

**Investigation in the circumstances surrounding the death of
a man at St Cross Hospital, Rugby, on 11 September 2004
while a serving prisoner at HMP Rye Hill**

Prisons and Probation Ombudsman for England and Wales

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This is a report into the death of a prisoner at HMP Rye Hill. On 11 September 2004, the man was found in his cell, struggling to breathe. He was rushed to St Cross Hospital for emergency treatment, but died later that night. The subsequent post-mortem examination established that the cause of death was an overdose of heroin. There was evidence that the drug had been taken intravenously.

I offer my sincere condolences to the man's family and friends for their loss.

I should also like to thank the Director, staff and prisoners of HMP Rye Hill, the Coroner and the local police for the co-operation throughout the investigation.

This report covers the man's time in prison prior to his death, the events on the day that he died and the actions of all the people involved in the incident. I understand the police investigation found that illegal drugs were readily available in the prison but concluded that there were no other unusual or suspicious circumstances surrounding the death.

A significant part of the investigation was devoted to a clinical review of the man's treatment and care.

The investigation was conducted on my behalf by one of my call-off contractors. However, I personally visited Rye Hill at the start of the investigation, spoke with the then Director and chair of the Independent Monitoring Board, and formed my own impressions, some of which are reflected in this report. In particular, I was struck by the inexperience of many staff, the level of staff turnover, and the consequences for good order and safety.

The man at the centre of this report died as a result of taking heroin. He was not the first, and will not be the last, prisoner to lose his life because of drug-taking. Nor is Rye Hill unique as a prison with a drugs problem. However, the current Director will need to look closely at the way drugs are entering the establishment and more generally at the experience, confidence and competence of his staff.

Although one cannot be certain, there are indications in this report that staff may have been 'conditioned' by prisoners with the consequence that the cause of the man's drowsiness and failure to respond was not identified earlier.

This report was first submitted in July 2005. This published version is identical save for the anonymisation of the main parties and some very minor changes to improve the clarity of the text.

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Summary

The man who died was 35 years old. He was serving an 11-year sentence for armed robbery. He arrived at Rye Hill prison on 22 June 2004. He had a history of asthma but this was not troubling him significantly and he was considered to be healthy, well-behaved and friendly and gave no cause for concern. Although he had a former history of drug-taking there was no indication that he had been using drugs whilst in prison.

On Saturday 11 September 2004, the man did not attend as required for work in the kitchen. Officers went to his cell several times during the day to speak to him but he did not wake up properly. However, he did make noises which suggested that he was aware that he had been spoken to and staff assumed he was simply having a weekend lie-in, as is normal for many prisoners. He did not attend for breakfast or lunch.

At about 2.00pm, two prisoners went to his cell and found him struggling to breathe. They raised the alarm and wing staff responded. Resuscitation attempts were made by the officers and then by Healthcare nurses who managed to maintain life signs. A paramedic team continued the treatment and the man was eventually taken to an outside hospital. Throughout the evening, the man had several cardiac arrests and the doctors at the hospital eventually concluded that his condition was irretrievable. Emergency support equipment was switched off and the man died at 9.05pm.

The subsequent post-mortem revealed that the man had died of an overdose of heroin. Other prisoners in the wing informed staff that he had been taking illegal drugs and, possibly, alcohol on the night before he died. There were no signs of drug-taking equipment in the cell, but it is believed that any such evidence might have been removed by other prisoners prior to the alarm being raised.

The investigation concludes that there was no serious neglect or misbehaviour by any member of staff. There are, however, several recommendations regarding the need to be more alert to unusual situations and improvements to record-keeping and follow-up action to clinical matters. One example of good practice was also noted in the clinical review.

Conduct of the investigation

Following the man's death, the prison authorities contacted the local police, the Coroner and the Prisons and Probation Ombudsman's Office. The woman named as the man's next-of-kin was also contacted, but it later became clear that his long-time partner and mother of his children was more properly his next-of-kin. She subsequently visited the prison to collect all his property, and there was regular contact between her and the Ombudsman's Office during the investigation.

The investigation was carried out by a Senior Investigating Officer from amongst my call-off contractors. The man's family were informed and invited to meet with the investigating team if they wished. Notices were also posted inviting any prisoners or members of staff who might have information to contact the investigative team. The Coroner and the local police were informed.

Initially, a full review of all the documentary evidence was undertaken to ascertain whether there were any procedural failures or errors on the part of any member of staff. Since the police were also conducting an investigation, no interviews or further inquiries were made by the investigator in order to ensure that the police investigation was not compromised.

