Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Colin Wraight, a prisoner at HMP Rye Hill, on 28 October 2020

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 Colin Wraight died on 28 October 2020 of bronchopneumonia at HMP Rye Hill. He was 69 years old. I offer my condolences to Mr Wraight's family and friends.

The clinical reviewer found that the care that Mr Wraight received at Rye Hill was of a good standard and was at least equivalent to that which he would have received in the community. Mr Wraight had several complex, long-term health conditions which were treated and managed well by staff at Rye Hill and at HMP Swaleside (where he had been previously).

However, the clinical reviewer found that there were problems monitoring his health in the last week of his life. She was also concerned that on the morning of his death, the night nurse did not tell prison staff to stop CPR even though Mr Wraight had recently signed a form saying he did not want to be resuscitated if his heart or breathing stopped.

I am concerned it took 15 minutes for paramedics to get from the prison gate to Mr Wraight's cell. Although this did not affect the outcome for Mr Wraight as he did not want to be resuscitated, such a delay could make a critical difference in other medical emergencies.

I am also concerned that, from the information given to the PPO, there was no post-incident debrief.

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 **July 2021**

Contents

Summary

Events

1. In May 2017, Mr Colin Wraight was remanded into prison charged with sexual offences. In August, he was sentenced to an Extended Determinate Sentence (EDS) of 21 years and was transferred to HMP Swaleside.

2. On 30 June 2020, Mr Wraight transferred to HMP Rye Hill. On arrival he was put into a COVID-19 isolation regime for 14 days in line with prison and Public Health England (PHE) policy.

3. On 21 August, Mr Wraight was admitted to hospital with pneumonia. He returned to the prison on 26 August and was placed into a COVID-19 isolation regime.

4. Mr Wraight was admitted to hospital again on 24 September with chest pain and shortness of breath. He returned to the prison on 29 September and was placed into a COVID-19 isolation regime.

5. On 6 October, Mr Wraight signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form. This meant that he agreed that he did not want to be resuscitated in the event of a heart attack or if he stopped breathing.

6. On 21 October, Mr Wraight was diagnosed with an infection exacerbated by his Chronic Obstructive Pulmonary Disease (COPD) and prescribed antibiotics and steroids. He was not admitted to hospital as the staff treating him felt that they could manage his illness in the prison.

7. On 24 October, Mr Wraight was checked by a nurse at the request of officers on his wing as he was short of breath. He had a National Early Warning Score (NEWS-2) of 6 (medium risk of deterioration). He was not reviewed again.

8. On 28 October, shortly after midnight, Mr Wraight pressed his emergency cell bell and told the night officer that he could not breathe. The officer called a ‘code blue’ (a medical emergency code used when a prisoner is unconscious or having breathing difficulties) and he and other officers entered the cell.

9. At 12.35am, Mr Wraight collapsed. Prison officers began cardiopulmonary resuscitation (CPR). Ambulances arrived in the prison and at 1.24am, paramedics confirmed Mr Wraight had died.

Findings

10. The clinical reviewer concluded that the care that Mr Wraight received at HMP Rye Hill was of a good standard and was at least equivalent to that which he would have received in the community.

11. The clinical reviewer did, however, identify some concerns: Mr Wraight was not monitored by healthcare staff as he should have been in the last week of his life, and his DNACPR wishes were not followed.

12. There was delay of 15 minutes in getting paramedic crews from the prison gate to Mr Wraight’s cell. The first ambulance arrived at Rye Hill at 12.54am but was

misdirected through the prison and paramedics did not reach Mr Wraight's cell until 1.09am.

13. We are concerned that there was no immediate post-incident debrief and there are no minutes. Healthcare staff who were involved in Mr Wraight's care but not present on the night of his death were not offered a debrief or offered staff support.

14. The emergency cell bell system was operational on the night of Mr Wraight's death but the recording system had a fault and timed the activation of the cell bell inaccurately.

