

**Investigation into the circumstances surrounding the
death of a man, who was a prisoner at HMP Rye Hill,
on 5 October 2005**

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

November 2006

This is the report of an investigation into the death of a man who was a prisoner at HM Prison Rye Hill. The man died on 5 October 2005 at a local hospital. A post mortem examination concluded that he died of cardiopulmonary arrest due to infective endocarditis and cardiomegaly, due to a prosthetic aortic valve.

During his time in hospital, the man was visited regularly by his family. I wish to take this opportunity to offer my sincere condolences to them for their loss, and to apologise for the delay in producing this report.

The investigation was carried out on my behalf by one of my Investigators. An independent review of the man's medical care in prison was carried out by my Deputy Ombudsman.

I would also like to thank the Director and staff of HM Prison Rye Hill for their full and ready co-operation during the investigation.

I make one recommendation.

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

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Prisons and Probation Ombudsman

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SUMMARY

The man was first received into custody on remand on 8 September 1986. He was convicted and sentenced to life imprisonment on 17 December 1986. He spent time at a number of prisons, before transferring to HMP Rye Hill on 6 May 2005.

The man had suffered a number of problems with his heart since childhood. On two occasions in 2002, whilst at HMP Full Sutton, he collapsed on the wing. An Echo Cardiogram (ECG) taken after the second of these indicated cardiac changes consistent with ischaemic heart disease. Following this, he underwent an aortic valve replacement on 3 October 2003.

In January 2004, the man began to complain of pain in his left hip. An x-ray on 30 June 2004 revealed severe osteoarthritis and, around a month later, he began a course of physiotherapy. Despite the physiotherapy, the man's osteoarthritis deteriorated and, on 6 April 2005, he was placed on a waiting list for a total hip replacement. This was scheduled for 8 August, but was later cancelled. No further appointment was made before his death.

On 15 September 2005, the man was admitted to the healthcare centre at Rye Hill after complaining of shaking and sweating overnight. In the early morning of 16 September, he contacted the night nurse, to say that he could not stand up on account of a loss of strength in his left leg. The night nurse also noted that the man's left arm was limp and the left side of his face appeared 'dropped'.

The night nurse contacted the on-call doctor to discuss the man's condition, and was advised to observe him regularly through the night. At around 8.00am, the morning staff noted that his condition had deteriorated and an ambulance was called. The man was taken to a local hospital. Sadly, his condition continued to deteriorate, and he died at 11.50pm on 5 October 2005. The cause of death was recorded as cardiopulmonary arrest due to infective endocarditis and cardiomegaly due to a prosthetic aortic valve.

The clinical review concludes that the man was treated appropriately whilst at Rye Hill. I make one recommendation, with regard to establishing contact with next of kin.

INVESTIGATION METHODOLOGY

The investigation was opened on 6 October 2005, when my investigator issued notices announcing the investigation and its terms of reference to staff and prisoners at Rye Hill. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known. One prisoner came forward as a result.

On 10 November 2005, my investigator visited Rye Hill and familiarised himself with the Healthcare Centre and the wing on which the man had lived. He was given access to the man's prison files, including the Medical Record.

An independent clinical review into the man's health needs whilst he was in custody at Rye Hill was carried out by my Deputy Ombudsman, a qualified clinician. My Deputy Ombudsman visited Rye Hill on a number of occasions and interviewed staff.

One of my family liaison officers contacted the man's sister, on 16 November 2005. She said that she did not have any issues to raise about the man's care whilst he was in prison. However, she did express concern that it had taken the prison a week to let her know that the man was in hospital.

BACKGROUND

The man was born in 1948, and was 56 years old at the time of his death. He had problems with heart disease throughout his life, including childhood surgery for a coarctation of the aorta (a narrowing of the aorta, the main artery taking blood from the heart to the rest of the body), and was epileptic.

The man attended a comprehensive school, leaving at the age of 15 to take up employment as a store man. He did not stay in the same job for long and worked for a number of different employers, mostly as a labourer, until 1980, after which he was unemployed. He was convicted of a number of offences over this period, mainly for theft and burglary, although he did receive a sentence of five years imprisonment in 1970, following a conviction for arson.

On 17 December 1986 the man was convicted of the murder of two people, and sentenced to life imprisonment with a tariff of 20 years. He was initially held at HMP Birmingham and had spells at Gartree, Long Lartin, Nottingham, Whitemoor and Full Sutton before transferring to Rye Hill on 6 May 2005.

