Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Cryne a prisoner at HMP Dovegate on 20 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*

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 Paul Cryne died of sepsis, a diabetic foot infection and ischaemic heart disease on 20 January 2018 in hospital while a prisoner at HMP Dovegate. He was 69 years old. I offer my condolences to his family and friends.

Overall, Mr Cryne received a good standard of care at Dovegate, equivalent to that which he could have expected to receive in the community.

However, there is a need to improve to processes for following up missed podiatry appointments for patients who are high risk. I am also concerned that Mr Cryne was restrained when he was taken to hospital purely on the basis of his security category, without staff fully assessing his risk.

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
Deputy Ombudsman **February 2019**

Contents

Summary

1. On 8 August 2010, Mr Paul Cryne was convicted of murder, and sent to HMP Lewes. In August 2016, he was transferred to HMP Dovegate.

2. During his initial healthcare health screen, Mr Cryne told the nurse that he had various conditions, including post-traumatic stress disorder, Type 2 diabetes and high blood pressure.

3. Care plans were put into place to manage his conditions, and Mr Cryne had regular blood tests, with the aim of managing his diabetes.

4. There were no significant entries in his medical record until 29 March 2017 when Mr Cryne saw a podiatrist. She recorded that he should be monitored because the nerves in his feet were damaged (because of his diabetes).

5. Mr Cryne struggled to control his diet and reduce his blood sugar levels, resulting in an admission to hospital in July 2017. When he returned to Dovegate, healthcare staff monitored him closely, and managed his conditions through the care plans in place. Mr Cryne remained overweight, and therefore at risk of diabetes-related conditions.

6. On 1 December, a nurse saw Mr Cryne and noted that his toe was black and seeping blood. He was referred to a chiropodist, but in the interim, was transferred to hospital, where he was prescribed antibiotics for gangrene of his toe.

7. Mr Cryne attended regular chiropody clinics throughout December, but failed to do so on 28 December, and there was no explanation given for his absence.

8. The healthcare team continued to monitor him, and it was not until 12 January 2018 that Mr Cryne reported feeling unwell, and asked to see a nurse. The nurse recorded that the gangrene was worsening, and on the advice of a prison GP, Mr Cryne was sent to hospital. He was discharged that day, and a plan was put in place potentially to amputate his toe.

9. On 15 January, Mr Cryne became increasingly unwell, and reported vomiting for a lengthy period. A nurse took his observations and recorded that his blood glucose was high, and that he had low blood pressure. He was transferred to hospital and on 17 January, had his toe amputated. His health deteriorated in surgery and he developed multi-organ failure.

10. Mr Cryne was diagnosed with sepsis but did not respond to treatment. He remained in hospital, and died on 20 January.

Findings

11. We are satisfied that overall, Mr Cryne's care at Dovegate was equivalent to that which he could have expected to receive in the community. Mr Cryne had Type 2 diabetes when he arrived at prison. Healthcare staff tried hard to manage this effectively, and referred him to hospital when his condition deteriorated.

12. However, Mr Cryne failed to attend a podiatry appointment, and as a high-risk patient, this should have been followed up to allow closer monitoring of his condition.

13. The use of mechanical restraints when Mr Cryne was sent to hospital was disproportionate to the actual risk which Mr Cryne posed and did not consider the impact of his condition on those risks.

14. When it became apparent that Mr Cryne was critically unwell, the prison promptly appointed a family liaison officer who contacted Mr Cryne's family.

Recommendations

- The Head of Healthcare should review the podiatry service at HMP Dovegate, including the ability to flag high-risk patients if appointments are cancelled.

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

The Investigation Process

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

16. The investigator obtained copies of relevant extracts from Mr Cryne's prison and medical records.

17. NHS England commissioned a clinical reviewer to review Mr Cryne's clinical care at the prison.

18. 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 Dovegate

19. HMP Dovegate is run by Serco. The main prison holds around 933 remanded and sentenced adult men. There is also a therapeutic community, separate to the main prison, which holds up to 200 men. Care UK, who took over from Serco Health in October 2014, provides healthcare services.

