Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr George Haslam, a prisoner at HMP Wymott, on 21 October 2023

A report by the Prisons and Probation Ombudsman

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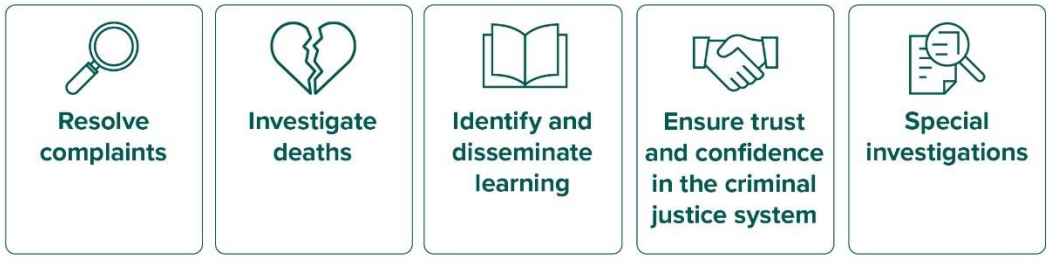
OUR VISION

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 George Haslam died from atheromatous coronary vascular disease and left ventricular hypertrophy on 21 October 2023 at HMP Wymott. He was 92 years old. I offer my condolences to Mr Haslam's family and friends.

The clinical reviewer concluded that the care Mr Haslam received at HMP Wymott was of a reasonable standard and was partially equivalent to what he could have expected to receive in the community. Mr Haslam had an active Do Not Resuscitate (DNACPR) order in place, however staff commenced resuscitation because they were not able to find his DNACPR paperwork.

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 **April 2024**

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Summary

Events

1. On 28 August 2020, Mr George Haslam was convicted of a sexual offence and sentenced to nine years in prison. He was 88 years old. On 30 August 2022, Mr Haslam was transferred to Wymott.

2. Mr Haslam had a significant medical history and already had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR - if a person has a cardiac arrest or stops breathing suddenly then CPR should not be performed) order in place when he moved to Wymott.

3. On 20 October 2023, a GP at the prison diagnosed Mr Haslam with a urine infection and prescribed him antibiotics.

4. On 21 October, an officer completed her daily welfare checks and found Mr Haslam was unresponsive. The officer was aware that Mr Haslam had a DNACPR in place and therefore did not call a code blue or commence cardiopulmonary resuscitation (CPR).

5. A few minutes later, a nurse and a custodial manager (CM) attended. The nurse started CPR as they were not able to find Mr Haslam's DNACPR paperwork. Control room staff rang the emergency services and asked for paramedics to attend the prison.

6. By the time paramedics arrived, healthcare staff had located Mr Haslam's DNACPR order and resuscitation attempts were stopped.

7. At 9.00am, the paramedics confirmed that Mr Haslam had died.

Findings

8. The clinical reviewer concluded that the care Mr Haslam received at Wymott was of reasonable standard and was partially equivalent to what he could have expected to receive in the community.

9. She found that when staff could not locate Mr Haslam's DNACPR, they started CPR. The clinical reviewer also found that healthcare staff did not complete a full review of Mr Haslam's long-term conditions which is not in line with NICE guidelines. These aspects of Mr Haslam's care were not equivalent.

Recommendation:

- The Head of Healthcare should ensure that patients with long-term conditions undergo reviews and receive treatment as outlined in NICE guidelines.

The Investigation Process

10. HMPPS notified us of Mr Haslam's death on 21 October 2023.

11. The investigator issued notices to staff and prisoners at HMP Wymott informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

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

13. We informed HM Coroner for Lancashire of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

14. The Ombudsman's family liaison officer contacted Mr Haslam's son to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond.

15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS and Greater Manchester West Mental Health NHS Foundation Trust pointed out some factual inaccuracies, and this report has been amended accordingly.

Background Information

HMP Wymott

16. HMP Wymott is a category C prison holding male prisoners. It is managed by HMPPS. Greater Manchester Mental Health NHS Foundation Trust provide healthcare services.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Wymott was in October 2020. Inspectors reported a nurse had been identified to lead on care for older prisoners but otherwise health services were limited, despite a large population of the prison were over 50. Furthermore, due to the shortage of skilled nursing staff, prisoners with long-term conditions were managed by the GP at the prison. There were no regular review clinics for prisoners with long-term conditions and the range of regular clinics offered were limited.

Independent Monitoring Board

18. 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 May 2023, the IMB reported that healthcare had struggled to run primary care clinics.

Previous deaths at HMP Wymott

19. Mr Haslam was the twenty sixth prisoner to die at Wymott since October 2020. Of the previous deaths 22 were from natural causes and three were self-inflicted. There are no similarities between our findings in the investigation into Mr Haslam's death and the investigation findings for the other deaths.

Key Events

20. On 28 August 2020, Mr George Haslam was convicted of a sexual offence and sentenced to nine years in prison. He was sent to HMP Preston. He was 88 years old.

21. Prior to Mr Haslam being sent to prison, he had ongoing health issues, including ischaemic heart disease, impaired left ventricular function and hypertension. In December 2018, Mr Haslam was fitted with a pacemaker and in April 2019, he suffered a heart attack.

22. On 6 February 2022, Mr Haslam was admitted to hospital and received treatment for a suspected urinary tract infection. On 6 March, the hospital completed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order on Mr Haslam's behalf, meaning that, in the event his heart or breathing stopped, he would not be resuscitated.

23. On 11 March, Mr Haslam was discharged from the hospital with antibiotics, but hospital staff were unsure where the source of the infection was. The DNACPR order was sent to the healthcare team at Preston.

