Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Osman Rageh, on 10 December 2022, following his release from HMP Maidstone

A report by the Prisons and Probation Ombudsman

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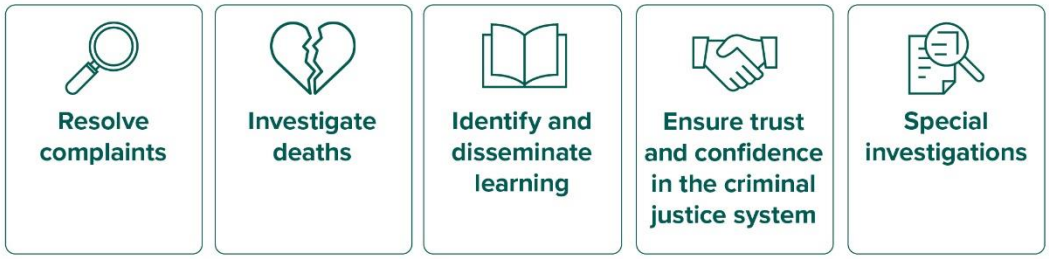
OUR VISION

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

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. From 6 September 2021, the PPO is investigating post-release deaths that occur within 14 days of the prisoner's release.

3. If my office is to best assist HM Prison 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.

4. Mr Osman Rageh died from diabetic ketoacidosis (a potentially life-threatening complication of diabetes caused by a lack of insulin in the body) caused by poorly controlled diabetes mellitus (Type 2 diabetes) on 10 December 2022, following his release from HMP Maidstone on 2 December. He was 34 years old. We offer our condolences to his family and friends.

5. On 19 March 2021, Mr Osman Rageh was remanded to HMP Wandsworth.

6. On 15 April, a GP at Wandsworth saw Mr Rageh and diagnosed cellulitis (a bacterial infection). He asked for blood tests, which indicated that Mr Rageh was at risk of developing diabetes. A second GP at Wandsworth recommended further blood tests per National Institute for Health and Care Excellence (NICE) guidance. The results showed that Mr Rageh was at high risk of developing diabetes.

7. Mr Rageh did not attend several further appointments for blood tests at Wandsworth. He was offered no further advice and guidance on his risk of developing diabetes.

8. There is no evidence of a healthcare release plan for Mr Rageh when he was released into the community from Maidstone on 2 December 2022.

9. On 10 December, Mr Rageh was found in cardiac arrest in the car park of the West Middlesex Hospital. Hospital staff started cardiopulmonary resuscitation (CPR) and transferred him into the hospital. At 12.53pm, they confirmed that Mr Rageh had died.

Recommendations

- The Head of Healthcare at HMP Wandsworth should ensure that prisoners are placed on a recall register when they are identified as being at high risk of developing a long-term health condition.

- The Head of Healthcare at HMP Wandsworth should review the Did Not Attend policy to ensure that prisoners with a high clinical risk are contacted to discuss their non-attendance and to set out the risks of not engaging with healthcare appointments.

- The Head of Healthcare at HMP Maidstone should ensure that there is a release care planning process in place so that prisoners released at short notice receive appropriate discharge care.

The Investigation Process

10. On 15 December 2022, the PPO was notified of Mr Rageh's death.

11. The PPO investigator obtained copies of relevant extracts from Mr Rageh's prison and probation records.

12. NHS England commissioned a clinical reviewer to review Mr Rageh's clinical care in prison.

13. We informed HM Coroner for London West of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report. The Coroner decided not to hold an inquest into Mr Rageh's death.

14. The Ombudsman's family liaison officer wrote to Mr Rageh's wife to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Rageh's wife asked for information about Mr Rageh's clinical care in prison.

15. We shared the initial report with HM Prison and Probation Service. There was one factual inaccuracy.

16. We shared the initial report with Mr Rageh's wife. She did not respond.

Background Information

HMP Maidstone

17. HMP Maidstone is a Category C training prison which holds approximately 579 foreign national male prisoners, many of whom will be deported at the end of their sentences. Oxleas NHS Foundation Trust provides healthcare services. Substance misuse services are provided by Change Grow Live (CGL).

HM Inspectorate of Prisons

18. The most recent inspection of HMP Maidstone was in October 2022. Inspectors reported that the level of support given to prisoners released back into the community was very limited because prison offender managers could not begin planning this process until the Home Office had made a decision about prisoners' immigration status.

HMP Wandsworth

19. HMP Wandsworth is a local Category B prison in London, with a Category C unit. It holds up to 1,452 men in eight residential wings. St George's University Hospital NHS Foundation Trust provides physical healthcare services at the prison. South London and Maudsley NHS Foundation Trust provide mental health and clinical substance misuse services. Change Grow Live (CGL) provide psychosocial services.

