Investigation into the circumstances surrounding the death of a man in September 2010 whilst in the custody of HMP Wymott

Report by the Prisons and Probation Ombudsman for England and Wales

January 2011

This is a report into the death of a man in September 2010 whilst in the custody of HMP Wymott. He died from natural causes and was 41 years old. He had been to the gym that day and, afterwards, complained of chest pain. A post mortem showed that he died from heart disease.

I offer my sincere condolences to his family and friends for their loss. My Senior Family Liaison Officer attempted to contact his wife to inform her about the investigation and provide her with an opportunity to raise any issues about the care he received in custody, but without success.

The investigation was carried out by my colleague. Both he and I would like to thank the Governor and his staff for their co-operation during the course of our enquiries.

I also thank the local Primary Care Trust for appointing a clinical reviewer to review his clinical care.

He made many complaints about his poor health and I am satisfied that prison healthcare staff tried hard to investigate their causes. He often refused hospital appointments and so his condition was not properly diagnosed.

As he died from natural causes, the findings of the clinical review play an essential part in my report. The review shows that he received good care whilst he was in custody which was equitable to what he could have expected in the community. I endorse one recommendation regarding the provision of secondary health screen assessments. I also recognise the speed and professionalism of the emergency response and the good practice in family liaison.

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

Jane Webb
Acting Prisons and Probation Ombudsman **Jnauary 2011**

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SUMMARY

On 4 July 2009, the man was remanded into custody and sent to HMP Hewell where he had a health screen assessment. He had a medical history which included high blood pressure, depression and diabetes. He had regular contact with healthcare staff at Hewell. However he often refused treatment, failed to attend appointments and refused to be referred to outside hospital, despite encouragement and advice.

He appeared at Crown Court on 14 May 2010 where he was convicted of sex offences and then returned to Hewell. He re-appeared at the same court on 17 June and was sentenced to five years in custody.

On 25 June, he transferred to HMP Wymott and, on arrival, saw a nurse who recorded his prescribed medication, and blood pressure. In the weeks that followed, he again had regular contact with healthcare staff. There were more occasions when he refused to be referred to outside hospital even though the seriousness of the implications to his heath was explained.

At approximately 4.30pm, on Saturday 4 September a uniformed officer was told by a prisoner that he was in his cell and had chest pains after going to a gym session earlier that afternoon. The officer asked for urgent medical assistance and a nurse responded immediately, assessing that an emergency ambulance was required.

The paramedics arrived and, whilst they conducted their assessment, he went into cardiac arrest. Having undertaken cardiopulmonary resuscitation the paramedics transferred him to hospital. He was taken to hospital where hospital doctors pronounced his death at 6.37pm.

His next of kin was recorded as his wife who lived some considerable distance away from the prison. The decision was taken to contact HMP Long Lartin, the nearest prison to the family, to ask their staff to break the news. Unfortunately no one was available at Long Lartin and so, to ensure that the news of his death was given as quickly as possible, the police were asked to tell his family.

I am satisfied that the care and attention he received at both Wymott and Hewell was equitable to what he could have expected to receive in the community. On several occasions, he exercised his right to refuse treatment. I endorse one recommendation regarding the provision of a secondary health screen. I also recognise the speed and professionalism of the emergency response.

THE INVESTIGATION PROCESS

1. The investigation was opened on 9 September 2010 when my investigator issued notices announcing the investigation to staff and prisoners. No one came forward as a result.

2. The investigator visited HMP Wymott on 14 September. He was given copies of all documentation relating to the man, saw where he lived and the gymnasium. The investigator returned to Wymott on 7 October and interviewed five members of staff and one prisoner.

3. The local Primary Care Trust asked a clinical reviewer to review the man's clinical care. The investigator and the clinical reviewer jointly discussed aspects of his treatment with healthcare staff at Wymott. I am grateful to her for her comprehensive and timely report.

4. The investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and request a copy of the post mortem report. Upon completion, the investigation report will be sent to the Coroner to assist his enquiries into the man's death.

5. My Senior Family Liaison Officer attempted to contact the man's wife on several occasions, by telephone and letter, to inform her about the investigation and invite her to ask any questions or raise any concerns about the care he received in prison. However, no response was received. A copy of this report will be made available to his wife should she choose to receive one.

