Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jason Pryce a resident at Southwell House Approved Premises on 7 February 2018

A report by the Prisons and Probation Ombudsman

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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 Jason Pryce died in hospital on 7 February 2018 from an infection caused by a perforated bowel while a resident at Southwell House Approved Premises. He was 44 years old. I offer my condolences to Mr Pryce's family and friends.

Mr Pryce had lived at Southwell House since September 2017, after his release from HMP Nottingham. He suffered from end-stage kidney disease and had a kidney transplant in January 2018. I am satisfied that staff at Southwell House appropriately supported Mr Pryce and there was nothing they could have done to prevent his death.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **August 2018**

Contents

Summary

Events

1. In September 2017, Mr Jason Pryce was released from prison on licence and was required to live at Southwell House Approved Premises in Nottingham. He had several long-term health conditions, including end-stage kidney disease, for which he attended regular hospital appointments for dialysis. Probation staff reviewed Mr Pryce frequently and offered him ongoing support. They issued him with his medication daily and facilitated his attendance at medical appointments.

2. On 15 January 2018, Mr Pryce had a kidney transplant operation at hospital. He returned to Southwell House five days later. On 27 January, Mr Pryce reported worsening back pain to a staff member who contacted the renal unit for advice and then sent him to hospital by taxi. Hospital staff admitted Mr Pryce for observation and on 4 February, he had an operation to correct a bowel obstruction caused by a hernia. Probation staff kept in regular contact with the hospital for updates on Mr Pryce's condition.

3. On 7 February, at 3pm, a member of staff from the hospital told Mr Pryce's offender manager that Mr Pryce had died. His offender manager notified the staff at Southwell House at 5.15pm.

4. The coroner confirmed that Mr Pryce died of an infection caused by faecal material from a perforated bowel entering the peritoneal cavity. His kidney transplant was listed as a contributory factor.

Findings

5. Mr Pryce received a good standard of care at Southwell House. The staff responded appropriately when he reported worsening back pain and we are satisfied they could not have done anything to prevent Mr Pryce's death.

The Investigation Process

6. The investigator issued notices to staff and residents at Southwell House informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

7. The investigator visited Southwell House on 20 February. He obtained copies of relevant extracts from Mr Pryce's prison, probation and medical record.

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

9. The investigator wrote to Mr Pryce's daughter to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not point out any factual inaccuracies.

Background Information

Southwell House Approved Premises

11. Approved premises (formerly known as probation or bail hostels) accommodate offenders released from prison on licence and those directed to live there by the courts as a condition of bail. Their purpose is to provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment. Residents are responsible for their own healthcare and are expected to register with a GP.

12. Southwell House Approved Premises in Nottingham, is managed by the National Probation Service. It has 18 single rooms. The accommodation is self catered and there are communal areas for eating and socialising. Each resident has a key worker to oversee their progress and well-being and see that they adhere to their individual licence conditions and the premises' rules. Staff are on duty at Southwell House 24 hours a day.

Previous deaths

13. Mr Pryce was the first person to die while a resident at Southwell House.

Key Events

14. In January 1999, Mr Jason Pryce was sentenced to life in prison for murder. He was released on licence in February 2016, but was recalled to HMP Nottingham on 7 September after breaching the conditions of his licence.

15. Mr Pryce suffered from several long-term health conditions including high cholesterol, high blood pressure and end-stage kidney disease. Healthcare staff reviewed him when they could, but he did not always attend his appointments and often failed to comply with his fluid restriction requirement of one litre a day. Staff attended regular multidisciplinary meetings to discuss Mr Pryce's care and officers facilitated his appointments at the hospital for dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly).

16. On 29 September 2017, Mr Pryce was released on licence and was required to live at Southwell House Approved Premises in Nottingham. When Mr Pryce arrived, a residential support worker went through the conditions of his licence and the approved premises' rules. She confirmed that Mr Pryce was registered with a local GP and obtained his permission for relevant information from his medical record to be shared with probation staff. Mr Pryce took several prescribed medications which staff kept in the office and he had to collect it daily. On 30 September, Mr Pryce completed a self-report health screen and noted that although he could mobilise independently, he had difficulty walking long distances.

