Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Francis Summers a prisoner at HMP Rye Hill on 2 June 2016

A report by the Prisons and Probation Ombudsman
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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*

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 Francis Summers died of multi organ failure and acute pancreatitis on 2 June 2016, while a prisoner at HMP Rye Hill. He was 71 years old. I offer my condolences to Mr Summers' family and friends.

I am satisfied that Mr Summers received a good standard of care in prison, equivalent to that he could have expected to receive in the community. Rye Hill's healthcare staff supported him well and promptly referred him to hospital when his condition deteriorated.

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 **December 2016**

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Summary

Events

1. Mr Francis Summers had been in prison since 4 November 2014 and was serving a sentence of 20 years. He had been at HMP Rye Hill since 1 May 2015. Mr Summers had several health problems, including type 2 diabetes, high blood pressure and heart disease. Healthcare staff frequently reviewed his medical conditions and prescribed medication to treat these conditions.

2. On 27 May 2016, Mr Summers complained of stomach pain and vomiting. Healthcare staff treated him with paracetamol.

3. On 28 May, Mr Summers complained that he was suffering with shortness of breath, diarrhoea and vomiting. A nurse took his clinical observations, which were below normal levels, and performed an electrocardiogram (ECG – a test to check the heart's rhythm and electrical activity) test. The ECG found that Mr Summers' pulse rate was high, at 120 beats per minute, so the nurse asked for an ambulance and Mr Summers went to hospital.

4. The following day, hospital staff treated Mr Summers for renal failure and pancreatitis. On 1 June, Mr Summers' health continued to deteriorate and hospital doctors placed him in an induced coma with ventilation assistance.

5. At 7.00pm on 2 June, hospital doctors decided to stop treatment. At 8.30pm, Mr Summers' life support machine was switched off and his death confirmed at 8.50pm.

Findings

6. Prison healthcare staff managed Mr Summers' health problems appropriately. His transfer to hospital was timely with healthcare staff sending him to hospital when he had concerning symptoms. There was good communication between the prison and hospital staff. We are satisfied that Mr Summers received a good standard of care at the prison, equivalent to that he could have expected to receive in the community.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Rye Hill informing them of the investigation and asking anyone with relevant information to contact her. One person responded and the investigator spoke to them on 13 July.

8. The investigator obtained copies of relevant extracts from Mr Summers' prison and medical records.

9. NHS England commissioned a clinical reviewer to review Mr Summers' clinical care at the prison.

10. We informed HM Coroner for Coventry of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

11. One of the Ombudsman's family liaison officers contacted Mr Summers' next of kin, his wife, to explain the investigation and to ask she had any matters she wanted the investigation to consider. She said that she had no specific issues she wanted the investigation to consider.

12. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

13. Mr Summers' wife received a copy of the initial report. She pointed out a factual inaccuracy. This report has been amended accordingly.

Background Information

HMP Rye Hill

14. HMP Rye Hill is run by G4S and it holds more than 600 men convicted of sex offences. G4S Forensic and Medical Services provides primary physical and mental health services, and Northamptonshire Healthcare NHS Foundation Trust (NHFT) provides secondary mental health services. The prison does not have an inpatient facility.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Rye Hill was in August 2015. Inspectors noted that the prison held a complex mix of serious offenders and some frail older men who needed significant levels of care. The inspection found that the quality of healthcare services was the weakest area of the prison. Services had not sufficiently adapted to meet the needs of the new population, when the prison had changed its role to take sex offenders in 2014. There were staff shortages and the available staff were not deployed efficiently. There were long waiting times for most clinics. A small group of regular GPs had run daily clinics since January 2015, which had improved consistency and prisoners' perceptions of service provision. However, prisoners waited up to three weeks for routine GP appointments. Prisoners had good access to pharmacy staff for advice.

Independent Monitoring Board

16. 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 March 2016, the IMB reported that healthcare provision remained under pressure and was a cause for concern. They found that recruiting and retaining suitable healthcare staff was an ongoing problem, which led to staff shortages particularly on weekends. The IMB also found that the number of clinics had increased, which had decreased waiting times.

Previous deaths at HMP Rye Hill

17. Mr Summers was the fourth person to die from natural causes at Rye Hill since January 2015. There were no significant similarities with the circumstances of the previous deaths.

Key Events

18. On 4 November 2014, Mr Francis Summers was remanded to custody and, a month later, was sentenced to 20 years in prison for sexual offences. He had been at HMP Rye Hill since 1 May 2015.

19. Mr Summers had several longstanding health problems, including type two diabetes, high blood pressure and heart disease. Healthcare staff reviewed Mr Summers' medical conditions frequently and prescribed appropriate medication to treat these conditions. Mr Summers also attended clinics for his ongoing chronic diseases and medication reviews.

20. On 28 March 2016, a nurse saw Mr Summers, who complained of chest pain and shortness of breath. His medical observations were within normal range and the nurse advised Mr Summers to use his prescribed spray medication. Mr Summers recovered and did not have any further problems until 27 May.

