Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Martyn Tucker a prisoner at HMP Rye Hill on 19 March 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 I oversee can improve their work in the future.

Mr Martyn Tucker died on 19 March 2018 of lung cancer and secondary brain cancer at HMP Rye Hill. He was 71 years old. I offer my condolences to Mr Tucker's family and friends.

I am satisfied that the care Mr Tucker received in prison was equivalent to that which he could have expected to receive in the community.

I am, though, concerned that prison staff did not inform Mr Tucker's next of kin of his death in person. I am also concerned that the prison continued to restrain him during hospital escorts for some time after he became ill. Staff should have given far more consideration to his mobility and condition when considering the appropriateness of restraints.

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** **September 2020**

## Contents

# Summary

## Events

1. On 13 May 2014, Mr Martyn Tucker was sentenced to 12 years' imprisonment for sexual offences. He was initially sent to HMP Altcourse. On 13 November 2014, he was transferred to HMP Rye Hill.

2. A health screen on his reception at Rye Hill, revealed some history of high blood pressure but no other relevant health concerns.

3. In November 2017, Mr Tucker was referred to hospital following complaints of pain in his left forearm. While he was at the hospital, investigations detected a possible secondary cancer but no clear primary source. In December, he was diagnosed with enlarged lymph nodes. Early in January 2018, he was diagnosed with advanced lung cancer with secondary brain lesions. His life expectancy was believed to be a matter of months and he received radiotherapy to ease his symptoms.

4. During the following months, Mr Tucker's condition steadily deteriorated. On 17 March, he became very ill, and his condition declined dramatically over that weekend. On Monday 19 March, transport was arranged to take Mr Tucker to a nearby hospice. At 11.45am, the ambulance arrived to transport him but he was too ill to move. At 12.20am, a prison GP confirmed Mr Tucker's death.

## Findings.

### Mr Tucker's clinical care

5. We agree with the clinical reviewer that the care Mr Tucker received was equivalent to that which he could have expected to receive in the community. Following his diagnosis of cancer, healthcare staff cared for him appropriately, and his end of life wishes were respected.

### Mr Tucker's location

6. Mr Tucker was appropriately located during his time in prison. Staff respected his wishes to remain in his own cell. When his condition deteriorated and Mr Tucker expressed his desire to move to a hospice, staff acted promptly to try and arrange this. Unfortunately, this attempt was unsuccessful.

### Restraints, security and escorts

7. We are concerned that the prison continued to restrain Mr Tucker when he was taken to hospital for appointments despite him clearly being unwell and undergoing serious treatment. We note that restraints were not used for his last two escorts to hospital but consider that this decision should have been taken sooner.

8. We acknowledge that the prison has since updated their policy and procedures regarding restraints in light of a previous recommendation from our office, and therefore make no recommendation.

### Liaison with Mr Tucker's family

9. Although we note that Mr Tucker's next of kin was generally pleased with the contact she had with the prison, we share her concerns that she was informed of his death by telephone.

### Compassionate Release

10. We are satisfied that the prison acted appropriately in making Mr Tucker's application for compassionate release when it did. Unfortunately, Mr Tucker's condition deteriorated before it could be completed.

## Recommendations

- The Director of Rye Hill should ensure that a member of staff informs a prisoner's family or next of kin of his death in person in line with national guidance.
- The Director of Rye Hill should ensure that written records of telephone conversations are made when staff speak to a prisoner's next of kin.

## The Investigation Process

11. 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.

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

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

14. We informed HM Coroner for Northamptonshire of the investigation. There was no post-mortem but she confirmed Mr Tucker's cause of death. We have sent the coroner a copy of this report.

15. The investigator spoke to Mr Tucker's next of kin to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. Mr Tucker's next of kin stated that while, overall, she was happy with how the prison had cared for him, and how staff communicated with her, she was concerned by the way the prison communicated his death. She also asked us to establish the circumstances surrounding his death, and his location when he died.

