations that are relevant to this report.

Her Majesty's Inspectorate of Prisons' (HMIP)

18. The last report published on Rye Hill by HM Inspectorate of Prisons followed an announced inspection in June 2011. The report found that Rye Hill was largely a safe prison. There were some good staff training materials on working with older prisoners, but no training had yet been delivered. Sharing of initial information about prisoners with disabilities was noted to be unsystematic. On healthcare, the report said:

    > "There was general prisoner dissatisfaction with the quality of health care, although our survey indicated that Rye Hill was viewed similarly to other category B training prisons. The general picture was of substantial recent progress that needed to be sustained. There were good working relationships at partnership board level and a shared vision for future developments. Clinical governance arrangements were robust … The range of therapeutic options for prisoners with emotional and mental health problems was underdeveloped."

19. In relation to the inpatient section of the healthcare centre, the report said:

    > "Admissions for non-health related problems did not occur and the inpatient unit was not used by default for prisoners with disabilities, although it offered bathing facilities for such prisoners. The unit offered 24-hour nursing care and there was a registered nurse and uniformed officer present at all times … Most inpatients had complex mental health problems and mental health in-reach team (MHIRT) nurses visited daily."

Independent Monitoring Board (IMB)

20. Each prison in England and Wales has an Independent Monitoring Board, made up of unpaid volunteers from the community who are responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are maintained.

21. The last report published by the IMB for Rye Hill for the year to March 2011 showed that the Board believed that the progress reported in the previous year had been maintained. The Prison had been stable and safe, and prisoners were treated with respect. The Board did note that the healthcare centre had been largely occupied by prisoners waiting for psychiatric appointments, assessments, or beds in outside establishments.

22. The investigator spoke to the Vice Chair of the IMB at Rye Hill. He knew the man, even though he had not made any applications to the Board. A member of the Board spoke to all prisoners at least once a week, and the man had never reported any problems.

KEY EVENTS

23. The man was born in Jamaica. He moved to the UK at the age of 22 and had good relationships with his large extended family here. Although he had some problems with his literacy, he had worked in a number of industrial professions, as well as working as a driver. He had worked for London councils for a number of years.

24. After losing a job at the age of 60, the man decided to retire. He apparently stopped drinking at that time and had never used illegal drugs. He had not suffered from any mental health problems. At the time of his arrest, he was taking several medications on a daily basis, including four inhalers for both long-term and acute relief of respiratory problems, and three medications used to treat high blood pressure and/or heart disease. He had also been prescribed aspirin to reduce the risk of heart attack or blood clots. He used a walking stick because of back problems. His sight was poor, more so in one eye than the other. .

25. The man was convicted of a number of historical sex offences. He had no previous convictions and sentencing was deferred to September. In a pre-sentence report, the man's probation officer noted that the man said that he suffered from Alzheimer's disease, although the probation officer was unable to confirm this. He reported that he had recently had an echocardiogram (a test using soundwaves to build a picture of the heart) and he appeared to have heart and blood pressure problems under investigation.

26. On 13 September 2010, the man was sentenced at to 13 years imprisonment. He was taken to HMP Wandsworth.

27. Although records from Wandsworth are limited (Wandsworth changed their computer systems soon after the man's arrival), they do show that the man had a reception health screen. The doctor prescribed medication which continued that which he had been receiving prior to his imprisonment. He was referred to the Disability Liaison Officer to assess his day-to-day needs. He was also noted to have a normal mental state and no substance misuse problems. The report noted that it would be appropriate to contact the man's doctor or hospital consultant in order to assess his care needs. A note on the man's medical file shows that contact was made with Homerton Hospital on 1 October to reschedule appointments that had been outstanding when he came into prison. However, there is no further indication of whether these appointments took place.

28. The man's OASys assessment was reviewed on 17 January 2011. The report noted that the man's health seemed to have deteriorated since the previous assessment in September. He was at times incoherent, and was visibly shaking. He said that he felt depressed at times due to being in prison, but did not report any thoughts of harming himself. The report noted that he was in poor health, and if Alzheimer's disease did develop,

this might mean that his care needs would become increasingly challenging over time.