HM Inspectorate of Prisons

20. The most recent inspection of Dovegate was conducted in May and June 2017. Health services staff were clearly identifiable. They knew their patients, and the inspectorate observed good-natured relationships with them. There was a wide range of Care UK policies, including those on communicable disease management and safeguarding. Information governance and the use of SystmOne (electronic case notes) were sound.

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 30 September 2017, the IMB reported that healthcare services were improving but retention of staff was a problem.

Previous deaths at HMP Dovegate

22. There have been eight previous deaths at HMP Dovegate since January 2015, three of which have been from natural causes. We have previously made a recommendation about the inappropriate use of restraints which the prison agreed to implement.

Key Events

23. On 6 August 2009, Mr Cryne was remanded to HMP Lewes, charged with murder. He was convicted on 8 August 2010, and returned to HMP Lewes. He was transferred to HMP Dovegate on 11 August 2016.

24. On Mr Cryne's arrival, a nurse completed his initial health screen. Mr Cryne had a history of post-traumatic stress disorder (PTSD), Type 2 diabetes (when the body does not produce enough insulin to control the amount of glucose in the blood), carpel tunnel syndrome (compression of a nerve in the hand), problems with his hips, hypertension (high blood pressure) and he had had a heart attack in 1996. Mr Cryne was advised to exercise as he was recorded as being overweight.

25. The nurse assessed him as suitable for standard location and to keep his medication in possession. Care plans were put into place to manage Mr Cryne's conditions, including heart disease and diabetes, for which he had regular reviews and blood tests.

26. There are no relevant entries in his medical records until 21 March 2017 when a nurse developed a new diabetes care plan. As part of this plan, she arranged for Mr Cryne to see a podiatrist on 29 March, who recorded that both his feet were at high risk due to diabetic neuropathy (damage to nerves).

27. On 31 May 2017, a nurse reviewed Mr Cryne's heart disease, and developed a separate hypertension care plan. Mr Cryne agreed with the plan, and his medical records noted that no review was necessary.

28. Over the following months, Mr Cryne struggled to reduce his blood sugar levels, which resulted in an emergency medical response being called on 14 July. He was not taken to hospital but, was advised to contact the healthcare team if he had any further concerns.

29. On 17 July, a nurse noted in Mr Cryne's medical records that a prisoner had told her that before Mr Cryne's diabetic attack on 14 July, he was seen eating foods high in sugar, and had been giving his insulin away. Mr Cryne denied giving his insulin away. The nurse advised him how to manage his diabetes and referred him to a diabetologist.

30. Over the following months, healthcare staff saw and supported Mr Cryne regularly. They managed his conditions through care plans, and when they identified clinical issues, they appropriately managed and followed them up.

31. On 4 September, a prison GP completed a medication review for Mr Cryne. He noted that Mr Cryne had not lost any weight, and that he had central obesity (which occurs when excessive abdominal fat has built up to the extent that it is likely to have a negative impact on health). The doctor made a referral to the diabetologist.

32. The following month, Mr Cryne was due to see a podiatrist as part of his diabetic care plan. The podiatrist, made an entry on 2 October which said that Mr Cryne had failed to attend his appointment. No explanation was given for his absence.

33. There were no significant entries in his medical records until 7 November when Mr Cryne had a video call with the diabetes specialist team to discuss his blood sugar levels. They advised him that he needed to keep a sugar diary to record readings, and that they would change his insulin. A plan was put into place to review him in three months.

34. On 1 December, a nurse prescriber noted that toes on Mr Cryne's right foot were seeping fluid and blood, and that the base of his big toe was black. She arranged for him to see a chiropodist, and dressed his foot as an interim solution.

