

**The death of a man at
HMP Rye Hill in August 2004**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

April 2005

This is the report of an investigation into the circumstances of the death of a man at HMP Rye Hill in August 2004. The man's primary cause of death was ischaemic heart disease (disease arising from an inadequate oxygen supply to the heart). The man was serving an eight-year sentence at the time of his death.

The investigation was carried out on my behalf by one of my investigators. A clinical review was carried out by a qualified nurse who also works for my office.

We would like to extend our condolences to the man's family for their loss. We would also like to thank the Director of Rye Hill, and the other members of his staff for their help.

This report commends Healthcare nursing staff for their professional care and treatment of the man and for the compassion with which they delivered that care.

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Prisons and Probation Ombudsman**

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Summary

The man was born in 1931 and was 73 years-old when he died in August 2004 from ischaemic heart disease. At the time of his death, he had served four years of an eight-year sentence. Following his conviction, the man had first gone to HMP Bullingdon, before being transferred to HMP Rye Hill in April 2001.

On arriving at HMP Rye Hill in April 2001, the man had a routine medical examination. The doctor noted that the man's clinical history included: diabetes, a myocardial infarction (heart attack) in 1981, a cardiovascular accident (stroke), and an operation on his carotid artery (the carotid artery is located in the front of the neck and carries blood from the heart to the brain).

Despite his clinical history, the man had no significant health problems over the course of the following two and a half years. Entries in his medical records for this period relate largely to the management of his diabetes and secondary conditions associated with that disease. Several entries in the record suggest that the man was feeling well for much of his time at Rye Hill.

The first documented instance of deterioration in the man's health was an entry in his medical record on 9 December 2003 when he reported that he was spitting blood. His health was consistently poor from that time onwards. The man had several admissions to outside hospital, one stay lasting almost two months, and when back at Rye Hill he spent most of his time in the Healthcare unit.

A clinical review of the man's treatment found that his death was not connected to the fact that he was in prison, or to the level of care that he received there.

This report commends Healthcare nursing staff while making recommendations about record keeping practices and standards.

Investigation Process

My practice in cases of apparent deaths from natural causes is to conduct an initial review to determine the extent of investigation required.

My investigator visited Rye Hill on 18 August 2004 when he visited the Healthcare unit where the man was nursed and where he died. My investigator spoke informally with a number of staff to outline the facts relating to the man's care and his subsequent death. My investigator was given access to all of his prison records, including the medical records.

My investigator also met a member of the Independent Monitoring Board (IMB). The IMB member told my investigator that he had met the man when he was a patient in the prison's Healthcare unit. The man had praised the Healthcare nurses for their care and commitment, adding that the care he received in the Healthcare unit was better than the care he had received in outside hospital. Although the IMB member had no matters of concern to raise with my investigator about the man's care and treatment, he did raise two issues of general concern. The first issue was his view that staff at Rye Hill were generally young and lacking in experience. The second issue was that staffing levels are such that there are sometimes no staff available to accompany prisoners to external hospital appointments, resulting in cancellation of the appointment.

My investigator spoke with a prison chaplain who had visited the man in Healthcare the week before his death. During their conversation the man had once again complimented the Healthcare nurses. Several weeks later, my investigator made a further, unrelated, visit to Rye Hill. On that day, the investigator met a second IMB member who, like others, mentioned the man's praise of Healthcare staff.

The investigator wrote to the man's son and next-of-kin to ask whether he had any concerns about his father's care and treatment. No response has been received to that enquiry.

A trained nurse carried out a clinical review of the man's care and treatment.

No formal interviews with staff were conducted, although my investigator spoke informally to several staff. This report is based upon those discussions and upon a review of relevant paperwork, including the man's clinical records.

HMP Rye Hill

Rye Hill was opened in early 2001 as a purpose built category B training prison. It has a 660-bed capacity, predominantly made up of single cells. Rye Hill is a privately managed prison run by Global Solutions Ltd.

Global Solutions Ltd's stated aims include the creation of a constructive prison regime through the provision of education, work and other programmes to best prepare people for re-integration into mainstream society.

The prison regime is based on a minimum of 35 hours per week purposeful activity including work, training and education (including physical education), and offending behaviour programmes, all of which are linked to a system of earned incentives and privileges.

Healthcare services at Rye Hill are provided by Primecare Forensic Medical, which is a private healthcare provider. The Healthcare unit is staffed 24 hours per day by qualified nurses and healthcare assistants who are supported by visiting specialists, including doctors, dentists and psychiatrists. The Healthcare unit has eight in-patient beds.

The Events Leading up to the Man's Death

The man was received at Rye Hill in April 2001, upon his transfer there from HMP Bullingdon. At initial medical assessment on 21 April 2001, the examining doctor noted that the man's past medical history included a heart attack in 1981, a stroke, diabetes, and a carotid embolectomy (surgical removal of an arterial blood clot). Despite this history, the doctor noted that the man looked reasonably well.

Over the course of the following two and a half years, the man had regular clinical reviews in the prison's Healthcare unit, which included appointments with opticians, dentists and chiropodists. Periodic notes were made in his clinical record that the man was feeling well.

The first indication of a decline in the man's health was noted on 9 December 2003, when an entry was made in his clinical record that he was complaining of a sore throat, cough, and was spitting blood. It was also recorded that he was short of breath on exertion. The man had no further Healthcare consultations that month, however on 13 January 2004 he again visited Healthcare to mention that he observed a speck of blood in his phlegm. One week later, the man returned to Healthcare to report that he was again coughing blood and so sputum samples were taken for testing. On the following day, 21 January, he was referred to outside hospital for tests. The man was admitted to hospital where he was diagnosed with bilateral pulmonary embolism that was treated with Warfarin. The man returned to Rye Hill on 3 February.

