

**Investigation into the death of a man
at the Royal Preston Hospital in July 2010 while in the
custody of HMP Wymott**

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

August 2011

This is the report of an investigation into the death from natural causes of a man at the Royal Preston Hospital in July 2010. At the time of his death, the man was a prisoner in the custody of HMP Wymott.

I extend my sincere condolences to the man's family and friends and all those affected by his loss. I apologise for the delay in issuing this report and for any additional distress that this may have caused.

I should like to thank the Governor of Wymott, and his staff for their co-operation. A clinical review of the man's care and treatment was carried out by Central Lancashire Primary Care Trust.

The man had been in the community on licence but was recalled to prison in September 2008. (A prisoner might serve part of a prison sentence on licence in the community. If the prisoner transgresses his licence conditions he is liable to be recalled to prison.) He was initially taken into HMP Manchester before being transferred to Wymott ten months later. Although a smoker, the man was then in apparent good health and rarely needed to consult healthcare.

In June 2010, the man reported to a nurse, symptoms of breathlessness persisting for the previous three weeks. He was sent to hospital that afternoon for further tests. He remained in hospital for just over the two weeks during which he was diagnosed with adenocarcinoma (lung cancer) of the left lung.

The man was discharged back to Wymott, but his condition deteriorated rapidly and he was sent back to hospital a few weeks later where he subsequently died. His cause of death was found to be adenocarcinoma of the left lung.

The clinical reviewer found that the man's treatment was equal to that which he could have expected in the outside community.

This report makes no recommendations.

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

Thea Walton
Acting Deputy Ombudsman

August 2011

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SUMMARY

1. The man was remanded into HMP Manchester in January 2003 charged with a number of serious offences. He was transferred to HMP Wymott in early 2004 where he undertook a Sex Offender Treatment Programme (SOTP) and in January 2007 was released early on parole.
2. In September 2008, his licence was revoked and he was recalled to prison. He was taken to HMP Manchester and remained there until July 2009, when he was again transferred to Wymott.
3. On arrival at Wymott, he reported that he was a smoker but also reported having no significant medical history and no current health concerns.
4. The man obtained a job in Wymott's commercial engineering unit and for the next 11 months all seemed well and he had very little contact with healthcare staff.
5. On 10 June 2010, he reported to a nurse that he had been experiencing breathlessness over the previous three weeks. He explained that he had stopped smoking to try to relieve his symptoms, but this had not helped. Following a discussion between the nurse and one of Wymott's doctors, he was sent to hospital that same afternoon for investigations.
6. He remained in hospital for just over two weeks, during which time he was diagnosed with adenocarcinoma of the lung. The cancer was then at an advanced stage. By 28 June, he was deemed fit enough to be discharged from hospital. He returned to Wymott and to his cell on his usual landing.
7. The man had not provided details of any next-of-kin on arrival at Wymott. When he was diagnosed as being terminally ill he was asked whether he wished anyone to be notified. He was adamant, however, that he did not.
8. In the early morning of 20 July, wing officers called for a nurse as the man seemed unwell. The nurse's view was that he needed immediate hospital treatment and an emergency ambulance was called. At hospital, he was treated with antibiotics and fluid was drained from his chest. Although he responded well to the initial treatment, he continued to deteriorate and he died later that month.
9. The clinical reviewer found that the man received timely and appropriate care from the healthcare staff at Wymott. She considered his care to have been equivalent to that provided in the outside community.
10. This report makes no recommendations.