The post-mortem examination subsequently established that the man had died of a heroin overdose and, since such drugs must have been illegally obtained, the police were obliged to carry out a detailed and protracted inquiry to ascertain whether there were any suspicious circumstances to the death, or any evidence that might lead to prosecution for any criminal activity. Additionally, two SIM cards for mobile phones were found in the man's cell, indicating that some smuggling of unauthorised items had taken place. This meant that the investigation by the Ombudsman's Office was delayed by several months.

In January 2005, the police completed their investigation. They were satisfied that there were no suspicious circumstances to the death and insufficient evidence to justify formal action of any kind. Copies of all the interview transcripts were passed to the investigator, as agreed by the Coroner.

Further visits were then made to the prison to speak to the people involved and obtain additional information regarding the circumstances of the man's death and the actions of prison staff.

Because illegal drugs had been used, the investigation also reviewed the prison's Drugs Strategy. This is a comprehensive and well-established plan for deterring drug use and supporting and helping those prisoners seeking assistance in avoiding future abuse. The investigation established that the authorities make considerable efforts to identify and prevent the entry of drugs into the prison. How far this is successful remains a matter of controversy.

A clinical review of procedures and treatment was undertaken by an experienced clinician appointed by the Ombudsman. There were no serious shortcomings or criticisms of the Healthcare staff or their practices and procedures. It was recognised, however, that the man might have had a better chance of survival if emergency treatment had been administered earlier.

The man who died

The man who died was aged 35. He had been born on 10 May 1969. He was initially remanded into Norwich Prison on 26 February 2004, before being sentenced to 11 years imprisonment by Norwich Crown Court on 7 June 2004 for offences of armed robbery. He was transferred to HMP Rye Hill on 22 June 2004.

The man had a long history of offending dating back to 1985, mainly for theft, burglary, taking vehicles and many associated Road Traffic Act offences. Several of his later offences were drink-related and there was one minor offence of violence and one drugs offence for which he was cautioned.

On reception into Rye Hill, the man was seen by members of staff during the Induction process and the usual assessments were made. There were no concerns expressed by the man himself or by Healthcare and Induction staff with regard to his health, general well-being or his mental state. He was placed on location with other category B prisoners.

During his time at Rye Hill, there were no recorded problems with the man. He appeared to get on well with other prisoners, and members of staff commented favourably on his good humour, his work effort and his relationships with others. Similar comments had been made at HMP Norwich.

An entry in the man's history sheets at Norwich is representative:

“Still part of a team. However, not sure if it is on the servery, or with the circus.”

It is clear that the man was well liked by staff and prisoners alike.

Details and history of HMP Rye Hill

HMP Rye Hill is a purpose-built category B adult training prison, opened in 2001 and run by a private company, Global Solutions Ltd, on a contract with the Home Office. The certified normal accommodation (CNA) is 600 but this can be increased to a maximum operating capacity (Op. Cap.) of 664, if needed. All the prisoners are male, serving over 4 years and there is capacity to hold up to 120 life sentence prisoners.

In the first four years after the prison opened, there were a total of 14 deaths in custody. There were no deaths in 2001, four in 2002, three in 2003 and three others in 2004 prior to this one. The earlier investigations found no serious neglect or shortcomings and made only minor recommendations regarding procedures.

The last Standards Audit report was satisfied with the procedures and plans for dealing with prisoners at risk and for handling deaths in custody. A few minor improvements to the F2052SH system were suggested and these were agreed by the prison authorities and carried out.

A full announced inspection of HM Prison Rye Hill was carried out by HM Chief Inspector of Prisons in June 2003. The report concluded that the prison's "open and relaxed approach" could carry risks: "Most officers were fairly new and young, often with far less experience of prison than the long-term prisoners in their care; and there were relatively few of them. We were not clear, on all wings, that the appropriate boundaries had been drawn and were being maintained."

Anxieties about Rye Hill have continued. During my own visit to Rye Hill at the beginning of this investigation, I was conscious that many staff and prisoners spoke openly about the availability of drugs. However, this contrasted with the formal Mandatory Drug Testing statistics which were at a low level.

The turnover of staff, and their relative lack of experience, was also striking and my contemporaneous notes cite staff concern about the availability of hooch, the potential for a major incident, and a shortage of staff affecting appointments with Healthcare. On the other hand, Rye Hill's activity hours were good (albeit below target) and the Units and grounds were clean and tidy.

