Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Duncan a prisoner at HMP Rye Hill on 25 June 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 John Duncan died of hypertensive heart disease on 25 June 2018 at HMP Rye Hill. He also had a fatty liver and was morbidly obese, which contributed to his death. He was 65 years old. I offer my condolences to his family and friends.

The investigation found that the clinical care that Mr Duncan received at Rye Hill was equivalent to that which he could have expected to receive in the community. Healthcare staff monitored him regularly and managed his conditions appropriately. When he was found unresponsive, prison staff called a medical emergency code promptly, and healthcare and prison staff made timely resuscitation attempts.

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

Sue McAllister, CB
Prisons and Probation Ombudsman **June 2019**

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Summary

Events

1. On 24 April 2014, Mr John Duncan was sentenced to 15 years in prison for historic sexual offences. He was initially sent to HMP Durham and in June, was transferred to HMP Rye Hill.

2. When Mr Duncan arrived at Rye Hill, a nurse completed his initial health screen, and recorded that he had a history of Type 2 diabetes, ischaemic heart disease and was obese. Mr Duncan was prescribed medications to manage his conditions, offered regular reviews for them and was given advice on weight loss.

3. On 1 September, Mr Duncan was prescribed weight loss medication, but it was unsuccessful, and the medication was stopped in February 2015. Healthcare staff continued to advise him about weight loss, and monitor him for his various conditions. By late December 2015, Mr Duncan made the first of many visits to the healthcare unit with skin conditions associated with obesity.

4. Mr Duncan then tried to take control of his weight, and by March 2016, he was noted to have lost 8.5kg.

5. After healthcare staff took routine blood tests in April 2016, Mr Duncan was diagnosed with an atrial fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate), for which he was medicated.

6. Over the following year, healthcare staff monitored Mr Duncan whose weight remained the same despite his attempts to lose some.

7. There were no significant entries in Mr Duncan's medical record until 25 June 2018, when Mr Duncan asked to see the healthcare team as he had been vomiting throughout the night. They saw him that morning, and twice later in the day. His observations were within the normal range, yet his stomach pain and vomiting continued. On the advice of an out of hours GP, a non-emergency ambulance was called.

8. At 8.15pm, a prison officer went to collect Mr Duncan from his cell, as the ambulance was waiting for him at the healthcare unit. Mr Duncan was found lying on his bed, unresponsive. A prison officer called a medical emergency code blue.

9. Both healthcare staff and prison staff tried to resuscitate Mr Duncan, and at 8.20pm, paramedics arrived at Mr Duncan's cell and continued resuscitation efforts. Their attempts were futile, and his death was confirmed at 8.24pm.

Findings

10. Mr Duncan died of heart disease. A fatty liver and morbid obesity contributed to his death. We are satisfied that Mr Duncan received a good standard of care at Rye Hill, equivalent to that which he could have expected to receive in the community. His conditions were effectively monitored, and efforts were put in place to help Mr Duncan lose weight.

11. We found that the emergency response from healthcare and prison staff was timely and sustained.

The Investigation Process

12. 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 him. No one responded.

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

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

15. We informed HM Coroner for Northamptonshire of the investigation. She provided us with a copy of Mr Duncan's post-mortem report. We have sent the Coroner a copy of this report.

16. The investigator telephoned Mr Duncan's sister and wrote to her to inform her of our investigation but received no response.

17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and this report has been amended accordingly.

Background Information

HMP Rye Hill

18. HMP Rye Hill is managed by G4S and holds over 600 men convicted of sex offences. G4S Forensic and Medical Services provide primary, physical and mental health services. The prison does not have an inpatient facility.

HM Inspectorate of Prisons

19. 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.

20. 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

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 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 it was giving prisoners the same level of care that they would receive in the community.

Previous deaths at HMP Rye Hill

22. Mr Duncan was the fifteenth prisoner to die of natural causes at Rye Hill since January 2015. There are no similarities between the previous deaths and that of Mr Duncan.

