

**Prisons &
Probation**

Ombudsman
Independent Investigations

**Independent investigation into
the death of Mr Raymon Coburn,
a prisoner at HMP Rye Hill,
on 25 November 2022**

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

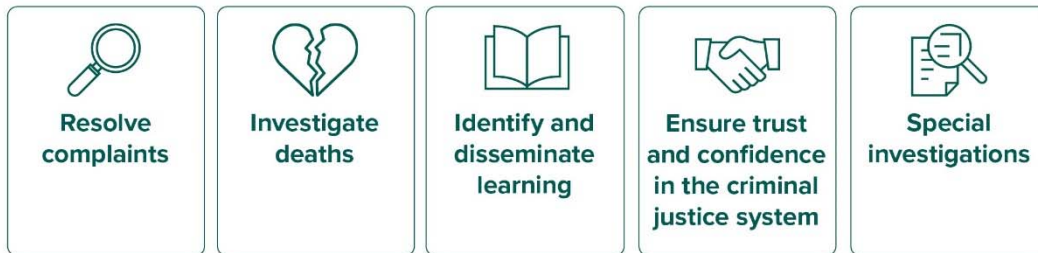
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



© Crown copyright, 2024

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 Raymon Coburn died in hospital on 25 November 2022 from rectal cancer, which had spread to other parts of his body, while a prisoner at HMP Rye Hill. He was 77 years old. We offer our condolences to his family and friends.
4. The clinical reviewer concluded that the clinical care that Mr Coburn received at Rye Hill was of a good standard and equivalent to that which he could have expected to receive in the community.
5. On 5 April, Mr Coburn should have had a telephone appointment with a consultant gastroenterologist under the NHS suspected cancer pathway. Prison staff took Mr Coburn back to his cell before the appointment took place. In the absence of evidence, we have been unable to establish why this happened. The missed appointment might have slightly delayed Mr Coburn's cancer diagnosis as he did not have a CT scan until 21 April.
6. We found that Mr Coburn was inappropriately restrained when he went to hospital for outpatient appointments on four occasions between March and June 2022, and again in October, when he was admitted to hospital a month before he died.

Recommendations

- The Director and Head of Healthcare should ensure that prisoners attend hospital telephone appointments under the NHS suspected cancer pathway.
- The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk he presents at the time.
- The Executive Director for Custodial Contracts should write to the Ombudsman within four weeks of receipt of this report to explain what has been done to address Rye Hill's continuing failure to comply with case law on the use of restraints.

The Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Coburn's clinical care at Rye Hill.
8. The PPO investigator investigated the non-clinical issues relating to Mr Coburn's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
9. The PPO family liaison officer wrote to Mr Coburn's son to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond.
10. We shared the initial report with the Prison Service. There were no factual inaccuracies.

Previous deaths at HMP Rye Hill

10. In the two years before Mr Coburn's death, eleven prisoners died at Rye Hill from natural causes, three of whom died as a result of COVID-19. Two prisoners have died from natural causes at Rye Hill since Mr Coburn's death.
11. Following the death of a prisoner at Rye Hill in December 2020 and of another prisoner in August 2021, the Director and Head of Healthcare agreed to implement training on the completion of escort risk assessment, including on taking into account the requirements of the *Graham* judgment. We were told that all risk assessments would include the principles of the judgment to help ensure that the decision-making process on the use of restraints was appropriate.

Key Events

12. On 23 January 2015, Mr Raymon Coburn was sentenced to 25 years in prison for sex offences. On 19 August 2016, he was transferred to HMP Rye Hill.
13. Mr Coburn had type 1 diabetes which caused him to have poor mobility.
14. On 10 January 2022, Mr Coburn told a nurse that he had had acid reflux for two weeks. A prison GP saw Mr Coburn and prescribed him an antacid.
15. On 19 January, a nurse saw Mr Coburn and found that he had a swollen abdomen and a hard lump in his upper abdomen. Blood tests showed that Mr Coburn had low haemoglobin levels (which can result in anaemia). The next day, a prison GP saw Mr Coburn and arranged for him to have an ultrasound scan. On 16 March, Mr Coburn went to hospital for the scan.
16. Before Mr Coburn left for hospital, prison staff completed an escort risk assessment. Healthcare staff completed the medical section and did not object to the use of restraints. An officer noted that Mr Coburn was a Category B prisoner who posed a medium risk of escape and a medium risk to prison staff and hospital staff. The Head of Residence noted that there was no known medical reason why the level of restraint should be lowered and authorised that he should be double cuffed. (Double cuffing is when the prisoner's hands are handcuffed in front of them, and one wrist is attached to a prison officer by an additional set of handcuffs.) When he went to hospital, prison staff restrained him with a double cuff.
17. On 17 March, a prison GP reviewed the ultrasound report and referred Mr Coburn to see a gastroenterology consultant under the NHS suspected cancer pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks.
18. On 5 April, Mr Coburn had a telephone appointment with a consultant gastroenterologist. After the appointment, the consultant wrote to the prison healthcare team and said that 'she was unable to obtain details of Mr Coburn at the time of his arranged appointment and that Mr Coburn was taken back to his cell'. She offered to speak to Mr Coburn later that morning but noted that the prison was not able to facilitate this.
19. On 7 April, the Head of Healthcare placed Mr Coburn on the palliative care register.
20. On 12 April, a nurse telephoned a gastroenterologist, who asked for Mr Coburn to have a CT scan and blood tests. On 21 April, Mr Coburn went to hospital for a CT scan.
21. On 7 May, the gastroenterologist wrote to prison healthcare staff and told them that Mr Coburn had upper rectal cancer which had spread to the lymph nodes in the rectum and liver. He said that Mr Coburn should have a sigmoidoscopy (an examination of the large intestine) and that he would be referred to the colorectal and oncology teams. On 19 May, Mr Coburn went to hospital for a sigmoidoscopy, but the examination did not take place because Mr Coburn had not taken bowel preparation medication before he left prison. The Head of Healthcare said that the Pharmacy team had not supplied it. He said that he had now put in place a process

