Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Selby Wardle, a prisoner at HMP Hull, on 8 May 2023

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

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.

If my office is to best assist His Majesty's 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.

Mr Selby Wardle died on 8 May 2023 of acute myocardial ischaemia (reduced blood flow to the heart) at HMP Hull. He was 72 years old. I offer my condolences to Mr Wardle's family and friends.

The clinical reviewer concluded that the healthcare Mr Wardle received at HMP Hull was of a good standard and equivalent to what he could have expected to receive in the community.

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

Adrian Usher
Prisons and Probation Ombudsman **December 2023**

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Summary

Events

1. On 22 October 2009, Mr Selby Wardle was remanded to HMP Leeds, charged with rape.

2. Mr Wardle had several medical conditions, which included bicuspid aortic valve disorder (a form of heart disease) and hypertension (high blood pressure). Mr Wardle also needed and was provided with appropriate care for a range of other health conditions.

3. On 26 March 2010, Mr Wardle received an indeterminate sentence for public protection (IPP) with a minimum tariff of 12 years in prison. Mr Wardle was transferred to several different prisons and on 10 November 2017, he was transferred to HMP Hull.

4. Healthcare staff referred Mr Wardle to the long-term conditions pathway clinic at Hull and offered him annual reviews, which he declined to attend.

5. On 30 June 2020, a GP at Hull completed a health check on Mr Wardle and conducted a QRisk2 assessment (a tool for predicting cardiovascular risk). The results showed that he had a high risk (over 20% chance) of a heart attack within the next ten years.

6. On 24 November 2022, Mr Wardle was sentenced to a further nine years in prison for sexual offences.

7. At about 5.00am on 8 May 2023, an Officer Support Grade (OSG) was conducting the morning routine check and saw Mr Wardle lying on the floor of his cell, unresponsive. The OSG radioed a medical emergency code and nursing and prison staff responded and started cardiopulmonary resuscitation (CPR).

8. Ambulance paramedics arrived and took over CPR, but at 5.27am, a paramedic confirmed that Mr Wardle had died.

Findings

9. The clinical reviewer concluded that the care Mr Wardle received at HMP Hull was of a good standard and equivalent to what he could have expected to receive in the community.

10. The clinical reviewer was satisfied that healthcare staff made good efforts to manage Mr Wardle’s long-term conditions and appropriate care plans were put in place for his conditions.

The Investigation Process

11. On 9 May 2023, HMPPS notified us of Mr Wardle's death. The investigator issued notices to staff and prisoners at HMP Hull informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

12. The investigator obtained copies of the relevant extracts from Mr Wardle's prison and medical records.

13. NHS England commissioned a clinical reviewer to review Mr Wardle's clinical care at the prison.

14. We informed HM Coroner for Hull of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

15. The Ombudsman's family liaison officer wrote to Mr Wardle's sister to explain the investigation and to ask if she had any matters she wanted us to consider. She had no specific questions.

16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies, and this report has been amended accordingly.

Background Information

HMP Hull

17. HMP Hull is a category B local prison for remanded and convicted prisoners over the age of 18. It holds approximately 1,000 male prisoners. Spectrum Community Health CIC provides healthcare services at the prison.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Hull was in April 2018. Inspectors reported that the health provision was reasonable and governance was mostly effective, but some health services had deteriorated since the last inspection. The team offered an appropriate range of primary care clinics within an acceptable time limit. Social care assessments were timely, and the provision was reasonably good. Healthcare staff supported prisoners with the greatest mental health needs well, but the range of interventions and staffing resources did not meet all low-level needs.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to July 2022, the IMB reported that the previous healthcare provider City Health Care Partnership (CHCP) was failing prisoners, with poor and inadequate service provision. The healthcare centre provided a wide range of physical and mental health services, however the effectiveness and quality of the delivery for those services were lacking under the CHCP provider.

Previous deaths at HMP Hull

20. Mr Wardle was the sixteenth prisoner to die at Hull since May 2020. Of the previous deaths, 11 were from natural causes, and four were self-inflicted. There are no significant similarities with our findings in the investigation into Mr Wardle's death and the findings of the previous deaths at Hull.