29. In April 2011, following examinations, the man was diagnosed with Chronic Obstructive Pulmonary Disease (COPD), and it was noted that he had reduced his smoking considerably.

30. The man had ongoing contact with healthcare during his time in Wandsworth and his medication was regularly prescribed. On 2 November 2011, he transferred to Rye Hill. The Person Escort Record (PER) form that accompanied him did not contain anything under the "health risks" section. All checks throughout the transfer were noted to be "ok".

31. On arrival at Rye Hill, the man was given a standard reception health screen. The nurse noted that he had restricted mobility and walked with the aid of a stick. She commented that he might need help with some daily activities and would need a suitable location. He was referred to the optician, chiropodist and dentist. Records show that he might have missed his medication for one day across the period of his transfer, but that this had no significant effect on his health. He was also referred to the doctor for review and assessment, and saw the doctor on 4 November. The doctor noted that he had a chest infection and prescribed antibiotics.

32. A personal emergency evacuation plan was completed on 6 November (arrangements to ensure a person with a disability can get to a place of safety in an emergency). The plan noted that the man was blind in his right eye and walked with the aid of a stick. A note on the wing file the same day describes the man as polite and compliant. It said that he is quiet and asked little of staff. It noted that other prisoners were collecting his meals for him because he struggled to walk.

33. Prison Custody Officer (PCO) A was the man's Offender Supervisor in Rye Hill. He made a note on the man's personal record on 8 November that the Mental Health In-Reach team had been asked to assess the man. The record does not, though, say why and there are no references to this in the man's medical record. On the same day, the man reported that was not eating because he could not chew his food. He was referred to the doctor and saw Dr A, a locum doctor, for assessment. He was prescribed medication for indigestion. He told the doctor that he also had sore eyes, and was given lubricating drops. The following day, 9 November, he complained of swelling in his legs, and was seen in his cell by Nurse A. He was advised to move around more and to raise his feet when sitting. He was told to call healthcare if his symptoms worsened. He was already prescribed diuretics (medicine to reduce the fluid in the body), so was referred for blood tests.

34. Assessed by Dr A on 10 November, the man had no symptoms further than some remaining swelling of his ankles. The wing file shows that the

man spent his time in his cell, sometimes being visited by other prisoners. The results of his blood tests were returned, but the tests were incomplete so were rescheduled. He saw the optician and was referred to an ophthalmologist to be tested for glaucoma. A further entry on the file on 26 November, shows that he had trouble sleeping at night so slept during the day instead.

35. A review of the man's security categorisation was held on 29 November, however he had not been at Rye Hill long enough for his security category to be lowered. The review noted that the man did not attend work owing to his age. Always polite, it was noted that while he did not require any specific long-term medical care at that time, he would need a level of support from healthcare because of his age and chronic health issues.

36. In the evening of 2 December, the man reported difficulty breathing. Nurse B saw him briefly at 8.25pm in his cell. She noted swelling in his legs and feet and a discharge from his eyes. The man was not distressed and was able to talk in full sentences. The nurse had arrived without equipment and informed the man that he would be more fully examined later. She asked the doctor to see him.

37. Shortly afterwards, Dr B examined the man. He told the doctor that he had been short of breath over previous days and it was getting worse. He did not have any chest pain. He had been suffering swelling in his legs over the previous few weeks and had been prescribed furosemide (a diuretic, used to flush out excess fluid from the body). He smoked four or five cigarettes a day, which was a reduction on his previous 35-40. He said that he had been under the care of a cardiologist some five years previously, when an echocardiogram (a test which uses soundwaves to build a picture of the heart) showed that he had a heart murmur (an irregular sound heard during the heart's beat). The doctor noted that the man had a chronic cough and had been diagnosed Chronic Obstructive Pulmonary Disease (COPD), and Congestive Cardiac Failure (CCF: where the heart loses its ability to pump blood efficiently, reducing the flow of oxygen and nutrients around the body and causing problems like fatigue and shortness of breath). Although he was not suffering any chest pain, the doctor said that the man needed to go to hospital as an emergency. He went at 11.25pm and was subsequently admitted as an in-patient.

