Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Andrew Crane a prisoner at HMP Rye Hill on 16 November 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*

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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 Andrew Crane died on 16 November 2016, of a heart attack at HMP Rye Hill. Mr Crane was 53 years old. I offer my condolences to Mr Crane's family and friends.

I am not satisfied that the healthcare Mr Crane received at Rye Hill was equivalent to that he could have expected to receive in the community. In particular, I am concerned that, despite frequent reminders, healthcare staff at Rye Hill failed to recognise that Mr Crane had a pre existing medical condition and consequently did not monitor his blood pressure and blood sugar levels as required. Although this lack of pro-active primary care management was not the sole reason for Mr Crane's death, it is likely to have contributed to it.

I am also concerned that Rye Hill had no clear pathway for the management of prisoners with diabetes.

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 2017**

Contents

Summary 1
The Investigation Process 3
Background Information 4
Key Events 5
Findings 8

Summary

Events

1. On 7 December 2012, Mr Andrew Crane was sentenced to 18 years in prison for sexual offences and was sent to HMP Nottingham. On 13 June 2013, he was moved to HMP Rye Hill.

2. Before Mr Crane's conviction, his community GP had diagnosed pre diabetes (higher than normal blood sugar levels) - a condition that requires annual monitoring to identify the potential onset of Type 2 diabetes. Although Nottingham received Mr Crane's community medical records, neither Nottingham nor Rye Hill recognised his condition and did not monitor or record his blood pressure or blood sugar levels as required.

3. In October 2014, a nurse took Mr Cane's blood pressure after he reported sores on his body. The nurse gave him paracetamol to control his pain. The blood pressure reading was high at 161/96mmHg, but there is no record of advice, treatment or further monitoring.

4. Other than for dental treatment, Mr Crane had very little contact with prison healthcare services until 1 August 2016, when a GP examined him after he reported weight loss. The GP arranged blood tests, which showed very high blood sugar levels. He diagnosed Type 2 diabetes and prescribed appropriate medication.

5. The GP discussed diabetes and its treatment with Mr Crane and he had further follow up appointments with healthcare staff. However, there is no note of healthcare staff recording baseline assessments or blood sugar level monitoring during these later appointments.

6. On 16 November, Mr Crane's cellmate rang their cell bell after he found Mr Crane on his knees on the floor and could not rouse him. An officer attended and radioed a Code Blue to signify a medical emergency and the control room called an ambulance. A senior prison officer attended with a nurse and entered Mr Crane's cell and began CPR. They gave Mr Crane oxygen, attached a defibrillator to his chest and followed the instructions of the machine until the first ambulance crew arrived. The defibrillator 'shocked' Mr Crane five times.

7. The paramedics took over from prison staff but, after approximately 20 minutes, at 7.05pm, they confirmed that Mr Crane had died. A post mortem examination later confirmed the cause of Mr Crane's death was from a heart attack caused by a thickening or hardening of his arteries.

Findings

8. The clinical reviewer considered that the care Mr Crane received at Rye Hill was not equivalent to that he could have expected to receive in the community.

9. Healthcare staff did not record any baseline medical assessment details after Mr Crane's initial health screen on his arrival at Rye Hill. They failed to recognise that he had a pre existing medical condition that required regular monitoring of

both blood pressure and blood sugar levels. Healthcare staff did not notice the computer generated reminders in Mr Crane's prison medical record from his community GP surgery and consequently his condition went unnoticed.

10. After a GP diagnosed Type 2 diabetes, he prescribed appropriate medication. However, no further assessment or blood sugar monitoring took place to establish the risk of diabetes associated complications, such as heart disease. The GP referred Mr Crane to the diabetes nurse but he did not see the nurse before his death, more than two months later.

Recommendations

- The Head of Healthcare should ensure that all clinicians performing any health screening tool within HMP Rye Hill should consistently include baseline observations.
- The Head of Healthcare should ensure that Rye Hill has a blood pressure pathway, based on national guidance that all clinicians adhere to in order to provide optimum primary care.
- The Head of Healthcare should ensure that Rye Hill has a diabetes care pathway, based on national guidance that all clinicians adhere to in order to provide optimum primary care. This should be supported by adequate clinical skills and knowledge and active liaison with local diabetes specialist nurses and Diabetes UK.