The IMB Report on Rye Hill refers to the "continuing level of staff turnover":

"The lack of experience and confidence amongst officers results in issues that should be dealt with at Unit level being referred to an unnecessarily higher level of management."

In pursuit of my complaints remit, this has been my experience personally and of the Ombudsman's Office as a whole.

Chronology of Events

Following his conviction and sentence, the man arrived at HMP Rye Hill on 22 June 2004. Throughout his time at Rye Hill, he was cheerful and well-behaved and got on well with staff and other prisoners, never giving cause for concern or alarm. He admitted to a drug problem in the past but stated that he had been 'clean' for several years prior to coming to prison. During his stay at Rye Hill he was given three drug tests, all of which proved negative. He was eventually given a job working in the kitchen.

At about 8.30am on Saturday 11 September, a prison custody officer (PCO) went into the man's cell to remind him that he was due to work that morning. The man was in bed, apparently asleep, but gave a groan, as if in acknowledgement, when the officer spoke to him. He made no attempt to get up and the PCO left. He told a fellow PCO that he did not think the man intended to go to work.

At about 9.20am, the kitchen phoned the wing and asked why the man had not attended and said that he should be told that he might lose his job if he did not attend, as required. The second PCO went to the man's cell and found him still in bed. She spoke to him but received no response. The man was lying on his side, facing the wall. The PCO went into the cell and touched him on the shoulder, but did not shake him. She gave the man the message from the kitchen. He gave a groan in response, but did not wake up. The PCO was satisfied that the man was simply sleeping. She returned to the office and informed the kitchen.

During the course of the morning, several prisoners made comments to the PCO about the man, saying that he was fine, just 'out of it'. The PCO, who was new to the wing, did not have any concern at this time accepting that, like a number of prisoners at weekend, he was just sleeping late. It is normal practice at Rye Hill, to allow prisoners to spend their weekend leisure time as they choose and many prisoners enjoy a late lie-in, often missing breakfast in order to do so. Staff are encouraged to allow this, provided there are no security or control implications for doing so.

The man was still sleeping at 11.30am when a roll-check was made. At 1.30pm, the first PCO commented that the man, along with several other prisoners, had not collected their lunchtime meal. The second PCO checked again and found the man still in bed, in a different position, but breathing deeply and normally as if asleep. She asked him about his meal and he again made a moaning noise in response.

At about 2.20pm, two prisoners went into the man's cell to borrow a newspaper. They noted that the man was having difficulty breathing and shouted to the officer to get help. The second PCO was talking to another prisoner at the time and both of them ran upstairs to the cell along with a third PCO. The first PCO went to the office and telephoned the Healthcare department to warn them that there might be an emergency.

When the second PCO got to the cell, she found the man lying on his back struggling to breathe. His eyes were wide open and he was taking short, rapid breaths. His forehead felt cold and the PCO could not detect a pulse in his wrist. She ran out of the cell and called down to a fourth PCO that this was a 'code 2' emergency. (This identifies the second level of emergency and includes someone with serious breathing difficulties.) Assisted by the prisoner to whom she had been talking, the PCO tried to turn the man onto his side to make his breathing easier, but he was too heavy and they could not move him. She spoke to him but he did not respond. The prisoner started to try to give the man mouth-to-mouth resuscitation. The man seemed to be breathing more deeply, therefore the third PCO told the prisoner to stop. She then felt his wrist and was able to detect a pulse.

A few seconds later, three nurses arrived with emergency equipment and took over. An emergency ambulance was called. The nurses gave the man oxygen but his breathing stopped and there was no pulse. The nurses commenced Cardio Pulmonary Resuscitation (CPR) and inserted an airway to assist his breathing. Staff continued to work on him until the emergency ambulance crew arrived about 20 minutes later and took over his treatment, assisted by the Healthcare nurses. At 3.30pm, the man's condition was stabilised and he was taken to St Cross Hospital in Rugby. Resuscitation measures were continued throughout the evening, but the man died at 9.05pm.

Comments made by prisoners suggested that the man had been taking illegal drugs or alcohol on the evening before his death. No drugs paraphernalia was found in the cell by the police, although two SIM cards for mobile phones were retrieved. The post-mortem examination established that the man died of a heroin overdose, suggesting that the speculation about his activities the night before may have been true. Several prisoners went into the cell during the morning and it is possible that any evidence of drug use was removed, either in a misguided attempt to protect the man or to be secreted for further use by others.