16. The investigation has assessed the main issues involved in Mr Tucker's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

17. Following the issuing of our initial report, Mr Tucker's next of kin raised a number of further issues with us. In particular, Mr Tucker's next of kin stated that the deputy family liaison officer informed her that Mr Tucker was in the ambulance and in transit when he died. She was also upset that no support was offered and nobody from the prison offered to collect her from the hospice, leaving her to drive home in a traumatised state. She said that it took her some time to be sufficiently recovered to drive to the prison and when she arrived, the deputy family liaison officer asked what had taken her so long.

18. The prison has subsequently responded to these comments. Rye Hill accepts that it informed Mr Tucker's next of kin of his death by telephone, but that support was given and the family liaison officer offered to collect her from the hospice. The prison does not accept that incorrect information was given to Mr Tucker's next of kin. We have made some amendments to this report. The prison provided an action plan which is annexed to this report.

# Background Information

## HM Prison Rye Hill

19. HMP Rye Hill is run 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

20. 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.

21. 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

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 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 the current service needed further investment and improvement if it was to ensure it was giving prisoners the same level of care they would receive in the community.

## Previous deaths at HMP Rye Hill

23. Mr Tucker was the fourteenth prisoner to die of natural causes at Rye Hill since January 2015. We have made recommendations about the inappropriate use of restraints on several occasions, with this being escalated following the previous death.

# Findings

24. On 13 May 2014, Mr Martyn Tucker was sentenced to 12 years' imprisonment for sexual offences. He was initially sent to HMP Altcourse. On 13 November, he was transferred to HMP Rye Hill.

25. A nurse reviewed Mr Tucker at a health screen on his reception at Rye Hill. He was on prescribed medication for high blood pressure but had no other health concerns. In November 2015, this medication was stopped after Mr Tucker's blood pressure remained stable throughout that period.

26. In 2016, Mr Tucker was twice temporarily transferred to Altcourse for court hearings. On 12 October, he was sentenced to a further 12 years' imprisonment, with a custodial term of 11 years.

### Diagnosis of Mr Tucker's terminal illness and informing him of his condition

27. On 8 August 2017, a prison GP reviewed Mr Tucker after he complained of pain in his right arm and numbness in his fingers. He diagnosed a compressed nerve in his wrist, and prescribed an anti-inflammatory gel. The prison GP also recorded that Mr Tucker's blood pressure was very high and agreed to resume his blood pressure medication to minimise his risk of stroke. For the next few months, healthcare staff monitored Mr Tucker's blood pressure.

28. Early on 24 November, a nurse saw Mr Tucker in his cell after he complained of pain in his left forearm. She noted that his blood pressure was very high and consulted the on-call GP who advised a hospital admission. Mr Tucker was taken to hospital. Later that day, he was discharged back to Rye Hill following investigations. On 27 November, a prison GP spoke to the hospital about Mr Tucker's condition. He noted that Mr Tucker might have secondary cancer which had spread from an unknown primary source. His case had been added to the lung cancer list at the hospital to be discussed at a multi-disciplinary meeting. The prison GP did not inform Mr Tucker at this stage because the information was incomplete and second-hand.

29. On 4 December, respiratory consultant reviewed Mr Tucker at the hospital. He diagnosed incidental mediastinal lymphadenopathy (enlarged lymph nodes) and advised further investigations. On 27 December, Mr Tucker had a CT scan (which uses x-rays and a computer to create detailed images of the inside of the body). This confirmed that Mr Tucker had lymphadenopathy in his neck, but no primary source was disclosed. On 4 January 2018, a healthcare administrator noted that the hospital had called to confirm that Mr Tucker had cancer in his lungs and lymph nodes. She also noted that they had scheduled a fast-track appointment for 12 January to investigate the location of his primary cancer and to determine treatment options.

30. On 8 January, a prison GP reviewed Mr Tucker after he continued to complain about weakness in his left arm. He observed that Mr Tucker had a follow-up appointment for lung cancer a few days later, and discussed this with him, despite there being no definitive diagnosis from the hospital. The prison GP also sent Mr Tucker to hospital for his arm to be assessed, and he was kept in overnight.

31. The next day, a consultant oncologist reviewed Mr Tucker while he was at hospital. She informed him that he was presumed to be suffering from primary lung cancer, with secondary metastases and malignant lesions in his brain. (Metastases are secondary malignant growths which have spread from a primary source.) She advised a course of radiotherapy to reduce the brain metastases, with a management plan to be considered once Mr Tucker's condition had been fully appraised. Later that day, Mr Tucker was discharged back to Rye Hill.

