Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Keith Ryman, a prisoner at HMP Doncaster, on 26 December 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*

Summary

1. 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.

2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

3. Mr Keith Ryman died in hospital on 26 December 2020, while a prisoner at HMP Doncaster. He was 77 years old. The cause of his death was COVID-19 pneumonia. He also had chronic obstructive pulmonary disease, ischaemic heart disease and chronic kidney disease. I offer my condolences to Mr Ryman's family and friends.

4. The clinical reviewer concluded that Mr Ryman's clinical care at Doncaster was not equivalent to that he could have expected to receive in the community. Full details of her findings are in the clinical review report.

5. Mr Ryman appears to have contracted the virus at Doncaster, as he had not left the prison within the usual incubation period for COVID-19. We are satisfied that the prison implemented appropriate infection control measures. However, we share the clinical reviewer's concerns that Mr Ryman did not receive a secondary health assessment; his long-term health conditions were not appropriately managed; he was not identified as at risk from COVID-19 infection; and hospital specialists were unable to access pre-arranged telephone appointments.

Recommendations

- The Head of Healthcare should ensure that all new prisoners receive a secondary health screen within seven days of their arrival, in line with NICE guidance 57 and that there is an auditable process to follow up those who do not attend their appointment.

- The Head of Healthcare should ensure that there is timely identification of long-term health conditions and appropriate care plans are put in place without delay.

- The Director and Head of Healthcare should ensure that secondary care specialists are able to contact patients for pre-arranged telephone consultations.

- The Head of Healthcare should ensure that all prisoners at risk of complications from contracting COVID-19 are correctly identified.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Ryman's clinical care at HMP Doncaster.

7. The PPO investigator investigated the non-clinical issues, including aspects of the prison's response to COVID-19 and shielding prisoners; Mr Ryman's location; the security arrangements for his journey and admission to hospital; liaison with his family; and whether early release was considered.

8. The PPO investigator and clinical reviewer interviewed four healthcare staff and a prison officer. The interviews were conducted by telephone due to the restrictions in place during the COVID-19 pandemic and summaries are attached as annexes.

9. The Ombudsman's family liaison officer wrote to Mr Ryman's next of kin, his sister, to explain the investigation and ask if she wanted any specific matters to be considered. She did not reply.

10. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies. They provided an action plan which is annexed to this report.

Previous deaths at HMP Doncaster

11. Mr Ryman was the 22nd prisoner at Doncaster to die since December 2018. Nine of the previous deaths were self-inflicted, ten were from natural causes and two were drug-related. Mr Ryman was the third prisoner in the prison's social care unit to die of COVID-19 related causes over a six-day period in December 2020. There have been three further deaths: one from natural causes (COVID-19), one self-inflicted and one awaiting classification.

12. In a recent investigation we made recommendations on the use of care plans for long-term conditions and following up non-attendance of appointments.

COVID-19 (coronavirus)

13. COVID-19 is an infectious disease that affects the lungs and airways. It is mainly spread through droplets when an infected person coughs, sneezes, speaks or breathes heavily. On 11 March 2020, the World Health Organisation (WHO) declared COVID-19 a worldwide pandemic.

14. COVID-19 can make anyone seriously ill, but some people are at higher risk of severe illness and developing complications from the infection. People at high risk (clinically extremely vulnerable) include those who have had an organ transplant; have severe lung or kidney disease; or are having certain types of cancer or other treatment which significantly increases the risk of infection. Examples of those at moderate risk (clinically vulnerable) are people over 70; people under 70 with an underlying health condition, such as diabetes, or chronic respiratory, heart, liver or kidney disease; those with a weakened immune system; or who are very overweight. (These lists are not exhaustive.)

15. In response to the initial pandemic outbreak, HM Prison and Probation Service (HMPPS) introduced several measures to try and contain the outbreak - to be implemented at local level, depending on the needs of individual prisons. (An outbreak is defined as two or more prisoners, or staff, who are clinically suspected, or have tested positive for COVID-19 within 14 days.) A key strategy is 'compartmentalisation' to cohort and protect prisoners at high and moderate risk; isolate those who are symptomatic; and separate newly-arrived prisoners from the main population. Other measures include social distancing and the use of personal protective equipment (PPE).

Key Events

16. Mr Keith Ryman was convicted of sexual offences on 12 October 2018 and sentenced to 16 years imprisonment. He was sent to HMP Hull. Mr Ryman transferred to HMP Doncaster on 11 September 2019.

17. Mr Ryman had a history of chronic obstructive pulmonary disease (COPD), chronic kidney disease, ischaemic heart disease and several other heart-related conditions. He had reduced mobility and used a wheelchair for longer distances. Mr Ryman lived on the social care unit, a dedicated unit for men over 60 with mobility or social care needs.

18. In line with national guidance on protecting those at most risk of complications from COVID-19, the prison's clinical matron reviewed Mr Ryman's records on 3 May 2020. She concluded that he was at low risk of and he was therefore not required to shield during the pandemic.

19. During the following months, face to face secondary care appointments were suspended due to the pandemic, but Mr Ryman's cardiologist arranged to monitor his condition through telephone appointments. (He was unable to get through to the prison on the phone in August and September, but successfully reviewed him in November.)

