Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jeffrey Goodwyn a prisoner at HMP Rye Hill on 3 May 2017

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 Jeffrey Goodwyn died in hospital on 3 May 2017 of a stroke, while a prisoner at HMP Rye Hill. He was 51 years old. We offer our condolences to those who knew him.

We are not satisfied that the healthcare Mr Goodwyn received at Rye Hill was equivalent to that which he could have expected to receive in the community. Our investigation found no record that Mr Goodwyn had received a reception health screen when he arrived at Rye Hill, he was not offered a health check in line with NHS guidelines, and opportunities were missed to discuss smoking cessation with him.

We are also concerned that Mr Goodwyn was restrained during his hospital transfer, when he was unresponsive after suffering a stroke. We consider the use of restraints was disproportionate. We have made recommendations to Rye Hill previously on the inappropriate use of restraints. It is very disappointing that we have to draw the prison's attention once again to their legal responsibility to properly consider the implications of restraining a very ill man.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **November 2017**

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Summary

Events

1. On 12 December 2014, Mr Jeffrey Goodwyn (known as Mr Jeffrey Goodwin in prison records) was recalled to prison for breaching the conditions of his licence and was sent to HMP Exeter.

2. Mr Goodwyn was transferred to HMP Rye Hill on 29 February 2016. There is no record of a reception health screen. Mr Goodwyn had very little contact with healthcare staff and failed to attend an appointment for the asthma clinic in February 2017.

3. Around 1.50pm on 2 May 2017, prison custody officers found Mr Goodwyn unresponsive on the floor of his cell. An officer radioed a code blue medical emergency code and the control room called an ambulance. Paramedics took Mr Goodwyn to hospital. Two officers escorted him and applied double handcuffs.

4. Hospital doctors diagnosed a stroke. Shortly after Mr Goodwyn's arrival at hospital, prison managers authorised the removal of the handcuffs. Mr Goodwyn's condition deteriorated and he died on 3 May.

Findings

5. The clinical reviewer considered that the care Mr Goodwyn received at Rye Hill was not equivalent to that which he could have expected to receive in the community. We found that healthcare staff at Rye Hill had failed to record whether they had carried out a reception health screen with Mr Goodwyn. We also found Mr Goodwyn was not offered a health check in line with NHS guidelines, staff failed to follow up a missed asthma clinic appointment, and there were missed opportunities to discuss smoking cessation with him.

6. When staff found Mr Goodwyn unresponsive in his cell, the emergency response was timely and appropriate. However, we are concerned that a prison manager at Rye Hill authorised the use of restraints during the hospital transfer. We found this to be disproportionate, given Mr Goodwyn's extremely poor state of health at that time.

7. We make five recommendations.

Recommendations

- The Head of Healthcare should ensure that all newly arrived prisoners have an appropriate health screen that reviews their medical history and identifies any outstanding appointments and relevant conditions.
- The Head of Healthcare should ensure that any missed appointments are followed up, with the reasons recorded.
- The Head of Healthcare should ensure that the NHS Health check is available to all prisoners aged between 40- 74, in line with that offered in the community.

- The Director should ensure the local policy document on hospital escorts is amended to ensure the guidance is in line with the legal requirements and national guidance.
- The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of the 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 Rye Hill informing them of the investigation and asking anyone with relevant information to contact her. Two prisoners responded.

9. The investigator obtained copies of relevant extracts from Mr Goodwyn's prison and medical records. The prison records show Mr Goodwyn's surname as 'Goodwin', but he had requested that his surname be spelt as in this report.

10. The investigator interviewed four members of staff at HMP Rye Hill on 14 June 2017. She also met with the two prisoners who had contacted her, but they had no information relevant to this investigation.

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

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

13. We were unable to contact Mr Goodwyn's family to inform them of the investigation. They had no contact with him.

14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy in the clinical review. The clinical reviewer has added information to the review.

Background Information

HMP Rye Hill

15. 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

16. 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

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 March 2017, 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. They said the current service needed further investment and improvement if it was to ensure it can give prisoners the same level of care they would receive in the community.