HM Inspectorate of Prisons

20. The most recent full inspection of HMP Wandsworth was in September 2021. Inspectors reported that there were staff vacancies in all clinical areas. They found a committed primary care team, well led by senior staff who provided a 24-hour service.

21. In June 2022, inspectors carried out an independent review of progress at Wandsworth. They reported that healthcare staffing levels had improved, a recruitment plan was in place and recruitment for most vacancies had been carried out.

Probation Service

22. The Probation Service work with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, as well as prepare reports to advise the Parole Board and have links with local partnerships to whom, where appropriate, they refer people for resettlement services. Post-release, the Probation Service supervises people throughout their licence period and post-sentence supervision.

Key Events

23. On 19 March 2021, Mr Osman Rageh, a Dutch national, was remanded to HMP Wandsworth charged with drug trafficking.

24. On 15 April, a GP at Wandsworth saw Mr Rageh because he had swollen legs. He diagnosed cellulitis (a bacterial infection), asked for blood tests and prescribed antibiotics. On 19 April, another GP reviewed the blood test results and found that Mr Rageh's HbA1c levels (a test that measures the amount of blood sugar attached to the haemoglobin) were above the normal range. This indicated that Mr Rageh was pre-diabetic and at risk of developing diabetes. He recommended a further HbA1c test in eight to twelve weeks as per National Institute for Health and Care Excellence (NICE) guidance for Type 2 diabetes.

25. On 27 April, eight days later, the tests were carried out. We do not know why the test took place just over a week later rather than the recommended eight to twelve weeks.

26. On 4 May, a GP at Wandsworth noted that Mr Rageh's latest HbA1c blood test result was higher and showed that he remained at high risk of developing diabetes.

27. On 6 May, a GP reviewed Mr Rageh, noting that his leg swelling had improved after the course of antibiotics. There is no record that he discussed Mr Rageh's risk of developing diabetes.

28. On 10 May, a GP at Wandsworth tried to telephone Mr Rageh on his in-cell telephone. He noted that the call could not be connected. (On another occasion, a nurse called Mr Rageh on the in-cell phone, but his cellmate said that he did not wish to speak.)

29. A GP discussed Mr Rageh with another GP and noted that the recent blood test results indicated a mildly raised BNP (a blood test for possible heart failure). He requested to repeat the BNP test and complete an electrocardiogram (ECG - a test that can be used to check the heart's rhythm and electrical activity).

30. On 14 May Mr Rageh did not attend a clinic for further blood tests. There is no record of the reason why he did not attend this or later blood test appointments.

31. On 25 May, Mr Rageh had the ECG, which was normal. The BNP blood tests were also within the normal range.

32. On 28 May, Mr Rageh did not attend a clinic for further blood tests. A GP asked for a further HbA1c test.

33. On 11 June, Mr Rageh did not attend a clinic for further blood tests.

34. There is no evidence that Mr Rageh had any further appointments with the healthcare department other than frequently attending appointments with the substance misuse service. There is no evidence of any further communication from healthcare staff regarding diabetes.

35. On 24 May 2022, Mr Rageh was transferred to HMP Wormwood Scrubs.

36. At his initial health screen, a nurse did not record that Mr Rageh had a family history of diabetes or that he was at risk of developing the condition in the future.

37. On 1 July, Mr Rageh was convicted of drug trafficking and sentenced to three years and four months in prison. On 19 July, he was transferred to HMP Brixton, and, on 2 August, he was transferred to HMP Maidstone.

38. At his initial health screen, a nurse noted that Mr Rageh had a family history of diabetes but did not record that he was at increased risk of developing diabetes in the future.

39. On 8 September 2022, Mr Rageh was allocated a community offender manager (COM).

40. On 21 September, a probation officer noted that Mr Rageh was listed for automatic deportation.

41. On 10 November, the COM emailed a pre-discharge report to the Offender Management Unit at Maidstone. She noted that she had assessed Mr Rageh's mother's house as a suitable address for his release.

42. On 18 November, Mr Rageh should have been released on licence, but the Home Office detained him, and he remained at Maidstone.

43. There is no evidence that Mr Rageh was reviewed by healthcare staff before his release (on 2 December) or that they were made aware that he was being released.

Post-release

44. On 2 December, Mr Rageh was released on bail by the Home Office. Following his release, Mr Rageh met the duty probation officer at Richmond probation office, who explained the terms of his licence and carried out his probation induction. Mr Rageh signed his probation contract agreement.