Recommendations

- The Head of Healthcare should ensure that clinically vulnerable patients are reviewed at appropriate intervals when suffering from acute infections.
- The Head of Healthcare and the Director should ensure that key staff, particularly clinical staff, are aware of all prisoners with an active Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) form and understand what this means during an emergency response.
- The Director should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies in line with Prison Service Instruction (PSI) 03/2013. In particular, the Director should ensure there are no delays in escorting ambulances and paramedics to the patient and should ensure that staff responding to a medical emergency are aware of the most appropriate routes for escorting ambulances.
- The Head of Healthcare should ensure that night staff respond to emergencies immediately.
- The Head of Healthcare should ensure that healthcare staff record evidence of the actions they took during an emergency and their decision-making in the patient's medical records.
- The Head of Healthcare should ensure that all staff, including those employed via agencies, make themselves available for interview by the PPO and clinical reviewer investigating a death in custody, in line with Prison Service Instruction (PSI) 58/2010.
- The Head of Healthcare should share this report with the nurse on duty when Mr Wraight died and with the agency that employs her to ensure they are aware of the Ombudsman's findings.
- The Director and Head of Healthcare should ensure that after all deaths in custody:
    - a hot debrief is held immediately, in line with PSI 02/2018;
    - a senior member of staff acts as the debriefer and a member of the care team attends;

    - all staff directly involved in the incident, including healthcare staff, are invited; and
    - consideration is given to whether any staff not directly involved in the emergency response, but who provided care, may need support and debriefing.
- The Director should ensure that the cell bell recording system is regularly checked and audited to make sure that the data is accurate.

The Investigation Process

15. 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. A prisoner wrote to him.

16. The investigator wrote to Rye Hill on 29 October 2020. He obtained a range of documents including copies of relevant extracts from Mr Wraight's prison and medical records.

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

18. The investigator and clinical reviewer interviewed five members of staff on 7 and 8 December 2020. The investigator also interviewed a prisoner on 7 December 2020. All the interviews were conducted by telephone because of the restrictions imposed in response to the COVID-19 pandemic.

19. 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.

20. One of the Ombudsman's family liaison officers contacted Mr Wraight's daughter to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked for a copy of our report.

21. Mr Wraight's family received a copy of the initial report. They pointed out one factual inaccuracy relating to the prison's financial contribution to Mr Wraight's funeral. This report has been amended accordingly.

22. Mr Wraight's family also raised several questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

23. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies and their action plan is annexed to this report.

24. The PPO found one inaccuracy and this report has been amended accordingly.

Background Information

HMP Rye Hill

25. Rye Hill is a medium security prison for up to 664 men convicted of sexual offences.

26. Healthcare services at Rye Hill are provided by G4S Healthcare. There is no inpatient facility at Rye Hill but there is 24-hour healthcare provision, with one nurse on duty at night.

HM Inspectorate of Prisons (HMIP)

27. The most recent inspection of HMP Rye Hill was an unannounced inspection in September 2019. Inspectors found that health services were reasonably good overall. Partnership working between the prison and health providers had improved since the previous inspection, and strong leadership 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 similar to those in the community. Long-term conditions management was reasonable and the service was developing.

28. HMIP also conducted a Short Scrutiny Visit of Rye Hill in June 2020 to report on the treatment and conditions of prisoners during the COVID-19 pandemic. They found that the prison had adopted clear plans to manage the pandemic at the start of the lockdown, identifying those who were most vulnerable so they could protect them and limit the spread of the virus. Health and safety protocols were in place and the prison remained calm, well ordered and safe. Most healthcare clinics had been suspended but managers had implemented a triage system to ensure that urgent cases were dealt with appropriately.

Independent Monitoring Board

29. 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 2020, the IMB reported on the challenges in providing facilities for frail and/or elderly prisoners.

Previous deaths at HMP Rye Hill

30. Mr Wraight was the 12th prisoner to die at HMP Rye Hill since October 2018. All the previous deaths were from natural causes (including one death from COVID-19).

31. In previous investigations we have recommended that the Head of Healthcare ensure that clinical staff received up-to-date training on how to review patients with chronic diseases, particularly heart disease, and the management of long-term conditions, and were aware of the triggers for escalation and when to organise further investigations.

Key Events

32. On 8 May 2017, Mr Colin Wraight was remanded into prison charged with sexual offences. On 8 August, he was sentenced to an Extended Determinate Sentence (EDS) of 21 years. On 24 August he was transferred to HMP Swaleside.