HMP WYMOTT

6. HMP Wymott is a large category C prison which holds sentenced prisoners. The prison accommodates both vulnerable prisoners (prisoners deemed at risk due to the nature of their offence) and prisoners on ordinary location.

7. Mainstream prisoners and vulnerable prisoners are held in separate accommodation and so Wymott is effectively two separate prisons with their own range of workshops, education and training facilities. The prison opened in 1979 and new accommodation was added in 1996. Vulnerable prisoners mainly live in the original house blocks. Wymott can hold a maximum of 1,176 prisoners.

8. Healthcare services at Wymott are commissioned and provided by the local Primary Care Trust. Services do not include inpatient beds and prisoners who need inpatient care often go to HMP Preston, which has an inpatients unit.

9. Wymott was last inspected by HM Chief Inspector of Prisons in October 2008. The Chief Inspector commented that:

> "Wymott is a large category C training prison, holding over a thousand men. It has expanded 25% since its last inspection in 2003. Unlike many training prisons which have undergone similar expansion, Wymott has managed to sustain its performance and the quality and quantity of activity available to its prisoners.
>
> "Recent changes to the core day had restricted prisoners' access to time out of cell, but the quality of education and training available was very good, and clearly linked to employability and sentence planning. Qualifications were available in all work areas, and the work met industry standards. PE provision was also good, with opportunities for older prisoners and those with disabilities.
>
> "Health services were commissioned and provided by the local Primary Care Trust (PCT), which also commissioned health services for HMPs Garth and Preston. A health needs assessment and health delivery plan had been completed. A partnership board, which met bimonthly, was held jointly for the three prisons.
>
> "The healthcare centre was centrally located. The department was on the first floor, with access by stairs or lift.
>
> "There was extensive emergency equipment, including six automated external defibrillators at strategic points around the site, with one in the healthcare centre. Each one also had a bag of emergency equipment with it. The equipment was checked daily, and records of this maintained."

10. In their annual report for the period ending May 2009, the Independent Monitoring Board (a body of local volunteers who independently monitor and report on the prison) made the following comments:

"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.

"Generally Healthcare in the Prison has improved since its takeover by the PCT and the appointment of a new Healthcare Manager in 2008. However the Board considers that the Unit still has some way to go before it achieves the NHS aim of treating prisoners to the same standard as patients in the community. Given the high concentrations of poor physical and mental health, drug addiction, general low self-esteem and lack of access to private medicine and retail pharmacies, the Board considers the PCT should be offering a service that exceeds what it provides for the general population."

11. There have been five deaths at HMP Wymott this year all of which were from natural causes. There are no similarities between the man's death and the other deaths at Wymott.

HMP HEWELL

12. HMP Hewell was created on 24 June 2008 by merging three separate prisons which were located on adjacent sites (HMP Blakenhurst, HMP Brockhill and HMP Hewell Grange). Hewell primarily serves the West Midlands, Worcestershire, and Warwickshire areas.

13. Healthcare is provided by the local Primary Care Trust. The unit has 24 hour nursing staff, with in-patient care situated on the lower floor of the unit. All in-patients are encouraged to associate out of their cells, including eating in a communal dining area. There is a varied timetable of activities with nursing staff supporting patients to actively socialise together. A weekly multi-disciplinary meeting is held to discuss individual cases (both those who are physically and mentally ill).

14. Hewell was last inspected by HM Chief Inspector of Prisons in November 2009. The Chief Inspector commented that:

> "Health services included a wide range of clinics delivered by in-house and visiting specialists. Primary care services were generally good, but access to all services varied between houseblocks, and prisoners' perception of healthcare was poor. Too many prisoners were failing to attend healthcare appointments, although work to reduce this was ongoing. Dental treatment was very good, but some treatment was restricted unnecessarily. Pharmacy services were also good, but nurses spent too much time on pharmacy duties, and hypnotic medicines were given too early in the day. There was mental health support from primary and secondary teams, but there were no daycare services for prisoners with low-level mental health needs. Inpatients had a high level of time out of cell, but there was little continuity in the nursing staff on the unit."

15. In their annual report for the period ending May 2009, the Independent Monitoring Board made the following comments:

> "The Governor has an open approach and her style of management not only identifies problems but ensures they are dealt with. The path of progression throughout the prison - *One prison, One vision* - is encouraging as is the continued consolidation of policies and protocols.
>
> "Healthcare is available equally to all prisoners and detainees and all receive an examination within 24 hours of reception. The Board is satisfied that prisoners are seen in privacy. There is now provision for prisoners to speak with nursing staff regarding the need for pain relief during the night."