Key Events

23. On 24 April 2014, Mr John Duncan was sentenced to 15 years in prison for historic sexual offences. He was initially sent to HMP Durham.

24. On 12 June 2014, Mr Duncan was transferred to HMP Rye Hill, where a nurse completed an initial health screen. He noted that Mr Duncan had a history of Type 2 diabetes, for which he had weekly reviews, and ischaemic heart disease. He took numerous medications to manage these conditions, and he was assessed as suitable to keep them in his possession.

25. Mr Duncan's observations were taken, and he was found to be obese. He was given dietary advice, and attended weekly diabetic reviews over the following months.

26. On 23 July, a nurse saw Mr Duncan. His blood sugar levels were recorded as high. The nurse recorded that Mr Duncan was on a controlled diet.

27. Mr Duncan's conditions were monitored, and on 1 September, a prison GP reviewed him. He recorded Mr Duncan's body mass index as 49, and recommended that he should use orlistat (medication to treat obesity). A prison GP reviewed Mr Duncan on 21 October, and assessed that Mr Duncan needed to lose 7kg by December 2014 to continue with his weight loss medication.

28. On 8 January 2015, a nurse reviewed Mr Duncan's weight, and again recorded that he needed to lose 7kg. Mr Duncan did not achieve this, and his medical records indicate that his weight loss medication was stopped in February.

29. Healthcare staff at Rye Hill continued to monitor Mr Duncan throughout the year and review his conditions as part of his healthcare plans. His blood pressure was taken regularly and his medical records indicate that he attended the healthcare unit with skin conditions associated with obesity from late 2015 to March 2016.

30. Mr Duncan was aware that his skin conditions would resolve if he lost weight so he tried harder to lead a healthier lifestyle. On 30 March 2016, he was noted to have lost 8.5kg.

31. On 4 April, a prison GP completed routine blood tests for Mr Duncan. His cholesterol and thyroid levels were within a normal range but his brain natriuretic peptide (BNP, a protein made by the heart and the blood vessels) levels were high (which was indicative of heart failure). Further tests were completed, and on 27 April, he was diagnosed with an atrial fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate).

32. Entries in Mr Duncan's medical records indicate that between July and August 2017, he did not attend a number of medical appointments to review his diabetes and hypertension. When he was asked why he had not attended his appointments, he said that he either forgot or was too busy.

33. Throughout the latter part of 2017, healthcare staff frequently took Mr Duncan's observations. His blood pressure was recorded in both the normal and higher

range. Mr Duncan told healthcare staff that despite trying to have a healthier diet, his weight remained the same.

34. There are no significant entries in Mr Duncan's medical records until 25 June 2018, when at 7.50am, a nurse visited Mr Duncan on Farley Unit, a residential wing. He had told wing staff that he was constipated, and had vomited throughout the night. She noted that his stomach felt distended, and advised him to rest in bed, and make sure that he stayed hydrated.

35. An officer said that he started his shift on Farley Unit at 1.30pm. Another officer and he had called the healthcare unit several times that day about Mr Duncan's condition as he was still vomiting.

36. At 5.15pm, a nurse was on Farley Unit administering medication. She said in her statement that prison staff asked her to see Mr Duncan. The nurse recorded in his medical records that he told her that he felt unwell, that he spoke in full sentences, and although pale in colour, there was no sign of cyanosis (a bluish colour to the skin due to a lack of oxygen). She told Mr Duncan that a member of the healthcare team would visit him soon, and recorded that he agreed with this decision.

37. A nurse saw Mr Duncan between 6.15pm and 6.30pm. She took his observations and recorded his blood oxygen saturation levels at 95%, which is in the normal range (values under 90% are considered low). His temperature was 37.3℃. (Anything above 37.5℃ is considered high.) The nurse recorded that Mr Duncan appeared well, but told her that he still had pain and bloating. She offered pain relief, which he declined, and she said that she would speak to a GP for advice.