The Investigation Process

11. 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 him. No one responded.

12. The investigator visited Rye Hill on 23 November 2016. He obtained copies of relevant extracts from Mr Crane's prison and medical records and interviewed Mr Crane's cellmate.

13. The investigator interviewed four members of staff at Rye Hill on 14 December 2016.

14. NHS England commissioned a clinical reviewer to review Mr Crane's clinical care at the prison. She conducted joint interviews with the investigator.

15. We informed HM Coroner for Northamptonshire of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.

16. The investigator wrote to Mr Crane's daughter to explain the investigation and to ask if she had any matters she wanted the investigation to address. She asked us to consider any delayed or cancelled medical appointments, delays in him receiving medication, the response to Mr Crane's weight loss, his diet and the emergency response.

17. Mr Crane's daughter received a copy of the initial report. She did not make any comments.

18. We shared the initial report with the Prison Service. There were no factual inaccuracies.

Background Information

HMP Rye Hill

19. 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

20. 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

21. 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. However, the IMB also found that the number of clinics had increased, which had decreased waiting times.

Previous deaths at HMP Rye Hill

22. Mr Crane's was the sixth prisoner 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

23. On 7 December 2012, at Crown Court, Mr Andrew Crane was convicted of sexual offences and sentenced to 18 years in prison. He was sent to HMP Nottingham.

24. HMP Nottingham received a summary of Mr Crane's medical records from his community GP which noted high blood pressure and raised fasting blood sugar levels. However, this information was not recorded in his prison medical record at Nottingham. Neither was the fact that, after further investigation by Mr Crane's community GP, he diagnosed a condition known as impaired fasting glycaemia or pre diabetes (where blood sugar levels during fasting are consistently higher than normal levels but not high enough to be diagnosed as diabetes mellitus). A condition that requires annual monitoring to identify the potential onset of diabetes mellitus at the earliest opportunity.

25. On 13 June 2013, Mr Crane was moved to HMP Rye Hill. A nurse did an initial health screen assessment, but there is no record of any baseline observations or discussion about his current or past physical health recorded in his medical notes. Mr Crane was overweight and a heavy smoker.

26. Other than for dental treatment, Mr Crane had very little contact with the healthcare services at Rye Hill. However, his medical records contain regular computer generated entries from his previous community GP surgery reminding him to attend for annual blood sugar and blood pressure monitoring. These entries continue from July 2013 until March 2016. It appears that, despite HMP Nottingham informing Mr Crane's GP surgery that he was in prison, the surgery did not take him off their recall system. Consequently, the surgery continued to send advisory reminders about blood pressure and blood sugar monitoring to his home address. A record of these reminders appears in his prison medical notes but healthcare staff at Rye Hill did not recognise or respond to them.

27. On 8 October 2014, a nurse took Mr Crane's blood pressure after he reported in-growing hair causing sores all over his body. The nurse gave Mr Crane paracetamol to control his pain and planned to consult a GP regarding antibiotics. There is no record of this consultation taking place or of a GP prescribing antibiotics. The blood pressure reading was high at 161/96mmHg.

28. Mr Crane had a number of dental appointments during 2015 and saw a prison GP in December for back pain. Otherwise he had very little contact with healthcare services until 1 August 2016, when locum GP examined him after he reported weight loss. Mr Crane had lost 11kg since December 2012, but told the GP that otherwise, he felt well. The GP arranged for blood tests.

29. The blood tests results identified that Mr Crane had very high blood sugar levels and on 2 September, after reviewing the results, a prison GP diagnosed Type 2 diabetes mellitus. (Type 2 diabetes can cause major health complications, particularly in the smallest blood vessels in the body that nourish the kidneys, nerves, and eyes. Type 2 diabetes also increases the risk of heart disease and stroke).

30. A prison GP prescribed metformin (an oral diabetes medicine that helps control blood sugar levels) but Mr Crane did not start taking it until 5 September, as the prison pharmacy did not have it in stock (until after the weekend). He discussed the disease and its treatment with Mr Crane, gave him an explanatory leaflet and referred him to the diabetic nurse.