KEY EVENTS

16. The man was born in September 1966 and, prior to coming into prison, he lived in Worcestershire. He was married with three children. He had a history of depression, was diabetic and a smoker. He was remanded into custody at HMP Hewell on 4 July 2009 charged with sex offences. He had previously been in prison for unrelated offences.

17. On arrival at Hewell, he had a health screen conducted by Nurse A. The nurse recorded that he was prescribed medication of furosemide (water tablet sometimes used in conjunction with high blood pressure medication), venlafaxine (anti-depressant), levothyroxine (thyroid hormone replacement), metformin (for diabetes), metronidazole (for bacterial skin infection) and Co-amokiclav (antibiotic) for a gum abscess. He told the nurse that he had been to the Accident and Emergency Department at hospital on 27 June 2009 as he had chest pains and also said that he suffered from claustrophobia. The nurse noted that he appeared very over weight and, given his medical conditions, admitted him to healthcare for observations.

18. The next morning Prison Doctor A examined him and reviewed his medication. His blood pressure was recorded as 190/120. (The normal range for blood pressure is 100/70 to 140/90, although the pressure varies throughout the day depending on the individual's activities. A blood pressure reading of greater than 140/90 is classed as high and a reading of 90/60 or below is classed as low.) The doctor prescribed irbesartan (for high blood pressure) and aspirin. He also referred him to the diabetic nurse and the mental health team. He was monitored by nursing staff throughout the rest of the day and no other concerns were recorded.

19. Over the next two days nursing staff monitored him on ten separate occasions recording his blood pressure, which remained consistently high, his diabetes and general wellbeing.

20. On 9 July, Prison Doctor B saw him as he complained of pain in his chest and his left arm. The doctor recorded his blood pressure as 210/130, his weight as 165.1Kg (26 stone) and his height 1.96m (six feet five inches). The doctor arranged for him to be admitted to the Emergency Department at hospital. However, he refused to go to hospital despite the doctor explaining that his blood pressure was dangerously high and he was at risk of a heart attack or stroke.

21. Later that evening, after encouragement from Nurse B, he agreed to go to hospital. A risk assessment was completed that authorised two officers to escort him using an escort chain which could be removed for treatment purposes only. (Whenever a prisoner is escorted outside of the prison a risk assessment is completed which considers the risk to the public, the potential for escape and likelihood of outside assistance. The assessment informs the decision about the number of escorting officers and the type of restraint to be used (single cuffs or two metre long escort chain with cuff at either end.) It also determines the circumstances and the authority required for the restraints to be

removed. The risk assessment is reviewed each day that a prisoner is in hospital and amended where necessary.

22. He was kept in hospital overnight but discharged himself the next morning, against medical advice, and returned to prison. Prison Doctor C saw him in his cell. Although he felt anxious, he had no chest pain but was breathless at times. He told the doctor that he had suffered from asthma since childhood and used to use an inhaler. The doctor prescribed salbutamol (for asthma) but did note that his ash tray was full, indicating he was still smoking quite heavily.

23. On 11 July, he appeared in court and was further remanded into prison and returned to Hewell where he remained in healthcare, being monitored by staff.

24. Two days later Prison Doctor D reviewed him as he complained of numbness in his left arm and leg. The doctor recorded that his blood pressure was 175/127 and proposed to admit him to hospital. He again refused to go to hospital and signed a disclaimer to confirm his refusal of hospital treatment against medical advice. The doctor prescribed amlodipine (for high blood pressure).

25. The next morning he saw Prison Doctor E who discussed the need to stop smoking. The doctor recommended nicotine replacement therapy but he declined saying that he would stop smoking by will power alone. The doctor also advised him that he should reduce his weight and take more exercise. He told the doctor that he had experienced hearing voices during the night (which is sometimes an indication of mental ill health). The doctor referred him to the mental health team and to the local hospital regarding his high blood pressure.

26. Later that same morning Nurse C, a member of the mental health team, saw him as requested by Prison Doctor E. The nurse recorded that there was no evidence of psychosis or depression and there was no cause for concern.