38. The nurse contacted an on-call GP, who advised her to contact the non-emergency ambulance service. The nurse did so at 6.40pm, and asked for an ambulance to attend within two hours. She was advised that there could be a wait of up to four hours, but if his condition became worse, she should call again.

39. At 7.35pm, an officer spoke to Mr Duncan when prisoners were being locked in their cells for the night, and told him that a non-emergency ambulance was on its way to take him to hospital. The officer stated that Mr Duncan called him back as he was leaving his cell. He said that Mr Duncan told him that he was having trouble breathing, and asked him to call the healthcare team. The officer contacted the second emergency response nurse and passed on the information about Mr Duncan. He observed that Mr Duncan could stand, and showed no signs of distress or breathlessness.

40. A nurse took the call from an officer and agreed to attend the Farley Unit. The nurse recorded that in less than a minute, she received a call to say that the non-emergency ambulance had arrived, and that the officer was collecting Mr Duncan to bring him to the healthcare unit.

41. The officer went to Mr Duncan's cell at approximately 8.15pm, where he found Mr Duncan lying on his bed. He stated that he touched Mr Duncan and called his name, but he was unresponsive. The officer then radioed a medical emergency code blue (which indicates breathing difficulties or chest pain).

42. The officer started cardiopulmonary resuscitation (CPR) when a nurse arrived. She attached the defibrillator (a device that uses an electrical shock to reset the electrical state of the heart), which advised that there was no shockable rhythm. Another officer arrived at Mr Duncan's cell at 8.19pm, and immediately started CPR, with the nurse.

43. The paramedics, who were waiting for Mr Duncan at the healthcare unit, arrived at Farley Unit at 8.20pm. They completed an echocardiogram (a test used to check the heart's rhythm) and took over CPR. Their efforts were futile, and paramedics pronounced Mr Duncan dead at approximately 8.24pm.

Contact with Mr Duncan's family

44. At approximately 9.30pm on 25 June, the Head of Activities was appointed as the family liaison officer (FLO) after Mr Duncan's death. An officer who worked in the Prisoner Transfers Team was appointed as the deputy family liaison officer.

45. The FLO and the deputy FLO arrived at the prison at approximately 10.30pm, and after a briefing from the Duty Director, they visited Mr Duncan's sister at 3.30am. They broke the news of Mr Duncan's death, and offered both practical and emotional support. The FLO remained in contact with Mr Duncan's family, and they both attended his funeral, which took place on 24 July 2018. The prison contributed towards the costs of the funeral in line with national policy.

Support for prisoners and staff

46. After Mr Duncan's death, the Head of Community Engagement debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

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

Post-mortem report

48. The post-mortem report gave the cause of death as hypertensive heart disease. Mr Duncan was found to have had a fatty liver and morbid obesity, both of which contributed to his death.

Findings

Clinical care

49. We agree with the clinical reviewer that the care that Mr Duncan received at Rye Hill was equivalent to that which he could have expected to receive in the community. He arrived at Rye Hill with numerous health conditions and was appropriately monitored and referred when new symptoms presented. Mr Duncan's obesity caused many of his conditions and healthcare staff supported him in his attempts to lose weight. Despite this, Mr Duncan was unable to maintain any significant weight loss. When he did not attend clinic appointments, staff sought to understand his absences and advised him to attend in future.

50. On 25 June, Mr Duncan complained of feeling unwell, and had been vomiting throughout the night. Nursing staff saw Mr Duncan three times on the day he died, and his observations were recorded as being within the normal range. Nursing staff appropriately sought advice from an on-call doctor, who advised them to call a non-emergency ambulance for Mr Duncan.

51. When Mr Duncan was found unresponsive in his cell, prison staff appropriately called a medical emergency code blue in line with Prison Service Instruction (PSI) 03/2013. Medical and prison staff alike were timely and sustained in performing CPR.

52. Mr Duncan's death was sudden and unexpected and there was nothing that healthcare staff could have done to prevent it.

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