

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Patrick Ryan a prisoner at HMP Doncaster on 30 August 2019

A report by the Prisons and Probation Ombudsman

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*



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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 Patrick Ryan died in hospital on 30 August 2019 of heart disease, while a prisoner at HMP Doncaster. He was 57 years old. I offer my condolences to Mr Ryan's family and friends.

The clinical reviewer was satisfied that Mr Ryan received a standard of care at Doncaster equivalent to that he could have expected to receive in the community. However, Mr Ryan was frequently non-compliant with his medication and the clinical reviewer considered that more could have been done to address this.

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

April 2020

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Summary

Events

1. On 17 May 1997, Mr Patrick Ryan was sentenced to life imprisonment for murder. On 21 December 2018, he was moved to HMP Doncaster.
2. Mr Ryan was prescribed medication for diabetes, high cholesterol and high blood pressure. However, he frequently failed to take it.
3. In June 2019, Mr Ryan had a heart attack but refused the hospital's attempts to fully investigate all his cardiac issues. He was returned to prison and although his medication compliance improved, there were still occasions when he did not take it.
4. On 26 August, Mr Ryan went to the healthcare unit complaining of chest pain. He vomited while he was there. Staff carried out an electrocardiogram (ECG) which showed Mr Ryan had a fast heartbeat. They sent him to hospital. Hospital doctors assessed that Mr Ryan had suffered a heart attack and moved him to the Coronary Care Unit.
5. On 30 August, Mr Ryan suffered another heart attack and died. Hospital doctors recorded the time of death as 4.02pm.

Findings

6. The clinical reviewer was satisfied that the care Mr Ryan received at HMP Doncaster was equivalent to that he could have expected to receive in the community. However, she noted that Mr Ryan did not get a secondary health screen as he should have done.
7. The clinical reviewer noted that staff made efforts to manage Mr Ryan's non-compliance with his medication, but she considered that the guidance on missed medication was not always followed and more could have been done.

Recommendations

- The Head of Healthcare should ensure that all prisoners are offered a secondary health screen in line with NICE guidelines.
- The Head of Healthcare should ensure that all staff follow NICE guidance and the Local Operating Procedure on Managing Omitted Doses of Medication and that when a prisoner becomes non-compliant with a critical medication they:
 - document and escalate any concerns;
 - review the prisoner's in-possession status; and
 - consider holding a multi-professional complex case clinic review.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Doncaster informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
9. The investigator obtained copies of relevant extracts from Mr Ryan's prison and medical records.
10. NHS England commissioned an independent clinical reviewer to review Mr Ryan's clinical care at the prison.
11. We informed HM Coroner for Yorkshire and South East District of the investigation. The coroner provided a copy of the post-mortem report. We have sent the coroner a copy of this report.
12. One of the Ombudsman's family liaison officers contacted Mr Ryan's next of kin, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not raise any issues.
13. Mr Ryan's next of kin received a copy of the initial report. She did not raise any further issues or comment on the factual accuracy of the report.
14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Doncaster

15. HMP Doncaster is a local prison, operated by Serco, which holds up to 1,145 remanded and sentenced men. Care UK provides physical and mental health services, and substance misuse services. Nurses and a paramedic are available 24 hours a day.

HM Inspectorate of Prisons

16. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Doncaster in July 2017. Inspectors reported that a great deal had been achieved since their inspection two years earlier.
17. Health services had improved significantly since the previous inspection in October 2015 and overall, were reasonably good. There was effective clinical management, with a range of clinics, mandatory staff training and access to professional development. There were no staff shortages and appropriate policies were in place. Patients had access to information and testing on a wide range of conditions and access to external appointments had improved, with rare cancellations. Inspectors considered that the management of prisoners with long-term conditions was particularly good.

Independent Monitoring Board

18. 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. No IMB report has been issued since the reporting year 2015-16.

Previous deaths at HMP Doncaster

19. Mr Ryan was the 13th prisoner to die at Doncaster since August 2017. Of the previous deaths, seven were from natural causes and five were self-inflicted. We have previously made a recommendation about secondary health screening.

Key events

20. On 17 May 1997, Mr Ryan was sentenced to life imprisonment for murder with a tariff of 14 years. On 21 December 2018, he was moved to HMP Doncaster.
21. Mr Ryan had type 2 diabetes, high cholesterol and high blood pressure. He had a history of not taking his medication for these conditions. Just before his transfer to Doncaster, Mr Ryan agreed to start taking medication again and metformin (for diabetes) was prescribed.
22. On 21 December 2018, a nurse carried out Mr Ryan's reception health screen at Doncaster. He discussed Mr Ryan's health history, took clinical observations and noted that he had seven days' worth of medication in possession.
23. On 16 January 2019, Mr Ryan failed to attend for an appointment he had made regarding back pain.
24. On 5 March, a nurse recorded that Mr Ryan had not collected his metformin for several weeks. There was no record that Mr Ryan had ever been approached about this. The nurse arranged a full diabetic review and added a diabetes care plan to his record.
25. The review took place on 10 April (an earlier date had been scheduled but clashed with an outpatient appointment). As part of the review, the nurse calculated Mr Ryan's cardiovascular risk score, and he was assessed to be at high risk of developing heart disease. Mr Ryan agreed to start a statin (cholesterol-lowering medication). Mr Ryan also told the nurse he had not been taking his medication because it upset his stomach, and the nurse agreed to make dosing adjustments, so the medicine released more slowly into Mr Ryan's system.
26. A nurse also arranged for Mr Ryan to have an electrocardiogram (ECG – a test to check the heart's rhythm) even though he did not complain of chest pain. The appointment was scheduled for 11 April, but Mr Ryan did not attend. It was rescheduled for 23 April and Mr Ryan attended. The ECG gave abnormal results which were to be reviewed by a prison GP.
27. A follow-up diabetes appointment was made for 1 May, but Mr Ryan did not attend despite the nurse calling for him several times.
28. On 15 May, a nurse carried out a full diabetes review and noted that Mr Ryan reported no ill effects since the metformin medication had been modified. The nurse explained the implications of non-compliance to Mr Ryan, but he declined his statin medication.
29. On 17 May, a prison GP saw Mr Ryan to discuss the abnormal ECG result. He noted that Mr Ryan was difficult to engage in meaningful conversation and was vague. Mr Ryan reported sometimes feeling pain in the right side of his chest with associated sickness (but no central chest pain). He referred Mr Ryan to a chest pain clinic at a hospital. Throughout the rest of the month Mr Ryan intermittently refused his medication and nurse interventions. Staff explained the risks to him.