27. On 15 July, Prison Doctor B saw him to review his medication and wellbeing. The doctor recorded that he was prescribed the appropriate medication and was to be transferred from healthcare to houseblock six. The doctor noted that the treatment plan for him included weekly blood pressure checks and regular reviews of his medication.

28. Between 16 July and 3 September, he had ten contacts with healthcare staff including four consultations with Nurse D, a community psychiatric nurse. No concerns were noted and the nurse recorded that he did not need secondary mental health services.

29. On 4 September, he was taken to the Care and Separation Unit (CSU) of the prison for breaching prison rules. (The CSU is where prisoners are segregated away from the main prison population and allocated single cells, with a restricted regime compared to the normal prison accommodation. The daily routine includes a visit from the duty governor, a member of the healthcare staff and one of the chaplaincy team.) He remained on the CSU for the next 23 days. He had an appointment at the hospital on 11 September, but on the day, he refused to attend and so a further appointment was made for 25 September.

30. He left the CSU and moved to houseblock five on 21 September after being reminded that a further breach of the rules would result in returning to the unit.

31. On 25 September, he again refused to go to the hospital for his appointment. He signed a disclaimer to say that he refused all hospital treatment. As a result, healthcare administration staff informed the hospital and no further appointments were made.

32. Three days later he saw Prison Doctor F as he complained of pain in his head, neck and left leg. The doctor examined him and recorded that he had good back movement with no pain when sitting or standing. The doctor advised him to exercise and prescribed paracetamol.

33. Prison Doctor G reviewed his medication on 7 November and confirmed it as irbesartan, levthyroxine, amlodipine, furosemide, venlafaxine, zopiclone (for insomnia), metformin and tramadol (for moderate to moderate severe pain relief).

34. On 11 November, discipline officers received information that suggested that he was selling his tramadol medication to other prisoners. As a result he was taken back to the CSU. He was unhappy about the punishment and refused to take his medication, despite encouragement from staff.

35. He remained in the CSU until he returned to houseblock 5 on 22 January 2010. Between 16 November and 11 January 2010, he saw the prison doctors eight times. The consequences of refusing his medication were explained to him and a disclaimer signed. On two occasions, despite complaining of abdominal pain and groin pain, he refused to be examined.

36. On 31 January, Prison Doctor A reviewed his prescribed medication and no changes were made. By 11 February, he was taken back in the CSU due to breaching prison rules.

37. Prison Doctor D saw him on 22 February as he complained of swelling around the ribs. The doctor recorded that he had lost some weight which made the ribs more prominent. If he reduced his weight significantly, the doctor thought that he might not require the blood pressure tablets.

38. He saw an unidentified nurse on 1 March as he complained of a broken right upper molar. The nurse made an appointment with the dentist the following day but did not attend. The reason for his refusal is not recorded.

39. Prison Doctor F saw him on 3 March as he complained of toothache and then prescribed paracetamol. Later that same afternoon Nurse E saw him as he complained of hearing voices, experienced visual hallucinations and had nightmares. When the nurse asked about the nightmares, he would not say. The nurse referred him to the mental health team.

40. He saw two forensic psychiatrists the following day. He told them that he heard the voices of two dead relatives who told him not to worry. He also said that he saw a man with a beard and a black cloak in the corner of his cell. Psychiatrist A recorded that he was a large man, who was calm and rational throughout the consultation, and denied any thoughts of harming himself. The doctors' assessment was that he had no symptoms of a depressive or psychotic illness.

41. He remained in the CSU for the next nine days and, following a review on 15 March, he returned to houseblock 5.

42. Two days later, he saw Prison Doctor B as he complained of being tired all the time. Blood tests were conducted and the doctor recorded that the results were normal and no further action was required.

43. On 1 April, he saw Nurse F as he felt dizzy and said that he had vomited eight times. The nurse recorded that he looked well and there was no evidence that he had been sick. The nurse advised him to drink plenty of water, not to eat anything for 24 hours and to relax on his bed.

44. Ten days later Nurse F saw him as he still complained of dizziness. The nurse recorded his blood pressure 150/88 when laying down and 148/90 on standing. The nurse noted that he was not dizzy when standing. He was advised to look after his own wellbeing by losing weight and stopping smoking.

45. On 13 April, he was taken back to the CSU following a racial incident on houseblock 5. He remained there for the next 14 days and no concerns were recorded.

