

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Steven Dodd a prisoner at HMP Rye Hill on 17 January 2018

**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 Steven Dodd died in hospital on 17 January 2018 of a ruptured aortic aneurysm while a prisoner at HMP Rye Hill. He was 68 years old. I offer my condolences to Mr Dodd's family and friends.

Mr Dodd had many chronic conditions. Healthcare staff appropriately reviewed him and prescribed medications, as needed, and I am satisfied that Mr Dodd's care at Rye Hill was equivalent to that he could have expected to receive in the community.

I am, however, concerned that prison staff did not inform Mr Dodd's family when he became seriously ill and was admitted to hospital.

I am also concerned that Mr Dodd was restrained when he was transferred to hospital, seriously ill. His condition and immobility were not adequately considered. My office has made previous recommendations to Rye Hill about the inappropriate use of restraints. It is troubling that I have to draw the prison's attention once again to this issue. Her Majesty's Prison and Probation Service should take steps to ensure that it is properly addressed.

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

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

**July 2018**

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# Summary

## Events

1. Mr Dodd was serving life in prison for sexual offences, and having spent time in a number of prisons, he arrived at HMP Rye Hill on 16 October 2010. He had a number of chronic diseases, including chronic obstructive pulmonary disease (COPD), ischaemic heart disease, hypertension (high blood pressure), peripheral vascular disease, diverticulitis (a gastrointestinal disease), an enlarged prostate and gastric reflux. He had had a stroke and in 2006, was diagnosed with an abdominal aortic aneurysm. He had reduced mobility due to arthritis and was a wheelchair user.
2. Healthcare staff reviewed him regularly and ensured that he was taking his medications.
3. On 13 January, Mr Dodd told an officer that he had chest pains and breathing difficulties. She called for an ambulance. Paramedics took Mr Dodd to hospital. Two officers escorted him and they restrained him, using an escort chain. At the request of hospital staff, they removed the escort chain for treatment.
4. In hospital, Mr Dodd's condition deteriorated and he died at 9.33am on 17 January 2018.

## Findings

5. Mr Dodd received a good standard of clinical care at Rye Hill. We agree with the clinical reviewer that Mr Dodd's overall care at the prison was equivalent to the level of care he would have received in the community.
6. Despite being elderly and in very poor health, a prison manager authorised the use of restraints. We consider that the security risk assessment carried out for his hospital admission did not address the requirements of caselaw and, specifically, did not reflect the impact of Mr Dodd's condition on his risk of escape. There is no evidence within the risk assessment to justify their use.
7. When Mr Dodd became seriously ill and admitted to hospital, prison staff did not inform his family.

## Recommendations

- The Director and Head of Healthcare should ensure all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.
- The Head of Operational Contracts at Her Majesty's Prison and Probation Service should assure himself that meaningful action is taken to ensure that this happens.
- The Director should ensure that staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill.

## 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. No one responded.
9. The investigator obtained copies of relevant extracts from Mr Dodd's prison and medical records.
10. The investigator interviewed two members of staff by telephone on 26 and 27 March 2018.
11. NHS England commissioned a clinical reviewer to review Mr Dodd's clinical care at the prison.
12. We informed HM Coroner for Coventry & Warwickshire District of the investigation who gave us the cause of death. We have sent the Coroner a copy of this report.
13. The investigator contacted Mr Dodd's wife, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond.
14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

## Background Information

### HMP Rye Hill

15. HMP Rye Hill is run by G4S and 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 conducted 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. Inspectors found that the quality of healthcare services was the weakest area of the prison. They found that after Rye Hill changed its role to take sex offenders in 2014, services had not sufficiently adapted to meet the needs of the new population.
17. Inspectors noted that there were healthcare staff shortages and the available staff were not deployed efficiently. They found that there were long waiting times for most clinics. They noted that a small group of regular GPs had run daily clinics since January 2015, which had improved the consistency of service and prisoners' perceptions of that service. However, they noted that prisoners waited up to three weeks for routine GP appointments. Inspectors found that prisoners had good access to pharmacy staff for advice.

