

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Investigation into the death of a man, a prisoner at HMP Rye Hill, on 15 February 2015

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

**We are:**

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

The man died of pancreatic cancer on 15 February 2015, while a prisoner at HMP Rye Hill. He was 61 years old. I offer my condolences to his family and friends.

I consider that the man received an appropriate standard of care at Rye Hill. His cancer was identified after an acute admission to hospital and I do not consider that healthcare staff at the prison could have detected his cancer earlier. However, I am not satisfied that the prison made an appropriate contribution to reasonable funeral expenses, as a national Prison Service instruction requires.

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**

**September 2015**

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# Summary

## Events

1. In January 2013, the man was remanded to HMP Nottingham. In February, he was sentenced to 12 years for sexual offences.
2. At Nottingham, the man had several episodes of fainting and healthcare staff referred him to hospital twice. Doctors found that his fainting was due to a previous spine injury and heart problem. A blood test in July 2014 established that his liver function was normal.
3. The man transferred to Rye Hill on 18 November 2014. At an initial health screen, a nurse recorded that his weight was consistent with previous records that year. On 9 December, a nurse examined him, after he complained of generalised pain. The nurse noted that he had fibromyalgia (a chronic condition that causes pain all over the body including muscle and joint pain) and referred him to the GP. On 23 December, a GP reviewed him, who said he had stomach pain associated with flatulence and constipation. The GP found no worrying features and prescribed medication.
4. On 6 January 2015, the man collapsed at work and told a nurse that he had a severe pain in his side and was constipated. A doctor prescribed medication for constipation. On 12 January, he collapsed again with chest and stomach pains and was taken to hospital.
5. At the hospital, doctors diagnosed the man with liver and pancreatic cancer and said he had only weeks or months to live. He remained in hospital and later transferred to a hospice, where he died on 15 February.

## Findings

6. The clinical reviewer was satisfied that the man received an equivalent standard of care at both Nottingham and Rye Hill to that he could have expected to have received in the community. He considered there was no opportunity to identify his cancer sooner.
7. We are satisfied that the man received an appropriate standard of healthcare in prison.
8. The prison contributed towards some of the costs of the man's funeral, but we are not satisfied that this was sufficient or in line with the reasonable expenses required by Prison Service instructions.

## Recommendations

- The Director of HMP Rye Hill should ensure that, in line with Prison Service instructions, the prison offers to pay a contribution towards reasonable funeral expenses of up to £3,000.

## The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Rye Hill and HMP Nottingham informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
10. The investigator obtained copies of relevant extracts from the man's prison and medical records. He interviewed two members of staff by telephone on 20 and 21 May 2015.
11. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.
12. We informed HM Coroner for Northamptonshire of the investigation who gave the cause of death. We have sent the coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted the man's daughter to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She had no concerns about her father's care at Rye Hill but had some questions about his healthcare at Nottingham. These issues were not related to the circumstances of his death, but are covered in the clinical review and we have written to his daughter separately about this aspect of his care.
14. The investigation has assessed the main issues involved in the man's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.
15. The man's daughter received a copy of the draft report. She did not raise any further issues, or comment on the factual accuracy of the report.
16. The draft report was shared with the Prison Service. There were no factual inaccuracies and the action plan has been added to the end of this report.

# Background Information

## HMP Rye Hill

17. HMP Rye Hill is run by G4S and holds more than 600 convicted men. Since 2014, it has been a national resource for men who have been convicted of a current or previous sex offence. G4S Justice Health provides nursing cover 24 hours a day. The prison does not have an inpatient healthcare facility.

## HM Inspectorate of Prisons

18. The most recent inspection of HMP Rye Hill was in July 2011. At the time, inspectors found that the general picture of healthcare services 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. There was a reasonable range of clinics for primary care and lifelong conditions. Waiting lists and failure to attend rates were reducing. Inspectors found that a poor healthcare environment sometimes compromised professional patient care. There was a palliative care pathway and an end-of-life policy, which were used occasionally.

## Independent Monitoring Board

19. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published annual report for the year to March 2014, the IMB found that healthcare was understaffed and the use of bank staff through the year had led to insufficient continuity. GP cover consisted of part time and locum doctors. The IMB noted that the inpatient unit had closed in December 2013.

## Previous deaths at HMP [prison]

20. There have been three deaths at Rye Hill since January 2012. An investigation into a death at another prison in 2014, also examined relevant aspects of the prisoner's care at Rye Hill, including the use of restraints in hospital. We have previously made recommendations about issues relating to clinical care, compassionate release and the unjustified use of restraints.

