Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Chambers a prisoner at HMP Ranby on 3 June 2017

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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Paul Chambers died on 3 June 2017, of acute exacerbation of chronic obstructive airways disease at HMP Ranby. He was 48 years old. We offer our condolences to Mr Chambers' family and friends.

We are satisfied that, overall, the care Mr Chambers received at Ranby was equivalent to that which he could have expected to receive in the community.

We are concerned; however, that healthcare staff at Ranby did not refer Mr Chambers for a chest x-ray when he arrived at the prison (although this was not a significant factor in his death). We are also concerned about the delay in informing Mr Chambers' next of kin of his death.

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

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

Contents

Summary

Events

1. On 7 June 2006, Mr Paul Chambers was sentenced to seven years in prison for robbery and possession of a firearm. He was released on licence and on 1 September 2015, he was recalled to prison. On 17 January 2017, he was moved to HMP Sudbury.

2. On 5 April, a nurse saw Mr Chambers in his cell because he had chest pains. He told her he had a pain on the left side of his chest and back. Mr Chambers was sent to hospital. He had an x-ray, which showed he had an infection. The radiologist asked him to come back in eight weeks and he was sent back to prison. On 25 April, a healthcare administrator sent a request to the hospital for Mr Chambers to have another x-ray.

3. On 3 May 2017, Mr Chambers was transferred to HMP Ranby. The next day, a nurse completed an initial health screening. She said he had heart disease, high blood pressure and chronic obstructive pulmonary disease (COPD - inflamed airways and damaged air sacs in the lungs). She noted that Mr Chambers was due an x-ray.

4. Mr Chambers was in possession of medication, including salbutamol for asthma and COPD. This drug can be used in a nebuliser (a compressor used to turn liquid medication into a fine mist). He also used an inhaler and was prescribed uniphyllin for asthma, breathing difficulties and COPD. He continued to receive his medication.

5. On 1 June, a practice nurse reviewed Mr Chambers' COPD care plan. The review was not due until July, but was brought forward because his symptoms were worse. She tasked a GP to review his medication.

6. At 7.37am on 3rd June, Mr Chambers pressed his cell bell. He told a prison officer that he was out of breath and having difficulty breathing. The officer switched on Mr Chambers' nebuliser and told him to sit on the bed and breathe in, using the device.

7. Mr Chambers told the officers that he had COPD. Officers called an ambulance. Mr Chambers went pale, fell forward and became unconscious. An officer called a medical emergency code blue (which indicates that a prisoner is unconscious or not breathing). Officers placed Mr Chambers in the recovery position, checked his airway and breathing. There was blood in his mouth as he had bitten his tongue. He stopped breathing and went into cardiac arrest.

8. A supervising officer attended and with another officer, started cardiopulmonary resuscitation (CPR). They used a defibrillator and on three occasions, it indicated there were non-shockable rhythms. They continued CPR. A nurse arrived and also continued CPR.

9. At 7.48am, an ambulance arrived at the prison and paramedics attended to Mr Chambers. Together with healthcare and prison staff, they continued CPR and treatment until 8.51am, when he was pronounced dead.

Findings

Clinical care

10. The clinical reviewer found that overall; the care Mr Chambers received at Ranby was equivalent to that which he could have expected to receive in the community. In the short period he was at the prison, he received assessments from the substance misuse team and the mental health team and had a COPD review.

11. However, we found that healthcare staff at Ranby omitted to refer Mr Chambers for a chest x-ray when he arrived at the prison, and he did not therefore have the follow-up requested by a consultant when at Sudbury. The clinical reviewer found, though, that this was not significant in Mr Chambers' death.

Contact with Mr Chambers' family

12. It took nine hours from Mr Chambers' death for a police officer to visit his next of kin, his mother, and almost 12 hours before she was told of his death. This was an unacceptable delay. We are concerned that the contact details for Mr Chambers' next of kin were not kept up to date and this contributed to the delay. While we recognise that there was traffic congestion, it would have been quicker for staff at Cardiff to have travelled by foot to the address than involve the police who were equally affected by the travel difficulties.

Recommendations

- The Head of Healthcare at Ranby should ensure that the reception screening process triggers appropriate review and referral when a newly arrived prisoner has an outstanding hospital appointment.
- The Governor of Ranby should ensure that emergency contact details for prisoners' next of kin are accurate and kept up to date and, in the event of a death, ensure that the prisoner's family is informed as soon as possible in line with national guidance.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Ranby informing them of the investigation and asking anyone with relevant information to contact him. No one responded

14. The investigator obtained copies of relevant extracts from Mr Chambers' prison and medical records.

15. The investigator interviewed a member of staff on the telephone on 12 July.

16. NHS England commissioned a clinical reviewer to review Mr Chambers' clinical care at the prison. The investigator interviewed seven members of staff with Mr Watson at Ranby on 5 July.