### Independent Monitoring Board

18. 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. It found that recruiting and retaining suitable healthcare staff was an ongoing problem. It said that the current service needed further investment and improvement if it was to ensure that it was giving prisoners the same level of care that they would receive in the community.

### Previous deaths at HMP Rye Hill

19. Mr Dodd was the thirteenth prisoner to die from natural causes at Rye Hill since January 2015. There has been one death from natural causes since Mr Dodd's death which is under investigation. We have made recommendations about the inappropriate use of restraints on 5 separate occasions.

## Key Events

20. On 3 December 1999, Mr Steven Dodd was sentenced to life imprisonment for sexual offences. He spent time in several prisons and on 16 October 2010, he was transferred to HMP Rye Hill.
21. Mr Dodd had various health problems, including chronic obstructive pulmonary disease (COPD), ischaemic heart disease, hypertension (high blood pressure), peripheral vascular disease, diverticulitis (gastrointestinal disease), an enlarged prostate and gastric reflux. He had had a stroke and in 2006, was diagnosed with an abdominal aortic aneurysm. He had reduced mobility due to arthritis and used a wheelchair. He was a smoker who refused help to stop smoking. Mr Dodd lived in an adapted, ground floor cell which had a wider door for wheelchair access.
22. Healthcare staff reviewed him regularly and ensured that he took his medications appropriately. From 22 August 2016, he had regular reviews for his abdominal aortic aneurysm to assess any growth in size as part of a screening programme. For large aneurysms, surgery is considered as a treatment option.
23. On 25 August 2016, a prison GP told Mr Dodd that he may not be fit enough for surgery and if his aneurysm burst, he could die. He noted that Mr Dodd understood.
24. On 7 September 2017, a hospital vascular surgeon told healthcare staff at Rye Hill that he was considering surgery as Mr Dodd's aneurysm had grown. However, he had concerns about his frailty. Mr Dodd was undergoing hospital assessments when his condition declined.

### Events of 13 January 2018

25. At 6.50pm, Mr Dodd rang his cell bell and told a prison officer that he had chest pains and breathing difficulties. The officer said that she and another officer unlocked and went into Mr Dodd's cell, where they found him lying on his bed. She said that his breathing was "laboured". She radioed an emergency code blue (which indicates that a prisoner is unconscious, not breathing or has breathing difficulties).
26. At 6.51pm, staff in the control room called for an ambulance. Two nurses from the prison also responded. One of the nurses noted that Mr Dodd was unable to speak in full sentences, had an intense pain in his upper abdomen, felt sick and had high blood pressure. The Ambulance Service said that the nurses should administer four aspirins. One of the nurses noted that Mr Dodd vomited twice. When the paramedics arrived, they issued pain relief and took him to hospital. Two officers escorted Mr Dodd, and they restrained him, using an escort chain. At the request of hospital staff, they removed the escort chain for treatment.
27. In hospital, doctors diagnosed that Mr Dodd's aneurysm was leaking and inoperable. His condition deteriorated and he died at 9.33am on 17 January 2018.

### **Contact with Mr Dodd's family**

28. On 17 January, the prison appointed a prison manager as the family liaison officer (FLO). Mr Dodd's nominated next of kin was his wife. After Mr Dodd died, the FLO and a prison officer visited Mrs Dodd to break the news of her husband's death and offer their condolences and support. (When they arrived, she already knew as the hospital had called her.) Rye Hill arranged and paid for Mr Dodd's funeral, which was held on 31 January 2018.

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

29. After Mr Dodd's death, a prison manager debriefed the staff involved in the hospital bedwatch to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
30. The prison posted notices informing other prisoners of Mr Dodd'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 his death.

### **Cause of death**

31. The Coroner gave the cause of death as a ruptured abdominal aortic aneurysm and peripheral vascular disease (a blood circulation disorder). Significant contributory factors were acute pancreatitis, ischaemic heart disease and chronic obstructive pulmonary disease (lung disease).