THE INVESTIGATION PROCESS

11. The investigator visited to HMP Wymott on 9 August 2010 when he met with senior prison managers and the chair of the local Independent Monitoring Board (IMB). The investigator took copies of the man's prison and healthcare records.
12. Notices of the investigation were issued to staff and prisoners inviting those who wished to provide information regarding the man's death to make themselves known to the investigator. No one came forward in response to the notices. The Ombudsman's investigator did not conduct any formal interviews however he had an informal conversation with the Head of Healthcare.
13. Central Lancashire Primary Care Trust appointed a clinical reviewer to carry out a review of the man's clinical care and treatment at Wymott. I am grateful to the clinical reviewer for her report, a copy of which is attached as an annex to this report.
14. The has been in contact with HM Coroner for Preston and West Lancashire. A copy of this report will be sent to the Coroner to assist him with his own enquiries.
15. When the man arrived at Wymott he did not list any next-of-kin. When it was realised that he might not have very much time left to live he was asked again whether he wished anyone to be contacted and he said that he did not. There has thus been no family involvement in this investigation.
16. The chair of the IMB told the Ombudsman's investigator that throughout his time at Wymott the man never submitted a complaint to his Board nor asked to see an IMB member. The chair of IMB said that his Board was aware that the man had been taken into hospital and at one time IMB members would visit prisoners in hospital as a matter of routine. The IMB no longer do that and he thought that it would be good practice to do so. He added that he thought that the officers on I wing (where the man lived) do an excellent job.

HMP WYMOTT

17. HMP Wymott is a category C training prison near Preston. It holds adult male prisoners serving sentences longer than six months. It has an operational capacity of 1,176. It has facilities for both vulnerable prisoners¹, who make up over half the total population, and prisoners on ordinary location.
18. The commissioning of healthcare at Wymott is the responsibility of Central Lancashire Primary Care Trust (PCT). The prison does not have inpatient facilities. There is a general practitioner (GP) surgery in the prison which prisoners can access five days a week. Overnight and weekend services are covered by the same provider. Wymott has around the clock nursing cover throughout the week.
19. The most recent inspection of Wymott by Her Majesty's Chief Inspector of Prisons was a full announced inspection in October 2008. The Inspector's findings included:

"Overall, this is a very positive report on a prison that has managed to progress despite a considerably increased, and very varied population ...

"All the interactions we observed between staff and prisoners were positive and respectful. Prisoners and staff were relaxed with each other ..."
20. All prisons in England and Wales have an Independent Monitoring Board (IMB). IMB members are volunteers who monitor day-to-day life in the prison to help ensure proper standards of care and decency are maintained. In its report for the year from June 2009 to May 2010, the IMB at Wymott wrote in its summary that:

"The Board considers that the prison is providing a safe environment in which prisoners are treated with decency and respect and have access to an extensive programme of education and skills. The Senior Management of the prison have set out to address those areas where prisoners are not treated decently within the limitations of what the prison can do given its national resource allocation."

"The Board considers that Healthcare provision at HMP Wymott is satisfactory but there needs to be an improvement in the level of service in order to bring it up to that provided in the wider community."
21. Since my office took over responsibility for investigating all deaths in prison custody in 2004, there have been 23 deaths attributed to natural causes at Wymott. This high number is unsurprising given the number of older prisoners held at this prison.

¹ Vulnerable prisoners are those who might be at potential risk from other prisoners. Most often, this will be due to the nature of their offences.

KEY EVENTS

22. The man was born in Manchester. He had three siblings and described having had a stable upbringing. After leaving school he obtained employment.
23. Although it is possible that the man's work might have taken him to other parts of the UK, and even to Europe, his main place of residence remained as Manchester.
24. In January 2003, the man was arrested and charged with a number of serious offences and was remanded into HMP Manchester. He was convicted in June 2003 and was subsequently sentenced to ten years imprisonment, including a four-year extended licence. (An extended licence covers a period following time in custody where the court considers there is a need for a longer than normal supervision period to help prevent future re-offending through support and rehabilitation of the offender. The offender may be recalled back to prison at any time during the licence period.)
25. The man was transferred to HMP Wymott in early 2004. As part of his sentence planning, he was required to undertake a Sex Offender Treatment Programme (SOTP). A report on his engagement with the course revealed that he had some difficulty in understanding some of the concepts explored.
26. In January 2007, the man was released early on parole. His release was dependent on his compliance with certain licence conditions. He remained compliant for his first 18 months back in the community, but he was then assessed as needing to repeat the SOTP course. He refused to repeat the course and in September 2008 his licence was revoked and he was recalled to prison.
27. Upon his re-arrest, he was taken into HMP Manchester and remained there until July 2009 when he was again transferred to HMP Wymott. The final entry in his wing file before his transfer was: "Well behaved, polite and attends labour regularly. Never ... a problem to staff."
28. On arriving at Wymott, the man was seen for a standard first reception healthcare assessment. He reported having no significant medical history or concerns about his current health. (Clinical records from his previous periods in Wymott and Manchester show that he rarely needed to consult doctors and nurses.) The man reported that he smoked and he was given information about smoking cessation.
29. During his induction interview the man declined the offer of a reception telephone call. (A reception telephone call is free to the prisoner and it allows him to notify family or friends of his whereabouts.)
30. In October, the man obtained a job carrying out quality control in Wymott's commercial engineering unit.

