Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr William Potter, a prisoner at HMP Rye Hill, on 14 November 2019

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 William Potter died on 14 November 2019 of congestive heart failure at HMP Rye Hill. He was 76 years old. I offer my condolences to Mr Potter's family and friends.

Mr Potter had a number of serious, chronic medical conditions, but frequently refused to attend prison healthcare and hospital appointments. Healthcare staff encouraged him to attend his appointments and explained the risks of not doing so. Although the clinical reviewer identified some concerns, she is satisfied that the clinical care Mr Potter received at Rye Hill was equivalent to that which he could have expected to receive in the community.

I am concerned that poor communication between prison staff and healthcare staff meant that Mr Potter was not seen by a nurse when he reported that he was unwell on the morning of his death. Staff also called the incorrect emergency medical code when Mr Potter was found unresponsive in his cell later that morning.

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 **May 2020**

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Summary

Events

1. In 2014, Mr William Potter received a 13-year sentence for sexual offences. He was sent to HMP Chelmsford, before being transferred to HMP Rye Hill on 23 May 2014.

2. Mr Potter had several serious, chronic health issues including fibromyalgia (a long-term condition, which causes pain all over the body), osteoarthritis (a condition causing painful and stiff joints), COPD (chronic obstructive pulmonary disease), asthma, emphysema (a lung condition causing shortness of breath), rheumatoid arthritis (swollen and stiff joints) and osteoporosis (weakened bones). Mr Potter was also registered as disabled, due to an injury to his right hand and had had his left thumb amputated due to cancer.

3. Mr Potter was prescribed inhalers at his reception screening and was given pain relief for generalised pain. Over the next five years, he regularly complained of shortness of breath, chronic pain and chest pain. However, he often refused to attend medical appointments both in prison and at hospital.

4. On the morning of 14 November 2019, Mr Potter reported that he had pain all over his body and asked to see a nurse. A prison custody officer (PCO) contacted the healthcare team and was told that Mr Potter would need to make an appointment, or that he should call Hotel 2 (the healthcare first responder) on his radio. The PCO advised Mr Potter to make an appointment to see a member of the healthcare team.

5. At 12.15pm, the PCO found Mr Potter unresponsive in his cell. He incorrectly called a code red emergency (indicating blood loss). A manager responded and called a healthcare emergency and requested an emergency ambulance. Officers started CPR. Healthcare staff arrived and administered medical treatment.

6. Paramedics arrived at 12.38pm and took over Mr Potter's care and treatment. At 1.15pm, the paramedics pronounced that Mr Potter had died.

7. The coroner gave Mr Potter's cause of death as congestive heart failure.

Findings

8. The clinical reviewer concluded that the care Mr Potter received at Rye Hill was equivalent to that which he could have expected to receive in the community.

9. She did, however, identify some concerns. Healthcare staff failed to review and update Mr Potter's care plans for his long-term conditions regularly. They did not refer him for management under the vulnerable prisoner's framework when he failed to attend healthcare appointments and disengaged with healthcare services. Healthcare staff also failed to record the reasons for his disengagement, which is not in line with national guidance.

10. There was a breakdown in communication between operational staff and healthcare staff on the morning of 14 November when Mr Potter complained of being unwell. As a result, Mr Potter was not seen by a nurse.

11. Prison staff also failed to call the correct medical emergency code when Mr Potter was found unresponsive in his cell later that morning, which meant that healthcare staff did not arrive with the correct emergency equipment.

Recommendations

- The Head of Healthcare should ensure that healthcare staff create, document and review care plans for all prisoners with long-term medical conditions in line with national guidelines.
- The Head of Healthcare should ensure that all prisoners who display self-neglect and non-compliance with healthcare services are considered for referral to the vulnerable adult framework in accordance with national guidance.
- The Director and Head of Healthcare should ensure that prison staff receive appropriate training on communicating prisoners' symptoms and presentation effectively to healthcare staff when they are presenting as unwell.
- The Head of Healthcare should ensure that healthcare staff ask prison staff appropriate clinical questions so that they can obtain the prisoner's full clinical presentation when a prisoner is presenting as unwell.
- The Director should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that they use the appropriate emergency medical code to communicate the nature of the emergency effectively.
- The Director and Head of Healthcare should ensure that a copy of this report is shared with the prison custody officer, healthcare administrator and Nurse A and that a senior manager discusses the Ombudsman's findings with them.

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 her. A prisoner responded.