31. A nurse saw Mr Crane on 28 September, and completed an older person health check. No baseline observations or blood sugar levels were recorded.

32. On 7 October, a prison GP reviewed Mr Crane and locum GP saw him three weeks later. Both noted he said he felt better and that he had tolerated gradual increases in medication. Mr Crane said he had more energy and had gained some weight. The locum GP told Mr Crane they would do more blood tests in December and then consider increasing his medication. No other observations or blood sugar monitoring was recorded.

Events on 16 November 2016

33. On 16 November, at approximately 4.00am, Mr Crane woke in his cell and told his cellmate he had indigestion. After a brief conversation Mr Crane took some indigestion medication and both men settled back down to sleep.

34. At 5.53am, Mr Crane rang his cell bell. A prison custody officer (PCO) responded immediately and spoke to Mr Crane through the flap in the cell door. Mr Crane told him he had a pain in his chest which he had had, on and off, all night. Mr Crane was standing up; he was not clutching his chest or displaying any signs of needing immediate help. The PCO did not consider it to be an emergency and he told Mr Crane that he would get the nurse to come and see him.

35. The PCO returned to the wing office, a short distance away. He telephoned the healthcare unit and spoke to a nurse. She did not know Mr Crane but said she would check his medical records then come and see him.

36. However, at 5.55am the cellmate was woken by a loud noise, similar to snoring. He switched the cell light on and saw Mr Crane on the floor, on his knees. He asked him if he was alright but he did not reply. He rang the cell bell and the PCO got there in less than a minute. The PCO spoke briefly to the cellmate, who told him he could not rouse Mr Crane. The PCO radioed a Code Blue (to signify a medical emergency when a prisoner is unconscious or having breathing difficulties) and control room staff immediately called an ambulance.

37. The nurse was on her way to see Mr Crane when she heard the Code Blue on the radio. She returned to the healthcare unit to collect the medical emergency bag then made her way to the cell.

38. A Senior Officer (SO), the night manager, made his way to Mr Crane's cell when he heard the Code Blue. He was very close to the wing and got to the cell within two minutes. The night procedure policy at Rye Hill relating to medical assistance states that no cell unlock will take place unless the night manager is in attendance and safe levels of staff are available.

39. The SO and PCO spent about a minute outside the cell speaking to the cellmate and trying to get some reaction from Mr Crane. When the cellmate told them that he could not tell if Mr Crane was breathing, they unlocked the cell and went in.

40. The nurse arrived just after the officers had entered the cell. She checked for a pulse and signs of breathing but could find neither so began chest compressions. The officers unpacked the defibrillator and she attached the pads to Mr Crane's chest. The officers continued chest compressions while she gave Mr Crane oxygen. They followed the directions of the defibrillator. The machine shocked Mr Crane five times.

41. Other officers arrived and assisted with CPR. At 6.32am, the control room telephoned the ambulance service again as the ambulance had not arrived. At 6.37am, the oxygen tank ran out and the nurse had to leave briefly to get a replacement.

42. The first ambulance arrived at the prison at 6.42am and paramedics were at Mr Crane's cell at 6.46am. They took over from prison staff. A second ambulance arrived at 6.59am. At approximately 7.05am a paramedic confirmed that Mr Crane had died. A locum GP certified death at 8.35am.

Contact with Crane's family

43. After Mr Crane's death, the prison appointed a family liaison officer. Mr Crane had previously named his daughter as his next of kin. At 10.30am, the family liaison officer and the prison Director visited Mr Crane's daughter at her workplace and told her Mr Crane had died. They offered their condolences.

44. The next day the family liaison officer spoke to Mr Crane's daughter on the telephone. She arranged for her to see her father at the mortuary and they discussed the return of his property and arrangements for his funeral. She stayed in contact with Mr Crane's daughter until his funeral on 12 December. The prison contributed towards the cost of the funeral in line with national policy.

Support for prisoners and staff

45. After Mr Crane's death, a senior officer debriefed the discipline staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. Healthcare staff were not present and held a separate debrief. All staff were offered support and access to the Care and Welfare services.

46. The prison posted notices informing other prisoners and staff of Mr Crane's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Crane's death.