## **HMP Nottingham**

21. HMP Nottingham is a local prison serving the courts in Nottinghamshire and Derbyshire and holds over 1,000 men. Nottinghamshire Healthcare Trust provides health services at the prison. Prisoners who need nursing care are located in an enhanced care area on F Wing, where nurses are on duty 24 hours a day.

## **HM Inspectorate of Prisons**

22. The most recent inspection of Nottingham was in September 2014. The Inspectorate noted that an experienced nurse manager led service delivery, but staff vacancies had affected provision and waiting times. A core group of flexible and well-motivated staff, supported by regular agency staff, and primary mental health nurses, covered all essential activities and were available twenty-four hours a day. Inspectors found that prisoners were dissatisfied with access to most health services, but healthcare was reasonably good.

## **Independent Monitoring Board**

23. In its most recently published report, for the year to February 2014, the IMB repeated previous concerns about the lack of healthcare staff involvement in prisoner induction programmes. The IMB noted that an increasing reliance on agency healthcare staff had the potential to affect the continuity of care for prisoners.

# Findings

## The diagnosis of the man's terminal illness and informing him of his condition

24. The man was remanded to HMP Nottingham in January 2013. In February, he was sentenced to twelve years in prison for sexual offences. When he arrived at Nottingham, he had a number of medical conditions including diabetes, fibromyalgia (a chronic condition that causes pain all over the body including muscle and joint pain), an historical cervical spine injury and a congenital heart problem (which caused fainting). In April 2014, he was diagnosed with glaucoma.
25. On 23 July 2014, a prison GP recorded the results of a blood test to monitor his diabetes, which showed normal liver function. The medical records show that the man's weight fell by 8kg while he was at Nottingham. Healthcare staff gave him dietary advice, but did not consider his weight loss was concerning.
26. On 18 November 2014, the man transferred to HMP Rye Hill. When he arrived, he saw a GP, who prescribed medication and pain relief for his health conditions. In the last week of November, nurses gave him paracetamol six times for 'generalised pains' or a headache. A healthcare assistant booked an appointment for him to see a GP on 3 December, but he did not attend. No reasons were recorded. On 9 December, he told a nurse that he had suffered from general aches and pains since he had arrived at Rye Hill. The nurse noted that he had fibromyalgia, advised him to keep taking his pain relief medication and referred him for a GP appointment.
27. On 23 December, a locum GP examined the man, who said he had had stomach pain for around five weeks, associated with flatulence and constipation after eating. The GP found no serious concerns and noted that he might have gastroparesis (a condition where food passes through the stomach more slowly than usual and can be caused by diabetes). He prescribed a course of omeprazole medication, which reduces stomach acid.
28. On 6 January 2015, the man collapsed at work. He told a nurse that he had severe pain in his lower left side, felt sick and reported symptoms of constipation. The nurse spoke to the doctor who prescribed medication for constipation. Three days later, a nurse gave him a sick note for a half day off work, as he had stomach pains. He asked him to see a nurse again that evening to review his condition. There is no record that he did.
29. On the morning of the 12 January, the man collapsed with chest and stomach pains. An officer radioed a code blue medical emergency and the control room requested an ambulance immediately, in line with national instructions. A nurse gave him some oxygen to help with his breathing, glyceryl trinitrate spray for chest pain and took him to the healthcare centre in a wheelchair to wait for the ambulance. An emergency ambulance took him to hospital in Coventry.
30. The man was admitted to hospital and tests showed he had liver and pancreatic cancer. On 16 January, doctors told him his diagnosis and he decided he did not want to have chemotherapy. A nurse and the Head of Safer Custody discussed the diagnosis with him and offered support. On 26 January, a consultant at the hospital said that his prognosis was weeks to months at that stage.

31. The clinical reviewer considered that, although the man complained of stomach pains in December 2014 and January 2015, clinicians could not have anticipated the eventual diagnosis of liver and pancreatic cancer, which was made after an acute hospital admission. We are satisfied that there was no delay in diagnosing his illness and that he was appropriately informed and supported after the cancer was diagnosed.