# Findings

## Clinical care

32. The clinical reviewer said that Mr Dodd's overall care at the prison was equivalent to the level of care that he could have expected to receive in the community. He said that he had no concerns about the management of Mr Dodd's complex medical conditions.
33. The clinical reviewer noted that Mr Dodd had regular reviews of his abdominal aorta aneurysm. Hospital specialists considered surgery but Mr Dodd was considered too frail for that.
34. The clinical reviewer said that the emergency response on 13 January was appropriate.

## Restraints, security and escorts

35. 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 considers the prisoner's health and mobility.
36. 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, including the risk to the public in the event of such 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.
37. On 13 January 2018, a prison manager authorised the use of single handcuffs for Mr Dodd's transfer to hospital. The prison manager said that a duty prison manager contacted her at home and said that Mr Dodd was unwell and had to go to hospital. She said the duty manager alluded to the fact that Mr Dodd may have been feigning his illness. She said at that time, it was not known if his condition was life-threatening. The prison manager incorrectly stated that Mr Dodd was able-bodied and a Category B prisoner.
38. The prison manager sent the investigator a copy of the risk of death in custody form which she said the duty manager completed when Mr Dodd was in hospital. Contrary to the duty manager's comments, this noted that ambulance staff had advised that death was a possibility due to Mr Dodd's age and ongoing medical conditions.
39. A nurse completed the medical assessment at 8.00pm (when Mr Dodd was already at hospital) and noted that there were medical objections to restraints being used as Mr Dodd had extreme chest pain. She noted that his medical condition restricted his ability to move and that medical treatment might require the restraints to be removed.

40. The security risk assessment noted that Mr Dodd was a Category C prisoner, a wheelchair user and a risk to children.
41. The risk assessment did not consider Mr Dodd's health and lack of mobility at the time, or their impact on his risk of escape. His escort risk assessment was completed without any medical input at the time of departure. His medical record noted that he could move only short distances and used a wheelchair to get around. He needed help for all his care needs. It is difficult to see how the use of restraints was justified, not least as he was also escorted by prison staff.
42. 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. All staff involved need to ensure that a prisoner's health and mobility are fully considered in risk assessments for the use of restraints in line with the guidance in the 2007 High Court judgment. Ultimately, it is the Director's responsibility to ensure that the process is managed properly but the Head of Healthcare also needs to ensure that all healthcare staff understand their responsibilities and contribute appropriately to the risk assessment process.
43. We repeat our recommendation, which the Director has agreed to implement a number of times before, and address a further recommendation to Her Majesty's Prison and Probation Service given their overall responsibility for delivery of humane custodial services:

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

**The Head of Operational Contracts at Her Majesty's Prison and Probation Service should assure himself that meaningful action is taken to ensure that this happens.**

### Informing next of kin

44. Prison Rule 22(1) states that when a prisoner becomes seriously ill, the Governor should inform the prisoner's next of kin at once. Prison Service Instruction (PSI) 64/2011 on safer custody requires that prisons ensure that an appropriate member of staff engages promptly with the next of kin of prisoners who are seriously ill to try to ensure that the family do not find out about the death from another source.
45. PSI 64/2011 adds that if prisoners have a terminal illness or their physical health deteriorates unpredictably and/or rapidly, they must be encouraged to engage with their families or nominated person, where appropriate, and the prison should record their attempts to contact the family or their representatives.
46. Records show that when Mr Dodd was in hospital, prison staff did not try to contact his family. They said that the healthcare department had not completed

a risk of death notification until the morning of 17 January, and it was only when the hospital asked for the next of kin details that Rye Hill contacted his family.

47. Prison records showed that the prison managers had been notified on 13 January that death was possible. PSI 64/2011 requires prisons to have arrangements to engage with the next of kin, or other nominated person, when prisoners are seriously ill. When Mr Dodd was admitted to hospital on 13 January, Rye Hill should have informed his next of kin. We make the following recommendation:

**The Director should ensure that staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill.**

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