

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

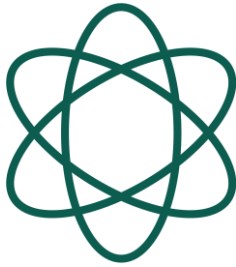
# **Independent investigation into the death of Mr Mohammed Miah, a prisoner at HMP Rye Hill, on 27 April 2020**

**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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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.

If my office is to best assist HM Prisons and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Mohammed Miah died in hospital on 27 April 2020, while a prisoner at HMP Rye Hill. The cause of his death was COVID-19. He also had underlying diabetes. Mr Miah was 40 years old. I offer my condolences to his family and friends.

Mr Miah's clinical care was not equivalent to that he could have expected in the community. I acknowledge that these were extremely challenging times for prison managers and staff, who were dealing with frequently changing circumstances and instructions. However, I am concerned that Rye Hill did not comply with some of the fundamental elements of the national guidance on managing prisoners, such as shielding and protecting Mr Miah (who was at high risk of contracting COVID-19).

A previous investigation at Rye Hill found that healthcare staff did not use a key clinical assessment tool. This tool was used when Mr Miah became unwell, but I am concerned staff did not follow the escalation procedures when the score indicated that he required urgent review and frequent monitoring.

I am also concerned that staff did not initially remove Mr Miah's restraints when he was admitted to the intensive care unit. The inappropriate use of restraints at Rye Hill is a matter that this office has previously raised with both the Director and the Head of Operational Contracts at HM Prison and Probation Service.

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

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**July 2023**

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# Summary

## Events

1. Mr Mohammed Miah had been in prison since 10 October 2011 and moved to HMP Rye Hill on 5 March 2015.
2. Mr Miah had congenital scoliosis which caused pain and mobility problems. In September 2018, he was diagnosed with diabetes. In 2019 and 2020, he had several steroid injections, which suppress the body's immune system.
3. On 18 April, Mr Miah reported symptoms of joint pain and a high temperature. A healthcare assistant reviewed him, using the National Early Warning Score 2 (NEWS2) assessment tool, which scored him as medium risk and he was isolated in his cell.
4. On 19 April, Mr Miah developed breathing difficulties. He was taken to hospital, escorted by two prison officers in full PPE, using an escort chain. On 21 April, he was admitted to the intensive care unit and the diagnosis of COVID-19 was confirmed on that day. The restraints were removed just before Mr Miah was placed in an induced coma on 22 April.
5. The hospital decided to withdraw Mr Miah's life support on 27 April, and he died that day.

## Findings

6. The clinical reviewer identified several weaknesses in the management of Mr Miah's long-term health conditions and his vulnerability to COVID-19. He concluded that Mr Miah's clinical care was not equivalent to that he could have expected to receive in the community.
7. The investigation found that despite Mr Miah's clinical vulnerability and high risk of infection, he was not shielded to reduce his risk of contracting COVID-19.
8. Healthcare staff did not adhere to the escalation process when Mr Miah's NEWS2 score indicated that he required an urgent review by a senior clinician and hourly monitoring.
9. There is a requirement to review security risk assessments when circumstances change. There was no such review and Mr Miah remained in restraints when he was first admitted to the intensive care unit on 20 April. The escort chain was removed just before he was sedated on 22 April. We have expressed concern about the inappropriate use of restraints at Rye Hill in previous investigations.

## Recommendations

- The Director and Head of Healthcare should ensure that prisoners who are either at high risk of contracting COVID-19, or of developing complications if they contract it, are managed in line with national guidance.

- The Head of Healthcare should ensure that staff follow the recommended clinical escalation procedures when using the NEWS2 assessment tool.
- The Director should ensure that all staff understand the legal requirement to take account of the prisoner's health and mobility when completing and authorising escort risk assessments and review the use of restraints when circumstances change.
- The Prison Group Director for Privately Managed Prisons should write to the Ombudsman setting out what action he is taking to ensure that restraints are not used inappropriately at Rye Hill.