Post-mortem report

47. A post-mortem examination indicated the immediate cause of Mr Crane's death was from acute myocardial insufficiency (heart attack) caused by coronary artery atherosclerosis (a thickening or hardening of the arteries)

Findings

Clinical care

48. In 2012, staff at HMP Nottingham did not record a summary of Mr Crane's medical history, including a diagnosis of pre diabetes, into his medical record. Had they done so it is more likely that healthcare staff at Rye Hill would have been aware of his condition and monitored him more closely. But they did not and the clinical reviewer did not consider that the care Mr Crane then received at Rye Hill was equivalent to that he could have expected to receive in the community.

49. Mr Crane was overweight and a heavy smoker when he was sent to Rye Hill in July 2013, but healthcare staff did not record baseline observations at his initial health screen. His first recorded blood pressure reading was in October 2014, over a year later and, although this was high, there is no record of further monitoring.

50. There were no details of Mr Crane's pre existing medical conditions documented in his prison medical record and no note of an earlier diagnosis by his community GP of impaired fasting glycaemia or pre diabetes, a condition that requires annual monitoring of blood pressure and blood sugar levels. Regular entries in Mr Crane's prison medical records, generated from the community GP system, highlighted the need for regular blood pressure and blood sugar monitoring but healthcare staff did not notice or respond to them.

51. A prison GP diagnosed Type 2 diabetes in September 2016 and prescribed medication, however there is no record of further assessment or blood sugar monitoring to establish Mr Crane's risk of diabetes associated complications, such as heart disease. On 5 September, a GP referred Mr Crane to the diabetes nurse but there is no record that he saw the nurse before his death.

52. Mr Crane died from heart disease, a common complication of diabetes and high blood pressure. The clinical reviewer considered that the lack of pro-active primary care management, both before and after his diagnosis of diabetes, though not the sole reason for his death, will have contributed to it.

53. We agree with the clinical reviewer that the primary care Mr Crane received at HMP Rye Hill cannot be considered equivalent to that he could have expected to receive in the community. We make the following recommendations:

    The Head of Healthcare should ensure that all clinicians performing any health screening tool within HMP Rye Hill consistently include baseline observations.

    The Head of Healthcare should ensure that Rye Hill has a blood pressure pathway, based on national guidance that all clinicians adhere to in order to provide optimum primary care.

    The Head of Healthcare should ensure that Rye Hill has a diabetes care pathway, based on national guidance that all clinicians adhere to in order

to provide optimum primary care. This should be supported by adequate clinical skills and knowledge and active liaison with local diabetes specialist nurses and Diabetes UK.

Emergency Response

54. Mr Crane's cellmate rang the cell bell after he saw Mr Crane on his knees on the floor of their cell and could not rouse him. The PCO got there in less than a minute and radioed a Code Blue, to signify a medical emergency. Staff in the control immediately called an ambulance. The SO made his way to Mr Crane's cell; he was very close to the wing and got to the cell within two minutes. The PCO told the investigator that he could hear doors unlocking so knew that Mr French would not be long.

55. The night procedure policy at Rye Hill relating to medical assistance states that no cell unlock will take place other than where necessary to save life unless the night manager is in attendance and safe levels of staff are available. The SO explained that ordinarily, for a double cell with two prisoners, at least three members of staff should be present and that this formed part of his risk assessment when he considered whether or not to enter the cell immediately.

56. The SO and PCO spent about a minute outside the cell speaking to the cellmate, but when he told them that he could not tell if Mr Crane was breathing they unlocked the cell and went in without waiting for further assistance.

57. Medical guidance regarding CPR is that every minute delay is equivalent to a 10% reduction in survival. It is understandable, though regrettable, that the officers did not enter the cell sooner. The clinical reviewer indicated that 'on balance' it is unlikely that the minute delay made much difference to the outcome for Mr Crane who, as the post mortem report recorded, had significant heart disease.

58. From the time of the original call it took the emergency ambulance more than 45 minutes to get to the prison. This was despite further calls from the prison control room. The clinical reviewer has raised concerns about the length of time it took the ambulance to arrive. We draw this to the attention of the Head of Healthcare who should raise it with the ambulance service.

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