PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in November 2014, while a prisoner at HMP Ranby

Our Vision

To be a leading, independent investigatory body,
a model to others, that makes a significant contribution
to
safer, fairer custody and offender supervision.

This is the investigation report into the death of a man, who died in November 2014 from cardio-respiratory failure due to bronchopneumonia and cirrhosis of the liver. He had been found unconscious in his cell at HMP Ranby the previous day. He was 40 years old. I offer my condolences to his family and friends.

A clinical review of the man's care in prison was undertaken.

The man had been at Ranby just a short time, after transferring from HMP Bullingdon on 4 November 2014. He had a history of drug and alcohol abuse and suffered from cirrhosis of the liver. When he arrived at Ranby, he continued the medication he had been prescribed at Bullingdon. A GP examined him on 10 November and reviewed his medical history. He did not report any further health concerns while he was at Ranby.

Early on the morning of 17 November, the man's cellmate pressed the cell bell to summon help, as the man had been vomiting and he could not rouse him. The night patrol officer said he arrived at 5.30am and saw him lying on his bed, apparently unconscious. The officer asked his cellmate to try to wake him, but he did not respond. The officer did not call an emergency code to summon an ambulance, but asked the night orderly officer, the manager in charge of the prison, to attend. When the orderly officer arrived, at 5.40am, he asked the control room to call an ambulance. Paramedics arrived at 5.50am and, after emergency treatment, took him to hospital, where he later died.

The clinical reviewer was satisfied that the standard of the man's healthcare was equivalent to that he could have expected in the community. However, I am concerned that there was a significant delay between finding him unconscious and calling an ambulance. The need for a swift and effective response in an emergency is a matter I have raised with Ranby before and it is apparent that staff still do not follow expected emergency procedures. The Governor needs to ensure that this happens. I am also concerned that he was unnecessarily restrained when he was taken to hospital and remained restrained for some time, despite being unconscious.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **May 2015**

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SUMMARY

1. On 16 December 2013, the man was sent to prison for fourteen days for failing to surrender to bail. He was sent to HMP Bullingdon. On 22 January 2014, he was sentenced to three years and six months in prison for burglary.

2. While he was at Bullingdon, the man received medication for cirrhosis of the liver and depression. Staff described him as settled. On 4 November 2014, he transferred to Ranby because of overcrowding at Bullingdon. He continued to receive the same medication he had been prescribed at Bullingdon. He did not report any further health concerns while he was at Ranby. Nurses noted he appeared jaundiced but he reassured them that this was his normal colour and he felt well. A GP reviewed him on 10 November and had no significant concerns.

3. At around 5.30am on 18 November, the man's cellmate pressed the cell bell to alert staff. He had heard him vomiting but when he spoke to him, he did not respond. A night patrol officer answered the cell bell and radioed the night orderly officer for help. Two officers arrived and went into the cell and put him in the recovery position. The night orderly officer arrived and, at 5.40am, asked the control room to call an emergency ambulance.

4. Paramedics arrived at 5.50am and, after emergency treatment, took the man to hospital. He was still unconscious. The night orderly officer completed an escort risk assessment and noted that he was a low risk to the public or of escape. He arranged for two officers to escort him and decided that he should be handcuffed to one of the officers.

5. The man remained unconscious and was admitted to the hospital's intensive care unit. A second risk assessment, just before midday, said his risk was medium, although no reason for the change was given and there was no healthcare input. He continued to be restrained until 4.35pm, when he had a scan. Escort officers re-applied restraints after the scan, but they were removed shortly afterwards. He never regained consciousness. He suffered a cardiac arrest. Hospital staff resuscitated him but his condition continued to deteriorate and he later died.

6. The clinical reviewer was satisfied that the man's standard of healthcare was equivalent to that he might have expected to receive in the community. We are concerned that the night patrol officer did not use an emergency medical code to alert the control room to call an ambulance as soon as he was found unconscious. We do not consider that restraining him in hospital was justified by appropriately considered risk assessments. We make two recommendations.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Ranby, informing them of the investigation, and inviting anyone with relevant information to contact her. No one responded.

