Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Abdul Rehman a prisoner at HMP Humber on 3 February 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.

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

Mr Abdul Rehman was found dead in his cell on the morning of 3 February 2018. He had died from heart failure. Mr Rehman was 52 years old. I offer my condolences to Mr Rehman's family and friends.

Mr Rehman had been in prison for some years. In 2013 he had suffered a heart attack, and had stents fitted. On his return to prison he did not seem to have any further problems, though he remained on medication. On the evening of 2 February 2018, he did not raise any issues of feeling unwell. When prisoners were unlocked the following morning, he was found unresponsive and healthcare staff established that Mr Rehman had died.

From the information available, I am satisfied that Humber could not have foreseen or prevented Mr Rehman's death. The prison officer who unlocked him did not check his wellbeing, as she should have done, but it is likely that Mr Rehman was already dead by this time. The clinical reviewer noted that annual healthcare monitoring after Mr Rehman's heart attack was not done in line with guidance.

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
Deputy Prisons and Probation Ombudsman **February 2019**

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Summary

Events

1. Mr Rehman was sentenced to life imprisonment in 1999. He arrived at HMP Wolds, which later became part of HMP Humber, in 2011.

2. In 2013 Mr Rehman suffered a heart attack. He was treated in hospital and returned to prison with a careplan and with prescribed medication. He returned to hospital later that year for a planned heart procedure.

3. In 2016 Mr Rehman complained of losing weight and was referred for tests, which did not reveal any problems. In 2017 he reported a longstanding cough and was again referred for tests and for an x-ray. Again, no abnormalities were detected.

4. On the evening of 2 February, Mr Rehman spoke to a prison officer about a query over his pay, then retired to his cell. When prisoners were unlocked the following morning, the officer who unlocked Mr Rehman did not check on his welfare. Soon afterwards, fellow prisoners became concerned about him and summoned prison officers. They raised an emergency and called for medical staff but it was clear that Mr Rehman had died.

Findings

Roll check and unlock procedures

5. Guidance to staff on conducting roll checks states that these are intended to ensure that prisoners are in their cells, not to confirm their wellbeing. When unlocking cells, however, prison officers should satisfy themselves that they have a verbal response or note physical movement of a prisoner. The officer who unlocked Mr Rehman did not do so.

Mr Rehman's healthcare

6. The clinical reviewer noted that the careplan created after Mr Rehman's heart attack in 2013 was good. There was, though, no system in place in Humber to ensure that he had regular annual reviews in line with National Institute for Health and Clinical Excellence (NICE) guidelines. Mr Rehman was on the correct medication but not all the required tests were done each year.

7. The clinical reviewer noted that while Mr Rehman's healthcare was reasonable, and improved over time, initial care processes around his heart disease were not equivalent to that which he could have expected to receive in the community. Humber is working to improve its management of those with long-term conditions.

Recommendations

- The Governor should ensure that staff confirm the wellbeing of prisoners when unlocking cells; and

- The Head of Healthcare should ensure that prisoners with long-term conditions are managed and reviewed in line with guidance.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Humber informing them of the investigation and asking anyone with relevant information to contact him. There were no responses.

9. The investigator obtained copies of relevant extracts from Mr Rehman's prison and medical records. He interviewed two members of staff.

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

11. We informed HM Coroner for East Riding and Kingston upon Hull of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.

12. The investigator wrote to Mr Rehman's daughter, to explain the investigation and to ask whether she had any matters the family wanted the investigation to consider. She did not raise any specific issues.

13. Mr Rehman's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Humber

14. HMP Humber (formed when HMP The Wolds and HMP Everthorpe merged in April 2014) holds up to 1,062 prisoners. City Health Care Partnership provides healthcare services. Onsite healthcare cover is available 24 hours a day, seven days a week

HM Inspectorate of Prisons

15. The most recent inspection of HMP Humber was conducted in November and December 2017. Inspectors reported that the prison appeared to be improving. Prisoners complained of having to wait to see a GP, but care plans for prisoners with long-term conditions were good.

Independent Monitoring Board

16. 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 the latest annual report for Humber for the year to December 2016, the IMB noted that there had been a shortage of staff which affected the running of the prison. City Health Care Partnership delivered a good service and complaints had decreased.

Previous deaths at HMP Humber

17. Mr Rehman was the fifth prisoner to die from natural causes at HMP Humber since January 2015. There are no similarities with the circumstances of the other deaths.

Key Events

18. In 1999, Mr Rehman was convicted of murder and sentenced to life imprisonment. He arrived at HMP Wolds (which later became part of HMP Humber) in March 2011. His reception screening reflected no medical concerns, and no concerns over any substance misuse or mental health issues.

19. Mr Rehman settled well and was described in his records as calm and polite. In April 2012 he had to take some time off work as he was unwell. Reports continued to describe him as a polite and mature prisoner who presented no problems and worked to address his offending behaviour.

20. In February 2013, Mr Rehman suffered chest pain while using the gym. He went to see healthcare staff, and when tests showed anomalies he was taken to hospital where it was confirmed that he had had a heart attack. He was treated in hospital for three days, after which he returned to prison. The hospital provided the healthcare department with a care plan.

21. In June, Mr Rehman returned to hospital for planned, follow-up non-surgical treatment. He returned to prison the same day. Again, the hospital provided instructions for medication as well as for managing his healthcare. In August, Mr Rehman began to receive different medication. His medical notes do not reflect why it was changed.

22. In April 2016, Mr Rehman told the doctor that he was concerned about having lost weight rapidly, along with a change in his bowel habits. He was referred to hospital, and saw specialists that month, and again the following month, to investigate the possibility of cancer. Tests were negative, and Mr Rehman received formal confirmation of this in July. In August, Mr Rehman told the doctor that he had had a cough for several months. He was referred for tests, and an x-ray in September showed no abnormalities.