38. Following a security assessment, when taken to hospital the man was escorted by two prison officers, and was wearing handcuffs as well as being cuffed to one of the officers on a longer chain (known as an escort chain). The following day his security was reassessed, and it was agreed that while in the hospital bed the handcuffs could be removed, leaving just the escort chain to one of the escorting officers. The restraints could be removed for medical treatment. The security was reassessed one week later, 10 December, when it was agreed that the same level of security was required.

39. The man remained in hospital until discharged on 14 December. The hospital said that he would need to use an oxygen concentrator (provision of oxygen through a nasal cannula, two small tubes inserted into the patient's nostrils) so security clearance was gained for him to keep one in his cell. He was allocated to cell five in the healthcare centre. Being in healthcare meant that he was not allowed to smoke, so he was prescribed nicotine patches. This was the same situation he had been in while in hospital and the man was content with this.

40. PCO A saw the man on 15 December. The man told him that he felt better after his stay in hospital. PCO A saw him again on 22 December, when he noted that the man appeared frail. He spoke about his convictions and was shaky while talking about them. He said that he now remembered one of the offences, but denied the others.

41. While in the healthcare centre, the man remained under observation and was assessed every day. On weekdays, he was also usually seen by one of the prison doctors. He was using a nebuliser daily and was on various different medications. When his daily assessment was made on 20 December, his blood pressure was slightly raised. As a consequence, it was agreed that his prescription of aspirin would be withheld until his blood pressure dropped. When assessed the following day, this had happened, so aspirin was recommenced.

42. Members of the IMB regularly visit the healthcare centre. A member visited on 21 December and spoke to the man. He was watching television and said that he was okay. During the visit on 23 December, the man was asleep: the member noted that he looked poorly. When visited on 27 December, the member noted that he was on continuous oxygen. Again, he was watching television and told the member that he was okay.

43. The man was examined by a doctor 29 December, who noted that he was slightly short of breath. The doctor did not feel it was necessary to prescribe any specific treatment.

44. On 3 January, the man told the visiting IMB member that although he felt lonely, he was being well treated. On 5 January, the doctor noted that he had a chesty cough and prescribed antibiotics. The following day he told the doctor that he felt better.

45. When he saw the man on 6 January, PCO A noted that arrangements were being put in place for him to receive his next visit in his cell. It was not thought dignified for the man to have his oxygen concentrator with him in the visits hall.

46. During the night of 12 January, a prisoner in one of the healthcare cells adjacent to the man's caused a disturbance. The man was disturbed by the noise. Staff noted that his pulse was irregular and he was wheezing. He was given steroids and prescribed digoxin (a treatment for congestive

heart failure which addresses symptoms such as shortness of breath). When assessed by the doctor at lunchtime on 13 January, his pulse was still irregular and his medication was adjusted accordingly. His breathing had improved. When a nurse assessed him that afternoon, he was more settled and there were no concerns about his breathing.

47. In his assessment on 16 January, the man's heart beat was irregular. He also had a blocked nose. A member of the IMB visited the healthcare centre that day but, during the visit, the man was asleep in his chair. The man had been nervous about sleeping in his bed, worrying about falling over the wires and tubes from the oxygen concentrator, but a note in the wing observation book on 17 January showed that he had agreed to sleep in the bed if the furniture was rearranged. On 18 January, the man told the doctor that he was now able to walk short distances without needing his oxygen. On 19 January, the doctor noted that he was "not too bad", and his pulse was less irregular.

48. During the afternoon of 19 January, Rye Hill's deputy controller, went to the healthcare centre. He spoke to the man, who told him that he had taken a bath that day. The man said that he felt that he was being looked after. The deputy controller noted that the man seemed to be comfortable.

49. At approximately 1.30am on 20 January, a prisoner in one of the cells in healthcare began causing a disturbance. Discipline staff were trying to persuade him to stop, when the man pressed his cell call bell. Nurse B went to his cell, and saw that he was sitting on the edge of his bed. He appeared to be upset by the noise. The man often awoke at about this time and asked for his nebuliser. The nurse offered to fetch it for him and the man accepted, so the nurse told him to breathe slowly and said she would be back soon.