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

14. The investigator interviewed three members of staff and one prisoner at HMP Rye Hill on 16 December 2019.

15. NHS England commissioned an independent clinical reviewer to review Mr Potter's clinical care at the prison.

16. We informed HM Coroner for Northamptonshire of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

17. Mr Potter had listed his probation officer as his next of kin and the prison was unable to identify any relatives.

18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy which has been amended.

Background Information

HMP Rye Hill

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

HM Inspectorate of Prisons

20. The most recent full inspection of HMP Rye Hill was carried out in September 2019. Inspectors found that there was strong leadership of healthcare which had driven recent improvements in the delivery of primary care. However, too few healthcare staff had completed mandatory training. Waiting times for services had been reduced since the previous inspection and were now mostly like those in the community. Long-term conditions management was reasonable and the service was developing. Social care governance arrangements were robust and care provision was good.

21. However, all health services were affected by the poor connection to SystmOne (the electronic clinical information system), including clinics, which were often delayed. Partnership working between the prison and health providers had improved and local clinical governance meetings had recently reconvened, which was positive. There was no overall health promotion strategy, but the drug and alcohol recovery team (DART) provided some excellent support. The number and range of health screenings were improving and vaccinations were due to be introduced.

Independent Monitoring Board

22. 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 31 March 2019, the IMB reported that feedback to the prison in April 2018, from an audit of the healthcare department, carried out by the NHS and Her Majesty's Prison and Probation Service (HMPPS), described significant improvements in all aspects of delivery. However, there were still improvements outstanding in some areas and healthcare remained an area of concern for the Board.

23. The IMB noted that new senior staff had joined the healthcare team in February 2019. Subsequent appointments (in April and May) included a new practice manager and a new clinical lead, two primary care mental health nurses, and a registered general nurse with a background in working with people with learning difficulties. The IMB was aware of the Head of Healthcare’s encouraging plans to provide specialist services including mental health, learning disabilities, distribution of medication, and assessment of new arrivals. The IMB welcomed this change which took a wider, longer term view of healthcare needs.

Previous deaths at HMP Rye Hill

24. Mr Potter was the tenth prisoner to die at Rye Hill since November 2017. All the previous deaths were from natural causes. There are no similarities between our findings in the investigation of Mr Potter's death and the other deaths.

Key Events

25. On 21 February 2014, Mr William Potter received a thirteen-year prison sentence for sexual offences. He was sent to HMP Chelmsford. On 23 May, Mr Potter was transferred to HMP Rye Hill.

26. Mr Potter had several complex and chronic physical health conditions, including fibromyalgia, osteoarthritis, COPD, asthma, emphysema, rheumatoid arthritis and osteoporosis. Mr Potter was also registered as disabled, because of an injury to his right hand and he had had his left thumb amputated due to cancer.

27. On his arrival at Rye Hill, a nurse completed Mr Potter's reception screening. She noted that he had asthma and was prescribed inhalers. She referred Mr Potter for a GP review.

28. In June 2014, a prison GP reviewed Mr Potter. He noted that Mr Potter was experiencing chronic generalised pain and was prescribed pain relief.

29. During his time at Rye Hill, Mr Potter regularly complained of chronic pain, chest pain and episodes of breathlessness. However, there were ongoing issues with his compliance and he regularly refused to attend healthcare appointments, to see healthcare professionals and to attend hospital appointments.

30. In August 2015, a prison GP was concerned that Mr Potter might have lung cancer and referred him to hospital for tests. However, Mr Potter continually refused to attend these appointments because he did not want to be handcuffed.

31. In January 2016, Mr Potter attended a hospital appointment for an X-ray of his chest. The results were consistent with a chest infection and the consultant advised him to have a CT scan to rule out tuberculosis (TB). A further appointment was made, but Mr Potter refused to attend because he did not want to be strip searched. He later agreed to attend for a scan on the basis that he could be strip searched in his cell rather than in reception. This was granted by prison staff but he still refused to attend (for unknown reasons).

32. In June 2017, a prison GP discussed the possibility of lung cancer with Mr Potter and encouraged him to accept a referral for a CT scan, saying if it was left untreated it may kill him, but Mr Potter continued to refuse. Mr Potter subsequently agreed to an urgent CT scan but then refused to attend five appointments between August and December 2017.

