

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

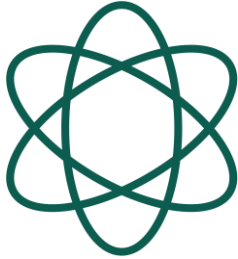
# **Independent investigation into the death of Mr Eamonn Doyle, a prisoner at HMP Rye Hill, on 25 July 2022**

**A report by the Prisons and Probation Ombudsman**



## 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

**OGI**

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## 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 Eamonn Doyle died in hospital of cancer on 25 July 2022, while a prisoner at HMP Rye Hill. He was 69 years old. We offer our condolences to Mr Doyle's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Doyle received at Rye Hill was equivalent to that which he could have expected to receive in the community. However, she was concerned that when a nurse examined Mr Doyle after a fall in his cell on 21 February, she did not fully explore his head injury. The clinical reviewer found that nurses assessed head injuries inconsistently.
5. We found no non-clinical issues of concern.

## Recommendations

- The Head of Healthcare should ensure that all staff have undertaken head injury training and can carry out a full assessment ensuring the mechanism of injury, neurological assessment, Glasgow Coma Scale and National Early Warning Score (NEWS2) are documented clearly.
- The Head of Healthcare should ensure that staff document clinical presentation/findings following a head injury in a concise manner.

## The Investigation Process

6. NHS England commissioned an independent clinical reviewer, to review Mr Doyle's clinical care at Rye Hill.
7. The PPO investigator investigated the non-clinical issues relating to Mr Doyle's care, including Mr Doyle's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. The PPO family liaison officer wrote to Mr Doyle's next of kin, his partner, to explain the investigation and to ask if she had any matters they wanted us to consider. She did not respond to our letter.
9. We shared our initial report with HM Prison and Probation Service (HMPPS). They found a factual inaccuracy relating to the number of previous deaths at HMP Rye Hill. This has been corrected in the final report. They provided an action plan which is annexed to this report.

### Previous deaths at HMP Rye Hill

10. Mr Doyle was the 11th prisoner to die at Rye Hill since July 2020. All previous deaths were from natural causes. There are no similarities between our findings in the investigation into Mr Doyle's death and our investigation findings for the previous deaths.

## Key Events

11. On 22 October 2018, Mr Eamonn Doyle was sentenced to 24 years imprisonment for sexual offences.
12. On 23 July 2020, Mr Doyle was moved to HMP Rye Hill.
13. On 30 January 2022, a nurse saw Mr Doyle, after he told staff he had been experiencing sickness, diarrhoea and dizzy spells. The nurse took his clinical observations, all of which were within a normal range. She arranged an appointment for him with the prison GP.
14. On 1 February, a prison GP saw Mr Doyle. The GP prescribed him medication for vertigo (a condition causing sickness and dizziness).
15. Over the next two weeks, Mr Doyle continued to feel unwell and was seen by healthcare staff on several occasions. They encouraged him to take his vertigo medication.
16. On 20 February, Mr Doyle fell outside his cell. A nurse attended, who reported no injuries or immediate concerns.
17. The following day, a nurse saw Mr Doyle after he fell in his cell. She completed observations and recorded injuries to his head. There was no record that the nurse considered whether Mr Doyle had lost consciousness because of his fall.
18. On 22 February, a nurse saw Mr Doyle. He said he was short of breath, struggling to walk and had had a headache since his fall the previous day. The nurse completed observations and recorded a high blood pressure. She requested an ambulance and Mr Doyle was taken to hospital, where a scan showed that he had a pocket of blood at the back of his head. He was admitted and a hospital consultant requested further scans.
19. On 27 February, a prison nurse rang the hospital for an update. She was told Mr Doyle had a bleed on the surface of the brain and further tests were required to identify the cause. He was discharged on 3 March while awaiting the results.
20. On 11 April, a prison GP told Mr Doyle he had oesophageal cancer which had spread to his brain. The GP told Mr Doyle that his cancer was unlikely to be cured.
21. In the early hours of 10 June, a prison officer called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). Paramedics attended the prison to assess Mr Doyle and considered Mr Doyle did not need to be taken to hospital.
22. Later that morning, a nurse examined Mr Doyle after prison officers found him on the floor of his cell. The nurse requested an ambulance and Mr Doyle was taken to hospital.
23. Mr Doyle's condition continued to deteriorate and he did not return to Rye Hill. On 25 July at 4.00am, Mr Doyle died in hospital.

## **Cause of death**

24. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Doyle's cause of death as metastatic (spreading) oesophageal cancer. The doctor also found that type two diabetes, hypertension (high blood pressure) and ischaemic heart disease were contributing factors in his death.
25. At an inquest hearing on 28 April 2023, the coroner concluded that Mr Doyle died from natural causes.

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**June 2023**

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