35. A nurse reviewed Mr Cryne on 3 December, and arranged for him to go to hospital for a review of his foot. Mr Cryne was transferred on 5 December, and was restrained by double handcuffs. The hospital prescribed him antibiotics for diabetic gangrene of his toe.

36. Mr Cryne was returned to the prison on 11 December. A prison GP reviewed him on 20 December, and prescribed a second course of antibiotics as an infection was still present. Mr Cryne attended the dressings clinic on 21 December, but did not attend his next appointment on 28 December. The medical records do not explain his absence.

37. A substance misuse practitioner saw Mr Cryne on 29 December. He recorded that Mr Cryne had asked for a new blood glucose meter and glucose testing strips.

38. On 31 December, an officer called a medical emergency code blue (indicating breathing difficulties) for Mr Cryne. A nurse responded and, when she arrived at Mr Cryne's cell, an officer told her that Mr Cryne had something in his mouth that obstructed his breathing. The nurse took his observations and noted that he had a fast pulse at 124 beats per minute and a raised blood glucose level. He was transferred to another hospital and discharged that same day with a course of antibiotics. The discharge letter confirmed that Mr Cryne had an infection of his uvula (a fleshy extension at the back of the soft palate above the throat). It stated that he had had multiple recent infections.

39. On 9 January 2018, a prison GP reviewed Mr Cryne. He noted that Mr Cryne was still not managing his diabetes well, and advised him how to do so. The doctor noted that he had gangrene of his big toe, and was at high risk of further gangrene, so referred him to a chiropodist.

40. On 11 January, Mr Cryne saw a nurse in the dressings clinic. She noted that his toe was not covered, and reminded him of the importance of keeping it clean.

41. On 12 January, a member of prison staff asked the healthcare team to see Mr Cryne as he had reported not feeling well. A nurse prescriber saw him and noted that his haemoglobin level was above 75, which is considered high, and that the gangrene in his toe was worsening. The nurse spoke to a prison GP for advice. The doctor authorised his transfer to hospital.

42. Mr Cryne was returned to the prison later that day, with his toe dressed. The discharge letter stated that Mr Cryne had been seen in hospital about his toe, and that he should be referred there for potential amputation.

43. A member of wing staff reported that Mr Cryne had been vomiting since midnight on the night of 14/15 January, and that he had abdominal pain, a nurse visited him, and made an entry in his medical records at 3.27am on 15 January. The nurse took his observations and noted that his blood pressure was low and blood glucose high. He was described as looking unwell and an ambulance was called for further assessment. The paramedics assessed Mr Cryne and transferred him to hospital, that morning.

44. On 16 January, a nurse contacted the hospital and was informed that Mr Cryne's white blood cell count was raised (which suggested an infection), and that he was being given intravenous antibiotics. He was transferred that day to another hospital, with a view to amputate his toe.

45. On 17 January, the Head of Healthcare contacted the hospital for an update. The critical care sister told him that Mr Cryne had had surgery, and that his condition was critical.

46. On 18 January, the Deputy Head of Healthcare and the Assistant Director visited Mr Cryne in hospital. They spoke to the consultant in the Critical Care Unit, who explained that Mr Cryne's health had deteriorated significantly during surgery and that he now had multi-organ failure. He had also been diagnosed with sepsis but was not responding to treatment.

47. The prison remained in contact with the hospital, and Mr Cryne's health continued to decline. At approximately 4.30am on 20 January, Mr Cryne died.

Contact with Mr Cryne's family

48. On 18 January, when Mr Cryne's health declined further, a family liaison officer was appointed. Mr Cryne had nominated his ex-partner who lived in Thailand as his next of kin. The family liaison officer contacted the Thai embassy that day as there was no telephone number available for his next of kin. However, contact could not be made with his ex-partner.

