

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alan Housley, a prisoner at HMP Rye Hill, on 2 February 2020

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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

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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Alan Housley died in hospital of sepsis and multiple organ failure on 2 February 2020, while a prisoner at HMP Rye Hill. He was 68 years old. I offer my condolences to Mr Housley's family and friends.

Mr Housley had Type 1 diabetes. The clinical reviewer found that his healthcare during his five and a half years at Rye Hill was not equivalent to that which he could have expected to receive in the community, and that the management of Mr Housley's diabetes was very poor. Both we and the clinical reviewer have made recommendations which the Head of Healthcare will need to address urgently.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Kimberley Bingham
Acting Prisons and Probation Ombudsman

April 2023

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Summary

Events

1. On 19 April 2012, Mr Alan Housley was sentenced to 15 years in prison for sexual offences. He was sent to HMP Doncaster.
2. Mr Housley entered prison with Type 1 diabetes and poor mobility (as a result of nerve damage in his feet caused by diabetes). He had little significant contact with healthcare staff at Doncaster.
3. In May 2014, Mr Housley transferred to HMP Rye Hill.
4. In July 2014, a blood test to check his diabetes control showed an abnormal result and he was seen by a prison GP. The blood test was not repeated again until July 2019, when it again showed an abnormally high result.
5. From 2015-2016, Mr Housley was treated for an ulcerated foot (a complication of diabetes). He failed to attend numerous medical appointments.
6. From August to September 2019, Mr Housley was reviewed three times at hospital, but did not attend follow up appointments. The blood test to check his diabetes control was not repeated.
7. On 1 and 2 January 2020, Mr Housley was seen by nurses after he reported vomiting and not eating for several days. It was agreed he should be taken to hospital, but there were no prison staff available to escort him, and a prison GP subsequently decided it was not necessary.
8. Mr Housley's condition deteriorated and on 7 January he was taken to hospital by emergency ambulance. He was diagnosed with sepsis and was admitted to the hospital's critical care unit. His condition continued to deteriorate and at 11.18pm on 2 February Mr Housley died.
9. The coroner accepted the cause of death as sepsis and multiple organ failure.

Findings

10. The clinical reviewer concluded that the care Mr Housley received at Rye Hill was not equivalent to that which he could have expected to receive in the community, and that the management of his diabetes was very poor.
11. The clinical reviewer found that healthcare staff failed to manage Mr Housley's diabetes in line with national guidelines, including failing to monitor his condition regularly and follow up missed appointments. They also failed to provide follow up care when he was unable to go to hospital for review.
12. The clinical reviewer also found that staff did not record a National Early Warning Score (NEWS) after their encounters with Mr Housley and when he was showing clear signs of ill health in January 2020. This would have provided an indication of his deterioration.

13. We are also concerned that Mr Housley was restrained when he was taken to hospital for the final time on 7 January. We do not consider that this was appropriate given that Mr Housley was very ill and had great difficulty walking even when well.

Recommendations

- The Head of Healthcare should ensure that there is a multi-disciplinary team approach to diabetes management and that all diabetic prisoners have their HbA1c blood levels tested at least every six months, in accordance with NICE guidelines.
- The Head of Healthcare should ensure that all prisoners with long-term conditions are seen at least yearly for a follow up review and that a recall system is fully implemented and recorded in the appropriate section of SystmOne.
- The Head of Healthcare should ensure that prisoners who regularly do not attend appointments are spoken to by a senior member of healthcare staff about the health implications of non-attendance and that this is documented in their SystmOne records.
- The Head of Healthcare should ensure that when a prisoner is unwell on the wing there is consistent follow up and communication between members of the multi-disciplinary team.
- The Head of Healthcare should ensure that staff use the NEWS2 assessment tool and follow the recommended clinical escalation procedures.
- The Head of Healthcare should share this report with Nurse A and Dr A and discuss the Ombudsman's findings with them.
- The Head of Healthcare should ensure that the other recommendations made in the clinical review are addressed urgently.
- The Director should ensure that staff are aware of the legal requirements when completing an escort risk assessment, and that all relevant sections of a risk assessment are properly completed. Healthcare staff must provide information on the prisoner's current state of health and mobility. The risk assessment should fully take into account the medical condition of the prisoner and his/her physical capacity at the time of the escort.

