

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Shane Ray a prisoner at HMP Bullingdon on 10 September 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.

Mr Shane Ray died on 10 September 2015, of bacterial and tuberculous pneumonia, exacerbated by chronic obstructive pulmonary disease, while a prisoner at HMP Bullingdon. He was 52 years old. I offer my condolences to Mr Ray's family and friends.

Despite his lung conditions, Mr Ray continued to smoke heavily and refused help to give up. He had very poor lung function and was prone to infection. I am satisfied that the prison followed relevant national guidelines in caring for Mr Ray and that he received a standard of care equivalent to that he could have expected to receive in the community. Restraints were used when Mr Ray was taken to hospital three days before his death. Although they were removed quickly when Mr Ray collapsed, the prison has been unable to provide a risk assessment and authority for their use. In the light of Mr Ray's medical condition and poor mobility at the time, it is difficult to see how they were justified.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

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

**May 2016**

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# Summary

## Events

1. On 28 February 2006, Mr Shane Ray was sentenced to an indeterminate sentence for public protection. In January 2007, he transferred to HMP Albany (now part of HMP Isle of Wight). Mr Ray was a heavy cigarette smoker and declined advice and help to give up.
2. In April 2010, a doctor diagnosed Mr Ray with chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases, including chronic bronchitis and emphysema). In June, hospital doctors also diagnosed chronic pulmonary tuberculosis (TB – an infectious bacterial lung disease). In October, Mr Ray was treated in hospital for an exacerbation of COPD.
3. In June 2011, Mr Ray tested negative for TB and he completed his course of medication for the condition in July. In September, Mr Ray suffered acute respiratory failure and was treated for a collapsed lung. In November, doctors noted he had severe COPD.
4. In October 2014, Mr Ray transferred to HMP Bullingdon and his shortness of breath became worse. By August 2015, Mr Ray's health had deteriorated significantly. He had a prisoner carer to help him with daily tasks and a wheelchair to help get about.
5. On 7 September, Mr Ray's cellmate called for help when Mr Ray went grey and struggled to breathe. Healthcare staff gave Mr Ray oxygen and he was admitted to hospital. He was restrained by an escort chain but this was removed after he collapsed shortly after arriving at the hospital. Mr Ray's condition continued to deteriorate and he died in hospital on 10 September.

## Findings

6. We are satisfied that Mr Ray received an appropriate standard of care in prison. Healthcare staff looked after Mr Ray well and managed his COPD and TB in line with national clinical guidelines. We consider that Mr Ray's care in prison was equivalent to that he could have expected to receive in the community.
7. While restraints were removed shortly after Mr Ray collapsed at hospital on 7 September, we are not satisfied that their initial use was justified by a fully considered risk assessment, which took account of his condition at the time and how this affected his risk of escape.

## Recommendation

- The Governor should ensure that when restraints are used for prisoners taken to hospital, there are properly considered risk assessments, in line with the legal guidance, which fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

## The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Bullingdon informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
9. The investigator obtained copies of relevant extracts from Mr Ray's prison and medical records.
10. NHS England commissioned a clinical reviewer to review Mr Ray's clinical care at the prison.
11. We informed HM Coroner for the County of Oxfordshire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
12. One of the Ombudsman's family liaison officers contacted Mr Ray's brother to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr Ray's brother asked whether Mr Ray had active tuberculosis and when he had been diagnosed with COPD.
13. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.
14. Mr Ray's brother received a copy of the initial report. He did not raise any further issues, or comment on the factual accuracy of the report.

## Background Information

### HMP Bullingdon

15. HMP Bullingdon is a training and local prison, serving the courts of Oxfordshire and Berkshire. It holds up to 1,114 men. Virgin Care provides healthcare services. There is 24-hour healthcare cover with 21 in-patient beds.

### HM Inspectorate of Prisons

16. The most recent inspection of HMP Bullingdon was in June 2015. The inspectorate noted that healthcare services had improved from a relatively low base and was now reasonably good. Support for those with lifelong conditions was good. There was good access to smoking cessation services, immunisations and treatment for blood-borne viruses. Pharmacy staff provided a range of clinics, including respiratory and smoking cessation, and medicine use reviews. Emergency bags, oxygen and automated defibrillators, were located across the prison and checked regularly.

### Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to July 2015, the IMB noted there had been improvements in healthcare; recruitment was more effective, waiting lists had reduced and patient attendance rates had increased. Following implementation of the Care Act 2014, staff from the community based Adult Health and Social Care Team were now assessing and providing targeted personal care for prisoners on all wings.

### Previous deaths at HMP Bullingdon

18. Mr Ray was the second person to die of natural causes at Bullingdon since January 2014. There were no significant similarities with the circumstances of the previous death.