32. On 12 January, a nurse recorded a telephone conversation she had with a lung cancer specialist nurse from the hospital. She noted that that Mr Tucker had advanced lung cancer with secondary brain lesions. This was incurable, with a prognosis of weeks to months to live. She was informed that Mr Tucker was aware of the cancer but not the poor prognosis. She recorded that Mr Tucker was starting radiotherapy the following week. There is no record of exactly when Mr Tucker was informed of his poor prognosis.

33. We are satisfied that the prison acted appropriately in managing Mr Tucker's terminal cancer diagnosis. Although he was not referred for investigations by the prison, we consider that prison healthcare staff and GPs acted appropriately given the symptoms he presented with. Once it was clear that he might have a terminal illness, the prison ensured that he was promptly referred for further tests, and liaised well with hospital specialists.

### Mr Tucker's clinical care

34. On 17 January, Mr Tucker started a course of palliative radiotherapy to reduce the brain metastases. On 29 January, a prison GP reviewed Mr Tucker and noted that he was coping well with the radiotherapy.

35. On 4 February, a nurse saw Mr Tucker in his cell after complaints that he was short of breath and had been coughing up blood through the night. She consulted a prison GP and Mr Tucker was sent to hospital where he was admitted and treated for pneumonia. On 5 February, a nurse noted that a referral had been made to the palliative care team at Rugby. On 9 February, Mr Tucker was discharged back to Rye Hill.

36. On 12 February, a prison GP reviewed Mr Tucker and discussed his end of life wishes with him. The prison GP noted that Mr Tucker was "not for CPR" and that he "also doesn't want serious intervention at the hospital". On 21 February, a nurse confirmed Mr Tucker's DNACPR wishes, and the following day the form was completed. (A Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order means that in the event of cardiac or respiratory arrest no attempt at resuscitation will be made. All other appropriate treatment and care will continue to be provided.)

37. On 26 February, a prison GP confirmed Mr Tucker's end of life wishes to have no further active treatment or hospital appointments.

38. On 23 February, the consultant oncologist wrote to healthcare staff at Rye Hill. She said that Mr Tucker had completed his course of radiotherapy, tolerated it well, and that his symptoms had improved. She added that she had not scheduled a review for Mr Tucker, but invited the prison to do so if required.

39. The same day, Mr Tucker was issued with a personal alarm in case he fell in his cell. On 25 February, a safer custody officer offered him social care, but he declined because he wanted to remain as independent as possible. Mr Tucker also continued to work as a Listener, but with a reduced workload. On 8 March, a nurse created a palliative end of life care plan for Mr Tucker. Healthcare staff continued to monitor Mr Tucker and he was regularly reviewed by the GP.

40. On 15 March, a nurse saw Mr Tucker in his cell following an emergency call. There is no record of who made this call but the ambulance was stood down before it arrived. Instead, a prison GP reviewed Mr Tucker that afternoon. The prison GP recorded that Mr Tucker was aware that his condition was life-limiting and noted that he was for palliative care only.

41. On Saturday 17 March, a nurse reviewed Mr Tucker in his cell after his condition deteriorated. There were also reports that he had fallen out of his bed twice earlier in the day. She observed that he had not injured himself when he fell, but noted that he struggled to take his medication, felt weak and was experiencing moderate pain. The nurse consulted a prison GP, who said that Mr Tucker appeared to be nearing the end of his life.

42. Mr Tucker's condition deteriorated over the weekend, but he refused to go to hospital despite an ambulance crew attending at one point. Prison nursing staff attended to Mr Tucker around the clock, and ensured that he was as comfortable as possible. The prison GP liaised with healthcare throughout Sunday, and authorised changes to his pain relief medication.

43. On Sunday 18 March, at 7pm, the prison GP visited Mr Tucker at the prison to assess his condition. He noted that Mr Tucker was "very unlikely to survive this incident" but recognised his desire not to die in a hospital. He reminded staff that he was not to be resuscitated, and should not be taken to hospital.