23. On the evening of 2 February 2018, Mr Rehman spoke to an officer about his pay in the wing office for about five minutes. The officer said in interview that Mr Rehman was calm and not agitated. He made no complaints of feeling unwell and the officer did not notice anything about him that was out of the ordinary.

24. Prisoners were then locked into their cells for the night. Mr Rehman lived in a single cell and when the officer conducted the roll check at 5.15pm, Mr Rehman was sitting in a chair watching television. The officer said goodnight and Mr Rehman replied in the same terms. Again, he made no complaint of feeling unwell, nor did the officer notice anything untoward.

25. The wing observation book contains no entries relating to Mr Rehman during the night.

26. Local instructions say that when staff conduct the morning roll check, they are not expected to gain a response from prisoners, only to confirm that the correct number of prisoners are present. The roll checks confirmed that all prisoners were in their cells. When day staff came on duty at approximately 7.00am, night staff gave a handover briefing. No issues were raised in relation to Mr Rehman.

27. Staff began unlocking prisoners for the day, and an officer arrived at Mr Rehman's door at approximately 8.35am. She unlocked the cell and said "Good morning" to Mr Rehman, who was lying in his bed. She did not get a response before moving on to unlock the next cell.

28. A fellow prisoner went to see Mr Rehman. He opened the door and called to him but it appeared that Mr Rehman was still asleep in bed. He went to the servery area, where Mr Rehman worked, and another prisoner asked him if Mr Rehman was coming to work. He returned to Mr Rehman's cell. He was still in the same position, so he went into the cell and touched his arm. Mr Rehman was cold and had a discharge from his mouth. He went and asked the other prisoner to come back with him and check on Mr Rehman. They went back to the cell and, unable to get a response, called the officer.

29. The officer went to Mr Rehman's cell, but was unable to get a response from him. She shouted to another officer to call a code blue emergency over the radio, which he did. (This indicates a prisoner not breathing or having difficulty doing so.) This prompted the control room to request an ambulance. The emergency call was made at 9.02am.

30. A nurse responded to the emergency call, arrived at Mr Rehman's cell approximately three minutes after the call and assessed him. Other nurses arrived but they were unable to find any signs of life. They agreed that Mr Rehman was clearly dead and that it would be inappropriate to attempt resuscitation. Ambulance paramedics arrived and, at 9.25am, pronounced Mr Rehman dead.

Contact with Mr Rehman's family

31. Prison staff identified Mr Rehman's next of kin as his wife. A family liaison officer travelled to her address and informed her that Mr Rehman had died. In line with Prison Service guidance, the prison offered a contribution to the cost of the funeral.

Support for prisoners and staff

32. A debrief was held for staff involved in the emergency response. The care team were in attendance. Staff were advised of avenues of support if required.

33. The prison posted notices informing other prisoners of Mr Rehman's death, offering support. All prisoners subject to special monitoring had their circumstances assessed in case they had any adverse reaction to Mr Rehman's death.

Post-mortem report

34. At Mr Rehman's family's request, a digital, non-invasive post-mortem scan was conducted. The post-mortem report showed that Mr Rehman had died from heart failure due to heart disease.

Findings

Roll check and unlock procedures

35. Guidance to staff on conducting roll checks is contained in the Local Security Strategy. The strategy states that roll checks are conducted to ensure that the correct number of prisoners are present, and that each prisoner is in the correct cell. Staff need to obtain a clear view of the prisoner, waking them if necessary, but only to ensure his presence. The early morning roll check therefore confirmed Mr Rehman's presence, but not his wellbeing, in line with guidance.

36. In May 2017, the Governor at Humber issued a Staff Information Notice on checking on prisoners at unlock. The notice stated that staff "… MUST satisfy themselves at unlock times that they obtain a verbal response or note physical movement of prisoners, before moving on … ". The officer said in interview that she was aware of this guidance, but did not get a response from Mr Rehman when unlocking him. It is likely that he was already dead by this time, so this did not affect the outcome here. It could, however, in future instances. We make the following recommendation:

    The Governor should ensure that staff confirm the wellbeing of prisoners when unlocking cells.

Mr Rehman's healthcare

37. When Mr Rehman returned from hospital after his heart attack in 2013, a care plan was added to his prison healthcare record. The clinical reviewer noted that the content was good, as was the information provided to Mr Rehman. However, there was no system in place at the time to ensure that regular reviews took place. National Institute for Health and Clinical Excellence (NICE) guidelines on heart disease reviews state that blood tests should be carried out annually for liver and kidney function, full blood count, glucose and cholesterol. The clinical reviewer noted that not all the tests were done every year.

38. When Mr Rehman was concerned about his health in April 2016, he was treated appropriately. He was referred to specialists, and seen within proper timescales. He was similarly appropriately treated when he complained of a persistent cough in August that year.

39. Mr Rehman was assessed as competent to hold his medication in his own possession, and it was issued to him every four weeks. There is nothing to suggest that Mr Rehman did not comply with his prescriptions.

40. The clinical reviewer noted that while Mr Rehman's healthcare was reasonable, and improved over time, initial care processes around his heart disease were not equivalent to that which he could have expected to receive in the community. He was placed on the correct medication after his heart attack, but tests were not held annually as they should have been, which made monitoring ongoing risk factors more difficult. She noted that work was ongoing to improve the system in Humber to manage prisoners with long-term conditions but recommended that this should be kept under scrutiny. We agree, and make the following recommendation:

The Head of Healthcare should ensure that prisoners with long-term conditions are managed and reviewed in line with guidance.

41. The clinical reviewer made other recommendations, which the Head of Healthcare should consider.

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