The Investigation Process

14. 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.
15. NHS England commissioned a clinical reviewer to review Mr Housley's clinical care at the prison.
16. We informed HM Coroner for Northamptonshire of the investigation. The coroner gave us the cause of death. We have sent the coroner a copy of this report.
17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.
18. Mr Housley had no contact with his family or friends and had listed his probation officer as his next of kin.

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 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 delivering primary care. However, too few healthcare staff had completed mandatory training. The management of prisoners with long-term conditions was considered to be reasonable but the service was still developing. Social care governance arrangements were robust and care provision was good.
21. Inspectors also found that all health services were affected by a poor connection to SystmOne (the electronic clinical information system), including clinics, which were often delayed. However, partnership working between the prison and health providers had improved and local clinical governance meetings had recently reconvened.

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 an audit of the healthcare department, carried out by the NHS and HMPPS in April 2018, had found 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.

Previous deaths at HMP Rye Hill

24. Mr Housley was the 12th prisoner to die at Rye Hill since January 2018, all of the deaths were from natural causes. There have been four further deaths from natural causes since Mr Housley's death.
25. In our investigations into the death of prisoners in December 2018 and November 2019, we identified shortcomings in the healthcare management of prisoners with long-term conditions and in the procedures for following up prisoners who regularly failed to attend medical appointments. The prison told us in May 2020 that these problems had been addressed.

Key Events

26. On 19 April 2012, Mr Alan Housley was sentenced to 15 years in prison for sexual offences. He was sent to HMP Doncaster.
27. Before entering prison, Mr Housley had been diagnosed with Type 1 diabetes. He also had mobility issues. He had little significant contact with healthcare staff at Doncaster.
28. On 20 May 2014, Mr Housley transferred to HMP Rye Hill.
29. During his initial health screen at Rye Hill, a nurse noted that Mr Housley had Type 1 diabetes and mobility issues, and sometimes used a wheelchair. His prescribed medications were reviewed and updated.
30. In June 2014, Mr Housley was seen by a prison GP. She noted that he had not had recent blood tests and added him to the blood clinic list. She also noted that he was on the waiting list for the chiropodist, optician, diabetic clinic and for retinal screening. (All of these multi-disciplinary team members are vital in the care of diabetic patients.) She also recorded that Mr Housley needed to have his feet checked for diabetic neuropathy (a type of nerve damage that can occur in patients with diabetes, causing pain and numbness in the legs and feet).
31. In July, Mr Housley had some blood tests taken including his HbA1c level. This is a blood test that gives a 2-3-month past history of diabetic control. Mr Housley's HbA1c was high, indicating that his diabetes was poorly controlled. An entry was made in his medical records that this was abnormal and that he needed to see the GP, but no appointment took place.
32. From 2015-2016, Mr Housley was treated for an ulcerated foot (a complication of diabetes). However, he did not have a HbA1c blood test taken from June 2014 until July 2019, did not have yearly follow up appointments to assess his diabetes, check his compliance with his diet and insulin or to check his feet for neuropathy, and did not attend his retinal screening after October 2014.

2019

33. In June 2019, Mr Housley was seen by a nurse. He said that his diabetic neuropathy symptoms had worsened and as a result he was having problems with balance. A nurse referred him to a GP for review.
34. A week later, Mr Housley was seen by a prison GP. She considered there was evidence of muscle wastage in his legs. She recorded that although Mr Housley's blood sugar levels had been tested regularly, he had not had his HbA1c levels recorded since 2014, and she noted that he had been 'lost to follow up checks'. She adjusted his medications and made a referral to the endocrinology and neurology departments at University Hospital of Coventry and Warwickshire (UHCW). She also requested that full blood tests be carried out.
35. The blood tests were conducted on 16 July. They showed that Mr Housley's HbA1C level was abnormally high and that he also had a high concentration of

red blood cells, meaning that his blood was thicker than normal. The GP referred him for a haematology review at the hospital.