31. The man was seemingly in good health and had little contact with healthcare staff for the next 11 months following his arrival into Wymott. However, in June 2010, prison staff raised concern about his condition with the nurse who was dispensing medication on the wing. The dispensing nurse referred the man to a nurse prescriber², and she saw the man in surgery that afternoon. The nurse prescriber noted:

“[History for approximately 3 weeks]. Began with a cold. After [four] days cold symptoms had gone but [patient] remained breathless. [Patient] states that after sleeping [symptoms of breathlessness] feel better, exertion aggravatesnot producing any sputum, no cough. [Patient] states he had back ache for [approximately] one week last week but has now resolved ...

“... Smoker but has not smoked for [three weeks] since complaint.

“[Past medical history] nil to note. No [family history of cancer]. No [family history] of respiratory diseases, nil self.”

32. The nurse prescriber discussed her findings with a locum doctor. The doctor examined the man and diagnosed a pleural effusion (a build-up of fluid between the lung and chest wall). He was sent to outside hospital that afternoon for further assessment. He was deemed to pose a risk to children and was accompanied into hospital by two escorting officers. He was handcuffed and an escort chain was used to cuff one of his hands to one of the officers. (When prisoners are sent to outside hospital a standardised risk assessment is used to assess the risk to the public. The use of two or more escorting officers is common practice as is the use of handcuffs and escort chains. The level of restraint should be regularly reassessed taking into account the prisoner’s current medical condition.)
33. At hospital a chest x-ray confirmed that the man had an extensive pleural effusion with an associated collapse of the left lung. Excess fluid was drained from his chest and examination of the fluid revealed presence of malignant cells. The man remained in hospital for the next few weeks while further tests and examinations were carried out.
34. My investigator spoke with one of Wymott’s chaplains, who visited the man in hospital on 24 June. The man told the chaplain that he had never had any problems with his health, but was worried about his diagnosis. He spoke very positively, however, about the care and attention he had received from the prison. The chaplain told my investigator that the interaction he observed between the bed watch officers and the man was very good.
35. On 28 June, an entry in the man’s prison clinical records confirmed that the hospital had diagnosed a malignant tumour of the lung, which was at “stage

² the nurse prescriber who had completed the first year of an advanced practitioner course. Advanced practitioners are trained nurses who, after extensive training, will make professionally autonomous decisions for which they are accountable.

3" (advanced). The man was discharged from hospital back to Wymott the following day.