46. Following review he was moved to houseblock 2 on 26 April. Prison Doctor B reviewed his medication on 12 May and no changes were made.

47. He appeared at Crown Court on 14 May and was convicted of sex offences, to be sentenced at a later date, and returned to Hewell.

48. Prison Doctor B conducted two further reviews of his medication on 26 May and 9 June and made no changes to the prescription. No other concerns were recorded in the medical records.

49. He re-appeared at Crown Court on 17 June and was sentenced to five years in custody.

Transfer to HMP Wymott

50. On 25 June, he transferred to HMP Wymott and, on arrival, saw Nurse G for the routine reception healthscreen. The nurse listed his prescribed medication, and noted that his blood pressure was 143/88. There is no evidence in the medical records that a secondary healthscreen was conducted by a member of healthcare staff.

51. Five days later Prison Doctor H saw him as he complained of pain in his left ear, dizziness and pain in his left knee. The doctor examined his left ear and leg and found them to be normal. He was described as obese and requiring a diabetic diet.

52. He completed a Physical Activity Readiness Questionnaire for the Physical Education Department (PED) at Wymott. This is a standard questionnaire completed by prisoners before they use the gym. Healthcare staff do not contribute to the assessment unless the prisoner answers some questions in the affirmative. He was required to answer questions about his health and sign a declaration. Specific health questions on the form were "Have you ever been told you have high blood pressure?" and "Are you currently taking any medication". He answered no to both these questions even though he knew his blood pressure was high and he was taking medication. The form states that, if the prisoner answers "yes", then healthcare permission is required before they are allowed to use the gym. In addition he stated incorrectly that he was born in September 1976 and was 34 years of age, although he was actually ten years older.

53. At interview, Senior Officer (SO) A, Head of the PED, said that any prisoner answering yes to the questions would be referred immediately to healthcare to assess their suitability to use the gym. He said that PED staff do not have access to confidential medical information although each member of the PED staff is fully trained in first aid.

54. Prison Doctor H saw him on 22 July as he complained of nausea, pain in his spine and pain in his right knee. He told the doctor that his brother had been diagnosed with multiple sclerosis some four years earlier. The doctor examined him and recorded that there was mild restriction in movement in his spine. The doctor diagnosed osteoarthritis and prescribed naproxen (anti-inflammatory). As a precaution he was referred to hospital for consideration of whether he too had multiple sclerosis.

55. On 18 August, he saw Prison Doctor I as he had cut his right thumb. He told the doctor that he was unable to move his thumb but refused to allow his hand to be examined. The doctor recorded that it was a simple laceration to the thumb and noted that his hand was not bruised or swollen.

56. The next day he saw Prison Doctor H as he was experiencing pain in his right knee. The doctor examined his knee which appeared normal with no signs of discomfort. He was advised that he was fit to use the gym. No reference made by either him or the doctor during the consultation to the laceration to the right thumb.

57. The following day he had an appointment at the hospital for the assessment regarding multiple sclerosis. However on the day, he refused to go to the appointment.

58. Three days later Prison Doctor H saw him and conducted blood tests. The results were all within normal range with the exception of a low vitamin B level for which the doctor prescribed vitamin B tablets.

59. On 26 August, he saw the same doctor as he complained of pain in his left ear, bleeding from the same ear and pain in his right hand. The doctor examined him and confirmed that there was redness in his left ear canal and his right hand was normal with a healed laceration. The doctor prescribed trimovate cream (for skin infections) for the left ear and co-codamol (for pain relief), noting that no more pain relief was to be prescribed.

Saturday 4 September

60. At around 3.00pm, he went to the recreational gym session with fellow prisoner. He said at interview that the man used the rowing machine, exercise bike and lifted some dumbbell weights. He said that he told him that he felt dizzy which he thought was because he had not been to the gym for a few weeks.

61. They both returned to their cells on the same wing at approximately 4.00pm. He recalled that the man was sweaty and said that his legs ached a little. He told him that he would see him later and went for a shower.

62. At approximately 4.30pm, Officer A was told by another prisoner that the man was in his cell and had chest pains. The officer went to his cell to find him lying on his bed, with his face covered in perspiration and his skin turned a pale colour. The officer noticed that he had vomited into his bin. He told the officer that he had pain in his chest and head. Due to his condition, the officer called a Code Blue over the radio network at 4.35pm. (Code Blue alerts staff that an emergency response is required for a prisoner found with breathing difficulties.)