49. Although not appointed as his next of kin, Mr Cryne's son's name and address were on his records. As he lived in Devon, the prison arranged for the police to make contact with him, and inform him of his father's declining health. Due to the distance, Mr Cryne's son did not think that he would visit his father and it was agreed that he would be contacted by telephone when his father had died.

50. On 20 January, after Mr Cryne's death, another family liaison officer was appointed as the family liaison officer. At 2.35pm, he telephoned Mr Cryne's son and broke the news of his father's death. He arranged for him to view his father's body, and for Mr Cryne's belongings to be returned.

51. Mr Cryne's funeral, for which Dovegate paid, took place on 8 February 2018. The two family liaison officers both attended.

Support for prisoners and staff

52. After Mr Cryne's death, the staff present were debriefed when Mr Cryne died to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

53. The prison posted notices informing other prisoners of Mr Cryne's death, and offering support.

Post-mortem report

54. The post-mortem report gave the cause of death as sepsis, a diabetic foot infection and ischaemic heart disease.

Findings

Clinical care

55. The clinical reviewer concluded that the overall care that Mr Cryne received was equivalent to that which he could have expected to receive in the community. The care plans in place at Dovegate were implemented and reviewed in line with NICE guidelines. In addition to the routine blood testing and medication reviews to manage his diabetes, Mr Cryne had regular screening from the diabetic retinopathy team and was also under the care of the podiatry service.

56. The clinical reviewer noted that it was concerning that, although Mr Cryne was a high-risk patient, no one recorded the reason in his medical records when Mr Cryne missed an appointment with a podiatrist on 2 October 2017. Although this appointment was rescheduled, Mr Cryne was not seen because the podiatrist was on sick leave. The clinical reviewer spoke to the Deputy Head of Healthcare, who told her that Mr Cryne was due to be seen every eight weeks but there were no contingency plans in the event of staff sickness. We make the following recommendation:

    The Head of Healthcare should review the podiatry service at HMP Dovegate, including the ability to flag high-risk patients if appointments are cancelled.

57. The clinical reviewer noted that sepsis symptoms usually develop rapidly and are treated as a medical emergency. Mr Cryne had had recent infections before he died. As a diabetic, he also had an impaired immune system, skin breaks on his feet and legs, and was likely to have met the medium-risk threshold for sepsis.

58. However, it is not known whether the hospital assessed him for sepsis. When he was discharged from hospital on 12 January, the doctor overseeing his care said that Mr Cryne did not appear unwell. It was only when he admitted to hospital on 15 January 2018, that the admission assessment identified that Mr Cryne might have sepsis.

Restraints

59. 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.

60. Mr Cryne went to hospital several times for investigations and treatment. On each occasion, the escort risk assessments completed indicated that he was a medium risk to hospital staff, hostage taking, risk to the public and of escape,

and the Assistant Director authorised officers to restrain Mr Cryne with double handcuffs for the journey to the hospital and when in hospital. (Double cuffing is when the prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs.) This was however reviewed and replaced with an escort chain when he was having treatment. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.)

61. We are concerned that the process for reaching the decision to double cuff Mr Cryne did not reflect the requirements of the High Court judgement, as the medical section of the form, which did not record any objection to the use of restraints, but did not comment on how his condition affected his risk of escape, as it should have.

62. When Mr Cryne was admitted to hospital on 15 January, the Assistant Director again authorised officers to restrain Mr Cryne with double cuffs. Although staff subsequently reviewed his risk on 17 January and removed the restraints, we query how, given his deteriorating condition, he posed a realistic risk of escape, to the extent that mechanical restraints, particularly of this level, were necessary in addition to the two escorting officers for his final admission to hospital.

63. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances. Mr Cryne was a Category B prisoner but he was unwell at the time of his last admission and did not pose a high risk. The records suggest that prison managers based their decisions on the nature of his offences rather on his actual risk at the time. We make 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 on the use of restraints and that assessments are proportionate, fully take into account a prisoner's health, and are based on the actual risk a prisoner presents at the time.

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