33. During health screening processes in 2017, Mr Wraight informed staff of his medical conditions including Chronic Obstructive Pulmonary Disease (COPD) and hypertension (high blood pressure).

34. Mr Wraight was appropriately treated by clinicians at HMP Elmley and HMP Swaleside to manage his long-term conditions, with referral to specialists and outside hospital as needed.

35. Between January 2018 and his death, Mr Wraight had 18 episodes of acute respiratory infection caused or exacerbated by his COPD. Three of these episodes required him to be admitted to hospital.

36. On 3 April 2020, following the national COVID-19 lockdown, Mr Wraight was advised to shield for 12 weeks in line with prison and Public Health England (PHE) guidance for extremely clinically vulnerable people. He was given written information about shielding.

HMP Rye Hill

37. On 30 June, Mr Wraight transferred to HMP Rye Hill. On arrival, he was put into a COVID-19 isolation regime for 14 days in line with prison and Public Health England policy.

38. On 21 August, Mr Wraight was admitted to hospital with pneumonia. He returned to the prison on 26 August and was placed into a COVID-19 isolation regime.

39. On 24 September, Mr Wraight was admitted to hospital again with chest pain and shortness of breath. He returned to the prison on 29 September and was placed into a COVID-19 isolation regime. The diagnosis this time was cor pulmonale (a failure of the right side of the heart).

40. On 6 October, Mr Wraight signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form. This meant that he did not want to be resuscitated in the event of a heart attack or if he stopped breathing.

41. On 21 October, Mr Wraight was diagnosed with an infection exacerbated by his COPD. He was reviewed by a nurse and a prison paramedic. They referred Mr Wraight to a prison GP, who prescribed antibiotics and steroids. Mr Wraight was not admitted to hospital because the staff treating him felt that they could manage his illness within the prison. Healthcare did not review him again that day or on the following two days.

42. On 24 October, Mr Wraight was checked by a nurse at the request of officers on his wing because he was short of breath. He had a National Early Warning Score (NEWS-2 - a tool to measure clinical deterioration) of 6, indicating he was at medium risk and required urgent review to decide whether escalation was

necessary. This score was based on his low blood pressure, fast pulse and respiratory rate. The nurse assessed his score was due to anxiety. She reassured him and encouraged him to do his breathing exercises.

43. Mr Wraight was not reviewed again that day or the following three days.

Events of 28 October 2020

44. On 28 October, shortly before 12.30am, Mr Wraight pressed his emergency cell bell. He told the night officer that he could not breathe. The officer called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties) and the Night Orderly Officer, a Custodial Manager (CM), and an officer arrived in response.

45. At 12.30am, they entered the cell and found Mr Wraight leaning over his bed, conscious but in distress. He said he could not breathe but was not in pain. At 12.32am, control room staff called an ambulance, which was despatched at 12.34am. Meanwhile, prison officers attempted to get Mr Wraight to use his inhaler. At 12.35am, Mr Wraight slid off his bed onto the floor and lost consciousness. An officer and the CM placed Mr Wraight in the recovery position.

46. The nurse on duty that night had not responded to the code blue and the control room had to call her again. (She was not available for interview, so we do not know why.) She arrived at Mr Wraight's cell at 12.36am.

47. Prison staff moved Mr Wraight onto his back and started CPR, including mouth-to-mouth resuscitation. At 12.39am, the control room rang the ambulance service again to tell them that Mr Wraight was unconscious. A second ambulance was despatched to the prison.

48. At 12.43am, prison officers applied the defibrillator which advised "no-shock"; they continued CPR. At 12.47am, the control room rang the ambulance service for a third time to get an update on the ambulances' arrival. The ambulances had been delayed due to roadworks, so the ambulance service also sent an air ambulance.

49. At 12.54am, the first ambulance arrived at the prison. Three minutes later the second ambulance and the air ambulance arrived. At least one of the ambulances was directed by prison staff into a part of the prison that was still locked and then had to be re-routed to the correct gate. One of the ambulances then became stuck in soft ground. This delayed them reaching Mr Wraight.