33. Mr Potter's physical health deteriorated in the last twelve months of his life and he suffered with poorly controlled COPD and chronic generalised pain, and frequently complained of chest pain and breathlessness. Staff called a code blue medical emergency on 16 May 2019 when Mr Potter complained of pain all over his body, and again on 28 May when Mr Potter experienced breathing difficulties.

34. On 6 November 2019, a 'Mini Mental State' examination (an assessment used to measure levels of cognitive impairment) was completed. Mr Potter scored 30, the maximum, indicating no concerns about cognitive impairment.

Events of 14 November

35. At 8.20am, a prisoner told a prison custody officer (PCO) that Mr Potter was feeling unwell. The PCO went to the cell. Mr Potter said that he had pain all over his body and asked to see a member of healthcare staff.

36. The PCO contacted the communications room via his radio and asked for a member of healthcare staff to contact him. He was told to contact the healthcare team directly, which he did. The PCO said that a healthcare administrator told him to contact the medication hatch directly. Nurse A, who was administering medication, answered the call. She said she told the PCO to contact Hotel 2 (the emergency response nurse) for further assistance or that Mr Potter should make an appointment to see healthcare staff via the CMS (the electronic booking system).

37. The PCO told Mr Potter to make an appointment on the CMS system. Mr Potter told the PCO that he did not feel any better.

38. At 12.15pm, the PCO began to lock prisoners in their cells and saw that Mr Potter was lying on his bed, with his legs to one side, and had been incontinent of urine. The PCO went into the cell and saw that Mr Potter was cold to the touch and not breathing. He called a code red emergency (a medical emergency code used when a prisoner has significant blood loss).

39. A senior manager and a first line manager (FLM) responded and went to the cell. They placed Mr Potter on the floor and the FLM started chest compressions. He called a 'healthcare emergency' over his radio and asked for an emergency ambulance to be called.

40. The emergency response nurse went to the cell and asked that Mr Potter be moved to the corridor for treatment. Staff used a defibrillator but it advised no shock. Medical treatment continued until paramedics arrived at 12.38pm.

41. Paramedics continued with CPR, but at 1.15pm they pronounced that Mr Potter had died.

Post-mortem report

42. The post-mortem report gave Mr Potter's cause of death as congestive heart failure. He also had chronic obstructive pulmonary disease and hypertensive heart disease which contributed to but did not cause his death.

Contact with Mr Potter's family

43. The Duty Director appointed a safer custody manager as the family liaison officer (FLO). Mr Potter did not have any family registered in his prison record and despite the FLO's best efforts, she could not locate any family members.

44. Mr Potter had nominated his probation officer, as his next of kin. The FLO informed his probation officer of Mr Potter's death.

45. The prison arranged Mr Potter's funeral and paid for the funeral costs in line with Prison Service instructions.

Support for prisoners and staff

46. The Director held a hot debrief after Mr Potter's death. Staff were given the opportunity to discuss the incident, discuss any issues arising and were offered support.

47. The prison posted notices informing staff and prisoners of Mr Potter's death and offering support.

Findings

Clinical care

48. The clinical reviewer concluded that the clinical care Mr Potter received at Rye Hill was of a reasonable standard and equivalent to that which he could have expected to receive in the community.

49. The clinical reviewer did, however, identify some concerns, although these did not contribute to Mr Potter's death.

50. The National Institute of Clinical Excellence (NICE) Quality Standard (2017) for 'Physical Healthcare of People in Prison' says that older people with chronic conditions should be considered for frequent monitoring. Mr Potter had several complex and chronic physical health conditions. He had poorly controlled COPD, chronic generalised pain, and frequently complained of chest pain and breathlessness. Despite Mr Potter's medical conditions, there is no evidence in his medical record that care plans were reviewed or kept up to date. After the care plans were opened in 2016, they were not reviewed again until 2019.

51. The clinical reviewer is satisfied that the lack of recorded care planning did not necessarily affect the care that Mr Potter received. She said, however, that up to date documented care plans, as outlined in the national guidance, are essential to provide both the appropriate management of medical conditions and to support healthcare staff. We make the following recommendation:

    The Head of Healthcare should ensure that healthcare staff create, document and review care plans for all prisoners with long-term medical conditions in line with national guidelines.

52. The clinical reviewer found that, at times, Mr Potter decided to refuse to attend medical appointments, which presented healthcare staff with some difficult challenges. Despite his refusal to engage, healthcare staff continued to encourage Mr Potter to attend and engage with medical appointments.