Previous deaths at HMP Rye Hill

18. Mr Goodwyn was the ninth prisoner to die from natural causes at Rye Hill since January 2016. There has been one death from natural causes since Mr Goodwyn's death. We have previously made recommendations about the inappropriate use of restraints.

Key Events

19. On 13 January 2012, Mr Jeffrey Goodwyn was convicted of sexual offences and was given an imprisonment for public protection (IPP) sentence. He was sent to HMP Pentonville. The Court of Appeal quashed the IPP sentence on 26 November 2014 and replaced it with an extended sentence of eight years (three years in prison and five years extended sentence). Mr Goodwyn was released on 5 December 2014. However, probation staff recalled him to prison on 12 December 2014 for breaching the terms of his licence. In addition, he faced further charges for sexual offences.

20. Mr Goodwyn spent time in several prisons. On 16 December 2015, Mr Goodwyn was given 20 years extended sentence (12 years in prison and eight years on licence). He was transferred to HMP Parc the same day.

21. On 3 February 2016, Mr Goodwyn submitted an application form to healthcare asking for an appointment with the asthma clinic as he had difficulty breathing. On 11 February, Mr Goodwyn saw a nurse and told her he was a heavy smoker. She checked his observations, which were all within normal range, and conducted a peak flow test used to diagnose asthma. She noted the result was 320L/min, which was below the expected range for a man of his age, height and weight, but she did not comment on this in his medical notes and did not formally diagnose asthma. She added him to the annual recall list for the asthma clinic. She also gave him advice about stopping smoking and said she would review him after one month. However, Mr Goodwyn declined smoking cessation support and the planned follow up was not completed as Mr Goodwyn was transferred to Rye Hill on 29 February.

22. On arrival at Rye Hill, healthcare staff did not conduct a reception medical screen. Mr Goodwyn had very little contact with healthcare staff at Rye Hill. He occasionally asked nurses for paracetamol for headaches.

23. On 27 February 2017, Mr Goodwyn failed to attend his appointment at the asthma clinic.

Events on 2 May 2017

24. On 2 May 2017, just after 1.30pm, two Prison Custody Officers (PCOs) began unlocking prisoners so they could go to work or education. They also checked on the welfare of prisoners not scheduled to leave the unit.

25. When one PCO reached Mr Goodwyn's cell, he opened the flap on the cell door and saw Mr Goodwyn on the floor. He appeared to be having a fit. At 1.53pm, he used his radio to call a "code blue" medical emergency (indicating a life threatening incident involving breathing difficulties). Staff in the communications room immediately telephoned for an ambulance. Both PCOs went into the cell. Mr Goodwyn was lying in the recovery position on the floor surrounded by vomit. A PCO asked Mr Goodwyn if he was okay, but he did not respond. A nurse and the duty manager responded to the emergency call.

26. The nurse said she heard the emergency radio call and immediately went to the cell with another nurse and healthcare assistant. She spoke to Mr Goodwyn but

there was no response. She said his observations, were all within normal range. She said Mr Goodwyn's pupils were "sluggish" and she became concerned that he had suffered some kind of brain injury.

27. The nurse administered oxygen, made Mr Goodwyn comfortable and ensured his observations remained stable until the paramedics arrived at 2.22pm. Paramedics took Mr Goodwyn to hospital at 2.55pm. Two officers escorted him and they restrained him using a double handcuff.

28. In hospital, doctors diagnosed a stroke. Mr Goodwyn's condition deteriorated and at 8.00pm, the escorting staff removed the handcuffs. Mr Goodwyn died at 9.27pm on 3 May 2017.

Contact with Mr Goodwyn's family

29. After Mr Goodwyn's death, the prison appointed a prison manager as the family liaison officer. Mr Goodwyn had previously told prison staff that he did not have any next of kin. Prison staff found that his family had severed all contact with him.