24. On 11 August, a GP at the prison completed a new DNACPR order for Mr Haslam as his old one was missing.

25. On 30 August, Mr Haslam was transferred to Wymott.

26. That day, a nurse completed Mr Haslam's first and secondary health screen together, which is not in line with the NICE guidelines (evidence based recommendations for health and care in England and Wales). She noted that Mr Haslam needed social care assistance with his lower limbs, he was able to shower independently using the shower chair but needed assistance. After his assessment, Mr Haslam was moved into a disabled access cell located on the Haven Unit (the social care unit at the prison) and he used an electric wheelchair to get around independently.

27. The nurse noted that when he transferred to Wymott, Mr Haslam had an active DNACPR order in place. However, healthcare staff did not review this during his time there.

28. On 7 September, the social care team at Wymott reviewed Mr Haslam's assessment of needs. The staff supported him with personal hygiene, reviewed his pressure areas and helped him get dressed. A prisoner buddy also provided support with daily tasks. On 25 September, healthcare staff started a care plan to continue monitoring Mr Haslam.

29. At 4.29pm on 20 October 2023, a nurse told a GP at the prison that Mr Haslam was unwell during the afternoon. He had been bumping into objects and his urine had a strong smell. The GP made a note that Mr Haslam's NEWS2 score (National Early Warning Score-a tool used to facilitate early detection of deterioration and categorises the severity) was two, but there were no notes of any physical observations being taken at that time. (A NEWS2 score of two indicates a nurse led response).

30. Mr Haslam had his urine tested for infection and the result was positive. The GP prescribed antibiotics. She also asked healthcare staff to record Mr Haslam's physical observations twice per day.

Events of 21 October 2023

31. At approximately 8:30am on 21 October, an officer was carrying out her daily welfare checks and found that Mr Haslam was lying on his bed in his cell, unresponsive. His eyes were open, and his skin was drained of colour. She said that he was cold to touch, and he did not appear to be breathing.

32. At 8.36am, the officer used her radio to private call healthcare staff for assistance and to also inform the communications room as she believed Mr Haslam had died. She was aware that a DNACPR order was in place for Mr Haslam and, as a result, she did not commence CPR and did not radio a code blue (indicating a prisoner is unconscious or is having breathing difficulties).

33. A few minutes later, a nurse and a Custodial Manager (CM) attended. The nurse asked to see a copy of the DNACPR paperwork for Mr Haslam that should have been in the office folder. However, staff were not able to locate it. (We were told that DNACPR orders were filed in the wing office, but Mr Haslam's was hidden behind that of another prisoner and so staff did not find it).

34. The CM, nurse and Mr Haslam's prisoner buddy moved Mr Haslam off his bed onto the floor to start CPR. The CM applied the defibrillator pads to Mr Haslam, but no shocks were advised. The nurse started CPR. At 8.38am, control room staff called an ambulance.

35. A few minutes later, another CM attended the cell and asked more healthcare staff to attend. When more healthcare staff arrived, the nurse asked her colleagues to get Mr Haslam's DNACPR order from his medical records.

36. At 8.50am, the ambulance paramedics arrived at the prison, and healthcare confirmed there was a DNACPR in place for Mr Haslam, therefore all attempts of resuscitation were stopped. At 9.00am, the paramedics confirmed that Mr Haslam had died.

Contact with Mr Haslam's family

37. Following Mr Haslam's death, the prison appointed the Family Liaison Officer (FLO). The FLO and the Deputy Governor visited Mr Haslam's son at his home address and informed him of his father's death. They offered their condolences and on-going support.

38. The prison contributed to the funeral costs in line with prison policy.

Support for prisoners and staff

39. After Mr Haslam's death, a senior manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. Line managers followed up with Employee Assistance

(EAP- providing a range of services such as counselling and crisis intervention) and care procedures for the officers involved and all staff involved were referred to the Trauma Risk Management (TRIM-offering support to staff after a traumatic experience) lead.

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

Post-mortem report

41. The post-mortem report gave Mr Haslam's cause of death as atheromatous coronary vascular disease and left ventricular hypertrophy (heart disease).

42. At the inquest held on the 8 October 2024, the Coroner concluded that Mr Haslam died of natural causes.

Findings

Clinical care

43. The clinical reviewer concluded that the care Mr Haslam received at HMP Wymott was of a reasonable standard and partially equivalent to what he could have expected to receive in the community. She did, however, conclude that management of his long-term conditions and DNACPR order were not equivalent.

Emergency Response

44. The clinical reviewer noted that no staff involved in the emergency response called a code blue. However, we are satisfied that the officer was aware that Mr Haslam had an active DNACPR in place and she believed that he had died, therefore it was appropriate that she did not call a code blue.

45. The clinical reviewer also found that staff were unable to locate Mr Haslam's DNACPR order in a timely manner. The prison told us that all DNACPR paperwork was kept in the wing office, and it was also marked on the notice boards on the wings. However, staff did not notice this during the emergency response. Mr Haslam's DNACPR paperwork was located in the correct file, but it was hidden behind another prisoner's paperwork. Prisoners with active DNACPR's are now read out in the staff briefings at the start of each shift so that staff working on the wing are reminded and made aware. Furthermore, notifications of DNACPR's are sent out on the daily safety briefing to all staff each day. We are satisfied that these changes will avoid confusion in future. We make no recommendation.

Management of Mr Haslam's long-term conditions

46. Mr Haslam was reviewed by the long-term conditions team on the 21 November 2022 for his ischaemic heart disease; however, they only reviewed his physical observations and did not complete a full review as per NICE guidelines. There is no evidence to suggest anything further was discussed with Mr Haslam, and the Head of Healthcare confirmed full reviews were not completed at the time. We recommend:

    The Head of Healthcare should ensure that patients with long-term conditions undergo reviews and receive treatment as outlined in NICE guidelines.

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