## The Investigation Process

10. Notices were issued to staff and prisoners at HMP Rye Hill informing them of the investigation and asking anyone with relevant information to contact the investigator. No one responded.
11. The investigator obtained copies of relevant extracts from Mr Miah's prison and medical records. She investigated non-clinical issues, including aspects of the prison's response to COVID-19 and shielding prisoners; Mr Miah's location; the security arrangements for his admission to hospital; liaison with his family; and whether early release was considered.
12. NHS England commissioned an independent clinical reviewer to review Mr Miah's clinical care at the prison.
13. We informed HM Coroner for Northamptonshire of the investigation. She gave us the cause of death. We have sent the coroner a copy of this report.
14. The PPO family liaison officer wrote to Mr Miah's next of kin, his sister, to explain the investigation and ask if she had any matters for the investigation to consider. Mr Miah's sister did not reply.
15. The initial report was shared with HM Prison and Probation Service (HMPPS), who reported factual inaccuracies. They also identified that a significant entry about another prisoner had been written in Mr Miah's medical record by mistake and that this had caused errors in the PPO report. The inaccuracies have been amended. HMPPS accepted our recommendations.

## **Background Information**

### **HMP Rye Hill**

16. HMP Rye Hill is managed by G4S and holds over 600 men convicted of sex offences. G4S Health provides primary, physical and mental health services. There are no inpatient facilities.

### **HM Inspectorate of Prisons**

17. The most recent full 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 primary care. The management of prisoners with long-term conditions was reasonable, but the service was still developing.
18. HM Chief Inspector of Prisons issued a report in June 2020, following a short scrutiny visit to Rye Hill during the COVID-19 pandemic. Inspectors found that Rye Hill had health and safety protocols in place, but it had been difficult to maintain social distancing because of the physical layout of the prison and sometimes a lack of care. Prisoners had access to healthcare through the in-cell telephone and urgent appointments were available following triage. Staff had identified prisoners most at risk who needed to be shielded. The Chief Inspector identified positive practice, including innovative use of the information channel on the in-cell television to keep prisoners informed and occupied.

### **Independent Monitoring Board**

19. 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 2020, the IMB reported that health provision had been a concern for several years, but had improved, with stable staffing and better access to clinics and the GP.

### **Previous deaths at HMP Rye Hill**

20. Mr Miah was the 12th prisoner to die at Rye Hill since January 2018. There has since been a further death. All the deaths were due to natural causes. We have previously raised the issues of use of the NEWS2 assessment tool and the use of restraints.
21. There have been no other COVID-19 related deaths.

### **COVID-19 (coronavirus)**

22. COVID-19 is an infectious disease that affects the lungs and airways. It is mainly spread through droplets when an infected person coughs or sneezes. The first reported case of COVID-19 in the UK was in February 2020. On 11 March, the World Health Organisation (WHO) declared COVID-19 as a worldwide pandemic.