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

18. One of the Ombudsman's family liaison officers contacted Mr Chambers' mother, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Chambers' mother said she was concerned by how long it took the prison to inform her of his death.

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

Background Information

HMP Ranby

20. HMP Ranby is a category C prison for prisoners who do not require a high level of security, but are not ready for open conditions. It holds over a thousand men. Nottinghamshire Healthcare Trust provides primary healthcare services.

Her Majesty's Inspectorate of Prisons

21. The most recent inspection of Ranby was in September 2015. The report found that safety remained a significant concern, fuelled by a surge in the availability of new psychoactive substances (NPS) which meant that healthcare services were at risk of being seriously overwhelmed. However, healthcare services were reasonably good and continuing to develop. While inspectors found that healthcare services were well governed and integrated, healthcare for prisoners out of hours was inadequate. Pharmacy services had improved but the administration of medicine to prisoners needed to be better supervised.

Independent Monitoring Board (IMB)

22. Each prison in England and Wales has an Independent Monitoring Board of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. The most recent IMB annual report, for the year to March 2017, commended healthcare staff at Ranby for their continuing hard work and commitment to prisoners' wellbeing.

Previous deaths at HMP Ranby

23. There have been no previous deaths from natural causes in the last 12 months.

Key Events

24. On 7 June 2006, Mr Paul Chambers was sentenced to seven years in prison for robbery and possession of a firearm. He was released on licence in 2014 and on 1 September 2015, he was recalled to prison. On 17 January 2017, he was transferred to HMP Sudbury.

25. On 5 April, a nurse saw Mr Chambers in his cell because he had chest pains. He told her he had a pain on the left side of his chest and back. Mr Chambers went to hospital. He had an x-ray, which showed he had an infection of the lower lung. Hospital staff said he also had a muscle strain due to a chronic cough. The radiologist recommended a follow up x-ray in eight weeks and Mr Chambers went back to prison. On 25 April, a healthcare administrator sent a request to the hospital for the follow-up x-ray.

26. On 3 May 2017, Mr Chambers was transferred to HMP Ranby. The next day, a nurse completed an initial health screening. She noted that he had heart disease, high blood pressure and chronic obstructive pulmonary disease (COPD - inflamed airways and damaged air sacs in his lungs). He said he was a light smoker and had a history of substance misuse. She noted that Mr Chambers was due for an x-ray, but she did not follow this up and ask a GP to arrange an x-ray.

27. Mr Chambers was in possession of the following medication for his COPD: salbutamol (which can be used in a nebuliser), an inhaler (to make breathing easier), uniphyllin (for asthma, breathing difficulties and COPD) and glyceryl trinitrate (GTN, a spray for relief from angina). He continued to receive this medication.

28. On 1 June, a nurse saw Mr Chambers to review his COPD care plan. The review was not due until July but was brought forward because his symptoms were worse. Mr Chambers said he had had ten flare-ups in the past year. He said he knew how to use his inhaler and nebuliser. He was exceeding his dose of uniphyllin but did not collect it that day. He was taking his other medication correctly. She tasked a GP to review Mr Chambers' medication.

29. At 7.37am on 3 June, Mr Chambers pressed his cell bell. He told Officer A that he was out of breath and had difficulty breathing. She asked Officer B to inform the orderly officer who was the on-call manager. Officer A switched on Mr Chambers' nebuliser and told him to sit on the bed and breathe in, using the device.

30. Mr Chambers told the officers that he had COPD. Officer B told the orderly officer by telephone, and she arranged for an ambulance to be called. Mr Chambers then went pale, fell forward and lost consciousness. At 7.41am, Officer A called a medical emergency code blue, indicating a life-threatening situation.

31. The officers placed Mr Chambers in the recovery position, checked his airway and breathing. There was blood in his mouth as he had bitten his tongue. Mr Chambers stopped breathing and went into cardiac arrest.

32. A Supervising Officer (SO) attended, with Officer B and started cardiopulmonary resuscitation (CPR). The orderly officer attended, and told Officer A to get the defibrillator, which was in the wing office a short distance away. The SO applied the defibrillator pads. On three occasions, the defibrillator indicated that there were non-shockable rhythms. They continued CPR.

