Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Algie, a prisoner at HMP Wymott, on 11 July 2024

A report by the Prisons and Probation Ombudsman

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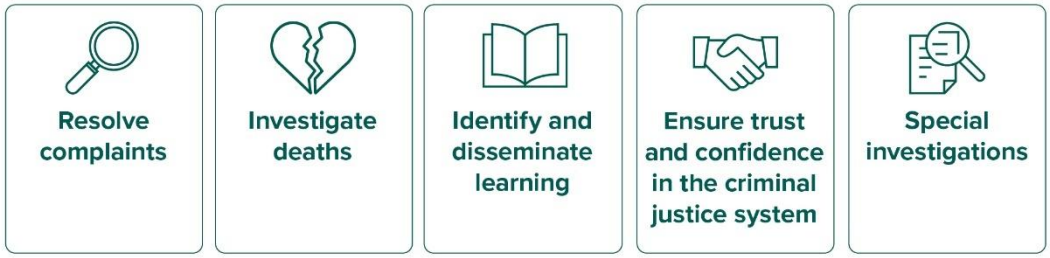
OUR VISION

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. 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.

3. Mr David Algie died on 11 July, while a prisoner at HMP Wymott. He was 38 years old. The cause of Mr Algie's death was a brain haemorrhage. We offer our condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care Mr Algie received at Wymott was of a reasonable standard, equivalent to that which he could have expected to receive in the community. He made recommendations about record keeping, access to Person Escort Records and debriefing staff. These issues did not impact on the cause of Mr Algie's death, but the Head of Healthcare will wish to consider them.

5. We found that the prison used restraints while Mr Algie was in a coma during his journey and initial admission to hospital. We have raised the issue of inappropriate use of restraints with Wymott before and consider that more needs to be done to ensure staff make better judgements.

Recommendations

- The Governor and Head of Healthcare should implement further measures to ensure that staff are appropriately skilled to complete and authorise escort risk assessments; decisions are based on a prisoner's medical condition and the actual risk they present at the time; restraints are not used during serious or invasive treatment, unless there are exceptional reasons for doing so; and quality assurance processes are introduced/strengthened to ensure that staff routinely comply with the Graham Judgement.

The Investigation Process

6. HMPPS notified us of Mr Algie's death on 11 July.

7. NHS England commissioned an independent clinical reviewer to review Mr Algie's clinical care at HMP Wymott.

8. The PPO investigator investigated the non-clinical issues relating to Mr Algie's care. The investigator and the clinical reviewer jointly interviewed three members of staff from Wymott on 2 and 19 September.

9. The Ombudsman's office wrote to Mr Algie's aunt, his next of kin, to explain the investigation. Mr Algie's aunt did not have any specific questions for the investigation to consider.

10. We sent a copy of our initial report to Mr Algie's next of kin. She did not notify any factual inaccuracies.

11. The initial report was shared with HM Prison and Probation Service (HMPPS) who reported a typographical error, which we have amended. HMPPS accepted our recommendation.

Previous deaths at HMP Wymott

12. Mr Algie was the 30th prisoner to die at Wymott since July 2021. Of the previous deaths, three were self-inflicted and the remainder were due to natural causes. We have previously raised concerns about the completion of security risk assessments and the use of restraints, and the prison provided guidance to staff.

Key Events

13. Mr David Algie was remanded to prison on 26 January 2006. He was convicted of murder on 14 December and sentenced to life imprisonment, with a minimum period to serve of 15 years.

14. On 20 March 2023, Mr Algie was released, but he breached the conditions of his licence and returned to prison on 13 April. He transferred from HMP Forest Bank to HMP Wymott on 10 May.

15. Mr Algie's reception and second-stage health screens were completed on 10 and 13 May, respectively. No significant physical health conditions or concerns were identified. However, he was referred to the mental health team, as he had been diagnosed with paranoid schizophrenia in 2020, and a care plan was put in place.

16. Mr Algie had a history of substance misuse in the community and in prison. He was promptly assessed by the drug and alcohol recovery service, a recovery plan was created, and he received continuing support during his sentence. In spite of this, he continued to use illicit drugs in prison. (On 21 June 2024, he was found under the influence and on 1 July, he refused to take a mandatory drug test.)

17. In 2023 and 2024, Mr Algie had annual health checks. Blood tests in April and June 2024, were mainly within normal range but indicated some abnormalities. (An appointment was made for a GP review on 23 July, but Mr Algie died before this took place.)

Events of 6 July 2024

18. At 2.50pm on 6 July 2024, a prisoner told an officer that Mr Algie was unwell. The officer went to Mr Algie's cell and found that he was vomiting, with a headache and dizziness. The officer radioed a code blue medical emergency (which indicates that a prisoner is either unresponsive or has difficulty breathing) and an ambulance was requested. A nurse assessed Mr Algie. As she did not consider him to be acutely unwell, she asked for the ambulance to be stood down.

19. At around 4.20pm, the officer went to check Mr Algie and saw him lying on the floor of his cell. He was responsive but incoherent. The officer again called a code blue and placed Mr Algie in the recovery position while waiting for a nurse.

20. A nurse helped Mr Algie to his bed and took clinical observations. He recorded that Mr Algie's speech was slurred, his pupils were dilated, and he became 'slightly unresponsive'. The nurse suspected he was under the influence of drugs and administered naloxone (a medication to reverse the effects of an opioid overdose). He noted that after five minutes, Mr Algie became 'slightly responsive'.