23. COVID-19 can make anyone seriously ill, but the risk is higher for some people. There are two levels of higher risk: high-risk (clinically extremely vulnerable); and moderate risk (clinically vulnerable). People at high risk include those who have had an organ transplant; have a severe lung condition; are having certain types of treatment for cancer; or have a condition with a very high risk of getting infections. Those at moderate risk include people over 70; people with a lung condition or a chronic medical condition, such as diabetes, heart, liver, or chronic kidney disease; or those who are very obese (this list is not exhaustive).
24. To reduce the spread of the virus, the Government introduced voluntary and mandatory actions, such as 'social distancing' and 'lockdown' (on 16 and 23 March, respectively). Public Health England (PHE), HM Prison & Probation Service (HMPPS) and NHS England worked together to devise measures to contain the outbreak, achieve social distancing, reduce the risk to the most vulnerable in prisons in England and protect the NHS (by reducing the number of people requiring specialist care in community-based hospitals).
25. On 13 March, PHE's National Health and Justice team issued an interim notice providing advice on preventing and controlling outbreaks of COVID-19 in prisons. HMPPS issued further instructions over the following weeks with guidance on the appropriate use of personal protective equipment (PPE), hygiene, cleaning schedules and stock checks. The guidance set out the importance of effective preventative measures and that methodical cleaning would help prevent infection spread.
26. On 24 March, HMPPS issued an instruction, in line with Government advice, to all prisons to introduce social distancing and to implement a restricted regime and supported enforcement of social distancing of two metres for staff and prisoners wherever possible. The most vulnerable prisoners were identified and put into protective isolation.
27. From 31 March, HMPPS put in place further measures to contain COVID-19, including reducing transfers between prisons and 'compartmentalisation'. These measures were designed to be implemented at local level, depending on the needs of each individual establishment, and included:
  - Protective Isolation Units (PIUs): to accommodate known or probable COVID-19 cases, ideally in single-cell accommodation.
  - Shielding Units (SUs): to protect the most vulnerable identified through collaboration with NHS England, with enhanced levels of bio-security including dedicated staff.
  - Reverse Cohorting Units (RCUs): to accommodate new receptions or transfers in for a period of 14 days to detect any emergent infectious cases before entering general population. These units could also accommodate anyone returning from hospital.

## Key Events

28. Mr Mohammed Miah was remanded to prison on 10 October 2011. He was later convicted of sexual offences and sentenced to Imprisonment for Public Protection, with a minimum period to serve of nine and a half years.
29. Mr Miah had been at HMP Rye Hill since 5 March 2015. He was morbidly obese and had congenital scoliosis, a curvature of the spine, which caused pain and mobility problems. In September 2018, Mr Miah was diagnosed with diabetes. In 2019 and 2020, he had several steroid injections, which reduce the effect of the body's immune system (and so placed him at high risk of contracting infections).
30. On 18 April 2020, a healthcare professional (paramedic) reviewed Mr Miah. His symptoms were joint pain and a high temperature, but no cough. The paramedic used the National Early Warning Score 2 (NEWS2), a tool to detect acute illness and deterioration. The NEWS2 score was 5, which indicated medium risk. Suspected COVID-19 was again noted, and Mr Miah was given paracetamol and isolated on the advice of the prison GP. The wing observation book stated that staff should wear full PPE when dealing with Mr Miah.
31. On 19 April, Mr Miah's condition worsened. He had breathing difficulties, with increasing shortness of breath and needed oxygen. An ambulance was called, and he was taken to University Hospital Coventry. Mr Miah was escorted by two officers in full PPE, using an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). Healthcare staff kept in touch with the hospital.
32. At 2.00pm on 21 April, Mr Miah was moved to the intensive care unit. The hospital was concerned about the escort officers remaining in an infectious area, so they were trained and fitted with FFP3 masks and wore full PPE. (They later moved to reception, where they could observe Mr Miah safely.)
33. The diagnosis of COVID-19 was confirmed on 21 April. Mr Miah's condition worsened overnight, and, in the early hours of 22 April, he was intubated and placed in an induced coma. A prison manager authorised removal of the restraints just before this took place.
34. Prison managers sought advice about early release on compassionate grounds, but Mr Miah did not meet the criteria for this to be formally considered.
35. On 27 April, the hospital withdrew Mr Miah's life support and he died at 1.22pm.

## Contact with Mr Miah's family

36. The prison appointed a family liaison officer on 21 April. She tried to contact Mr Miah's next of kin, his sister, several times that day and evening, but there was no response on the landline number. Mr Miah's brother provided a telephone number the next day.
37. The family liaison officer informed Mr Miah's sister of his condition and remained in close contact while he was in hospital. Family members were able to speak to Mr

Miah by telephone. The family liaison officer continued to provide support after his death.