20. On 29 October, an advanced nurse practitioner discovered that Mr Ryman had been diagnosed with COPD in 2018. She arranged for a review in December, but Mr Ryman died before this took place.

21. On 13 December, wing staff asked a healthcare support worker to assess Mr Ryman, as he felt unwell. He reported a persistent cough that had started the previous night, severe back pain and feeling hot. Clinical observations showed low blood oxygen saturations and a National Early Warning Score (NEWS) 2 of 11 indicated that he needed urgent critical care. (NEWS2 is a tool to monitor clinical deterioration in patients.) The healthcare support worker noted that Mr Ryman had been exposed to someone who had contracted COVID-19. (At interview, she clarified that there had been COVID-19 positive prisoners on the unit, but he had not been in direct contact with them.) Healthcare staff requested an ambulance and gave Mr Ryman oxygen while waiting.

22. The paramedics took Mr Ryman to hospital and he was admitted as an inpatient. He was escorted by two prison officers, with no restraints. Healthcare staff contacted the hospital regularly for updates on Mr Ryman's condition. On 16 December, it was confirmed that he had tested positive for COVID-19.

23. On 21 December, the prison assigned a family liaison officer to Mr Ryman. As he was estranged from his family, she liaised with his offender manager and solicitor to obtain up to date contact details. His family declined contact with him.

24. Mr Ryman died at 10.40pm on 26 December. The next day, the family liaison notified his next of kin's daughter, who reiterated that his family did not want to be involved.

25. Notices were issued to staff and prisoners, informing them of Mr Ryman's death and offering support.

26. In line with national policy, the prison arranged and paid for Mr Ryman's funeral, which was held on 22 January 2021.

Post-mortem examination

27. After a post-mortem examination, the coroner confirmed that Mr Ryman had died from COVID-19 pneumonia. He also had chronic obstructive pulmonary disease, ischaemic heart disease and chronic kidney disease, which did not cause but contributed to his death.

Findings

Clinical Findings

28. The clinical reviewer concluded that Mr Ryman's care at Doncaster was variable and not equivalent to that he could have expected to receive in the community. Full details of the deficiencies are explained in the clinical reviewer's report. We highlight below the issues relevant to Mr Ryman's underlying conditions and cause of death and make similar recommendations to those in the clinical review.

Secondary health assessment

29. National Institute for Health and Care Excellence (NICE) Guideline 57, which covers the management of the physical health of people in prison, states that every prisoner should have a second-stage health assessment within seven days of their arrival. Although Mr Ryman had an initial health screen on reception at Doncaster, he did not attend the appointment for his secondary assessment and his non-attendance was not followed up. We recommend:

    The Head of Healthcare should ensure that all new prisoners receive a secondary health screen within seven days of their arrival, in line with NICE guidance 57 and that there is an auditable process to follow up those who do not attend their appointment.

Management of long-term conditions

30. Information obtained from Mr Ryman's community GP that he had been diagnosed with COPD was not properly recorded in his medical record. Therefore, this condition was not monitored in prison and there was no care plan in place. Similarly, there were no care plans to manage Mr Ryman's heart disease, or chronic kidney disease. We recommend:

    The Head of Healthcare should ensure that there is timely identification of long-term health conditions and appropriate care plans are put in place without delay.

31. Two planned telephone consultations did not take place, as Mr Ryman's cardiologist was unable to get through to the prison. In November, a gastroenterologist was also unable to contact Mr Ryman for a telephone consultation. It is unclear whether these missed appointments were caused by errors in timing, or technical problems. However, the investigator experienced considerable difficulties several times when dialling Doncaster's switchboard, but not with direct lines.

32. The Head of Healthcare said that there were plans to install additional telephone lines. In the meantime, it is essential that external clinical professionals are able to access patients with pre-arranged appointments and that access is improved for everyone who needs to contact the prison. We recommend:

    The Director and Head of Healthcare should ensure that secondary care specialists are able to contact patients for pre-arranged telephone consultations.

Management of Mr Ryman's risk of infection from COVID-19

33. Prison managers developed local policies, which were issued to staff and prisoners and updated in line with government advice and national Prison Service policy. Infection control measures were in place, with enhanced cleaning in the social care unit where Mr Ryman lived.

34. Mr Ryman's underlying health conditions were not fully considered and he had been incorrectly assessed as at low risk of serious illness from COVID-19. He was therefore not offered the opportunity to shield, as he should have been.

35. Due to the vulnerability of the residents on the social care unit, the regime was changed to provide added protection for all the residents. This included remaining locked in their cells, except for exercise and showers, and restricted access to the unit. Therefore, in essence, Mr Ryman had been subject to a form of shielding. He was sent to hospital as soon as he became critically unwell.

36. We are satisfied that Doncaster generally took appropriate steps to minimise the spread of the virus and the risk of infection. However, we are concerned that healthcare staff failed to identify that Mr Ryman was clinically vulnerable and at risk of complications from COVID-19. We recommend:

    The Head of Healthcare should ensure that all prisoners at risk of complications from contracting COVID-19 are correctly identified.

Sue McAllister CB
Prisons and Probation Ombudsman **July 2021**

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