36. On his return to Wymott, the man moved back to his original wing and he was prescribed in-possession paracetamol, dihydrocodeine (analgesia for moderate to severe pain) and food supplements. The dihydrocodeine was then taken away when the man said he did not want it.
37. On 5 July, the man was escorted to hospital for an outpatient appointment where treatment options were to be explained to him. Unfortunately, a mistake was made at some point and he was taken to the wrong hospital. The outpatient appointment was re-scheduled for the following week.
38. The man's re-scheduled appointment took place on 13 July. The consultant oncologist wrote to Wymott summarising the consultation. He explained that the man reported feeling very lethargic and breathless but had no other symptoms. The man confirmed that he was aware that his disease was incurable and he was told that depending on further tests, the hospital might be able to provide palliative chemotherapy (treatment to relieve symptoms but without the possibility of curing the disease).
39. On 14 July, the man was prescribed ibuprofen. A prison doctor visited him on the wing two days later when she noted in his clinical record that he was sweaty, but comfortable with the ibuprofen. The doctor prescribed some additional medication including a laxative, an antibiotic, medication for nausea and codeine phosphate (another analgesia for mild to moderate pain).
40. The next day a nurse was asked by wing staff to see the man. He complained to her that he was feeling clammy, dizzy, and generally weak and unwell. He denied any pain, saying that the paracetamol and ibuprofen were sufficient for the present time. He said that he was finding it difficult to eat due to having a "horrible" taste in his mouth. The nurse arranged for supplement drinks to be delivered to the wing. She also arranged a doctor's appointment for 19 July and told the man that if he felt no better he could ask for a nurse at any time.
41. On 19 July, the nurse and a prison doctor visited the man. The doctor noted similar symptoms to those recorded by the nurse a few days earlier, but the man was now reporting pain in his left upper posterior chest. He also reported that he was unable to drink the supplement drinks and the codeine phosphate was making him feel unwell. The doctor prescribed 5ml of Oramorph (oral solution of morphine sulphate used in the treatment of severe pain) and prescribed a different supplement drink. The doctor added that the man should be reviewed by a doctor again in two days and that if the effusion in his left lung increased, it might need draining again.
42. The following morning, another nurse received a radio call from wing staff reporting that the man was short of breath. The nurse went to the wing when the man told her that on waking 30 minutes earlier he had felt something

“pop” in his left side and was now in excruciating pain. The nurse noted that the man’s colour was “waxen” and his pulse was weak. She noted that it was clear he needed immediate hospital treatment and an emergency ambulance was called. Paramedics arrived on the wing in less than 30 minutes and took the man to Chorley District Hospital. He was again accompanied by escorting officers.

43. Wymott’s primary care manager visited the man in hospital later that day. She recorded in his prison clinical record that the indications were that he had an abscess at the site of the previous chest drain. The plan was to transfer him to the Royal Preston Hospital for drainage of chest fluid and further management.
44. Wymott’s primary care manager noted on the morning of 21 July that the man was then in the Royal Preston Hospital. He was said to be responding to intravenous antibiotics (delivered directly into the bloodstream via a needle) and had stabilised. Two bed watch officers were present with him and as his condition improved he was cuffed once again. (Again, his wrists were cuffed together and an escort chain was used to cuff him to one of the bed watch officers.).
45. The duty governor carried out a risk assessment on 24 July and decided that due to the man’s condition the hand cuffs should be removed, although the bed watch officers should remain with him.
46. When one of Wymott’s nurses telephoned the hospital on 26 July for an update, she was told that the man was responding well to the antibiotics. He seemed brighter and had been up and out of bed for a short time. He was on continuous oxygen and was receiving morphine. An oncology review was awaited to determine further palliative care management.
47. A member of the hospital palliative care team telephoned one of Wymott’s nurses on the afternoon of 28 July to explain that the man was still on continuous oxygen and adjustments had been made to his analgesia to help control his pain. The nurse was told that the man was not currently fit for palliative chemotherapy and it was possible that he only had weeks to live. The nurse was told that the hospital wanted to consider a move to a hospice for symptom control. Following this conversation the nurse contacted the duty governor who said he would seek further advice and would report back the next morning.
48. The duty governor carried out a further risk assessment in the early afternoon of 30 July. He noted that only one bed watch officer needed to be present. He also completed a risk assessment to consider the man’s suitability for release on temporary licence. (In certain circumstances prisoners can be granted release permanently under compassionate grounds, or on temporary licence (ROTL). In order to ensure public safety prisoners are only granted ROTL after being rigorously assessed and approved by an authorised senior manager.) His recommendation was that ROTL should be granted to allow the man to be cared for either at hospital or a hospice. Wymott’s governing

Governor approved the application that same day. Unfortunately the man deteriorated rapidly and he died that evening.