36. Mr Housley was seen by the haematology department and the diabetes clinic in August. No changes were suggested to his prescribed medications and on both occasions, he was discharged from the service the same day. There is no record that Mr Housley's HbA1c levels were monitored by the prison after this. A further appointment with the diabetes clinic was made for October but there is no record that Mr Housley attended this.
37. In September, Mr Housley was seen by the neurology department at UHCW for his diabetic neuropathy. Hospital staff considered that he had bad, longstanding diabetic sensory motor neuropathy. They did not plan any active treatment but advised prison healthcare staff that the effects could be lessened slightly by improvement in Mr Housley's diabetic control. He was referred for surgical splints to help his mobility but refused to attend an appointment for this in December.
38. In October, Mr Housley went to UHCW for tests designed to stimulate the nerves in his legs and feet. He was given a follow up outpatient appointment in November, but it is not clear if he attended it.
39. Mr Housley did not attend the prison's healthcare unit from 1 November onwards, apart from seeing the dentist in December. He repeatedly refused to attend his hospital appointments and signed a medical disclaimer to that effect.

January 2020

40. On 1 January 2020, Mr Housley was seen by a nurse after he reported feeling unwell. He told her that he had not eaten for the previous two days due to feeling sick. She took his observations (checks of a patient's breathing, pulse, temperature, blood pressure and oxygen levels to give an indicator of their physical condition) which were normal. She also measured his blood sugar level which was within the normal range. She did not take his National Early Warning Score (NEWS) 2 (a tool to assess the severity of a patient's condition, with 0 being no symptoms and 5 needing urgent clinical assessment). She saw him again later the same day and noted some improvement. She did not record his NEWS2 but referred him to a GP for further review.
41. Around midday on 2 January 2020, Nurse A saw Mr Housley in his cell at the request of prison officers because he was unwell. He took Mr Housley's physical observations (which were acceptable) but did not test his blood sugar "due to technical problems" or take his NEWS2. He encouraged Mr Housley to continue to drink plenty of fluids and take plenty of rest.
42. A nurse saw Mr Housley in the afternoon. He told her that he had been vomiting brown vomit since 24 December. She noted that it was 'coffee ground vomit' (which can be a sign of a gastrointestinal bleed). She took his observations, which were in normal range, and his blood sugar level which was high. She did not take his NEWS2.
43. The nurse then spoke to a prison GP for advice. He considered that Mr Housley should be sent to hospital for further investigation. However, due to staff shortages, the prison was unable to provide any prison escorts to take Mr Housley to hospital.