to ensure that healthcare staff were aware that prisoners requiring bowel assessment needed to be given bowel preparation medication the previous day. The appointment was rearranged for 30 May, but Mr Coburn refused to attend and said that he did not want any more tests.

22. On 8 June, Mr Coburn attended hospital, where he saw a colorectal consultant surgeon. He accepted that he would not benefit from chemotherapy. When Mr Coburn went to hospital, he was double cuffed.
23. On 21 June, the healthcare team held a multidisciplinary team meeting to discuss Mr Coburn's palliative care requirements. After the meeting, a nurse completed a palliative care plan.
24. On 25 October, a nurse sent Mr Coburn to hospital for an ascites tap (a procedure to drain fluid trapped in an internal body cavity, most commonly the abdomen).
25. Before Mr Coburn went to hospital, prison staff completed an escort risk assessment. The nurse did not object to the use of restraints but noted that Mr Coburn was not fully mobile. A security manager noted that he was a Category B prisoner who used a wheelchair which made escape difficult. She authorised that he should be restrained with 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). Mr Coburn went to hospital, restrained with an escort chain. The next day, the Head of Expansion noted that Mr Coburn was medically unwell and frail, was a wheelchair user and found transferring to the bed difficult. She noted that the likelihood of Mr Coburn evading staff was very low and authorised that the restraint should be removed.
26. Mr Coburn stayed in hospital, where he died on 25 November.
27. There was no post-mortem examination. A hospital doctor said that Mr Coburn died of metastatic rectal carcinoma (rectal cancer which had spread to other parts of the body).

Inquest

28. At the inquest into Mr Coburn's death on 14 February 2024, the Coroner concluded that Mr Coburn died from natural causes.

Findings

Clinical care

29. The clinical reviewer concluded that the clinical care that Mr Coburn received at Rye Hill was of a good standard and equivalent to that which he could have expected to receive in the community.
30. However, on 5 April, Mr Coburn should have had a telephone appointment with a consultant gastroenterologist under the NHS suspected cancer pathway. Prison staff took Mr Coburn back to his cell before the appointment took place. In the absence of evidence, we have been unable to establish why the appointment did not take place. The missed appointment might have slightly delayed Mr Coburn's cancer diagnosis as it was not until a prison nurse telephoned the hospital gastroenterologist a week later that an appointment was made for Mr Coburn to have a CT scan on 21 April. We make the following recommendation:

The Director and Head of Healthcare should ensure that prisoners attend hospital telephone appointments under the NHS suspected cancer pathway.

Restraints, security and escorts

31. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when he has a serious medical condition. It said that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.
32. Before Mr Coburn went to hospital for outpatient appointments on 16 March, 21 April, 19 May and 8 June 2022, prison managers authorised that he be double cuffed. During the appointment on 19 May, when Mr Coburn had a sigmoidoscopy appointment, the level of restraint was reduced to an escort chain. On 25 October, when Mr Coburn was admitted to hospital, a prison manager authorised that Mr Coburn should be restrained with an escort chain.
33. While we recognise that a prison manager authorised the next day that the escort chain should be removed, we are concerned that Mr Coburn went to hospital restrained on four occasions and that healthcare staff did not object to the use of restraints, despite his poor mobility, age (he was 77 years old), and poor health. We found no evidence that healthcare staff, prison staff or prison managers took into account these factors when completing Mr Coburn's escort risk assessments.
34. Instead, until October 2022, prison managers defaulted to double cuffing Mr Coburn which appears to have been done on the basis of Mr Coburn being a Category B

prisoner without considering any other factors. It was only when Mr Coburn went to hospital in October, the month before he died, that healthcare staff recorded that he was not fully mobile, and a prison manager downgraded the restraint to an escort chain.

35. We saw no justification for Mr Coburn to be double cuffed when he went to hospital for outpatient appointments between March and June 2022 and no justification for an escort chain to have been used when he went to hospital on 26 October. We are particularly concerned that following our investigations into two earlier deaths, Rye Hill agreed to implement training on the completion of escort risk assessment, including training to ensure staff take into account the requirements of the *Graham* judgment. Although we were told that all risk assessments would include the principles of the judgment to help ensure that decision-making was appropriate, we cannot see that this happened in Mr Coburn's case. We therefore make the following recommendations:

The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk he presents at the time.

The Executive Director for Custodial Contracts should write to the Ombudsman within four weeks of receipt of this report to explain what has been done to address Rye Hill's continuing failure to comply with case law on the use of restraints.

**Caroline Mills
Assistant Ombudsman**

October 2023

**Prisons &
Probation**

Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100