Key Events

21. On 22 October 2009, Mr Selby Wardle was remanded to HMP Leeds charged with sexual offences. On 26 March 2010, he received an indeterminate sentence for public protection (IPP) for rape with a minimum tariff of 12 years. On 24 November 2022, Mr Wardle was sentenced to a further nine years in prison for other sexual offences.

22. Mr Wardle had a number of pre-existing health conditions, including bicuspid aortic valve disorder, hypertension, osteoarthritis (degeneration of joint cartilage and underlying bone) in both knees, prostate cancer in 2012, incontinence lumbar spondylosis (an age-related degeneration of the vertebrae and disks in lower back) arthritis, a hernia, asthma and high cholesterol.

23. On 30 June 2020, a GP at Hull calculated that Mr Wardle had a QRISK2 score of 27.97% which meant he had more than a one in four chance of having a heart attack or stroke in the next 10 years. He discussed this with Mr Wardle and decided to increase his statin medication to 40mg. Mr Wardle understood and was happy with the plan.

24. During Mr Wardle's time at Hull, he declined to attend numerous care planning appointments, long-term condition reviews, annual reviews and hospital appointments. For some of the missed appointments, Mr Wardle had signed a disclaimer. Healthcare staff had no concerns about Mr Wardle's capacity to make these decisions. Mr Wardle's last annual review took place on 2 December 2022, but he declined to attend a care planning appointment on 21 March 2023.

25. On 18 April, a GP at the prison saw Mr Wardle, re-prescribed his medications, and asked healthcare staff to complete a routine blood test. On 3 May, Mr Wardle attended the clinic for his blood test. A Healthcare Assistant found that his blood pressure was raised. There is no evidence that she escalated this to a senior clinician as she should have done.

26. On 5 May, a GP at the prison reviewed Mr Wardle's blood test results and they were normal.

Events of 8 May 2023

27. At about 5.00am on 8 May, an OSG conducted the morning routine check and saw Mr Wardle lying on the floor of his cell, unresponsive. He radioed a code blue (indicating a prisoner is unconscious or is having breathing difficulties). Nursing and prison staff responded to the code blue and went to Mr Wardle's cell. They started CPR and attached a defibrillator, which advised no shock to be given.

28. At 5:20am, ambulance paramedics arrived and took over Mr Wardle's care and at 5.27am, a paramedic confirmed that Mr Wardle had died.

Contact with Mr Wardle's family

29. On 8 May, the prison appointed a family liaison officer. He telephoned Mr Wardle's sister and informed her that Mr Wardle had died.

30. Mr Wardle's funeral took place on 18 May. The prison contributed to the funeral costs in line with prison policy.

Support for prisoners and staff

31. After Mr Wardle's death, a prison manager debriefed the staff who were involved with the incident, to ensure they had the opportunity to discuss any issues arising, and to offer support. Trauma in Management (TRiM) and PAM assist also offered support to staff during this debrief.

32. The prison posted notices informing other staff and prisoners of Mr Wardle's death and offering support.

Post-mortem report

33. The post-mortem report gave Mr Wardle's cause of death as acute myocardial ischaemia, caused by ischaemic heart disease and severe coronary atheroma. He also had chronic kidney disease and hypertension which did not cause but contributed to his death.

Findings

Clinical care

34. The clinical reviewer concluded that the clinical care Mr Wardle received at Hull was of a good standard and was equivalent to what he could have expected to receive in the community.

35. The clinical reviewer found that healthcare staff appropriately initiated and updated the care plans for Mr Wardle's long-term conditions.

36. The clinical reviewer made two recommendations about ensuring there is a process in place to manage prisoners who refuse to attend medical appointments and escalating unusual events, which we do not repeat in this report, but which the Head of Healthcare will wish to address.

Good practice

37. Healthcare staff offered Mr Wardle appropriate care for his long-term health conditions, including annual reviews. They saw him regularly and provided good continuity of care.

38. Prison and healthcare staff responded well to the emergency response on 8 May 2023.

Inquest

39. At the inquest held on 2 July 2024, the coroner concluded that Mr Wardle died of natural causes.

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