HM PRISON RYE HILL

HMP Rye Hill is a privately managed category B training prison, for adult male prisoners serving sentences of four years or more. It is run by Global Solutions Ltd (GSL) and has been operating since early 2001. Rye Hill has an eight bed in-patient Healthcare Centre, which is not included in the certified normal accommodation of 600 prisoners.

Healthcare in Rye Hill is delivered by contract from Primecare FMS and accountability is to the Area Operational Manager for Primecare. Healthcare staff working in the Healthcare Centre are all medically qualified. A local General Practitioner provides a surgery each week-day. Medical cover is provided during the weekends, evenings and overnight by the local practice. Nursing care is provided on a 24 hour basis.

KEY EVENTS

The man who died was initially received into HMP Birmingham on remand on 8 September 1986, before being convicted and sentenced to life imprisonment on 17 December. He attempted suicide by cutting his wrists around three months after sentencing. Over time, however, the man became accustomed to his situation, and was generally regarded as a polite and well-mannered prisoner at each jail where he was located.

Since childhood, the man had had problems with his heart. At the age of 14 he had surgery for a coarctation of the aorta. During the first 15 years or so of his sentence he endured a number of different health problems, including hip and back pain, each of which was dealt with at the time.

On 13 September 2002, whilst at Full Sutton, the man collapsed on the wing and was admitted to healthcare for a review. He told the nurse who saw him that he had collapsed five weeks previously, but had not reported this. He had also previously fainted in the kitchen at Gartree in November 2000. On 24 December 2002, the man again collapsed on the wing and was unconscious for around three minutes. An ECG was taken by a GP at Full Sutton, which indicated cardiac changes consistent with ischaemic heart disease. Despite this, and advice to the contrary, the man refused admission to the Healthcare Centre and returned to the wing. Advice was given by the GP at Full Sutton that if he suffered any further dizzy spells he should be admitted to hospital.

On 3 October 2003, the man underwent an aortic valve replacement at a major hospital in the area. Following the operation, he was reviewed on a weekly basis until the end of the year. He reported no significant problems, other than pain on either side of his chest scar which, on examination, was found to be a muscular rather than a cardiac problem.

In January 2004, the man complained of pain in his left hip, groin and upper leg. He was prescribed a course of aspirin to ease the pain. An x-ray on 30 June revealed that he had severe osteoarthritis. He was kept on the same medication and, at a review on 26 July, was prescribed a course of regular physiotherapy.

Despite the physiotherapy, the man's osteoarthritis got worse and his pain increased. On 6 April 2005, he was placed on a waiting list at a local hospital for a total hip replacement. The procedure was scheduled for 8 August, by which time he had transferred to Rye Hill on a progressive move (whereby a prisoner moves to an establishment with a lower security category in order to undertake the offending behaviour programmes necessary to facilitate his future release on licence). He therefore returned to Full Sutton on 4 August in preparation for the hospital admission, only for the operation to be cancelled by the hospital. The man was transferred back to Rye Hill on 16 August. No further appointment was made before his death.

On 15 September, the man was admitted to the Healthcare Centre at Rye Hill after complaining of shaking and sweating overnight. He was noted to have swelling down the left side of his face and was very pale. On arrival at the Healthcare Centre at 1.45pm, his temperature was recorded as 40.3° Celsius (the normal body temperature is around 36.9°C). Fan therapy was therefore applied in an effort to cool him down. The prison GP was contacted and he advised the commencement of paracetamol and amoxicillin.

At a later assessment at 3.30pm, a nurse recorded a drop in temperature to 39.6°C. Fan therapy was continued, and the man was encouraged to take on more fluids. He was assessed again at 7.00pm, by which time his temperature had dropped further to 38.9°C. He also said that he felt very tired. At the same time, the man refused food but took two cups of water.

At 12.35am on 16 September, the man alerted the night nurse that he could not get up to go to the toilet. He complained of a loss of strength in his left leg which meant that he was unable to stand. The night nurse also noted that the man's left arm was limp and that the left side of his face appeared 'dropped'. His blood pressure and pulse were taken by the night nurse. His blood pressure, at 80/50, was below the normal average of 120/80, and his pulse was slightly elevated at 95 beats per minute. The man's temperature was also taken, and it had fallen to within normal limits.