44. During the early hours of Monday 19 March, nurses monitored Mr Tucker but, when asked, he denied being in pain. At 9am, the prison GP reviewed Mr Tucker and told him that he was being transferred to a hospice later that morning. He noted that he appeared happy at this news. At 11.45am, a private ambulance arrived to transfer Mr Tucker to the hospice. The crew stated that he was too unwell to be moved, so Mr Tucker remained in his cell.

45. Shortly afterwards, staff called the prison GP to inform him that Mr Tucker had died. At 12.20pm, the prison GP attended Mr Tucker's cell and pronounced him dead.

46. We agree with the clinical reviewer that the clinical care Mr Tucker received at Rye Hill was equivalent to that which he could have expected in the community. Following his cancer diagnosis, Mr Tucker was regularly reviewed by healthcare staff, and had his wishes concerning his end of life care carefully considered. The prison also enabled him to continue performing his role as a Listener for as long as possible. We are satisfied that Mr Tucker was well cared for at Rye Hill.

47. We also share the clinical reviewer's view that the healthcare team at Rye Hill demonstrated good and compassionate care for Mr Tucker. A prison GP and a

nurse in particular are to be commended for the extra care they took to ensure that Mr Tucker's end of life wishes were respected.

### Mr Tucker's location

48. On 21 February, a nurse noted that Mr Tucker was housed in a cell on the second floor. She asked him whether he would prefer a lower floor cell but he stated he was happy to remain on the upper floor.

49. On 17 March, when Mr Tucker's condition deteriorated, he expressed a wish not to go to a hospital although he was happy to go to a hospice. A prison GP liaised with a hospice with a view to obtaining a bed for Mr Tucker. On 19 March, the hospice confirmed that they had a bed for Mr Tucker. Transport was arranged to transfer him there but Mr Tucker died in the prison before he could be moved.

50. We are satisfied that Mr Tucker was appropriately located while he was at Rye Hill, and that his wishes were respected.

### Restraints, security and escorts

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 considers the prisoner's health and mobility.

52. 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, including the risk to the public in the event of such 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.

53. On 4 December 2017, Mr Tucker was placed under restraint with double cuffs for his escort to a hospital appointment. (Double cuffing is when the prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs.)

54. The consultant recorded in his clinic letter that Mr Tucker "came into clinic in handcuffs accompanied by three prison officers from Rye Hill".

55. On 17 January 2018, Mr Tucker was restrained with double cuffs for his first radiotherapy appointment. These were removed for the treatment, but then reapplied afterwards. By his second radiology appointment on 19 January, Mr Tucker was restrained with single cuffs, with the risk assessment stating that this was due to his age and the nature of this treatment. By the time of Mr Tucker's escort to hospital on 5 February, the prison risk assessment deemed that restraints were unnecessary due to his medical condition. However, on 22 February, the prison risk assessment deemed that he should be restrained with single cuffs while in transit, but not restrained at the hospital.

56. We acknowledge that the prison has a duty to protect the public, but any security measures must be proportionate to the actual risk a prisoner poses. We are concerned that despite being 71 years of age at the time, and in very poor health, the prison decided to restrain Mr Tucker with double cuffs as late as 17 January 2018 while he was undergoing radiotherapy. It then continued to restrain him with single cuffs for a further week during this treatment. We do not consider that these decisions were proportionate to the actual risk posed.

57. We acknowledge that Rye Hill has responded to recent recommendations and input from our office, and has reviewed its procedure for restraints, especially in respect of elderly or infirm prisoners. In particular, Rye Hill now plans to hold regular multi-disciplinary meetings to devise pre-agreed risk assessments for terminally ill prisoners, which can be updated as necessary when circumstances change. These risk assessments will then be available to Orderly Officers to use when arranging for escorts. The prison also plans to update its guidance to senior managers, to ensure they are aware of the legal position with respect to restraints.

58. Given these developments (which we welcome), we make no recommendation.

### Liaison with Mr Tucker's family

59. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody),* states that "Wherever possible, the FLO and another member of staff must visit in person the next of kin or nominated person to break the news of the death. …If a face-to-face prison notification is not possible or where another prison's FLO or the police have visited the family, then a follow up visit by the prison must be arranged as soon as practicable."