Following the conclusion of the police investigation, a review of the man's medical care was carried out by an experienced clinician. The review noted that the man was in generally good health on first admission to prison on 26 February 2004 although he was having a little difficulty sleeping, probably from the stress of being in prison. He was prescribed medication for this.

He was subsequently transferred to Rye Hill on 22 June 2004 and was once again considered quite fit for all activities. It was not until 21 July 2004 that the man mentioned a history of asthma. Although he seemed well at the time, he was prescribed an inhaler and arrangements were made for him to attend an asthma clinic.

On 2 August, he was seen again by the Medical Officer and it was suggested that information should be sought from the man's GP regarding his asthma. However, there is no indication that the man attended an asthma clinic or that a letter was sent to his GP.

The review also notes the drug (naloxone) administered to the man by the paramedic team when they arrived and says that, “earlier administration of this drug ... may have improved his chances of survival.”

There are two recommendations and one example of good practice made in the clinical review.

Findings and conclusions

The man was serving a lengthy prison sentence for robbery offences. Although he had a history of drug-taking, there was no indication that he had been involved in using illicit drugs prior to his death. His behaviour in prison was very good, he responded positively to the regime at HMP Rye Hill and seemed to get on well with all staff and prisoners.

The man was a kitchen worker and was supposed to be on weekend duty in the kitchen on the day that he died. One of the wing officers went to his cell to remind him he should be at work. He was still lying in bed, apparently asleep, but gave a moan in response when the officer spoke to him. A second officer went to his cell about an hour later and received a similar response.

Throughout the morning several more people, staff and prisoners, went to his cell. He did not wake up but gave some indication that he was aware that he was being spoken to. No-one felt any serious concern, believing that the man was simply having a long lie-in as many Rye Hill prisoners do at weekend.

At about 2.30pm, two more prisoners went into his cell and recognised that he was in serious distress and was struggling to breathe. They raised the alarm and two wing officers responded. They were unable to wake the man or turn him over. An emergency call was made to the prison Healthcare department and nurses responded immediately.

A prisoner who had also entered the cell tried to give mouth-to-mouth resuscitation. The man appeared to breathe more easily and an officer told the prisoner to stop and allow him to breathe unaided. The nurses then took over and continued to treat him until an ambulance team from St Cross Hospital arrived.

After about 40 minutes, the man was stable enough to move to the outside hospital, accompanied by two Prisoner Custody Officers. The medical staff at the hospital continued to give emergency treatment for several hours during which time the man had several cardiac arrests. Eventually it became clear that he could not survive and the life support systems were switched off. The man died at about 9.00pm.

Subsequently, several prisoners volunteered the information that the man might have taken drugs or alcohol the night before. No mention was made of this to staff until after the man's serious condition became known. It is possible that prisoners knew this and believed that the man was sleeping off a drug-induced condition. There would have been a reluctance to inform the officers of this until it became clear that his life was in danger. The absence of any drug-taking equipment in the cell may also be the result of prisoners removing such incriminating evidence before staff became aware of the man's situation.

It seems clear from the clinical review that the man would have had a better chance of survival if his condition had been discovered earlier and appropriate treatment given. The reluctance of staff to rouse him properly and ascertain his state of health contributed to this delay. Given the ethos of the establishment, the actions of the staff involved are understandable but, in this case, they had tragic consequences. It is possible that staff were unduly influenced by the comments of other prisoners that the man was 'fine'.

Recommendations

1. All staff should be reminded of the need to be alert to any unusual circumstances with regard to prisoners and to recognise their duty of care. In particular, they should not be distracted or influenced by comments made by other prisoners.
2. All staff should be reminded that prisoners should not be allowed to give emergency assistance to other prisoners. It is the responsibility of properly-trained staff to take appropriate action, as laid down in the establishment's emergency procedures.
3. The Director of Rye Hill should review security and searching practices to maximise searching and reduce the availability of drugs, alcohol and mobile phone SIM cards.

Clinical Review Recommendations

1. The Healthcare Manager should ensure audits of records and record-keeping are carried out on a regular basis to ensure appropriate standards of record-keeping are achieved and maintained.
2. Healthcare staff should be trained in the administration of naloxone in emergency situations and a locally agreed policy developed to ensure safe and appropriate administration.

Good Practice

The use of the locally developed Risk Assessment tool is considered an example of good practice to provide appropriate and timely information for the development of effective pathways of care.