50. During the night, staff do not routinely carry keys for cell doors. Prison staff have a key in a sealed pouch, which is only to be used in a life-threatening emergency. Nurse B collected the man's nebuliser and at the same time rang the communication centre to request the night manager's attendance to open the cell. She then returned to the man's cell and saw him sitting on the edge of the bed. The noise from the other cell was continuing and the nurse shouted to the man that she was waiting for the night manager. The man said something in reply, but the nurse could not hear what he said above the noise. He had his arms round his chest, and the nurse shouted that he should breathe slowly and that she would be back.

51. Nurse B had to carry out a check on another prisoner. As she did this, the night manager arrived. This was at 1.45am. The night manager spoke to the prisoner causing the disturbance, and Nurse B went back to the man's cell. She looked through the window, and saw him kneeling on the floor, his head resting on the bed. She shouted for help and the night

manager, who was standing a few feet away, opened the door. Nurse B, the night manager and PCO B went in.

52. Nurse B and PCO B put the man in the recovery position while she assessed him. They moved him onto his back, and he was not breathing and she could not feel a pulse. The nurse and the PCO then began to perform cardiopulmonary resuscitation (CPR - a mixture of chest compressions and rescue breaths in order to maintain an oxygen flow around the body). The nurse told the night manager to summon an emergency ambulance, and gave her healthcare keys to PCO C and asked for the emergency bag and oxygen while she and PCO B continued with CPR. The night manager radioed through to the control centre and records show that the ambulance was requested at 1.53am. The night manager went to the office and collected the defibrillator (a machine which detects any heart activity and, if present, shocks the heart in an attempt to recommence a normal rhythm). PCO B took over chest compressions and the nurse inserted an airway into the man's mouth and attached an ambubag (which feeds breaths into the airway) over the man's face. The nurse then asked PCO D to manage the ambubag while she attached the defibrillator. It detected no rhythm, so staff continued to perform CPR.

53. The ambulance service sent a first response paramedic who arrived at the cell at 2.04am. Having been briefed by Nurse B, he took over the resuscitation attempts. At 2.22am, the full ambulance crew arrived and joined in attempts at resuscitation. They transferred the man into the ambulance at 2.35am. A risk assessment judged that the man did not require any physical restraints, and one officer should accompany him in the ambulance. A second officer followed in a car.

54. The ambulance took the man to University Hospital, which was the closest hospital able to treat a patient as ill as the man. (There is a hospital in Rugby with a minor injuries accident and emergency unit.) The ambulance arrived at the hospital at 2.57am. The man was pronounced dead at 3.10am.

Informing the family

55. The man had listed his son as next of kin. Rye Hill appointed a family liaison officer, PCO E who, along with the Chaplain, travelled to the given address early on 20 January. Although there was no reply at that time, they managed to trace the man's son later that day and told him of his father's death. The man's wife was abroad, but the following day she returned to the UK. The prison remained in contact with the man's wife as next of kin.

56. Having made the initial contact, the nominated family liaison officer subsequently reported sick. Contacts with the family were thereafter shared between the Chaplain and the Head of Safer Custody.

Debrief

57. After a death, prison managers should hold a “hot debrief”. This is a meeting of all the staff who were involved in the care and emergency response. The meeting should focus on reassurance, information sharing and how staff can support each other.

58. A hot debrief was held at 7.25am on 20 January, chaired by the Duty Director. Staff reported that they were okay. Support was discussed, including possible delayed impact and it was stressed that support was available on an ongoing basis, not just at the time.

59. The staff care team were informed and contacted individuals who had been involved in treating the man the following evening.

60. A notice was issued to all other staff informing them of the man’s death. The staff care team were placed on alert in case their services were required. The notice also reminded staff that if any prisoners appeared to be affected, support was available from Listeners and the Samaritans.