50. At 1.09am, paramedics arrived at Mr Wraight's cell and took over from prison officers and the nurse. At 1.24am, a paramedic confirmed that Mr Wraight had died.

Contact with Mr Wraight's family

51. Following Mr Wraight's death, the prison's Family Liaison Officer (FLO) and a senior prison manager left the prison around 3.15am and drove to the next of kin's home. They arrived at around 7.30am and broke the news to Mr Wraight's

family. Over the following days, the FLO provided support and information to the family.

52. Mr Wraight's funeral was held on 17 November 2020. While the prison told us that they had contributed to the cost of the funeral, Mr Wraight's family told us that this had not happened. We wrote to the prison on 20 May asking for clarification. They accepted that they had not made a financial contribution but told us that they would. They contacted Mr Wraight's family and told us they paid the invoice on 8 June.

Support for prisoners and staff

53. The prison posted notices informing other prisoners and staff of Mr Wraight'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 Wraight's death.

Post-mortem report

54. The post-mortem found that Mr Wraight died from bronchopneumonia (an inflammation of the airways and lung) caused by COPD (a chronic inflammatory lung disease that causes obstructed airflow from the lungs). Cor Pulmonale (a failure of the right side of the heart), hypertension (high blood pressure) and a fatty liver contributed to but did not cause Mr Wraight's death.

Findings

Clinical Assessment

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

56. The clinical reviewer did, however, identify some concerns.

57. The clinical reviewer found that in the last week of his life Mr Wraight was not seen as frequently as he should have been given his poor health. On 21 October, Mr Wraight was diagnosed with a chest infection which exacerbated his COPD. The clinical reviewed considered that he should have been reviewed daily after this and was concerned that this did not happen.

58. On 24 October, Mr Wraight was seen by a nurse at the request of officers on his wing because he was short of breath. The clinical reviewer was satisfied that the decision not to send him to hospital was appropriate - although he had a NEWS-2 score of 6, his oxygen level was satisfactory and he was not showing signs of severe respiratory distress. However, the clinical reviewer considered that he should have been reviewed at least daily following this consultation and was concerned that this did not happen.

59. At interview the Head of Healthcare acknowledged that Mr Wraight should have been added to the list of patients with complex medical problems and reviewed on a daily basis. She could not say why this had not happened. Mr Wraight was not seen again by a nurse until he collapsed in the early hours of 28 October.

60. We make the following recommendation:

    The Head of Healthcare should ensure that clinically vulnerable patients are reviewed at appropriate intervals when suffering from acute infections.

Do Not Attempt CardioPulmonary Resuscitation (DNACPR) forms

61. Mr Wraight had a DNACPR in place, which was agreed on 6 October. On 28 October, prison officers began CPR when he collapsed and lost consciousness. The clinical reviewer considered that this was a reasonable decision by the officers given he had collapsed in front of them and they were not medically trained and did not know about the DNACPR. However, the clinical reviewer considered that when the night nurse arrived at Mr Wraight's cell, she should have told the prison officers to stop CPR. This did not happen, and resuscitation went on for around 45 minutes. This was against Mr Wraight's wishes.

62. We were told that healthcare staff knew where the DNACPR folder was kept in the healthcare department. We were told this information was also kept in the Safer Custody department and sent to all staff daily. However, none of the night staff were aware of Mr Wraight's DNACPR. We make the following recommendation:

    The Head of Healthcare and the Director should ensure that key staff, particularly clinical staff, are aware of all prisoners with an active Do Not

Attempt Cardiopulmonary Resuscitation (DNACPR) form and understand what this means during an emergency response.

Emergency Response

63. Prison Service Instruction (PSI) 03/2013, *Medical Emergency Response Codes*, sets out the policy requirements for a medical emergency. It states:

"*As a minimum, local protocols must:*

Prevent any unnecessary delay in escorting ambulances and paramedics to the patient and discharging them from the prison (with or without the patient). This must include procedures for admitting and discharging ambulances during the night state"

64. The East Midlands Ambulance Service log recorded the two ambulances arriving at Rye Hill at 12.54am and 12.57am. The air ambulance arrived with the second ambulance.