8. On 27 November, the investigator visited Ranby and obtained the man's prison and healthcare records. She spoke to the Governor and the Head of Offender Management. She visited the man's cell and spoke to his cellmate. She interviewed staff on 5 January 2015. She asked to speak to other members of staff, including the officers who responded when he was found ill on 17 November, but was told they were unavailable. The Head of Offender Management did not respond to questions sent by email.

9. NHS England commissioned a clinical reviewer to review the clinical care and treatment the man received in prison.

10. We informed HM Coroner for Nottingham of the investigation who provided the results of the post-mortem examination. We have sent the coroner a copy of this report.

11. One of the Ombudsman's family liaison officers contacted the man's next of kin. They asked the following questions for the investigator to consider:

    a. Did he see a doctor while he was at Ranby?
    b. Was he receiving any medication?
    c. Why was he transferred to Ranby, which was a long way from his family?
    d. Had the transfer adversely affected his health or the ongoing support he had received at Bullingdon?

12. The family received a copy of the draft report and indicated that they agreed with the findings.

HMP RANBY

13. HMP Ranby is a medium security prison, which holds over a thousand sentenced men. Nottinghamshire Healthcare Trust provides primary healthcare services at Ranby.

Her Majesty's Inspectorate of Prisons

14. The most recent inspection of Ranby was in March 2014. Inspectors were concerned that the prison was unsafe. There had been increased levels of violence and intimidation, with inadequate direct supervision of prisoners. Inspectors found that there was increased availability of undetectable illicit drugs and diverted prescribed medication. Although most prisoners surveyed were dissatisfied with the quality of healthcare, inspectors noted that the prison had a wide range of health services and that mental health support was very good.

Independent Monitoring Board (IMB)

15. 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 2014 noted that there was an increasing amount of illicit substances in the prison. The IMB was concerned that Ranby did not have 24 hour healthcare provision.

Previous deaths at Ranby

16. Since 2013, there have been eight deaths at Ranby, including that of the man. In several previous investigations, we have found deficiencies in emergency response procedures.

KEY EVENTS

17. On 16 December 2013, the man was sent to HMP Bullingdon for 14 days for breach of bail. On 22 January 2014, he was sentenced to three years and six months in prison for burglary. He was due to be released on 17 July 2015.

18. The man had previously abused drugs and alcohol and suffered from cirrhosis of the liver. When he arrived at Bullingdon, a doctor prescribed medication for alcohol withdrawal symptoms and the substance misuse team saw him frequently in his initial days. His long-term partner and his mother had died recently and staff supported him with bereavement counselling. From January 2014, he was prescribed antidepressants. He found it difficult to stand for long periods because of an ongoing knee problem.

19. Throughout his time at Bullingdon, the healthcare team reviewed the man for his chronic liver disease and for some foot problems. A dietician saw him frequently to help manage his weight. On 8 April 2014, he was referred to a hospital hepatology (liver specialist) service, as he had signs and symptoms indicating that his liver condition had deteriorated. He attended a number of hospital appointments in relation to his liver disease. The hospital indicated his condition was stable, with evidence of a past but not active Hepatitis C infection. As part of the investigations into his liver disease, he had a gastroscopy, which concluded that he did not suffer any oesophageal varices - enlarged veins in the gullet that can lead to bleeding and which is a common complication in people with progressed liver disease. He had no other major medical issues during his time at Bullingdon.

20. Because of pressure on spaces at Bullingdon, it was decided that the man should transfer to HMP Ranby. There are no other recorded reasons for the move. On 4 November, a nurse saw him for a pre-transfer health check. She noted in his clinical record that, although he had cirrhosis of the liver, there were no specific medical concerns at the time of his transfer. She recorded that he had no outstanding hospital or GP appointments and was medically fit to transfer.