Informing prisoners

61. Prisoners who were identified as having been friends of the man and were spoken to individually. The prisoner who acted as the offender co-ordinator (responsible for formal liaison between prisoners and staff) was informed of the man’s death so that he could inform Listeners (prisoners selected and trained by the Samaritans to offer confidential support to fellow prisoners in distress) in case any prisoners needed support. Prisoners who had shared the man’s wing were spoken to by staff.

62. Other prisoners were informed of the man’s death through a notice from the Director. This notice reminded prisoners that Listeners and Samaritans were available to them if they needed support. All prisoners who were thought to be at potential risk of harming themselves and subject to special monitoring measures, or had recently been taken off such measures, had their circumstances reviewed.

Post Mortem

63. A post mortem was carried out by Professor Rutty at Leicester Royal Infirmary on 26 January. The professor concluded that the man’s death was due to:

    1a Left sided pneumothorax
    1b Chronic obstructive pulmonary disease.

64. Pneumothorax is a complication of COPD. Growths on the surface of the lung can rupture into the lung cavity, causing the lung to collapse.

Funeral

65. The funeral was held on 24 February and the prison contributed towards some of the cost. Following discussion with the man's family, the prison was not represented at the funeral.

ISSUES

The man's healthcare

66. The clinical reviewer notes that, during his imprisonment, the man had prompt access to healthcare staff at all times and his needs were effectively assessed. Records in Rye Hill were well kept, which allowed good quality care and planning of his treatment.

67. When he was first received into prison at HMP Wandsworth, the man had a reception health screen. Medication records are not sufficiently detailed on this, because HMP Wandsworth changed the computerised medical records system they used shortly after he arrived. However, the clinical reviewer is satisfied that the medication prescribed at that time correlated with that prescribed by his doctor prior to the man's imprisonment. Staff also noted concerns over the man's heart, and contact was made with the hospital where he had some appointments due so that these could be rescheduled. The records do not show whether these took place, although the clinical reviewer writes that there is no evidence that his care was disadvantaged. Staff also noted that the man said he had Alzheimer's disease and that this might develop. However there were no subsequent signs of this through his imprisonment.

68. Apart from a small oversight during his transfer between prisons, the man received his medication regularly. It was adjusted when necessary. The man's main chronic condition of COPD was correctly diagnosed and he had appropriate medication. In Rye Hill, when his COPD worsened, this was correctly identified and he was immediately transferred to hospital. In the clinical reviewer's opinion, the man received a level and standard of healthcare at least equal to that which he would have received in the community.

The man's location on his return from hospital

69. When the man returned to prison from hospital, there was good communication between the prison and hospital and appropriate plans were made for his discharge. Cell five in the healthcare centre is a large room, with a good-sized window. A settee was brought into the room for him to use. The man needed oxygen to be available to him at all times, and a concentrator (a device which provides oxygen to a patient) was obtained by the prison. This meant that he was unable to smoke, so he was issued with nicotine patches. Staff confirmed that he was content with this approach.

70. Being located in the healthcare centre meant that the man had the benefit of continual access to nursing staff. He was assessed by a doctor most days, and had a level of medical support which would have been unlikely to have been available to him in the community.

71. It is encouraging to see that once he was using the oxygen concentrator, arrangements were put in place for the man to receive any visitors in his cell. He needed the machine nearby at all times, and it was recognised that this would be difficult and affect his dignity to have it transported into the visits hall. This shows sensitive and considerate care.

72. One consequence of being in the healthcare centre, however, was the proximity to the cell used for prisoners on constant supervision (continuous observation by staff to stop them from harming themselves). This cell is the only one of its type in the prison. It can sometimes contain prisoners with serious behavioural problems, who might cause a disturbance. This was the case on two occasions in January 2012, including the night the man died. On both occasions, The man became distressed by the noise.

73. The clinical reviewer notes that the fact that the man collapsed and staff could detect no pulse so quickly indicates a sudden increase in the size of his pneumothorax. Although the commotion caused by another prisoner may have disturbed he man, it was unlikely to have triggered the problem that caused his death.