30. The prison arranged and paid for Mr Goodwyn's funeral, which was held on 2 June 2017, and Mr Crawford attended.

Support for prisoners and staff

31. After Mr Goodwyn's death, a prison manager went to the hospital and debriefed the escorting staff to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

32. The prison posted notices informing other prisoners and staff of Mr Goodwyn'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 Goodwyn's death.

Cause of death

33. The Coroner gave the cause of death as a large ischaemic stroke with asthma as a contributory factor.

Findings

Clinical care

34. The clinical reviewer concluded that although there did not appear to be any warning signs that Mr Goodwyn was going to have a stroke, there were aspects of his care that were not equivalent to the care that would have been expected in the community.

35. There was no record of a reception health screen when Mr Goodwyn arrived at Rye Hill. A screen is important for a nurse to note any ongoing healthcare issues that require a referral to a specialist. In addition, under the NHS, anyone over 40 should be invited to attend a NHS health check. The clinical reviewer noted that, unlike in the community, the NHS check was not available at Rye Hill.

36. Mr Goodwyn was a heavy smoker and was at increased risk of stroke as a result. The clinical reviewer found that healthcare staff had missed opportunities to discuss smoking cessation with Mr Goodwyn.

37. Mr Goodwyn was scheduled to attend the asthma clinic at Rye Hill in February 2017 but he failed to attend. There was no record of anyone at Rye Hill conducting an asthma assessment and there was no follow up to find out why he missed the appointment or to schedule another one.

38. We make the following recommendations:

    The Head of Healthcare should ensure that all newly arrived prisoners have an appropriate health screen that reviews their medical history and identifies any outstanding appointments and relevant conditions.

    The Head of Healthcare should ensure that any missed appointments are followed up, with the reasons recorded.

    The Head of Healthcare should ensure that the NHS Health check is available to all prisoners aged between 40- 74, in line with that offered in the community.

Restraints, security and escorts

39. 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 judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

40. The escort risk assessment for Mr Goodwyn noted that this was an emergency escort to hospital. The risk assessment concluded that Mr Goodwyn's risk to the

public, to hospital staff, of hostage taking, and escape potential were medium. The medical section of the risk assessment was not completed. The nurse said at interview that she told prison staff that they did not need to double handcuff Mr Goodwyn but this was never relayed to the manager who authorised the use of restraints.

41. The prison manager authorised officers to restrain Mr Goodwyn with double handcuffs for the ambulance journey. She said that she thought that a member of staff had told her that they thought he was feigning illness. She did not record this on the risk assessment and was not sure who had said this. She said she had not seen Mr Goodwyn or spoken to anyone from healthcare about him.

42. The prison manager said that the risk assessment form has recently been revised to state that the duty director had to contact healthcare staff to consider medical opinion with regard to the prisoner's ability to escape.

43. We are concerned that a prison manager took the decision that it would be appropriate to use double handcuffs on Mr Goodwyn. Double cuffing is usually required for moving category A or category B prisoners in good health. Mr Goodwyn was a category B prisoner who was unresponsive and in a very poor condition.

44. The Prison Service has a responsibility to protect the public, but security must be balanced with humanity and measures must be proportionate to a prisoner's individual circumstances. It is difficult to see how the assessments could conclude that an unresponsive, immobile man had the ability to escape unaided from two escort officers.

45. We are also concerned that Rye Hill's local policy document on hospital escorts says that, after the paramedic has placed the prisoner on a stretcher, "the prisoner is to be double handcuffed at this point". It says if the prisoner's health is classed as life threatening and he may need resuscitation, the handcuffs should be removed. The local policy does not ask staff to consider the current risk of escape, as the High Court judgment requires. We therefore recommend:

    The Director should ensure the local policy document on hospital escorts is amended to ensure the guidance is in line with the legal requirements and national guidance.

46. We have previously made recommendations about the use of restraints and, and it is disappointing that, despite the prison's assurances that actions have been taken to improve the process, we have to repeat the following recommendation:

    The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of the prisoner and are based on the actual risk the prisoner presents at the time.

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