38. Mr Miah's funeral was held on 29 April, and he was buried the next day. In line with national policy, the prison contributed to the funeral expenses. The prison also sent flowers, as the pandemic had prevented staff from attending the funeral.

### **Support for prisoners and staff**

39. After Mr Miah's death, a prison manager debriefed and offered support to the escort staff. The prison posted notices informing staff and other prisoners of his death and offering support.

### **Cause of death**

40. There was no post-mortem examination as the coroner accepted the cause of death certified by the hospital. The cause of death was given as COVID-19. Mr Miah also had underlying type 2 diabetes, which did not cause but contributed to his death.

# Findings

## Clinical findings

41. The clinical reviewer concluded that Mr Miah's clinical care was not equivalent to that he could have expected to receive in the community. He found several shortcomings, which the Head of Healthcare will need to address. Those relating to Mr Miah's death are outlined below.

### ***Management of Mr Miah's risk of infection from COVID-19***

42. It was initially impractical to create a designated isolation unit at Rye Hill, due to population pressures. Symptomatic prisoners and those suspected of contracting COVID-19 were, therefore, isolated in their cells. The prison provided detailed guidance to wing staff on protecting themselves and prisoners while providing meals and performing welfare checks.
43. Mr Miah was at high risk of COVID-19 due to his underlying medical conditions. This included increased vulnerability to infections due to immunosuppression following steroid injections, the last one given on 2 March. However, he was not shielded, as he should have been at that time. (The national guidance on shielding has since changed.) He was isolated on 18 April, after he appeared to be unwell. We make the following recommendation:

**The Director and Head of Healthcare should ensure that prisoners who are either at high risk of contracting COVID-19, or of developing complications if they contract it, are managed in line with national guidance.**

44. The clinical reviewer noted that the NEWS2 score of 5 on 19 April should have led to hourly monitoring and an urgent review by a senior healthcare professional. There is no evidence that this was done. We make the following recommendation:

**The Head of Healthcare should ensure that staff follow the recommended clinical escalation procedures when using the NEWS2 assessment tool.**

## Restraints, security and escorts

45. 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, considering factors such as the prisoner's health and mobility. This should be kept under review as circumstances change.
46. When Mr Miah was taken to hospital on 19 April, his health conditions included morbid obesity, as well as orthopaedic back and knee problems which impaired his mobility. He wore an orthopaedic brace and had received a series of steroid injections in his knee. He had been referred to the disability officer and the Occupational Therapy Service to be assessed for a walking aid. The security risk

assessment concluded that Mr Miah was medium risk and noted no behavioural concerns.

47. An escort chain was authorised. This was temporarily removed in hospital for treatment and to protect the escort staff when Mr Miah was moved to a ward for COVID-19 patients. However, the Director instructed the officers to reapply the restraints on the grounds that Mr Miah was mobile, and they were not permanently removed until he was placed in a medically induced coma on 22 April.
48. We acknowledge that the prison initially took a holistic approach to Mr Miah's circumstances and considered his breathing difficulties in determining the level of restraints. However, we are concerned that it was considered appropriate to continue using restraints, particularly without a formal review, when his condition was so severe as to warrant treatment in the intensive care unit. Admission to such a unit is an indication that a person is acutely ill with a life-threatening condition and high dependency needs. Although initially mobile when he went into hospital, by that stage, it is unlikely that Mr Miah would have had either the will or the strength to escape while escorted by two officers.
49. We have expressed concerns about the inappropriate use of restraints at Rye Hill in previous investigations.
50. We make the following recommendations:

**The Director should ensure that all staff understand the legal requirement to take account of the prisoner's health and mobility when completing and authorising escort risk assessments and review the use of restraints when circumstances change.**

**The Prison Group Director for Privately Managed Prisons should write to the Ombudsman setting out what action he is taking to ensure that restraints are not used inappropriately at Rye Hill.**

## **Inquest**

51. The inquest, heard on 23 April 2021, concluded that Mr Miah died from natural causes.

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