21. When the man arrived at Ranby later that day, a nurse carried out a reception health screen. She identified that he had ongoing knee pain, cirrhosis of the liver, raised blood pressure and he had used heroin in the past. She noted that he had several medications, including mirtazapine (for depression) spironolactone (to combat fluid retention, often caused by liver disease) and carvedilol (usually prescribed for heart problems and oesophageal varices, both common side effects of liver disease) nortriptyline (to help sleep) and paracetamol (for pain relief). On 5 November, a prison doctor re-prescribed his medication but did not see him in person.

22. A nurse noted that Christmas was a significant time for the man because of bereavement issues. He said that he did not have any thoughts of self-harm but said that he might need some extra support around Christmas. She referred him to the mental health team for a routine appointment.

23. On 9 November, a nurse administering medication noted that the man appeared extremely jaundiced. He said this was his usual colour but the nurse referred him to a GP. The next day, 10 November, a doctor examined him, reviewed his medical history and discussed his medication with him. He advised him to take paracetamol and ibuprofen sparingly, because of his condition. He discussed referring the man to the local liver team, as he was expected to have a review every six months. His next review was due in early 2015. (On 16 November, another nurse thought his skin was yellow but reviewed his notes and saw that this was consistent with his diagnosis.)

24. Earlier on 10 November, a mental health nurse had seen the man for a mental health assessment. He told her that he was okay at that time but would need support around Christmas. She told him about other means of support, such as the chaplaincy team, and that the mental health team would be available if he needed them over Christmas. She did not consider he needed further mental health support at the time.

25. The man shared a cell with another prisoner on Houseblock 3. The prisoner told the investigator that on 17 November, he went to sleep around 9.00pm. The man was using a PlayStation at the time. He said that in the early morning of 18 November, he heard him vomiting and he did not respond when he spoke to him. He pressed the cell bell to alert staff.

26. The electronic records show that the prisoner pressed the cell bell at 5.17am and this was reset at 5.18am. (In order to reset the bell, an officer has to go the cell.) However, according to his incident statement, the night patrol officer said he went to the cell at 5.30am. We were told, in May 2015, that the cell bell records are 16 minutes slow. When he arrived, he looked through the observation panel and saw that the man appeared unconscious, on the bottom bunk bed. He asked the prisoner to try to wake him, but he did not respond. The officer then asked the prisoner to put him in the recovery position on the floor, but he was too heavy for the prisoner to lift.

27. The officer then radioed the orderly officer in charge of the prison that night and told him the situation and asked for help. The officer did not use a medical emergency code, which should have resulted in the control room calling an ambulance immediately, and neither did the orderly officer. The officer did not consider going into the cell himself. (For security reasons most prison staff do not carry keys at night, but have a cell key in a sealed pouch for use in an emergency.)

28. The orderly officer was in the administration block some distance away and asked two officers who were close by on another houseblock, to go to the cell. He said to the investigator that he arrived at the cell just after the officers, who used an emergency key to open the door. The officers put the man in the recovery position on the floor. He was breathing but appeared unconscious. The orderly officer noticed that there was a lot of red coloured vomit.

29. As he arrived at the cell, the orderly officer radioed the control room to call an emergency ambulance. The control room log records that this was called at 5.40am, ten minutes after the officer said that he had gone to the cell.

30. The prisoner told the orderly officer that he was not aware that the man had taken anything that night. (He later told an officer and the investigator that he had seen him using heroin a few days earlier.) Paramedics arrived at the prison at 5.50am and another ambulance arrived at 6.30am. Paramedics administered emergency treatment and then decided to take him to hospital.

31. The orderly officer completed a security risk assessment for the hospital escort. He assessed that the man was low risk of harm to the public, hospital staff, females, escape and hostage taking, and decided that two officers should escort him, using a handcuff to restrain him. (The standard arrangement for a Category C prisoner in good health.) He told the investigator that he could not remember if the escort officers used handcuffs or an escort chain. (An escort chain is a long chain with a light handcuff at each end, one of which is attached to the prisoner and the other to an officer.) Two officers escorted the man. One officer noted in the escort log that he checked the restraints a number of times, and that the man was still unconscious.