53. The clinical reviewer asked the Head of Healthcare, whether there was a safeguarding policy in place for prisoners who were identified as self-neglecting and non-compliant with healthcare services. She said that prisoners in these circumstances would be subject to a 'Vulnerable Adult' framework. Despite Mr Potter's numerous medical conditions, non-compliance and disengagement from healthcare services, he was not subject to this framework. Healthcare staff also failed to record Mr Potter's reasons for his disengagement. We make the following recommendation:

    The Head of Healthcare should ensure that all prisoners who display self-neglect and non-compliance with healthcare services are considered for referral to the vulnerable adult framework in accordance with national guidance.

Emergency Response

Communication between prison and healthcare staff

54. The clinical reviewer found that when Mr Potter was found unresponsive in his cell, there was a clear breakdown in effective communication between prison staff and healthcare staff on the morning of Mr Potter's death.

55. The PCO and the healthcare staff involved gave different accounts of what was said.

56. The PCO told the investigator that when he rang healthcare staff for an emergency appointment, a healthcare administrator told him to call the medication hatch. The PCO said that Nurse A answered the call and advised him to tell Mr Potter to make an appointment on the CMS system. The PCO said that he felt that healthcare staff were unsympathetic and dismissed his concerns very quickly.

57. Healthcare staff said that the PCO did not communicate the clinical seriousness of Mr Potter's symptoms and presentation, which meant that they did not respond as quickly as they would have done if Mr Potter's condition had been reported accurately. They said they were not told Mr Potter was suffering with chest pain and shortness of breath but were told he had pain all over his body and generally felt unwell. They said that if they are told by officers that a patient has shortness of breath and chest pain, they would ordinarily advise them to call a 'code blue' emergency alarm.

58. The healthcare administrator said that when the PCO called for an emergency prison GP appointment for Mr Potter, she advised him to contact Hotel 2 (the emergency responder nurse). Nurse A said that she had also advised the PCO to call Hotel 2 if there were concerns about Mr Potter's health or to tell Mr Potter to make an appointment via the CMS system. The PCO did not call Hotel 2, despite his concerns. If he had he done so, Mr Potter would have been seen by medical staff much sooner.

59. The clinical reviewer also found that because Nurse A was contacted while undertaking other duties, she did not ask the PCO any questions about Mr Potter's clinical presentation, as she should have done. The prison told us they have learnt from this and that the medication hatch no longer receives direct phone calls from other disciplines.

60. The clinical reviewer considers that, given Mr Potter's significant health conditions and the fact that two code blue emergencies had been called in the last six months, healthcare staff should have asked more in-depth questions about Mr Potter's clinical presentation when the PCO asked for an emergency appointment.

61. The clinical reviewer concluded, however, that although there were evident concerns about Mr Potter's access to emergency healthcare on the day of his death, she did not believe he would have accessed emergency healthcare in the community (via a GP surgery) any quicker.

62. We recommend:

The Director and Head of Healthcare should ensure that prison staff receive appropriate training on communicating prisoners' symptoms and presentation effectively to healthcare staff when they are presenting as unwell.

The Head of Healthcare should ensure that healthcare staff ask prison staff appropriate clinical questions so that they can obtain the prisoner's full clinical presentation when a prisoner is presenting as unwell.

63. The clinical reviewer has made some additional recommendations which we do not repeat in this report but which the Head of Healthcare will wish to address.

Medical emergency codes

64. PSI 03/2013 on medical emergency response codes sets out the actions staff should take in a medical emergency. It requires governors and directors 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. It requires an ambulance to be called immediately if an emergency code is radioed.

65. When the PCO found Mr Potter unresponsive, he incorrectly radioed a code red emergency (the code for severe bleeding or burns). He should have called a code blue (the code used when a prisoner is unconscious or having breathing difficulties). It is also unclear what code the FLM called when he arrived at the cell.

66. However, the clinical reviewer is satisfied that CPR was started immediately and there was evidence of good teamwork between operational staff and healthcare staff.

67. We commend the prompt actions of the FLM and others in starting CPR. We are, however, concerned that because the PCO did not call the correct medical emergency code, the emergency response nurse attended without the appropriate equipment. Although this does not appear to have affected the outcome for Mr Potter, it might make a difference in other cases. We recommend:

The Director should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that they use the appropriate emergency medical code to communicate the nature of the emergency effectively.

The Director and Head of Healthcare should ensure that a copy of this report is shared with the prison custody officer, healthcare administrator and Nurse A and that a senior manager discusses the Ombudsman's findings with them.

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