21. An ambulance arrived at the prison at 4.40pm and the paramedics reached the cell at 4.55pm. They noted that Mr Algie scored 13/15 on the Glasgow Coma Scale (GCS - a tool to assess a patient's level of consciousness), which suggested a moderate traumatic brain injury. He was unable to move independently, and the paramedics suspected an opiate overdose or stroke. At 5.15pm, a GCS score of 8 indicated that he was in a coma. The paramedics took Mr Algie to the Royal Preston Hospital. He was escorted by two prison officers, who were instructed to

use an escort chain in the ambulance and single handcuffs at other times. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner, the other to an officer.) They left the prison at 5.29pm and when they arrived at the hospital at 6.02pm, the GCS score was 5/15, meaning a severe head injury (the lowest possible score is 3/15).

22. At 6.05pm, while Mr Algie was in the Major Trauma Unit, the escort officers recorded, "…advised by doctors that he should be kept on the escort chain as he is unresponsive." At 6.10pm, they contacted the Custodial Manager responsible for the operational management of the prison, who said the escort chain should remain on Mr Algie until he regained consciousness and could respond. At 6.23pm, a scan confirmed a bleed on the brain and the Custodial Manager authorised removal of the restraints at 6.26pm.

23. On 10 July, the prison began an application for early release on compassionate grounds. The hospital removed the ventilator that day and Mr Algie died at 2.20am on 11 July.

Post-mortem report

24. The report of the post-mortem examination concluded that the cause of Mr Algie's death was a spontaneous intracerebral haemorrhage due to cerebral arteriovenous malformation.

25. It was noted that, depending on Mr Algie's symptoms, it was probably reasonable for healthcare staff to have initially suspected a benign headache.

26. The toxicology report noted Mr Algie's history of using synthetic cannabinoids. However, there was no evidence of this, or any other illicit substances in the blood samples screened. The pathologist said that due to the interval between Mr Algie's hospital admission and death, it was highly unlikely that the toxicological tests reflected the compounds in his blood when he was first admitted to hospital. Although in rare cases, intracranial haemorrhages have occurred after the use of synthetic cannabinoids, the pathologist considered it unlikely that illicit substances made more than a minimal contribution to Mr Algie's death.

Findings

Clinical findings

27. The clinical reviewer concluded that Mr Algie's physical and mental healthcare were of a reasonable standard and at least equivalent to that which he could have expected to receive in the community. He noted that Mr Algie did not have any long-term health conditions and received adequate treatment for minor ailments.

28. The clinical reviewer noted the need for improvements in aspects of care not related to the cause of Mr Algie's death including record keeping; ensuring reception healthcare staff have access to Person Escort Records; and debriefing staff after an emergency incident. He made recommendations which are not repeated in this report, but the Head of Healthcare will wish to consider.

Non-clinical findings

Use of restraints

29. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.

30. A judgment in the High Court in 2007 (known as the Graham Judgement) made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. It said that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

31. The paramedics recorded that Mr Algie was, "unable to mobilise or coordinate his own movements" and they suspected his condition had been caused by a stroke or an opiate overdose. The clinical entry on Mr Algie's security risk assessment was ticked to indicate his medical condition was life threatening; it did not restrict his ability to escape; there were no objections to the use of restraints; and the restraints did not need to be removed for treatment.

32. Mr Algie's risk was assessed as 'normal' on the individual elements of the risk assessment (on a scale of low/normal/high). It was noted that he had absconded in 2003 and was a risk to staff and adults, but no supporting detail was given. Despite Mr Algie's poor condition and an escort of two officers, the prison concluded that he should be handcuffed with single handcuffs, reduced to an escort chain in the ambulance, with no justification as to why this was considered necessary. After his admission to hospital, the restraints remained in place for around 25 minutes, although prison staff knew that he was unconscious.

33. The Head of Healthcare told the investigator that the entry in the medical records was ambiguous, and a different nurse had completed the risk assessment. The

entry stated that Mr Algie was able to sit on the bed with assistance and was 'slightly unresponsive' then 'slightly responsive' but there was no mention that his condition was life-threatening. The Head of Security could not account for the decision on the use of restraints but said that the prison had previously tried to improve the risk assessment process, in collaboration with the healthcare department.

34. The judgements by healthcare and operational staff suggest some staff do not understand the policy and the factors to be considered when taking decisions on restraints. This is an issue we have raised with Wymott before. In 2023, the prison produced an action plan listing measures to raise the awareness of all custodial managers on completing risk assessments, as well as the importance of assessing an individual's risk against their health condition. Guidance was also sent to all operational and healthcare staff about the Graham Judgement and ensuring risk assessments are fully completed.

35. We consider that the use of restraints, particularly when Mr Algie was in a coma, was unacceptable and inhumane. It casts doubt on whether the steps already taken have been effective and shows that more work needs to be done to improve staff understanding of the process, as well as judgements in individual cases. We recommend:

The Governor and Head of Healthcare should implement further measures to ensure that staff are appropriately skilled to complete and authorise escort risk assessments; decisions are based on a prisoner's medical condition and the actual risk they present at the time; restraints are not used during serious or invasive treatment, unless there are exceptional reasons for doing so; and quality assurance processes are introduced/strengthened to ensure that staff routinely comply with the Graham Judgement.

Governor to note

Delays in access for ambulances

36. The paramedics noted delays entering and leaving the prison. It took some time to get to the wing and there was a further delay while the prison arranged for staff to escort Mr Algie to hospital. The Head of Security explained that there are two external vehicle gates and four additional vehicle gates to get to the wing. In spite of this, a delay of 15 minutes in a medical emergency seems excessive, with no particular mitigating reasons. We are aware of work conducted by HMPPS to speed the entry and egress of emergency services in prison. The Governor will wish to consider the learning from this investigation.

Inquest

37. At an inquest held on 16 April 2026, the coroner concluded that Mr Algie died of natural causes.

Adrian Usher
Prisons and Probation Ombudsman **March 2025**

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