32. A second escort risk assessment was completed at 11.53am on 18 November, and signed by an administrative officer in the security department. The man's level of risk was now noted as medium, although no reasons were given for the change. Staff were instructed to use single handcuffs and an escort chain as appropriate. There was no healthcare input into this assessment.

33. A nurse contacted the hospital at 1.14pm. Staff there told her that the man was still unconscious "in a sedative state" but was breathing by himself and his blood pressure was normal. Medical staff planned to monitor and support him and to allow him to come round naturally.

34. At 1.37pm, a nurse and the Head of the Offender Management Unit arrived at the hospital to see the man. They noted in his clinical record that they had told the hospital staff that they had found that he had all the medication he should have had in his cell. (At first, it had been considered that he might have overdosed on his medication but as this

was all accounted for, this was ruled out.) They also noted that his cellmate had told them that he had seen him using heroin a few nights before.

35. While they were at the hospital, staff told them that the man's health was deteriorating and the Head of the Offender Management Unit decided to inform his family that he was in hospital. When she got back to the prison, she asked an officer to act as the family liaison officer. The man had nominated his late partner's parents as his next of kin. The family liaison officer telephoned them and offered to arrange transport to get them to the hospital, but they said that they would make their own arrangements. They asked him to call them if the man's condition changed.

36. The man had a computerised tomography (CT) scan at 4.35pm. According to the log, the escort officers removed the restraints before reapplying them after the scan, at 4.42pm. Six minutes later, they contacted the Head of the Offender Management Unit, who asked them to remove restraints until he regained consciousness.

37. At 5.57pm, a hospital consultant told the escort officers that the man's prognosis was not good. Hospital staff attached a ventilator to support his breathing. They asked the officers to let the family know.

38. The family liaison officer telephoned the family and updated them about the change in his current condition. He again offered transport but they were unable to travel at that time and asked to be kept informed of any further changes.

39. The man had a cardiac arrest and hospital staff resuscitated him. The family liaison officer informed the family at 7.45am, who said that they planned to visit him at 11.00am that morning. At 8.15am, hospital staff telephoned the prison to say that his health was deteriorating. The family liaison officer telephoned the family and offered to provide a taxi but they decided to set off for the hospital immediately.

40. The man died at 8.45am. At 9.05am, hospital staff informed the family liaison officer. He rang the family, who were on the way to the hospital and they decided to go back home to support their grandchildren, the man's children. The family liaison officer visited them on 19 November, and continued to support them, and make funeral arrangements. The family told us that they were very appreciative of the support he gave them. The prison paid funeral costs in line with national policy.

41. A manager debriefed the staff involved in the emergency response and offered them the support of the duty care team. The Governor issued a notice to prisoners about the man's death and advised them how to get support if they needed it. The prisoner said that staff looked after him and moved him to a different cell.

Post-mortem and toxicology results

42. A post-mortem examination indicated that the man died from cardio-respiratory failure caused by bronchopneumonia and cirrhosis of the liver. Toxicology tests did not show any evidence that he had recently taken illegal substances.

ISSUES

Clinical care

43. The clinical reviewer reviewed the clinical care that the man received at Bullingdon and Ranby. He concluded that the standard of his care at both prisons was equivalent to that available for NHS patients in the community.

44. The clinical reviewer noted that blood tests had been planned at Bullingdon on the day that he transferred to Ranby, but healthcare staff at Bullingdon had not highlighted this on his medical record and Ranby did not pick this up when he arrived. He has made recommendations about transfer of information, which healthcare staff at Bullingdon and Ranby will need to address. We do not repeat them in this report, as he was satisfied that this issue had no bearing on the man's death. He noted that he was not yet due liver function tests and the blood tests performed while he was in hospital, indicated that his liver function was not at a level which would have explained the sudden deterioration in his condition. We are therefore satisfied that his transfer to Ranby did not adversely affect his health.