44. As Mr Housley could not go to hospital, the GP saw him later that day. He noted that Mr Housley had been vomiting for several days but that it was not 'coffee ground vomit'. He prescribed an anti-sickness medication and a stomach protection medication. He noted that Mr Housley's blood sugar level was normal (which was incorrect). He considered that Mr Housley did not need to go to hospital but recorded that if there was 'coffee ground vomit', Mr Housley should be taken to hospital by emergency ambulance.
45. On 4 January, Mr Housley was seen in his cell by a nurse. He was lying on his bed and appeared generally unwell. He told her that he had not eaten properly for the previous five days, felt very weak and had fallen while trying to use the toilet. She examined him but found no evidence of any injury. She took his observations which showed nothing of note. She explained to him the importance of eating as much as he could, which he agreed to try to do. She asked the prison officers who worked on Mr Housley's wing to try to encourage him to eat. She saw him again later that day. He told her that he had had food and drink and felt much better.
46. On 5 January, Mr Housley was seen by a prison paramedic. He noted that Mr Housley was less mobile and had become almost bed-bound. Mr Housley told the paramedic that he felt better in himself, but his legs felt very weak and would not support his weight. The paramedic asked the prison officers who worked on the wing to check on Mr Housley regularly. He also asked the nurse on overnight duty to review him.
47. The following day, Mr Housley was seen by a prison GP, Doctor A. He told the GP that he had been having trouble eating because of nausea and vomiting for the last week. The GP told Mr Housley that he needed to eat, or he would have to be sent to hospital. He did not take his blood sugar levels but prescribed him a short course of diet supplements to try to stimulate his appetite.
48. The prison paramedic saw Mr Housley in his cell on 7 January. He noted that Mr Housley was bed-bound, dehydrated, incontinent of urine and appeared generally unwell. He told Mr Housley that he would check on him later that day. Following his review, he asked that a GP prescribe Mr Housley a Fortisip supplement (a nutritional milkshake).
49. The prison paramedic discussed Mr Housley's condition with a prison GP. They agreed that he needed to be taken to hospital. Mr Housley was taken to UHCW by emergency ambulance. He was accompanied by two prison officers and restrained using an escort chain.
50. Hospital staff diagnosed Mr Housley with sepsis (a life-threatening reaction to infection). Prison staff removed his restraints. Mr Housley was admitted as an inpatient in the hospital's critical care unit, where he was given kidney dialysis and had surgery for a gastrointestinal bleed. He was sedated and placed on a ventilator to help him to breathe. Prison healthcare staff stayed in regular contact with hospital staff to obtain updates on Mr Housley's condition.
51. Mr Housley's health continued to deteriorate and at 23.18pm on 2 February, a hospital doctor confirmed that Mr Housley had died.

Cause of death

52. The coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out.
53. The doctor gave Mr Housley's cause of death as sepsis and multiple organ failure, caused by an abscess on the buttocks, which was complicated by necrotising fasciitis (a serious soft tissue infection) and hospital acquired pneumonia in a patient with diabetes. He had also had a haemorrhage due to a stomach ulcer which did not cause but contributed to his death.

Contact with Mr Housley's Family

54. On 28 January 2020, following hospital staff's decision to sedate Mr Housley and place him on a ventilator, the prison appointed a family liaison officer (FLO).
55. Mr Housley had had no contact with his family due to the nature of his offending. He had listed his probation officer as his next of kin. The FLO telephoned the probation officer to tell her that Mr Housley was seriously ill. She asked to be informed by telephone if Mr Housley died. Following Mr Housley's death, the FLO telephoned the probation officer to inform her.
56. Mr Housley's funeral was held on 4 March. The prison paid for the funeral in line with national guidance.

Support for prisoners and staff

57. The prison posted notices informing other prisoners of Mr Housley'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 his death.
58. After Mr Housley's death, the staff who had been with him at the hospital when he died were given the opportunity to discuss any issues arising and were also offered support by the staff care team.

Findings

Clinical care

59. Mr. Housley was a Type 1 diabetic on insulin treatment. The clinical reviewer concluded that the care Mr Housley received at Rye Hill was not equivalent to that which he could have expected to receive in the community. He had several concerns about Mr Housley's care and found that the management of his diabetes was very poor and not in accordance with National Institute for Health and Care Excellence (NICE) guidelines.

Diabetes care

60. Although Mr Housley had been in prison since 2014, the clinical reviewer could find no evidence in Mr Housley's medical records that a formal care plan was put in place to manage his diabetes until 2016.
61. The clinical reviewer was concerned that Mr Housley did not have yearly follow up appointments to assess his diabetes, check his compliance with his diet and insulin, or to check his feet for neuropathy.
62. The care plan completed in 2018 noted that Mr Housley's blood levels required ongoing routine monitoring, but there is no evidence that this took place. The clinical reviewer was particularly concerned about the lack of regular and routine HbA1c blood tests. Mr Housley did not have a HbA1c test from June 2014 until July 2019, when he was seen by a prison GP who noted he had been "lost to follow up". The clinical reviewer said that this was unacceptable and was not in line with the NICE guidelines under which Mr Housley should have been having his HbA1c monitored 3-6 monthly.
63. On several occasions, Mr Housley did not attend healthcare appointments made on his behalf. It is not clear how many of these were related to his diabetes care as there was no follow up and no records that a senior member of the healthcare team spoke to him about the importance of attending. He did not attend his retinal screening appointments and, again, there are no records to suggest that healthcare staff spoke to Mr Housley and told him that he could lose his sight if he was not screened.
64. We make the following recommendations:

The Head of Healthcare should ensure that there is a multi-disciplinary team approach to diabetes management and that all diabetic prisoners have their HbA1c blood levels tested at least every six months, in accordance with NICE guidelines.

The Head of Healthcare should ensure that all prisoners with long-term conditions are seen at least yearly for a follow up review and that a recall system is fully implemented and recorded in the appropriate section of SystemOne.

The Head of Healthcare should ensure that prisoners who regularly do not attend appointments are spoken to by a senior member of healthcare staff about the health implications of non-attendance and that this is documented in their SystemOne records.

Mr Housley's healthcare in January 2020

65. On 2 January, Nurse A recorded that he could not check Mr Housley's blood sugar level as the equipment was not working. The clinical reviewer considered that this was poor practice as Mr Housley was a diabetic who had been unwell and vomiting for three days with minimal food and drink. He considered that the nurse should have obtained another monitor and checked Mr Housley's blood sugar.
66. When Mr Housley was referred to a GP for review on 2 January, a GP was provided with the wrong blood sugar level reading. The clinical reviewer found that the correct reading indicated that Mr Housley's blood sugar levels was raised and that he was showing signs of diabetic ketoacidosis. The GP did consider that Mr Housley should be reviewed by the hospital but, due to staff shortages, there were no prison escorts available to take Mr Housley to hospital. The clinical reviewer considers that between 1 and 7 January, this was one of many missed opportunities to have Mr Housley seen by hospital doctors.
67. The GP saw Mr Housley later that day. He did not feel that he needed to be seen by hospital staff at that point. The clinical reviewer considers that this was another missed opportunity to send Mr Housley to hospital for review. The clinical reviewer was also concerned that there is no evidence that healthcare staff provided follow up care to Mr Housley the following day, despite how unwell he was.
68. The clinical reviewer was also concerned that, when Dr A saw Mr Housley on 6 January, he did not check his blood sugar, take a full set of observations, use the NEWS2 tool, or review his previous history. The clinical reviewer considered that this was poor practice given how unwell Mr Housley was.
69. The clinical reviewer also found that healthcare staff failed to use the NEWS2 on a number of occasions when assessing Mr Housley's condition. He said this would have been good practice and would have indicated the monitoring/escalation that was needed to manage Mr Housley's rapidly deteriorating in health.
70. We make the following recommendations:

The Head of Healthcare should ensure that when a prisoner is unwell on the wing there is consistent follow up and communication between members of the multi-disciplinary team.

The Head of Healthcare should ensure that staff use the NEWS2 assessment tool and follow the recommended clinical escalation procedures.

The Head of Healthcare should share this report with Nurse A and Dr A and discuss the Ombudsman's findings with them.

71. The clinical reviewer has made number of other recommendations about Mr Housley's healthcare which we do not repeat in this report but which the Head of Healthcare will need to address urgently.

Restraints, security and escorts

72. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public, but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility.
73. On his final admission to hospital on 7 January, Mr Housley was accompanied by two prison officers and was restrained using an escort chain. Although the escort risk assessment was reviewed and the chain was removed soon after Mr Housley arrived at the hospital, we do not consider that restraints were appropriate. Mr Housley was very ill and bedbound by this time and, even under normal circumstances, he was a frail elderly man who had great difficulty walking and used a wheelchair. We recommend:

The Director should ensure that staff are aware of the legal requirements to take account of a prisoner's current state of health and mobility when making escort risk assessments.

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