63. Nurse H responded immediately by collecting equipment from the treatment room and coming to the cell. He was very pale in colour, but was breathing without difficulty and was orientated but drowsy. He said that he had severe pain in the centre of his chest and his lips felt numb. He also told the nurse that he had been to the gym that afternoon and had eaten some toothpaste (used as a self administered treatment for heartburn). The nurse requested an emergency ambulance and collected a glyceryl trinitrate (GTN) spray (to treat angina), oxygen and aspirin from the treatment room on the wing. The nurse administered two puffs of the GTN spray, aspirin and oxygen therapy.

64. The nurse noted that, after a few minutes, his colour improved and he told the nurse that the pain had eased. Another prisoner passed by and asked him if he wanted his meal collecting for him to which he said yes.

65. The paramedics arrived at 5.00pm and began to assess his condition. Whilst they conducted their assessment, he went into cardiac arrest and the paramedics, with the assistance of three nurses, started cardiopulmonary resuscitation. The paramedics used a defibrillator (which monitors the heart rhythm and administers electrical shocks to the heart to restore the normal rhythm when necessary) to shock him twice before they decided that he should

be transferred to hospital. The officers helped the paramedics to swiftly transfer him to the ambulance. Two officers accompanied him in the ambulance and no restraints, such as handcuffs, were used.

66. The ambulance left the prison at 6.15pm and arrived at hospital 15 minutes later at 6.30pm. Following an assessment by hospital doctors, his death was pronounced at 6.37pm.

67. As his wife lived a considerable distance from the prison, the duty governor followed the guidance in Prison Service Order 2710 'Follow up to deaths in custody'. He contacted HMP Long Lartin, which is the prison closest to her home, to seek their assistance to break the news in person by a member of staff. The duty governor at Long Lartin had left for the evening but the duty chaplain did contact the governor but was unable to help. Therefore, due to the distance involved, the governor asked the police to break the news to his wife.

68. The following day, prison family liaison officer contacted the man's wife to offer support and financial assistance towards the funeral expenses. In the days that followed the prison maintained contact with her. The prison arranged and paid for her to travel to Wymott with a relative to see where her husband had lived and to visit his body at the chapel of rest. The prison was represented at his funeral in accordance with the family wishes.

ISSUES

Clinical care

69. The clinical reviewer and I are satisfied that the care the man received at Wymott and Hewell was equitable to what he could have expected in the community. The clinical review makes the following comments regarding his clinical care:

> "He received a great deal of attention from the prison health care services. He had a complex medical history; he also smoked and was a large man which all contributed to a cardiovascular risk to his well being.
>
> "He proved to be very difficult to manage medically as he manipulated his health needs to effect his own desired outcome. The healthcare staff were aware of his manipulating behaviours but remained vigilant to the high risk of cardiovascular disease he faced.
>
> "He was referred to outside hospitals for investigations on several occasions but he declined to attend appointments. He was not always compliant with healthcare appointments, treatments or taking medication during his time in prison.
>
> "It is possible if he had attended hospital for investigations and had accepted appropriate treatment his life may have been extended.
>
> "The care he received in the prison health care was equal to the care he would have received if he was in the community."

<u>Secondary Health screen at HMP Wymott</u>

70. The clinical reviewer highlights that there is no evidence whether he received a secondary health screen after his arrival at Wymott, and said in her report:

> "The Secondary Health Screening is a general health assessment and is offered to every prisoner in the week following first reception. This assessment is equivalent to a primary care assessment when registering with a GP in the community. It provides an opportunity for gathering further health information, health education and promotion. Importantly, it also checks how a prisoner is settling into the prison routine. It forms part of the induction wherever a prisoner is located. PSO 3050 underpins the process.
>
> "On this occasion the secondary screening does not appear to have taken place."

However the clinical reviewer recognised that:

> "On this occasion it did not have a detrimental outcome on his health."

71. Whilst it is not mandatory to undertake a secondary healthscreen when a prisoner transfers from another prison it is best practice to do so and it is my experience that this does take place elsewhere in the prison service. I therefore endorse the recommendation made by the clinical reviewer as follows:

The Head of Healthcare at HMP Wymott should consider the guidance in PSO 3050 and adopt the best practice that all prisoners transferred from another prison are subject to secondary screening.

