

**Investigation into the circumstances surrounding
the death of a man in hospital
whilst in the custody of HMP Wymott
in October 2008**

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

April 2009

This is the report of an investigation into the death of a man who died at the Royal Preston Hospital on 5 October 2008, whilst he was in the custody of HMP Wymott. The man had been admitted to hospital after collapsing in his cell earlier that same day. The cause of death was recorded as an intracerebral haemorrhage as a result of acute myeloid leukaemia. The man was 48 years old.

My colleagues and I would like to extend our condolences to the man's family for their loss. Losing a relative whilst they are held in custody can make it even harder for both family and friends to come to terms with their bereavement.

This investigation was led by one of my investigators. He was assisted by another of my colleagues. One of my Family Liaison Officers contacted the man's mother to inform her of my investigation and discuss her questions and concerns about her son's death.

A clinical review of the medical care and treatment the man received in custody was undertaken by the Healthcare Manager at HMP Altcourse. The clinical reviewer was asked to assess whether the medical care the man received in custody was comparable to that which he might have experienced had he been in the community. I am most grateful for her assistance. Similarly, I would like to extend my thanks to another healthcare professional, who completed an independent medical report in relation to the circumstances of the man's death and the adequacy of the primary care delivered to prisoners at Wymott.

I am also grateful to the Governor, staff and prisoners at Wymott for their full cooperation during the course of my investigation. In particular, I would like to thank the officer who liaised with my investigators and facilitated the interviews conducted at the prison.

The man had entered custody on 3 July 2008 and, after an initial stay at HMP Preston, was transferred on 19 September to Wymott, where he remained until his collapse on 5 October. A post mortem established that undiagnosed leukaemia had spread throughout the man's body. As his mother told my Family Liaison Officer, her son's death was sudden and unexpected. My investigator has tried to reflect the family's concerns in the course of this report.

I make no formal recommendations of my own, but I endorse one recommendation made in the independent medical report.

Stephen Shaw CBE
Prisons and Probation Ombudsman

April 2009

CONTENTS

Summary	4
The Investigation Process	6
HMP Wymott	8
Key Findings	10
Issues	18
Recommendation	23

SUMMARY

The man entered custody on 3 July 2008 after receiving an extended sentence for public protection at Preston Crown Court. He was initially held at HMP Preston, where he was considered by staff to be a mature and polite prisoner. The man did not report any significant health problems during his initial health screening upon arrival at Preston and did not ask to see the doctor prior to his transfer to HMP Wymott on 19 September.

At his reception health screening at Wymott, the man advised a nurse that he tended to bruise easily. She advised him to book an appointment with the doctor. On 1 October, the man was assessed by another nurse and reported bleeding gums and sores on his penis. The nurse booked an appointment with the doctor for the following day.

The man was examined by the doctor on 2 October. He did not report any other symptoms aside from those he had already told the nurse about. The doctor prescribed medication to address both of the man's complaints, and ordered blood tests as a matter of routine due to the number of days that the man's gums had been bleeding.

A second nurse was asked to assess the man on the evening of 3 October as he was experiencing stomach pain. The nurse assessed that this pain was a side effect of the medication that the doctor had prescribed the day before. He advised the man to stop taking the medication for the time being. He also advised the man to take in fluids, as he appeared dehydrated. The man told the nurse that he had stopped drinking the water at Wymott because he was 'allergic' to it.

The second nurse handed over to another nurse on the morning of 4 October, and asked her to review the man's health. This nurse did so, and found the man's condition to be improved. She also observed that the man appeared less dehydrated. She advised him to rest. The following morning (5 October), this nurse checked on the man again as a matter of routine and found him to be feeling better. However, she did observe spontaneous bruising around the man's left eye and, out of concern, ensured that he was listed for blood tests.

The man was locked in his cell at about 12.20pm that day. His cell was unlocked after the lunch period at about 2.05pm by an officer. A few minutes later, one of the man's fellow prisoners found him collapsed on the floor of his cell. He was bleeding from a cut to his head. The prisoner summoned staff, who in turn radioed for healthcare staff to attend. They also requested that an ambulance be called.