65. In internal statements seen by the PPO, two officers reported that they were at the gate to escort the ambulances to Mr Wraight's cell. The first officer wrote that he took the first ambulance into a yard where the doors to the residential unit were still double locked and therefore inaccessible. He wrote that the ambulance had to be re-routed with the other ambulance. In her statement, the second officer who was escorting the second ambulance wrote that she met the first officer and the first ambulance and noted it was stuck in the soft ground. They then escorted the second ambulance and the paramedics from the first ambulance onto Mr Wraight's unit through doors that were not double locked.

66. In interview, a prisoner on an adjacent unit said that he was alerted by the ambulance sirens and from the window in his cell, he saw prison staff trying to get into the residential unit but they could not due to the double locked doors. He then saw the ambulance leaving the yard.

67. It appears that there were errors made in the routing of the first ambulance through the prison. As a result, the paramedics were delayed and did not reach Mr Wraight until around 15 minutes after the ambulances first arrived.

68. The clinical reviewer concluded that this delay did not contribute to Mr Wraight's death since, if the DNACPR had been followed paramedics would not have been attending to resuscitate Mr Wraight. However, such a delay could make a critical difference in other medical emergencies. We make the following recommendation:

The Director should ensure that there are no delays in escorting ambulances and paramedics to the patient and should ensure that staff responding to a medical emergency are aware of the most appropriate routes for escorting ambulances.

Nurse on duty on the night Mr Wraight died

69. The clinical reviewer was concerned that the nurse's entry on SystmOne (Mr Wraight's electronic medical record) about her actions during the emergency

response was confused and lacked detail, and recorded the emergency response 15 minutes later than it occurred.

70. We also note that, after the code blue was called, it took the nurse over six minutes to reach Mr Wraight's cell, that she did not appear to acknowledge requests over the radio for her attendance, and that she did not tell prison staff that a DNACPR was in place.

71. We have not been able to ask the nurse to explain her actions. The investigator arranged with the prison that he would interview the nurse by telephone on 8 December 2020. The nurse did not attend the interview and we were told she was not contactable that day. The investigator asked the prison to contact her to identify a time for an interview or for her to provide a written statement answering specific questions. The Head of Healthcare emailed the nurse's agency on 11 December. We received no reply from the agency or the nurse. We make the following recommendations:

The Head of Healthcare should ensure that night staff respond to emergencies immediately.

The Head of Healthcare should ensure that healthcare staff record evidence of the actions they took during an emergency and their decision-making in the patient's medical records.

The Head of Healthcare should ensure that all staff, including those employed via agencies, make themselves available for interview by the PPO and clinical reviewer investigating a death in custody, in line with Prison Service Instruction (PSI) 58/2010.

The Head of Healthcare should share this report with the nurse on duty when Mr Wraight died and with the agency that employs her to ensure they are aware of the Ombudsman's findings.

Post Incident Debriefing and Staff Care

72. During the investigation we asked for records of the hot debrief with staff. We were told that there were no minutes of the debrief. Despite our enquiries we were unable to confirm that a hot debrief had taken place in line with PSI 02/2018, Post-Incident Care. In our interviews we were told that healthcare staff who had cared for Mr Wraight had not been debriefed or offered support. We make the following recommendation:

The Director and Head of Healthcare should ensure that after all deaths in custody:

- **a hot debrief is held immediately, in line with PSI 02/2018;**
- **a senior member of staff acts as the debriefer and a member of the care team attends;**
- **all staff directly involved in the incident, including healthcare staff, are invited; and**

- **consideration is given to whether any staff not directly involved in the emergency response, but who provided care, may need support and debriefing.**

Cell Bell System

73. We requested the cell bell system records for 28 October and were sent the system print out. It records the only cell bell activation for that day at 1.23am. This was around 55 minutes later than when an officer reported Mr Wraight pressed his cell bell.

74. The prison told us that there was a fault in the reporting system that has since been rectified. Given the importance of the system in recording prisoner emergencies and staff action, it is vital that it provides an accurate record of the timings of activations and responses. We make the following recommendation:

The Director should ensure that the cell bell recording system is regularly checked and audited to make sure that the data is accurate.

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