33. A nurse arrived and, together with Officer B and Officer C, continued CPR.

34. At 7.48am, an ambulance arrived at the prison and paramedics went to Mr Chambers' cell. Together with healthcare and prison staff, they continued CPR and treatment until 8.51am when the paramedics confirmed that Mr Chambers had died.

Contact with Mr Chambers' family

35. At 9.30am on 3 June, the head of residence and the duty governor, appointed an officer as the family liaison officer (FLO). Mr Chambers' next of kin, his mother, lived in Cardiff. The FLO told us that it would have been difficult to visit Mr Chamber's mother, to inform her of his death in person because there was a major football match at the Millennium Stadium in Cardiff.

36. The FLO, therefore contacted HMP Cardiff at 9.30 am, to ask them to inform Mr Chambers' mother. At 1.25pm, a senior manager at Cardiff tried to go to the address but was unable to enter the area due to road closures and congestion.

37. At 3.03pm, the FLO emailed South Wales Police to ask them to inform Mr Chambers' mother of his death. They said that, due to the football match, they could not treat this as an immediate response. Initially, police officers went to Mr Chambers' mother's previous address (as it was noted in Mr Chambers' prison records) and at 5.45pm, they went to the correct address, but there was no one in. At 8.15pm, they went back to the address and told her of her son's death.

38. At 8.20pm, Mr Chambers' mother spoke to Officer P. She asked her why an officer did not inform her of her son's death when he died. Officer P explained the reason for the delay. Mr Chambers' mother was not happy and ended the phone call.

39. On 4 June, Officer P and, a prison chaplain spoke to Mr Chambers' mother. They offered their condolences. Officer P explained the reason for the delay in telling her of Mr Chambers' death.

40. On 6 June, Officer P visited Mr Chambers' mother with the prison chaplain and the deputy governor. Mr Chambers' father was also present. The Governor offered his condolences on behalf of the prison.

41. Mr Chambers' funeral was held on 29 June. The prison contributed towards the cost in line with national policy.

Support for prisoners and staff

42. After Mr Chamber's death, the deputy governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

43. The prison posted notices informing other prisoners of Mr Chambers' 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 Chambers' death.

Post-mortem report

44. A post-mortem examination established that the cause of Mr Chambers' death was acute exacerbation of chronic obstructive airways disease. (Chronic obstructive airways disease is another name for COPD.) The pathologist gave hypertensive cardiac disease (high blood pressure) as a secondary factor.

Findings

Clinical care

45. The clinical reviewer, was satisfied that overall, the care Mr Chambers received at Ranby was equivalent to that which he could have expected to receive in the community. In the short time that he was at Ranby, he had a COPD review and received an assessment from the substance misuse team and the mental health team.

46. However, we are concerned that healthcare staff at Ranby did not refer Mr Chambers for a chest x-ray when he arrived at the prison. Mr Chambers' x-ray at a hospital, on 5 April, showed a potential infection of the lower left area of the lung and hospital staff asked for a follow up x-ray in eight weeks. On 25 April, staff at Sudbury asked the hospital to arrange this but Mr Chambers was transferred to Ranby before it was completed. At Mr Chambers' initial health assessment, it was noted that he was due to have a chest x-ray but no one asked the GP to arrange this through the medical database, SystmOne, and it was therefore not completed. The clinical reviewer concluded that this was not significant in Mr Chambers' death. However, it might be important in future cases and we, therefore, make the following recommendation:

The Head of Healthcare should ensure that the reception screening process triggers appropriate review and referral when a newly arrived prisoner has an outstanding hospital appointment.

Contact with Mr Chambers' family

47. It took twelve hours from the time Mr Chambers died until his mother was told of his death. This was an unacceptable delay. The senior manager at Ranby anticipated the travel difficulties in Cardiff and, in the circumstances; we consider it was reasonable that he asked Cardiff to break the news to Mr Chambers' mother. However, we are concerned that the contact details for Mr Chambers' next of kin were not up to date and that this increased the delay by nearly three hours in his mother being told of his death.

48. By the time Cardiff had organised family liaison, several hours had passed. Although they tried to visit Mr Chambers' mother, they said they were unable to because of the significant travel disruption. Although they told South Wales Police at 3.03pm to break the news, this was a number of hours after Mr Chambers had died, and in the circumstances (of significant congestion on the roads), it might have been better for prison staff to have travelled by foot to the address (which appears to have been less than three miles from the prison) as the police would have faced the same travel difficulties. We make the following recommendations:

The Governor of Ranby should ensure that emergency contact details for prisoners' next of kin are accurate and kept up to date and, in the event of a death, ensure that the prisoner's family is informed as soon as possible in line with national guidance.

Prisons & Probation Ombudsman
Independent Investigations

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