The man was referred to hospital again on 7 February when he complained to Healthcare of being short of breath and of feeling severe pain. He remained in hospital for the night of 7 February before returning to Rye Hill. The man had further and longer outside hospital admissions: from 19 February to 3 March; from 14 April to 8 June; and, finally, from 17 June to 21 June.

It is clear from the clinical review that the man's health was deteriorating, and for most of the time during his final months at Rye Hill he was an in-patient in the prison's Healthcare unit. To assist in his care, the prison obtained from the local NHS hospital a specialist pressure-relieving mattress. In an internal prison memo dated 16 July, a Healthcare doctor wrote: *'This man is in extremely poor health. He has long standing diabetes and ischaemic heart disease, both of which conditions are insidiously progressive. He is now in end stage cardiac failure and has chronic renal failure ...'*

On 3 August, an entry was made in the man's clinical record that he had told a Healthcare nurse that he believed he had little time left as his heart was weak. An entry in the clinical record made the following day referred to the man as appearing very frail and not as chatty as usual. No significant entries were made in the man's clinical record during the next few days.

A few days later the head of Healthcare, a trained nurse, arrived at work at 7.30am. She said good morning to the man before attending two health

clinics. The clinics had finished by 10am at which time the head of Healthcare took breakfast to the man. She moved him from bed and on to a wheelchair and they chatted briefly. Another Healthcare nurse checked the man at about 10.50am, at which time he was watching television. A prison officer would also have carried out a check of all prisoners in Healthcare that morning. Just after midday, the head of Healthcare went to the man's room to ask him what he wanted for lunch. She found him slumped in his wheelchair and on examination found that he was dead. She told my investigator that although the man was terminally ill, he was comparatively well that morning and so she was surprised that he then died so suddenly.

After the Man's Death

The Duty Director telephoned the man's son to inform him about his father's death. In the case of deaths through natural causes, Rye Hill's policy is to notify the next-of-kin by telephone and to make that call without delay to avoid the possibility of the next-of-kin hearing the news from other sources. Later on that day the Director at Rye Hill also telephoned the man's son and offered him the opportunity of a meeting.

Level of Compliance

Standards of health care in prison are intended to mirror those available in the outside community. This aspect of the man's care is described in the independent clinical review, which concludes that there appears to be no difference in the care that the man received at Rye Hill than if he had not been in custody. The clinical review commends nursing staff at Rye Hill for their liaison with the outside hospital. It is also evident that the man was highly appreciative of the commitment of the Healthcare nurses, as was independently reported to my investigator by two IMB members and a prison chaplain.

The post-incident response was fully compliant with Prison Service instructions on managing a death in custody.

Findings and Conclusions

The man was approaching his 70th birthday when he first arrived at Rye Hill in April 2001. His past medical history included a heart attack, a stroke, and surgery for removal of an arterial blood clot. Despite this history, the man's clinical records over the following two and a half years contain reference only to the ongoing monitoring of his health with no concerns being noted.

The first significant event occurred in December 2003 when the man reported a sore throat and that he was spitting blood. From that time onwards, his clinical records show that the man was becoming more and more unwell. Over the course of the following eight months, the man was referred to outside hospital on six different occasions – on one occasion he went out and came back on the same day, otherwise he remained in outside hospital for periods of time ranging from two days to almost two months. While back at Rye Hill, the man mainly stayed in Healthcare and he praised the Healthcare nurses when speaking to IMB members and a prison chaplain.

On 16 July, a Healthcare doctor described the man as being in end stage cardiac failure, and he died in the late morning in August. He was seen by nursing staff several times that morning – the last time just before 11am – but there had been nothing about his condition to cause staff any concern. However, when the head of Healthcare went to see the man just after midday, she found that he had died.

The clinical review found that the man was well cared for in Rye Hill with the health care he received there being probably at least as good as it would have been outside in the community.

However, my reviewer has commented in her clinical report on a number of areas where record keeping might have been improved. She advised that best practice would be achieved by keeping distinct nursing records, medical records, and records relating to the management of chronic diseases. She has also identified that the man's nursing notes report that he suffered three falls during the last month of his life, but there was only one accident report for a fall in his records. These areas form the recommendations of this report.

Good Practice

In her review of the man's clinical care my reviewer commended the good daily liaison between the prison's Healthcare nursing staff and the local hospital during his admissions to outside hospital. This liaison, she believed, was commendable both for, and of its self, and for the high standard of contemporaneous entries in the man's records. I also note a reference to two instances when Healthcare staff ensured that the man's discharge from outside hospital occurred only once sufficient preparation had been made for his safe management back at Rye Hill.

My reviewer also commended the involvement of local district nurses in the man's care.

I am happy to endorse all of these commendations. I also wish to add my own commendation of the Healthcare nurses who obviously treated the man with care and compassion during what were clearly recognised to be the final months of his life.

Recommendations

The clinical review found that the man received appropriate care and treatment while at Rye Hill, it also identified areas where record keeping could be improved. My recommendations, deriving from the clinical review, are as follows:

Local Recommendation: 1. A clear distinction between nursing records and the continuous medical record should be consistently maintained.

Local Recommendation: 2. The Healthcare unit should consider the creation within the clinical record of separate sections for chronic disease management.

Local Recommendation: 3. The system for reporting and following up accidents, including falls, should be reviewed in accordance with health and safety regulations.