17. On 5 October, a probation services officer saw Mr Pryce for a keywork session and completed a supervision plan focusing on areas such as moving on from Southwell House and health. On 24 November, Mr Pryce's offender manager received a phone call from the hospital advising her that Mr Pryce had been put forward for a kidney transplant and that he could be called for the procedure at any time. Over the next two months, staff at Southwell House monitored Mr Pryce frequently and helped to facilitate his attendance at hospital and GP appointments by reminding him in advance and providing taxis, when required.

18. On 5 January 2018, the probation services officer saw Mr Pryce for a keywork session and they discussed several aspects of his life, including his health. Mr Pryce said he was still waiting for a kidney donor and that he was managing with regular dialysis. On 15 January, while in the dialysis clinic at the hospital, Mr Pryce received notification that a suitable kidney had become available. He had the operation that evening and returned to Southwell House five days later. On 25 January, Mr Pryce told the probation services officer that he was coping and that he was glad to be back. The officer advised him to speak to staff if he had any problems or if he required additional support.

19. On 27 January, at around midnight, Mr Pryce reported worsening back pain to a residential support worker, who phoned the hospital's renal unit for advice. At 12.30am, on 28 January, he sent Mr Pryce by taxi to the hospital, as suggested. Hospital staff admitted Mr Pryce for further observation and on 4 February, he had an operation to correct a bowel obstruction caused by a hernia (a hernia occurs when an organ pushes through an opening in the muscle tissue that holds

it in place). The staff at Southwell House contacted the hospital frequently for updates on Mr Pryce's condition.

20. On 7 February, at 11am, the probation manager contacted the hospital for an update on Mr Pryce's condition. She recorded that he was recovering from bowel surgery on a ward and was not medically fit for discharge. Later that day, the probation services officer received a request from the hospital for Mr Pryce's next of kin details. He could not remember the exact time, but he told us that he received the request from a colleague between 12pm and 1pm. At 2.06pm, having checked Mr Pryce's probation record, he contacted the hospital and provided the requested information. At 3pm, the probation manager received a call from the hospital notifying her that Mr Pryce had died. She informed the staff at Southwell House, via email, at 5.15pm.

Contact with Pryce's family

21. On 9 February, the approved premises' manager contacted Mr Pryce's daughter, his nominated next of kin, to offer her condolences and support. She arranged for Mr Pryce's daughter to collect his property from Southwell House on 19 February and provided ongoing support.

22. Mr Pryce's funeral took place on 20 March and the approved premises' manager attended with another member of staff. The Probation Service paid for the funeral, in line with national policy.

Support for residents and staff

23. Following the news of Mr Pryce's death, the approved premises' manager telephoned the staff on duty to offer immediate support and told them that she was available during the night if needed. The next day, she offered support to all the staff who had worked with Mr Pryce at Southwell House.

24. On 7 February, residential support workers told residents individually that Mr Pryce had died and offered support. The residents were permitted to stay in the communal area for longer than normal so they could support each other and speak to staff if required. Notices were posted to inform all staff and residents of Mr Pryce's death and offering support.

Cause of death

25. The coroner confirmed that Mr Pryce died of an abdominal infection that was caused by faecal material from a perforated bowel entering the peritoneal cavity (a space that can occur between two layers of membrane that form the lining of the abdominal cavity). A kidney transplant operation was given as the underlying cause.

Findings

Care and support

26. Mr Pryce was 44 years old and suffered from several long-term health conditions including high blood pressure and end-stage kidney disease. Following his release on licence, the staff at Southwell House conducted a full induction and confirmed that he was registered with a local GP. Mr Pryce did not have his prescribed medication in his possession but collected it from staff daily. Records show that staff decided to personally dispense his medication so they could ensure he took it when required. We consider that this arrangement was appropriate.

27. Although Mr Pryce could only walk short distances he was independent and, as with anyone else in the community, was responsible for managing his own health and attending medical appointments. Nevertheless, the staff at Southwell House supported Mr Pryce with managing his conditions and helped him to get to his medical appointments by reminding him in advance and providing taxis, when required. Staff spoke to him daily and reviewed him during keywork sessions.

28. We are satisfied that staff at Southwell House could not have done anything to prevent Mr Pryce's death. They ensured that he received appropriate treatment by contacting the renal unit for advice and sending him to hospital as directed.

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