21. At 3.30am on 27 May, prison staff called a nurse to see Mr Summers because he was vomiting and had stomach pain. The nurse gave him two paracetamol and he settled down.

22. At 2.48pm on 28 May, a nurse saw Mr Summers in his cell with shortness of breath. Mr Summers told the nurse had had been vomiting with diarrhoea for two days. The nurse took Mr Summers' clinical observations several times to monitor his condition and performed an electrocardiogram (ECG). While his blood pressure remained within normal limits, his pulse rate was high at 120 beats per minute. The nurse administered oxygen and gave Mr Summers aspirin.

23. At 3.13pm, Mr Summers' condition deteriorated and he became cold and clammy. The nurse found that his blood pressure and temperature were below normal levels (90/71 and 34.2°C respectively). A nurse asked the control room to call for an emergency ambulance. The ambulance arrived at 3.35pm and took Mr Summers to hospital. Two prison officers escorted Mr Summers to hospital and restrained him with 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).

24. On 29 May, bed watch notes indicated that the hospital were treating Mr Summers in the critical care unit for acute renal failure and severe pancreatitis. (Acute pancreatitis is a serious condition where the pancreas becomes inflamed over a short period and severe cases have serious complications that can be fatal.) Doctors prescribed a course of dialysis for the renal failure and medication for pancreatitis.

25. Mr Summers' condition did not improve and doctors withdrew the dialysis and antibiotics for pancreatitis. He was now receiving treatment for respiratory distress. In light of his deterioration, the Director authorised officers to remove the escort chain, which they did not reapply.

26. On 1 June, Mr Summers' condition deteriorated further. Doctors placed him in an induced coma with ventilation assistance. The prison's nurse manager visited

Mr Summers in hospital. She noted that he was now seriously ill and on a life support machine.

27. At 7.00pm on 2 June, hospital staff agreed that no further medical interventions would benefit Mr Summers. They stopped his treatment and switched off his life support machine at 8.30pm. Mr Summers died at 8.50pm.

Contact with Mr Summers' family

28. On 29 May, the prison appointed an officer as Mr Summers' family liaison officer. She spoke to Mr Summers' nominated next of kin, his wife, and offered her transport for a hospital visit. Mr Summers' wife declined the offer but asked her to update her on Mr Summers' condition.

29. The officer also contacted Mr Summers' sister. She declined a hospital visit but wanted updates on her brother's health. She kept in close contact with both Mr Summers' wife and sister over the following days.

30. At 10.45am on 2 June, the officer visited Mr Summers in hospital to support him. Later that evening, she spoke to both his wife and sister to tell them of Mr Summers' death and to offer her condolences. Neither wanted a home visit. She spoke to Mr Summers' wife and sister about funeral arrangements, but they asked the prison to arrange the funeral.

31. Mr Summers' funeral took place on 30 June, which the prison arranged and paid for in line with national guideline.

Support for prisoners and staff

32. After Mr Summers' death, a prison manager debriefed the staff involved in the bedwatch to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

33. The prison posted notices informing other prisoners of Mr Summers' death, and offering support.

Post-mortem report

34. The report of the post-mortem examination concluded that Mr Summers died of multi organ failure and acute pancreatitis.

Findings

Clinical care

35. When Mr Summers' arrived at Rye Hill, he was noted to have some chronic illnesses. However, he was able to self-control his diabetes and medication for high blood pressure. He regularly attended his diabetic and blood pressure clinics including medication reviews.

36. A prisoner responded to our notices of investigation. He was concerned that Mr Summers would have benefitted from being transferred to hospital 24 hours early. The clinical reviewer considered the prison's response and noted that Mr Summers' symptoms on 27 May were not serious enough for him to be sent to hospital. When his condition deteriorated, healthcare staff appropriately sent Mr Summers to hospital. We agree with the clinical reviewer that the treatment that healthcare staff gave Mr Summers was appropriate and that an earlier transfer to hospital would not have changed the outcome.

37. Mr Summers' sudden illness was not foreseeable and, when he became unwell, healthcare staff made a timely referral to hospital. We consider that the clinical care he received was equivalent to that they could have expected in the community.

Restraints, security and escorts

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

39. Mr Summers was restrained on an escort chain when he left Rye Hill on 28 May. A medical assessment on the use of restraints indicated that Mr Summers was a diabetic with heart problems. However, there was no written medical objection to restraints. Due to the urgency of Mr Summers transfer to hospital, a prison manager authorised officers to restrain him with an escort chain. Officers removed the escort chain while Mr Summers underwent various tests but reapplied it when Mr Summers was admitted to a ward.

40. During the morning of 29 May, Mr Summers' condition deteriorated and he moved to the critical care unit. Officers removed the escort chain for further medical investigations and treatments before, at 2.30pm, the Director of Rye Hill authorised that restraints should not be reapplied.

41. The use of restraints was appropriate when Mr Summers left the prison for jospital. When Mr Summers transferred to the critical care unit, we are satisfied that prison staff reviewed the appropriateness of restraints and decided that they should be removed.

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