Several nurses and prison officers attended to the man in his cell. The ambulance arrived at just after 2.30pm, and the paramedics arrived on the wing within minutes. Healthcare staff handed over to the paramedics and the man was transferred to the ambulance. A different nurse travelled with the escorting officers to offer medical assistance. The ambulance left Wymott shortly after 3.00pm but had to stop on the way to hospital to allow the man to be treated.

The ambulance arrived at the Royal Preston Hospital at 3.40pm. The man was subsequently taken for a computed axial tomography (CT) scan in order to diagnose his condition. In the meanwhile, his next of kin had been informed of the emergency, and his mother and sister arrived at the hospital shortly after 6.00pm. The man's relatives gave permission for his life support machine to be switched off later that night. He died at 11.05pm.

The post mortem report recorded the cause of death as an intracerebral haemorrhage as a result of acute myeloid leukaemia. Essentially, the man died as a result of spontaneous bleeding into his brain tissue. This in turn had been caused by the leukaemia, which is a cancer of either the blood or bone marrow.

Although I make no formal recommendations as a result of my investigation, I endorse one recommendation made in the independent medical report in relation to the delivery of healthcare at Wymott.

THE INVESTIGATION PROCESS

1. My investigator was formally notified of the man's death on 20 October 2008, fifteen days after his passing. Notices were subsequently issued to both staff and prisoners at Wymott informing them of the investigation process, and giving them the opportunity to contact my investigator if they felt that they could assist in providing relevant information. No responses were received as a result of these notices.
2. My investigator formally opened the investigation on 28 October when he visited Wymott. He met the prison's liaison officer and was given full access to all of the prison records relating to the man. He familiarised himself with the prison's healthcare centre and the wing on which the man had lived. He also visited the cell where the man had been housed whilst at Wymott and where he was found following his collapse.
3. On 27 November, having examined all of the relevant documentation, my investigator returned to Wymott and conducted six interviews. Four interviews were with healthcare staff, one with a senior prison officer and one with the prisoner who had found the man collapsed. My investigator also subsequently interviewed a prison officer by telephone on 12 December, as the officer had been unavailable during the initial interviewing process.
4. My investigator wrote to HM Coroner to inform him of the nature and scope of my investigation, and to request a copy of the post mortem report. The Coroner will also receive a copy of my report.
5. My investigator contacted Central Lancashire Primary Care Trust (PCT) and requested that a clinical review be carried out into the care the man received whilst in custody. The purpose of the review is to assess whether the medical care and treatment that the man received in prison was comparable to that which he would have received had he been living in the community. The Head of Healthcare at HMP Altcourse, was commissioned to carry out this review. Her review is annexed to this report.
6. On 14 November, one of my Family Liaison Officers contacted the man's mother as his listed next of kin. She gave the man's mother the opportunity to discuss the purpose of the investigation and raise any concerns or questions the family wished us to explore during the investigation. The man's mother said her son's death had come as a complete shock. She told my Family Liaison Officer that she was aware that her son had visited the prison's healthcare centre. She wanted to know why blood tests, which would have highlighted her son's extensive leukaemia, were not carried out. I trust I have addressed the family's concerns within my report. I hope it gives them a better understanding of the events leading up to the man's death.

HMP WYMOTT

7. Wymott is a category C training prison for adult male prisoners serving sentences longer than six months. It is situated close to the town of Leyland in Lancashire. It has dedicated facilities for vulnerable prisoners, most of whom will have committed a sexual offence. These vulnerable prisoners make up approximately half of the prison's population. The maximum operational capacity of the establishment is just over 1,040 prisoners.
8. Since my office took responsibility for investigating deaths in prison custody in April 2004, I have investigated 18 previous deaths at Wymott. Of these, 14 were attributable to natural causes, and four were apparently self-inflicted. As a result of my previous investigations, I have made a number of recommendations relating to the delivery of healthcare at Wymott. One of these, relating to the introduction of electronic record keeping, is reflected in my current recommendations resulting from the death of the man.
9. The commissioning of healthcare within Wymott is the responsibility of the Central Lancashire Primary Care Trust (PCT). The prison does not have inpatient facilities and prisoners who need inpatient care are referred to HMP Preston or to the local hospital. There is a general practitioner (GP) surgery within the prison which prisoners can access five days a week. Overnight and weekend services are covered by a local GP who is on call in the event that they are required. There is also a clinically qualified member of healthcare staff on duty within the prison during these periods.
10. An unannounced inspection of Wymott was carried out by Dame Anne Owers, HM Chief Inspector of Prisons, between 30 October and 1 November 2006. Following her inspection, Dame Anne wrote:

‘This inspection confirmed that Wymott continued to perform reasonably well and managers and staff deserve credit for the improvements achieved since our last inspection – and for putting in hand further improvements.’
11. The Independent Monitoring Board (IMB) at Wymott has recently published its annual report, covering the year from 1 June 2007 to 31 May 2008. (The IMB at each prison is made up of members of the public who are both independent and unpaid. They monitor the day-to-day life in their prison and ensure that proper standards of care and decency are maintained.) With regard to the provision of healthcare at Wymott, the IMB commented in their report:

‘The full transfer to the Primary Care Trust of responsibility for both healthcare service commissioning and provision is to be welcomed ... the Board wishes to acknowledge the professional and committed approach of the healthcare staff ...’

However, the IMB also noted:

'... a significant reduction in the provision of GP services, mirroring the ratios in community provision ...'

KEY FINDINGS

From 3 July 2008 until the man transferred to HMP Wymott

12. The man entered custody at HMP Preston on 3 July 2008 after receiving an extended sentence for public protection at Preston Crown Court. This sentence was to be made up of a four year period spent in prison, followed by a four year period spent on licence in the community under the supervision of the Probation Service.
13. Upon arrival at Preston, the man completed a Well Man Assessment and a First Reception Health Screening. In neither document did he identify any significant health problems. The man did mention a history of depression when he completed the forms, but indicated that he had not previously sought either medication or counselling in this regard. He told staff that he had never intentionally harmed himself, nor had he had any suicidal thoughts.
14. During his initial health screening, the man was assessed as being physically fit and suitable to perform manual work. At the point of entering custody the man applied for, and was granted, status as a vulnerable prisoner as a result of his offence. He named his mother as his next of kin.
15. The man returned to Preston Crown Court on 15 July, where, due to a legal problem, his original sentence was reviewed. At this hearing, an identical sentence, comprising four years spent in custody and four years subsequently on licence, was imposed in place of the original. This sentence ran from 15 July 2008.
16. On 26 July, staff made an entry in the man's wing history document. They commented that he was a 'mature, polite and tidy' prisoner who was complying with the prison regime. During the weeks that followed, prior to his transfer to HMP Wymott, the man seems to have complied with all that was asked of him.

From 19 September until 4 October

17. The man was transferred from Preston to Wymott on 19 September. He was placed in a cell on the ground floor landing on G wing. A new healthcare reception screening was completed upon his arrival at Wymott by the reception nurse. The only significant issue raised was that the man tended to 'bruise easily'. He was advised by the reception nurse to apply to see the prison doctor, but no actual appointment was made.
18. The reception nurse told my investigator that there was no actual bruising evident to her on 19 September, and that the man did not complain unduly about this issue during the screening. He did not appear unwell, and she did not therefore make an immediate referral to a doctor. She expected that, having advised the man to see a doctor, he would obtain an appointment within the next two weeks, should he make such an application.

19. The man's weight was recorded at the screening, and had decreased from 72.6kg upon his admission to custody on 3 July to 70kg on 19 September. It was noted by staff that the man was pleased to have been transferred to Wymott, as he had been held there during an earlier prison sentence in 2001.
20. On 1 October, the man was assessed by another nurse. He complained of bleeding gums and sores on his penis. He did not mention any other concerns with regard to his health. The nurse arranged for the man to be examined by the doctor the next day.
21. The man visited the doctor the following day (2 October). He told the doctor about his bleeding gums and also reported that his 'glands were up'. He informed the doctor that he had felt like this for the past two weeks. The doctor proceeded to examine the man, checking his glands, his gums, and the sores on his penis. She looked through his medical records and confirmed that he had not previously seen a doctor since he entered custody, either at Preston or Wymott. The doctor noted that the man's glands were slightly enlarged, which was consistent with bleeding gums and a mouth infection, and also that he had two ulcers on his penis.
22. The doctor told my investigator that she did not make comprehensive notes relating to her assessment of the man at the time because she had felt that it was an entirely routine examination. She subsequently confirmed in a statement to the Governor that, on 2 October, the man had a clear chest, did not have a raised temperature, had not lost his appetite and showed no signs of any significant weight loss. The doctor told my investigator that there was no significant difference in the man's weight in comparison with his previous period in custody.
23. Following her assessment of the man, the doctor prescribed a week's supply of Erythromycin and Metronidazole to address his gingivitis (inflammation of the gums) and Fucidin to treat his penile ulcers. The doctor also ordered full blood tests (this is normal practice in prison and had not yet been carried out in the man's case). She was also concerned that the man had reported bleeding gums over a ten day period, which was unusual, and she hoped that the blood tests might provide an explanation. (The post mortem report confirms that bleeding gums and ulcers are both classic signs of advanced leukaemia.)
24. The blood tests were booked for 10 October. The tests were not expedited because the doctor did not consider that the man presented with any symptoms which required urgent attention. The doctor checked with the man if anything else was the matter. The man did not tell the doctor about any other symptoms, such as headaches or dizziness. There was no sign of any bruising upon examination. The doctor told my investigator that she thought that ordering routine blood tests was appropriate to the observations she made during her examination of the man.