The night nurse administered 1g of paracetamol for the pain in the man's left arm. The night nurse also contacted the prison GP to discuss the situation. The prison GP agreed that it sounded like a cerebrovascular accident (a stroke or stroke-like incident). He advised the night nurse to give 300mg aspirin, and to take regular observations around every two hours.

The night nurse took observations on a further four occasions through the course of the night, the last of which was at 7.00am. The man's observations remained stable through this period. At around 7.30am, a day nurse took over from the night nurse.

At 8.00am, the day nurse noted that the man's condition was deteriorating slowly. His speech was becoming increasingly slurred, and he was having spells of confusion. An ambulance was therefore called, and the man was taken to a local hospital at 8.20am.

When he was transferred to hospital, the man was initially restrained by double cuffs as he was a category B prisoner. This was soon changed to an escort chain as his condition deteriorated. At 8.00pm, his condition was described as critical, by which time the man had transferred to the emergency admissions unit at a larger hospital. On 17 September, it was confirmed that he had suffered a major stroke and his prognosis was described as very poor.

On 19 September, the man was diagnosed with endocarditis (an infection of the lining of the heart). On the same day, following the duty security manager's visit, his restraints were removed on account of his deteriorating condition.

The man's next of kin were recorded on LIDS (Local Inmate Data System, the prison-based computer system that records prisoner's details) as being his parents, with a contact address but no telephone number recorded. On 16 September, the local police were therefore asked to visit to inform them of their son's transfer to hospital. Sadly, it became apparent that his father had passed away and his mother was not well enough to understand that the man was ill. The police were subsequently asked to locate and inform a further member of the family.

A note in the man's medical record on 17 September says that his next of kin had been established as his daughter (this should have read step-daughter), and that she was to be informed later that day. The man's sister was traced through his telephone records and told of his illness on 24 September.

Sadly, the man's condition did not improve following his move to hospital and, at 11.50pm on 5 October, he died. The post mortem recorded the cause of death as cardiopulmonary arrest due to infective endocarditis, and cardiomegaly, due to prosthetic aortic valve.

The funeral was held on 25 October 2006. The prison provided funding to help meet the costs.

ISSUES

Quality of healthcare provided at Rye Hill

One prisoner at Rye Hill came forward to speak to my investigator during the course of the investigation. He said that he worked as a cleaner in the Healthcare Centre, and had seen the man when he was admitted on 15 September 2005. The prisoner said that it was his opinion that the man had suffered a stroke on 15 September, and that he should have been taken to hospital on that day rather than a day later on 16 September.

The clinical review, conducted by my Deputy Ombudsman, concludes that the man was treated appropriately whilst at Rye Hill. The reviewer also notes that the man was appropriately transferred to hospital when it became apparent that his condition was deteriorating.

The reviewer considers the man's clinical records from Rye Hill to be comprehensive, and notes that they provide clear evidence of the care that he received. However, she says that there are numerous occasions on which staff sign after an entry, but do not provide their name in an easily identifiable format. The reviewer makes the housekeeping point that staff should be reminded of the need to print their name after their signature. I agree.

Contact with the man's family

When he was taken to hospital on 16 September, staff at the prison attempted to contact the man's next of kin in order to tell them what had occurred. His next of kin were recorded as being his parents, and the local police were asked to visit them as no telephone number was registered. Sadly, his father had passed away and his mother was not well enough to understand that the man was ill. Prison staff were unaware of these circumstances.

The man's step-daughter was traced on 17 September and told what had happened and about his condition. His sister was traced through the man's telephone records and informed on 24 September. When my family liaison officer spoke to his sister, she expressed concern that it had taken the prison a week to inform her of her brother's illness. After viewing the draft report, the man's sister repeated her anger that it had taken so long for the prison to contact her.

In her clinical review, my Deputy Ombudsman suggests that it would be good practice for the healthcare admission sheet to have a section identifying next of kin and their contact details in case of an emergency. I agree with this suggestion. However, I consider that it is imperative that staff throughout the prison, not just in healthcare, have easily accessible up to date information on a prisoner's next of kin. Given the distress caused to the man's sister by the delay in contacting her, I therefore make the following recommendation.

The Director should ensure that appropriate steps are taken to update next of kin details recorded in prisoner's core records, and ensure that these are reviewed on a regular basis.

RECOMMENDATIONS

The Director should ensure that appropriate steps are taken to update next of kin details recorded in prisoner's core records, and ensure that these are reviewed on a regular basis.

Accepted – this will be completed annually in line with the OASys reviews