30. On 1 June, a nurse called Mr Ryan to the medication hatch to discuss his non-compliance. He swore at him and said that his heart and diabetes medication did him no good. A carer was arranged to escort him daily to the medication hatch and to encourage compliance.
31. On 5 June, Mr Ryan attended the healthcare clinic. He was short of breath, pale and sweating. Mr Ryan was very anxious, unable to keep still and had lost control of his bowels. A prison paramedic took Mr Ryan's observations and his NEWS (National Early Warning Score) was nine. She called an emergency ambulance and Mr Ryan was taken to the hospital.
32. On 14 June, Mr Ryan was returned to Doncaster. The discharge summary said he had had a heart attack and had heart failure. There were other issues that required investigation (including blood in his heart 'leaking backwards') but Mr Ryan had refused to consent. He had been put on different medication for his diabetes and new heart medication (in total he was on 13 different medications).
33. On 19 June, staff discussed Mr Ryan's plan of care and his tendency to not comply at the multi-professional complex care clinic meetings. Any non-attendance or non-compliance with medications was to be reported. No medication was to be in-possession.
34. Regular entries in the medical record show Mr Ryan was frequently assessed and monitored; instances of non-compliance decreased.
35. On 15 August, Mr Ryan had an appointment with a locum cardiologist. His subsequent letter said that Mr Ryan looked well, stable and the medication spray was effective for easing right sided chest pain. The treatment plan, as agreed with Mr Ryan, was for a cardiac MRI (magnetic resonance imaging). This was as an alternative to a cardiac angiogram (an invasive procedure to check the heart) – something Mr Ryan had previously refused.
36. On 24 August, Mr Ryan was called for his medications but did not collect them.
37. On 26 August, at 2.42pm, Mr Ryan attended the healthcare unit complaining of chest pain. He vomited in the toilet there. A nurse took Mr Ryan's observations and his NEWS score was four. Mr Ryan was fully alert, orientated, clammy and had right-sided chest pain. An ECG showed Mr Ryan was experiencing sinus tachycardia (fast heartbeat). Staff decided he needed further assessment in hospital and called an ambulance. Mr Ryan was taken to hospital.
38. During his stay in hospital, Mr Ryan was restrained using single cuffs or just an escort chain when being treated/assessed (occasionally restraints came off completely for tests).
39. On 30 August, Mr Ryan's condition deteriorated and at approximately 1.48pm restraints were removed and he was taken to another hospital in Sheffield. Mr Ryan died at 4.02pm.

Liaison with Mr Ryan's family

40. On 27 August 2019, the prison appointed an officer as the family liaison officer (FLO). The FLO tried to contact Mr Ryan's next of kin over the following days to

explain that Mr Ryan was in hospital but received no answer to her numerous calls. On 30 August, when Mr Ryan died, the FLO was still unable to contact the next of kin. The prison had been in touch with the police about tracing the next of kin, and they had made contact (and broken the news) before the prison had the opportunity to do so.

41. Mr Ryan's funeral was on 18 October 2019. The FLO and another family liaison officer, attended. The prison paid for the funeral, in line with national policy.

Support for prisoners and staff

42. After Mr Ryan's death, the duty director debriefed the staff on the hospital bedwatch to ensure they had the opportunity to discuss any issues arising, and to offer support.
43. The prison posted notices informing other prisoners of Mr Ryan's 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 Ryan's death.

Post-mortem report

44. The post-mortem report gave the cause of death as ischaemic heart disease.

Findings

Clinical care

45. The clinical reviewer was satisfied that the care Mr Ryan received at HMP Doncaster was equivalent to that he could have expected to receive in the community. He received full health reviews for his diabetes and cardiovascular disease and prison healthcare staff responded appropriately when Mr Ryan reported chest pain.
46. She noted, however, that Mr Ryan was never offered a secondary health screen as he should have been. We make the following recommendation:

The Head of Healthcare should ensure that all prisoners are offered a secondary health screen in line with NICE guidelines.

47. Mr Ryan was frequently non-compliant with his medication. Although staff explained the consequences to him and put some measures in place to try to improve his compliance, the clinical reviewer considered that the guidance on missed medication was not always followed and more could have been done.
48. It was not until 5 March 2019 that staff realised Mr Ryan was not taking his diabetes medication. The clinical reviewer considered there had been opportunities to identify and address this earlier. She also found that opportunities had been missed to convene multi-professional meetings earlier when Mr Ryan started failing to collect his heart medication. The clinical reviewer also found that Mr Ryan's medical record was not always updated to show that he had failed to collect his medication.
49. We make the following recommendation:
- The Head of Healthcare should ensure that all staff follow NICE guidance and the Local Operating Procedure on Managing Omitted Doses of Medication and that when a prisoner becomes non-compliant with a critical medication they:**
- document and escalate any concerns;
 - review the prisoner's in-possession status; and
 - consider holding a multi-professional complex case clinic review.

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