74. Nevertheless, patients who require in-patient healthcare should be disturbed as little as possible. Prison staff told the investigator that arrangements were underway for the constant-monitoring cell to be moved out of healthcare and this was planned to happen by October 2012. It is encouraging that this issue has been recognised and is being addressed. Nevertheless, we make the following recommendation:

    The Director should ensure that prisoners on constant supervision are only located within the healthcare centre in line with medical need.

75. The clinical reviewer concludes that the man received effective healthcare. This was delivered with due respect for his age and health by staff endeavouring to do their best for him.

Use of restraints

76. When prisoners are taken out of the prison, including to hospital, staff must consider the risk they present and provide security as necessary. When the man was taken to hospital in December 2011, he was subject to double cuff restraints and escorted by two prison officers. The man left Rye Hill at 11.25pm, and in an emergency ambulance. His security was reassessed the following day, when it was agreed that while he was in

hospital he should just be cuffed to a prison officer by an escort chain. This could be removed during any medical treatment. This was reassessed a week later, when the same security level was agreed.

77. As regards restraints, Rye Hill have a local security strategy based on the Prison Service National Security Framework. The risk assessment is completed and then presented to the Head of Security or Duty Director for them to make a decision based on the information available to them. Rye Hill say that in the man's case, the Duty Director's decision followed Prison Service policy and took into account the man's category B security status. This category had been decided in his previous prison and he had not been at Rye Hill for sufficient time to allow his security category to have been reviewed. Moreover, he was serving a significant sentence, which Rye Hill say would have reinforced the decision to retain some level of restraint.

78. The man was an elderly man who was clearly unwell. He was, though, conscious and mobile through this time. Security was reassessed the day after he was admitted to hospital, and further assessed one week later. He was a recent arrival in Rye Hill, and was to an extent an unknown quantity. He remained a category B prisoner. Nevertheless, we are concerned that the man was likely to have presented a very low risk of escape during his time in hospital, and at his age and in his state of health would have had difficulty evading two members of staff. We are not satisfied that the initial risk assessment fully took into account the man's individual circumstances and the risk of escape he actually presented at the time.

The Director should ensure that a prisoner's health, mobility and actual risk at the time are considered and taken fully into account in deciding the level of escort and whether restraints are needed.

The emergency response

79. At night, the night manager has keys to access cells. Other prison staff have cell keys in a sealed pouch. The seal is only to be broken for life-threatening emergencies. When Nurse B saw that the man was in some distress, there was no indication that the situation was life-threatening and she called for the night manager to come to the healthcare centre to open the cell so the man could be given his nebuliser. The night manager was already in the healthcare centre when it became clear that the man required emergency assistance. Entry to his cell was not delayed and staff provided medical aid immediately. An ambulance was summoned very quickly. Staff were deployed to the gate to ensure that paramedics were brought to the man without delay.

80. The clinical reviewer notes that staff had received appropriate training, and had immediate access to resuscitation equipment. Evidence from the camcorder footage shows that proper attempts to resuscitate the man were made. The paramedics who attended the prison praised the staff's

professionalism. They said that they “did exactly as their training demanded and no more could have been done by staff to help”.

Family liaison

81. When the man died, a trained prison family liaison officer was appointed. He and the Chaplain travelled to the address of the man’s next of kin to break the news. This was done appropriately according to guidance. However, after making the initial contact with the family, the family liaison officer went off sick from work. Owing to some staff having recently moved to a newly-opened prison, Rye Hill only had one other trained family liaison officer. She was not at work that week. Consequently, the Chaplain and the Head of Safer Custody took over the liaison with the man’s family and it appears that they offered all possible support. However, this did mean that the family had three different contacts at the prison. At such a stressful time for the bereaved family this situation is not ideal. While we understand more staff were due to be trained for the role, and the family expressed no concerns to us, the Director should ensure that there are sufficient trained family liaison officers available at all times.

    The Director should ensure that there are sufficient trained family liaison officers available at all times, so that a single point of contact is available for the bereaved family.