Emergency response

45. According to the cell bell record, the man's cellmate pressed his bell at 5.17am and it was reset a minute later. The officer said in his incident statement that he responded to the call about 5.30am. Ranby told us that the time on the cell bell clocks was, in May 2015, 16 minutes slow, which would account for this discrepancy. It is not clear what the difference was in November 2014, however. When the officer arrived at the cell, the man appeared unconscious and he radioed the orderly officer to ask for help. He did not use a medical emergency code.

46. When the orderly officer received the officer's radio message, he asked officers from a nearby houseblock to assist. The officer had told him that the man was unconscious but the orderly officer did not radio a medical emergency. It was not until he got to the cell a few minutes later, that he radioed the control room to call an emergency ambulance. This is noted on the control room log at 5.40am, so was at least six minutes after the officer went to answer the cell bell.

47. Prison Service Instructions (PSI) 03/2013 *Medical Emergency Response Codes,* issued in February 2013, contains mandatory instructions for governors to have a protocol for efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident, and that there are no delays in calling an ambulance.

48. The PSI explicitly states that all prison staff must be made aware of and understand this instruction and their responsibilities during medical

emergencies. It stipulates that, if an emergency code is called over the radio, an ambulance must be called immediately and if there is any doubt staff should call an ambulance. It should not be a requirement for a member of the healthcare team or a manager to attend the scene before staff call an ambulance. The PSI gives examples of when an emergency code should be called including when a prisoner has difficulty in breathing, is unconscious, is chocking, is fitting, or concussed. In line with the PSI, Ranby issued such a protocol in February 2013. However, in a previous investigation into a death at Ranby in April 2014, staff told that investigator that they had not generally followed it.

49. While there is no indication in this case that earlier intervention by emergency services would have saved the man, we cannot be sure. It is a serious concern that staff at Ranby do not follow mandatory emergency procedures. There was, at minimum, a delay of six minutes between the officer answering the cell bell and control room staff calling an ambulance. As the man was unconscious, the officer should have used an emergency code immediately and the orderly officer should have corrected this error when he received the call.

50. We have made previous recommendations about this matter. The prison accepted these recommendations and said that they had re-issued the guidance to staff. It is apparent that this is not enough and managers need to take further action to ensure that all staff understand and follow mandatory national instructions about emergency procedures. We make the following recommendation:

The Governor should take active steps to ensure that all staff understand and follow mandatory procedures in a medical emergency and use the appropriate emergency code, which results in an ambulance being called immediately.

Restraints and bedwatch

51. 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.

52. We are not satisfied that staff appropriately assessed the man's risk in line with court judgement and with Prison Service guidance issued subsequently. There was no healthcare assessment of his condition when he left the prison. We appreciate that there were no healthcare staff on duty at the time, but the night orderly officer could have asked the paramedics for an assessment of his condition. Although the orderly officer assessed him as low risk of escape, to the public and of re-offending, he decided he should be restrained using handcuffs. He was unconscious at the time, and we do not consider that this level of restraint reflected his assessed risk or his condition at the time.

53. Another risk assessment completed later that morning increased his level of risk to medium. The man's condition had not changed at this point, and there were no recorded reasons to justify the increase in the level of risk. Again, there was no healthcare input into the assessment, which commented on how his health and condition affected his risk, as the court judgment requires. Officers removed the restraints while he had a scan, but they were briefly reapplied before it was authorised that they should be removed while he remained unconscious. While we are pleased to note that restraints were not used again, we do not consider that the use of restraints at any time was necessary or respectful. We make the following recommendation:

The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

RECOMMENDATIONS

1. The Governor should take active steps to ensure that all staff understand and follow mandatory procedures in a medical emergency and use the appropriate emergency code, which results in an ambulance being called immediately.

2. The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.