## Key Events

19. On 28 February 2006, Mr Shane Ray was sentenced to an indeterminate sentence for public protection, with a minimum term of 30 months before he could be considered for release. (The Parole Board had never considered his risk of re-offending had reduced enough to direct his release.) Mr Ray was a heavy cigarette smoker and consistently declined help to give up.
20. On 10 January 2007, Mr Ray transferred to HMP Albany (now part of HMP Isle of Wight). Healthcare staff treated him for a number of conditions including asthma, chronic low back pain, depression and anxiety.

### 2010/11

21. On 9 March 2010, a prison GP examined Mr Ray, and requested blood tests, which were abnormal. On 6 April, the GP diagnosed Mr Ray with chronic obstructive pulmonary disease (COPD) and prescribed inhalers.
22. In May, a chest X-ray showed an acute infection in Mr Ray's lungs and doctors suspected tuberculosis (TB). On 11 June, hospital microbiological blood tests confirmed Mr Ray had chronic pulmonary TB. Mr Ray was held in isolation in the prison's inpatient unit and treated with antibiotics.
23. On 29 October, Mr Ray complained of chest pain and shortness of breath and was treated for an exacerbation of his COPD in hospital. Mr Ray discharged himself the next day and returned to isolation treatment at the prison for TB. Healthcare staff reviewed Mr Ray daily, and he left isolation on 3 December.
24. On 3 June 2011, Mr Ray's sputum cultures were negative for TB, and he completed his course of medication for TB on 26 July. On 20 September, Mr Ray suffered an acute respiratory failure and was admitted to hospital, where doctors treated him for a collapsed lung. Doctors told him that if he did not give up smoking, his life expectancy was five to seven years. Mr Ray returned to the prison the next day.
25. Mr Ray continued to suffer from breathlessness and continued to smoke, against advice. He attended hospital respiratory and chest clinics regularly and had a nebuliser to use in his cell. (A nebuliser administers medication in the form of a mist.) On 2 November, hospital doctors diagnosed him with severe COPD and noted he was clear of TB.

### 2012/13

26. In 2012, there was a new case of TB at the prison, so staff arranged for Mr Ray to be tested again. Sputum samples showed he did not have active TB. Mr Ray had COPD reviews in October 2012 and August 2013 and staff noted he was still smoking. His clinical observations remained within normal limits and no further action to treat his COPD was required.

### 2014

27. On 21 October 2014, Mr Ray was moved to HMP Bullingdon. At an initial health assessment, Mr Ray said he had difficulty in breathing as he had COPD. He still

smoked. He said he had no history of tuberculosis and had had no tuberculosis contact (which was not correct). Mr Ray had laboured breathing and collapsed in reception but quickly regained his breath. He refused to be admitted for observation in the prison's inpatient unit.

28. On 30 October, a respiratory nurse, Nurse A, carried out Mr Ray's annual COPD review. Mr Ray told her both his parents had had TB in the 1960's and that he had had TB at The Isle of Wight. He said he had pleurisy, COPD and emphysema. He had smoked from the age of 16 and had difficulty managing steps and stairs. Nurse A advised him about giving up smoking, discussed a care plan with him, and planned quarterly COPD reviews.

## 2015

29. On 22 January 2015, Nurse A saw Mr Ray for his quarterly COPD review. Mr Ray was short of breath and it took five minutes for him to recover. Mr Ray said he got very short of breath on exertion. His phlegm was very sticky, and stringy. The nurse assessed Mr Ray's shortness of breath as high with minimal activity and gave him a new nebuliser.
30. Mr Ray did not attend respiratory clinic appointments on 12 and 19 February or an appointment with Nurse B on 24 February. She spoke to a dietician who saw Mr Ray regularly about his nutrition, as he was underweight. The dietician told her that Mr Ray found it difficult to get to healthcare appointments, due to shortness of breath. They decided in future they would see Mr Ray on his wing and arranged for him to have a wheelchair.
31. On 31 July, the dietician noted Mr Ray had put on weight. His breathlessness had increased and he sometimes struggled to speak.
32. On 13 August, Nurse A saw Mr Ray for a quarterly COPD review. He said he did not use his nebuliser very often. He was still smoking, and continued to have yellow, sticky phlegm. Mr Ray said he felt he was declining and did not leave his cell much because he was so breathless. She advised Mr Ray to giving up smoking and he said he was thinking about it. She advised him on body positioning to aid his breathing and that he should use his salbutamol nebuliser when he was very short of breath. She gave him a new nebuliser.
33. On 20 August, Nurse A reviewed Mr Ray again. His oxygen saturation was 92% (the normal range is 95-100%) and his breathlessness was at the highest level on the scale. She advised Mr Ray that he should be admitted to the prison's inpatient unit but he wanted to stay where he was. He said he would let staff know if things got worse.
34. The next day, Nurse B saw Mr Ray for a social care assessment. She noted he had a prisoner carer, who collected his meals, did his laundry and pushed his wheelchair. Mr Ray said he was able to sit, stand and walk to the wheelchair but this caused him to become breathless and he needed time to recover.
35. On 27 August, Nurse A noted that he looked better but was still breathing through pursed lips, which she had noted earlier. Mr Ray said he did not like using the nebuliser. Nurse A suggested he should use the salbutamol inhaler,

but if it did not improve his breathing within ten minutes he needed to use the nebuliser.