82. Prison Service Order (PSO) 2710 offers guidance on procedures following a death in custody. [1]The PSO says that Governors “must offer to pay reasonable funeral expenses” to the family of the deceased. Further guidance states:

    > “Offer to pay <u>reasonable</u> funeral expenses or, if the family want particularly expensive arrangements, offer a contribution. £3000 is the sort of figure considered reasonable in 2005-06 but do not quibble over small sums. This offer should be made irrespective of whether the family is entitled to claim a grant from the Social Fund.”

83. In the experience of this office, dealing with establishments from across the prison estate, the cost of a funeral after a death in custody is almost always either met in full or by way of a contribution up to the suggested maximum of £3000, as set out the National Offender Management Service’s own guidance. Staff at Rye Hill discussed funeral costs with the man’s family and offered to contribute half of the overall cost. The full cost was lower than the recommended limit. Although the family indicated that they were content with this, they may not have been aware of the guidance and we are disappointed that the prison did not offer to meet the full costs.

[1] Since the man’s death, guidance has been reissued in Prison Service Instruction 64/2011

The Director should ensure that bereaved families are offered reasonable funeral costs in line with contribution suggested in national guidance.

CONCLUSION

84. The man was an elderly man who was not in the best of health when he was received into prison. He was prescribed appropriate medication for his conditions and these were kept under review.

85. In November 2011, the man transferred to Rye Hill. In early December he reported difficulty breathing. He was seen by a nurse, subsequently by a doctor, and diagnosed with COPD. He was taken to hospital as an emergency admission, and remained there for 12 days.

86. When discharged from hospital, the man needed constant use of an oxygen concentrator. The prison arranged security clearance for this, and allocated the man a large room in the healthcare centre where he could be more comfortable. He was assessed daily.

87. In the early hours of 12 January, a prisoner in another cell in the healthcare centre created a disturbance. This caused the man a degree of distress. He was given some medication, but his heart rate remained irregular through the following day.

88. In the early hours of 20 January, a different prisoner caused some disruption in the healthcare centre. Again, this disturbed the man and he pressed his cell call bell. The nurse who responded noted that he was distressed and offered him use of his nebuliser, an offer he accepted. She collected the nebuliser and asked the night manager to come to the healthcare centre to allow access to the cell. When she returned, the man had collapsed. Staff immediately entered the cell and provided first aid. An ambulance was summoned, and the man was transferred to hospital, where he was pronounced dead at 3.10am.

89. The clinical reviewer finds that the man received care at least equivalent to that which he could have expected in the community. Although he was disturbed by noise from a nearby cell on the night he died, she writes that it is unlikely that this caused the problem which led to his death.

90. We are satisfied that the man received good care in prison. Following his death there was an issue over the availability of trained family liaison officers in the establishment, and we consider that the prison ought to have paid all the funeral costs as these fell below the maximum contribution suggested in national guidance.

RECOMMENDATIONS

1. The Director should ensure that prisoners on constant supervision are only located within the healthcare centre in line with medical need.

   NOMS rejected this recommendation. They said that there is only one gated observation cell in the establishment and this is located in the Healthcare Unit. Prisoners will be located in this cell due to their assessed risk of suicide or potential fatal self-harm in line with the Safer Custody policy PSI 64/2011. There will not necessarily be a medical need for their location in this cell.

2. The Director should ensure that a prisoner's health, mobility and actual risk at the time are considered and taken fully into account in deciding the level of escort and whether restraints are needed.

   This recommendation was accepted. NOMS said that the Director will ensure that risk assessments for all escorts are based on an assessment of the offender's health and mobility at the time and any relevant security intelligence. Duty Directors and Managers responsible for completing escort risk assessments will receive refresher training to ensure that individual circumstances are always taken into account ensuring that the reasons for the decision are recorded appropriately.

3. The Director should ensure that there are sufficient trained family liaison officers available at all times, and that a single point of contact is available for the bereaved family.

   This recommendation was accepted. NOMS said that two further staff have been trained, which makes four staff in the prison available to undertake the role.

4. The Director should ensure that bereaved families are offered reasonable funeral costs in line with national guidance.

   NOMS accepted this recommendation, commenting that the Director will ensure that the relevant staff are reminded of this guidance to ensure that bereaved families are always offered reasonable funeral costs in line with this national guidance.