60. Mr Tucker's next of kin was his sister. On 9 January 2018, the prison appointed an officer as his family liaison officer (FLO), with a manager as the deputy family liaison officer. On 10 January, the FLO introduced herself to Mr Tucker, who asked her to change his next of kin.

61. On 4 February, the FLO contacted Mr Tucker's next of kin to inform her that he had been taken to hospital. The following day, Mr Tucker's next of kin visited him at the hospital. On 25 February, the FLO facilitated a visit for Mr Tucker's next of kin and sister at the prison. The FLO continued to update Mr Tucker's next of kin about Mr Tucker's condition.

62. On 17 March, the FLO informed Mr Tucker's next of kin about the deterioration in his condition. The FLO was off duty that weekend, but continued to update her. Mr Tucker's next of kin expressed her wish to see him, so in the evening of Sunday 18 March, she travelled to the area and stayed locally.

63. The FLO had not returned to work, so on Monday 19 March, an officer called Mr Tucker's next of kin to inform her that he was being taken to a hospice that morning. Mr Tucker's next of kin decided to go straight to the hospice to wait for him. Later that morning someone from the prison called her to say that the private ambulance had arrived, and would be leaving shortly. Later that morning, the deputy family liaison officer telephoned Mr Tucker's next of kin while she was

at the hospice and told her that Mr Tucker had died in the ambulance on the way to the hospice. The deputy family liaison officer informed her that Mr Tucker was in his cell, and invited her to the prison to see him. Mr Tucker's next of kin arrived a little over an hour later and paid her respects.

64. The FLO was informed of Mr Tucker's death, and went to the prison to meet his niece. She offered her support and continued to liaise with her for the next couple of weeks.

65. Mr Tucker's funeral was held on 10 April 2018. The prison contributed to the cost in line with national guidance.

66. While we note that Mr Tucker's next of kin was very pleased with the contact she had with the prison overall, we share her concerns that she was informed about his death by telephone. Staff at the prison were aware that Mr Tucker's next of kin was waiting for him to arrive at the hospice, and that the hospice was relatively local to the prison. The prison has since told us that Mr Tucker's next of kin was on the telephone to the prison regularly that morning, and that they took the decision to inform her as soon as possible rather than giving her false information over the phone.

67. While we recognise the prison's reasons for making the decision it did, we are concerned that they did not send someone to deliver the news in person. Mr Tucker's next of kin was left alone in an unfamiliar environment to deal with this news. She then also had to drive to the prison to pay her respects to him.

68. Since the initial report was issued, we reviewed the prison's liaison with Mr Tucker's next of kin in light of the further concerns she expressed. Mr Tucker's next of kin and the prison have given us conflicting accounts about the support that was offered, so we are unable to conclude whether it appropriately supported her after his death. We consider that the prison may not have given her accurate information about his death, and that this led to her enduring further distress. A written record of the telephone conversation would have clarified the conversation.

**The Director of Rye Hill should ensure that a member of staff informs a prisoner's family or next of kin of his death in person in line with national guidance.**

**The Director of Rye Hill should ensure that written records of telephone conversations are made when staff speak to a prisoner's next of kin.**

### Compassionate release

69. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000. Among the criteria is that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on

compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of the Her Majesty's Prisons and Probation Service (HMPPS).

70. On 29 January, a prison GP discussed Mr Tucker's prognosis with the lung cancer specialist nurse from the hospital. Later that day, he started an application for Mr Tucker to be released on compassionate grounds. On 1 February, a nurse recorded that the compassionate release paperwork had been completed and sent to the Offender Management Unit for their consideration. On 14 February, a probation officer that certain conditions would be necessary before compassionate release could be considered. On 12 March, the Director signed to indicate his support for Mr Tucker's application.

71. On 14 March 2018, a member of staff from the Public Protection Casework Section stated that there was insufficient information to decide about release on compassionate grounds at that stage. He indicated what information was required for a decision to be made.

72. We are satisfied that Rye Hill acted appropriately in making an application for compassionate release when it did. Mr Tucker died before the process could be completed.

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