45. On 6 December, Mr Rageh met his COM for a probation appointment. She noted that Mr Rageh was calm and polite but was upset throughout the appointment. Mr Rageh told her that he felt mentally low adjusting to life out of prison and not being able to stay with his son and girlfriend. She arranged to see Mr Rageh on 9 December.

46. At 1.59pm on 9 December, Mr Rageh telephoned his COM. He said that he couldn't stop being sick and needed to go to hospital to get a drip. Mr Rageh said that he had an underlying health condition and had to frequently go to hospital for a drip. (There is no record that Mr Rageh had ever been treated with a drip.) She asked Mr Rageh to provide her with evidence of the health condition. (We do not know if Mr Rageh went to hospital on 9 December.)

Circumstances of Mr Rageh's death

47. At about 12.30pm on 10 December, Mr Rageh was found collapsed in the car park of the West Middlesex Hospital. Mr Rageh was in cardiac arrest and hospital staff

started cardiopulmonary resuscitation (CPR) and took him into the hospital. At 12.53pm, they confirmed that Mr Rageh had died.

Post-mortem report

48. A post-mortem examination established that Mr Rageh died from diabetic ketoacidosis (a potentially life-threatening complication of diabetes caused by a lack of insulin in the body) caused by poorly controlled diabetes mellitus.

Coroner's inquest

49. On 5 May 2023, the Coroner discontinued his investigation, and an inquest was not held.

Support for staff

50. After Mr Rageh's death, the COM's line manager offered support and reminded her of the available support services.

Contact with Mr Rageh's family

51. Police officers told Mr Rageh's wife that he had died.

Findings

52. The clinical reviewer concluded that the clinical care that Mr Rageh received at Wandsworth and the further receiving prisons was not equivalent to that which he could have expected to receive in the community.

53. The clinical reviewer found that Mr Rageh was not aware that he had pre-diabetes during his time in prison, and it is unclear whether he knew this following his release. The clinical reviewer said that it appeared certain that the receiving prisons after Mr Rageh left Wandsworth were not aware that he was at risk of developing diabetes.

54. The GP at Wandsworth, who saw Mr Rageh on 6 May, did not discuss his risk of developing diabetes. The clinical reviewer found that this was a missed opportunity to explain this risk and provide advice.

55. While Mr Rageh did not attend several healthcare appointments at Wandsworth, the clinical reviewer found that more could have been done to inform him of the risk of developing diabetes, to offer him lifestyle advice and plan for future monitoring. Due to his non-attendance, it appears that the ongoing monitoring of this condition was missed.

56. NICE guidelines state that it is important for someone with raised HbA1c blood tests to receive advice on how to reduce the risk of diabetes particularly around changes that can be made to a person's lifestyle (for example, dietary, physical activity factors and smoking). There is no evidence that Mr Rageh received this advice. NICE guidelines also recommend that a register of people at risk of developing diabetes should be created by healthcare providers, which should include an inbuilt recall function to invite a patient for a regular review. For people at high risk, a further blood test should be offered at least once a year with a re-assessment of risk. It appears that this requirement for ongoing monitoring was missed, and this is likely to be the reason it was not handed over to the receiving prison establishments.

57. We make the following recommendations:

    The Head of Healthcare at HMP Wandsworth should ensure that prisoners are placed on a recall register when they are identified as being at high risk of developing a long-term health condition.

    The Head of Healthcare at HMP Wandsworth should review the Did Not Attend policy to ensure that prisoners with a high clinical risk are contacted to discuss their non-attendance and to set out the risks of not engaging with healthcare appointments.

58. At Maidstone, there is a nurse discharge coordinator who plans and implements prisoners' release from the prison from a healthcare perspective. However, this did not happen in Mr Rageh's case, seemingly because his release was decided quickly, and the discharge coordinator was not on shift on that day (Mr Rageh was released on a Saturday). Prison staff planned for Mr Rageh's release on 18 November, but he was not released on this date. The clinical reviewer found that

more could have been done from a healthcare perspective to plan for a quick release date being given.

59. Mr Rageh did receive his discharge medication, but the clinical reviewer found that this was incidental and not part of a discharge plan. Mr Rageh was not referred to a community GP and was not referred to community substance misuse services (Mr Rageh had a history of substance misuse).

60. Given the nature of the population at Maidstone, it is likely that other prisoners will receive similar short-notice releases.

We make the following recommendations:

The Head of Healthcare at HMP Maidstone should ensure that there is a release care planning process in place so that prisoners released at short notice receive appropriate discharge care.

Adrian Usher
Prisons and Probation Ombudsman **January 2024**

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