Gym assessment

72. There are safeguards in place at Wymott for the suitability of prisoners to use the gym facilities. Prisoners are required to complete a Physical Activity Readiness Questionnaire in which they answer health specific questions and sign a declaration. If health issues are highlighted on the questionnaire, the gym staff refer them to healthcare for an assessment before they are allowed to use the gym facilities.

73. The man completed a PED questionnaire on 2 July 2010 but was not truthful in his answers concerning his medical condition, his medication and his date of birth. He was allowed to use the gym without any further assessment.

74. Six weeks later, on 19 August, Prison Doctor H saw him regarding pain in his knee and advised him that he was fit to use the gym. Following this consultation the doctor did not make any further comment relating to his suitability or restrictions in the use of the gym. He was well known to healthcare staff and had been advised by them to exercise more and lose weight. I am satisfied that the doctor would not have confirmed his suitability had there been any doubts about it.

75. There are staff on duty during each gym session who are both qualified gym instructors and fully trained in first aid. I am satisfied that the PED at Wymott has appropriate safeguards in place to allow prisoners to use the facilities in an organised and safe way.

Emergency response

76. The clinical reviewer considered the response made by staff at Wymott and specifically made the following comments:

> "Officer A immediately made an urgent request for medical assistance using the prison's emergency call sign.
>
> "Nurse H acted promptly when she received the emergency health call. The nurse correctly identified that the man was experiencing a cardiac event and immediately called for an emergency ambulance. He suffered a cardiac arrest when the paramedics were in attendance.

"His prison health records accompanied him to the outside hospital which is good practice."

77. The clinical reviewer concluded that:

"He suffered a fatal cardiac event for which he received a timely and appropriate response and treatment from the healthcare staff. Unfortunately he did not recover from a cardiac arrest despite all efforts of the nurses, paramedics and hospital staff.

"There was nothing the staff at HMP Wymott could have done to prevent he suffering a cardiac episode."

78. The staff who responded to his need for emergency assistance acted with great speed and professionalism. I believe the Governor should recognise the professionalism displayed by the staff who were directly involved in giving swift emergency assistance to him.

Use of restraints

79. There have been too many reports in I have criticised the level of restraints used when prisoners are taken to outside hospital. It is pleasing to recognise the good practice adopted by Wymott which ensured that he was treated with dignity and respect on the day of his death.

Family liaison

80. I am pleased to note that Wymott contacted another prison in an attempt to seek their assistance to contact his next of kin. As the prison is closer to the family home, it should have meant that the news could have been broken face to face in a timely matter and by an appropriately trained member of the prison's staff. Wymott followed the guidance set out in PSO 2710, although it was regrettable that the other prison was unable to assist.

81. I accept that, as no assistance was made available to Wymott, and faced with the distance from the prison to the family home, the decision to use the police was the most best and most expedient way to break the news to his family.

82. I also recognise the additional work undertaken by Wymott in the arrangements made to allow his wife to visit the establishment, see where he had lived and see him in the chapel of rest.

CONCLUSION

83. I judge that prompt attention was paid to the man's health needs by staff at HMP Hewell and HMP Wymott and appropriate treatment was provided. The standard of care that he received was equitable to that which he could have expected to receive in the community. However, I also recognise that ultimately he had a responsibility for his own health and could have accepted medical attention but often exercised his right to refuse treatment. I do not think that his refusal of treatment had a bearing on his death.

84. He died soon after becoming ill following a session in the gym. Although he had given inaccurate information in the Physical Activity Readiness Questionnaire, he saw a doctor afterwards on an unrelated matter who confirmed that he was fit to exercise. I realise that gym assessments used to include a face to face review by a member of the healthcare team and have since been replaced with the questionnaire. I do not suggest that any more assessment would have been appropriate and I accept that many prisoners use the gym without ill effect.

85. I believe that he was treated with dignity and respect whilst he was in prison. Following his death Wymott appropriately followed the guidance given in PSO 2710, "Follow up to death in custody".

RECOMMENDATIONS

1. The Head of Healthcare at HMP Wymott should consider the guidance in PSO 3050 and adopt the best practice that all prisoners transferred from another prison are subject to secondary screening.