After the man's death

49. The man had not named any next-of-kin during his time in custody. When he was diagnosed as being terminally ill, he was asked if he wanted anyone to be notified. It seems that he was adamant that he wished no one to be informed. Wymott therefore arranged for the man to be cremated. In addition to the service at the crematorium, Wymott held a memorial service at the prison.
50. Staff at Wymott reviewed all of the prisoners on open ACCT plans. The prison care team were made available to any staff who felt in need of support.

ISSUES

Clinical care

51. When the man arrived in Wymott he received a standard first health screening reception assessment. He said that he had no past or present health problems, but reported that he smoked. He was therefore given information about help with stopping smoking.
52. Eleven months went by without the man having any significant contact with healthcare staff. However, on 10 June 2010 he consulted the nurse prescriber, an advanced practitioner in training. He reported to her that he had had symptoms of breathlessness for the past three weeks. He mentioned that he had tried to treat the condition himself by stopping smoking but his symptoms had persisted. He also mentioned having backache a week earlier but that this condition had resolved itself.
53. The nurse prescriber discussed the man's symptoms with a doctor, which resulted in him being sent to outside hospital that same day for further investigations. The clinical reviewer has commented that the nurse prescriber's prompt identification of the man's clinical problems prevented him from suffering any prolonged distress. The clinical reviewer has also commented that the introduction of an advanced practitioner into the prison healthcare unit is a great asset to the care provision at the prison. I concur with both of those findings.
54. The man remained at outside hospital for almost three weeks, during which time he was diagnosed with advanced adenocarcinoma of the left lung. The man was discharged back to Wymott at the end of June, but three weeks later his condition deteriorated and he was transferred back to hospital. He remained in hospital until his death ten days later.
55. The clinical reviewer has found that the man received prompt attention from the nurse who found him suffering a medical emergency on 20 July. Once again I concur with this finding.
56. In addition, I was impressed with the apparent good communication between wing staff and nursing staff. On both 10 June and 20 July it was the wing staff who alerted healthcare staff promptly of their concerns about the man's condition which led to swift and appropriate action by the healthcare staff.

Removal of cuffs

57. Risk assessments were conducted each time the man was taken to outside hospital. The man was deemed to pose a risk to children and it was decided, correctly, that he should be accompanied by two officers and that he should be cuffed. The final time that the man went to hospital was on 20 July. The restraints were rightly removed on 24 July as by then he was deemed to be very ill. Had his condition improved the risk assessment would have been

reconsidered and the restraints might have been replaced. Instead, the man continued to deteriorate and he died on 30 July.

Consideration of Release on Temporary Licence (ROTL)

58. After his final discharge to hospital on 20 July, the man's condition continued to deteriorate and hospital doctors advised that it might be beneficial to move him to a hospice as he was not fit for palliative chemotherapy. Once prison managers were made aware of this, they made the decision to start the process for his early release from prison. One option for this is permanent release on compassionate grounds. While this process can be completed quite quickly in certain circumstances, various assessments and approvals are required before such release can be authorised. ROTL is a speedier, though temporary, alternative. ROTL is used for a number of different purposes, including the granting of a special purpose licence for provision of medical treatment. A rigorous assessment must again be carried out but approval can be authorised speedily by a prison governor. The necessary processes were completed quickly in his case and ROTL was approved in the early afternoon of 30 July. Unfortunately his condition deteriorated rapidly and he died before the ROTL could be actioned.

CONCLUSION

59. The man was an apparently healthy man who rarely needed to consult healthcare staff. When he reported a brief period of symptoms of breathlessness in June 2010 he was sent the same day to outside hospital for investigations.
60. He remained at outside hospital for the next few weeks, during which time he was diagnosed with adenocarcinoma of the left lung. The disease was at an advanced stage. The man deteriorated rapidly and he died just six weeks after he first reported suspicious symptoms.