### **The man's medical treatment**

32. After the man's diagnosis, prison and healthcare staff contacted the hospital and visited him for regular updates on the progress of his condition. On 27 January, a member of staff at the hospital told a nurse that they planned to discharge him the next day. The nurse was concerned that the prison would not be able to meet his clinical needs. On 28 January, a member of the prison's healthcare team spoke to the hospital and explained that the prison did not have end of life care facilities. Hospital staff decided not to discharge him back to the prison as originally planned. On 12 February, he went to a hospice in Northampton.
33. After his diagnosis, all of the man's clinical care was the responsibility of the hospital and the hospice and he never went back to the prison. This care is outside the remit of this investigation.
34. A day after he arrived at the hospice, the man's health declined quickly and he died at 12.10am on 15 February.
35. The coroner did not require a post-mortem examination as the man died at the hospice. A doctor from the hospice confirmed that the cause of death was metastatic pancreatic cancer.
36. All of the man's care and treatment after his diagnosis was at the hospital and the hospice. We are therefore satisfied that the standard of care he received was equivalent to that anyone in the community would have received. There was good communication between the prison and the hospital to help ensure he received suitable end of life care.

### **The man's location**

37. As noted, the man remained in hospital after his diagnosis and subsequently transferred to a hospice for end of life care. He died very shortly after he arrived at the hospice. We are satisfied that the prison took reasonable steps to ensure his location was appropriate throughout his illness.

### **Restraints, security and escorts**

38. When prisoners have to travel outside of the prison to a hospital or hospice, a risk assessment is conducted to determine the nature and level of any security arrangements, including any restraints.
39. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity and maintain their dignity. The level of restraints used should be necessary in the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public

and which also takes account of factors such as the prisoner's health and mobility.

40. On 12 January, when the man was taken to hospital by emergency ambulance, two officers accompanied him and used double handcuffs to restrain him, the standard level of restraint for a category B prisoner. As he had been fit and working that day, we are satisfied that this was reasonable.
41. On 19 January, after the man had been diagnosed with cancer, the risk assessment was reviewed and the level of restraint was reduced to an escort chain. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.) On 7 February, prison staff reviewed his risk assessment again and decided that no restraints should be used from that point. The escort was reduced to one plain clothed officer.
42. We are satisfied that the prison, appropriately reviewed the man's level of risk as his illness progressed and reduced the level of restraint accordingly.

### **Liaison with the man's family**

43. On 16 January, the Head of Safer Custody telephoned the man's daughter to tell her that her father was in hospital and doctors had diagnosed cancer.
44. An officer acted as the prison's family liaison officer. She kept in frequent contact with the man's daughter to help organise visits and to give them updates on his health. When his health deteriorated significantly on 14 February, the officer contacted the man's family, who visited him that evening. He died in the early hours of the next morning.
45. After the man died, the Director at Rye Hill telephoned the man's daughter to offer his condolences. The Director remained in contact with the family to offer support and discuss funeral arrangements. We are satisfied the family was informed promptly when he was diagnosed with cancer and updated when his health deteriorated.
46. Rye Hill paid half the funeral costs. We have examined the funeral directors' invoice and are not satisfied that the prison paid reasonable funeral expenses as they are required to do under Prison Service Instruction 64/2011. This states that, "Prisons must offer to pay a contribution towards reasonable funeral expenses of up to £3,000". The PSI sets out the type of expenses it would be reasonable to pay, yet Rye Hill arbitrarily paid only half. We do not consider that the prison properly applied the requirements of the PSI and should reimburse the man's family for additional costs, covered by the PSI, that they were required to pay. We make the following recommendation:

**The Director should ensure that, in line with Prison Service instructions, the prison offers to pay a contribution towards reasonable funeral expenses of up to £3,000.**

### **Compassionate release**

47. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are

suffering from a terminal illness and have a life expectancy of less than three months.

48. On 26 January, a consultant at the hospital gave the man a terminal prognosis of weeks to months. The next day, a GP completed the medical section of an application for compassionate release. On the same day, a probation officer recorded on the application that he did not believe the proposed address for release was a suitable environment because of his risk of re-offending. On 3 February, the Director completed the final section of the application. Because of the probation officer's concerns, he did not support compassionate release.
49. The prison sent the man's application to the Public Protection Casework Section (PPCS) at the National Offender Management Service (NOMS). On 6 February, the PPCS contacted Rye Hill, and asked for a summary of his physical state. A nurse agreed to obtain a mobility assessment but he died before this was completed.
50. We are satisfied that the prison appropriately considered compassionate release. As soon as it was clear that the man only had a short time left to live, the prison started the application, but sadly, did not complete it before he died.

# Action plan

No	Recommendation	Accepted / Not accepted	Response	Target date for completion and Function Responsible	Progress (to be updated after 6 months)
1	The Director of HMP Rye Hill should ensure that, in line with Prison Service instructions, the prison offers to pay a contribution towards reasonable funeral expenses of up to £3,000.	Accepted	The Director will make adjustments to ensure that the prison offers to pay a contribution towards reasonable funeral expenses of up to £3,000, when required, to the family of the deceased.	31st July 2015 Director of Rye Hill	

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