36. On 4 September, the dietician noted Mr Ray was short of breath and wanted to focus on his breathing. On 7 September, Nurse C noted Mr Ray was very short of breath when he collected his morning medication. She asked him to wait until her medication round was completed so she could assess him. Mr Ray said he would be fine and wanted to go back to his cell to rest. The nurse arranged for someone to take Mr Ray back to his cell in a wheelchair.
37. At around 2.30pm, Mr Ray's cellmate asked for help, as Mr Ray looked grey and was struggling for breath. Nurse D attended very quickly and found Mr Ray lying on his bed, breathless, but talking and oriented. She called a medical emergency code and took Mr Ray's observations. The control room called an ambulance immediately. Other healthcare staff arrived and gave Mr Ray oxygen and a medication through a nebuliser. At 2.37pm, a first response paramedic arrived and, at 3.12pm, an ambulance took Mr Ray to a hospital Banbury. Mr Ray was restrained by 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).
38. Shortly after arriving at the hospital, Mr Ray suddenly collapsed and lost consciousness. The escort chain was removed and doctors placed Mr Ray into an induced coma. A CT scan revealed that Mr Ray had extensive, severe emphysema and changes in his lungs consistent with treated TB. There was no evidence of active TB.
39. Doctors treated Mr Ray for an infective exacerbation of COPD, but he did not respond. After discussion with Mr Ray's family, doctors switched off Mr Ray's ventilator. He died at 11.40am on 10 September.

### **Liaison with Mr Ray's family**

40. Mr Ray had two brothers recorded as his next of kin. The hospital contacted Mr Ray's brothers and they arranged to visit him on 9 September.
41. A prison manager acted as the prison's family liaison officer from 9 September. He visited Mr Ray and spoke to one of his brothers. They agreed that the prison manager would telephone if Mr Ray died. When Mr Ray died, the prison manager rang his brother, but the hospital had already informed him.
42. Mr Ray's funeral was on 24 September. The prison contributed towards the costs in line with national policy.

### **Support for prisoners and staff**

43. A senior manager debriefed the staff who had been involved in Mr Ray's care and offered support. The prison posted notices informing staff and prisoners of Mr Ray's death, and offered support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Ray's death.

## Post-mortem report

44. A post-mortem examination noted a combination of bronchopneumonia and tuberculous pneumonia with a background of chronic obstructive pulmonary disease caused by long term smoking. The cause of death was given as conventional bacterial and tuberculous pneumonia, and chronic obstructive pulmonary disease.

# Findings

## Clinical care

45. Mr Ray had been diagnosed with COPD in April 2010. In June 2011, he contracted TB and in November 2011, he was diagnosed with severe COPD. He was a long term, heavy cigarette smoker. Mr Ray's history of TB reduced his respiratory function but he continued to smoke. The combined effect of this gave him very poorly functioning lungs which were prone to infection and subject to acute deterioration. The frail state of his lungs was confirmed in September 2011, when he suffered from a collapsed lung and respiratory failure.
46. The clinical reviewer found that Mr Ray was well cared for in prison and clinicians appropriately followed national guidelines for the care of TB and COPD, including regular reviews. The clinical reviewer concluded that the care Mr Ray received in prison was equivalent to that he could have expected to receive in the community.

## Restraints, security and escorts

47. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgement indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process.
48. On 7 September, when Mr Ray went to hospital by ambulance, he was fully conscious, but had serious respiratory problems and was struggling to breathe. His mobility had been poor for some time and he used a wheelchair. He was restrained by an escort chain, but the prison has been unable to provide us with the risk assessment on which this decision was based. Shortly after arriving at the hospital Mr Ray lost consciousness and the escort chain was removed. Mr Ray was not restrained afterwards. While we recognise that restraints were used for only a brief period, we are concerned that the risk assessment did not take into account Mr Ray's health and mobility sufficiently, as the High Court judgment requires and it is difficult to see how the initial decision to restrain him was justified. We make the following recommendation:

**The Governor should ensure that when restraints are used for prisoners taken to hospital, there are properly considered risk assessments, in line with the legal guidance, which fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.**

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