25. In a letter to his mother dated 3 October, which she sadly received after his death, the man complained of feeling unwell. He wrote that he had struggled to get to the healthcare centre, because he was feeling weak.
26. During the evening of 3 October, a nurse who had been attending another prisoner on C and D wings, was asked to attend the man's cell. The nurse estimates that he arrived on G wing between 8.40pm and 9.00pm. Prior to examining the man, he contacted staff back in the healthcare centre and ascertained from the man's Inmate Medical Record (IMR) that the doctor had assessed him the previous day, and had prescribed two types of medication.
27. When he was asked to attend G wing, the nurse was informed that the man had collapsed. During interview, he told my investigator that, when he entered the cell, the man was in fact kneeling down against the bed, facing down onto the mattress. He had done this to achieve a more comfortable position, as he was complaining of abdominal pain. The nurse helped the man up onto the bed, and discussed the medication that he had been prescribed the day before.
28. The nurse said that the man had been sick, but that the vomit contained no trace of either bile or blood. He also noticed that the man's lips were dry and cracked. The man told the nurse that he had not been drinking liquids because he believed himself to be allergic to the water at Wymott. He was encouraged by the nurse to resume drinking water. The nurse remembered subsequently that it was unusual for a patient to say that they were allergic to water. There was no history of the man being dehydrated in Preston, and the nurse considered that this was something which began in his last few days at Wymott. The man had also told his friend and fellow prisoner about his reluctance to drink the water at Wymott.
29. Upon examining the man, the nurse noted a slight tenderness to his abdomen. He then verified the medication which the man had collected at lunchtime that day. He ascribed the stomach pain that the man was experiencing to the new medication which the doctor had prescribed the day before, as both types are known to have the potential to cause gastric upset. The nurse advised the man to stop taking the medications for the time being. He told the man that healthcare staff would review his condition in the morning with a view to referring him to a doctor if his stomach pain had not receded.
30. The following morning (Saturday 4 October), the nurse handed over to a colleague and asked that the man's condition be reviewed before the doctor arrived in case he required further examination. The nurse who checked the man the night before did not see him again, but checked on his condition with other staff when he returned to duty on the evening of 4 October. Aside from the stomach pain and dehydration which the man reported, and the gingivitis and penile ulcers which the doctor had addressed during her examination, the nurse who checked the man the night before had no further concerns about the man's health at this stage.

31. The nurse's colleague reviewed the man's condition in his cell between 9.15am and 9.30am on 4 October. She ascertained that indicators such as blood pressure and pulse were within normal limits. She found that his temperature was slightly raised. The man told her that he was feeling better, that he was no longer vomiting, and that he was drinking a little more water. The nurse observed that the man was less dehydrated in appearance than her colleague had described during their handover.
32. The nurse advised the man to rest in bed and to call healthcare staff if he felt unwell again. She considered his presentation to be improved from the night before, and consequently did not refer him to the doctor. She was unaware that her colleague had associated the man's abdominal pain with the new medication he was taking, and she was unable to recall in interview if the man had started to take this medication again over the weekend prior to his collapse.

The events of 5 October

33. The man was again examined by the same nurse as part of a routine visit to G wing at 10.20am on Sunday 5 October, approximately 24 hours after her earlier assessment. He had not asked to see a member of the healthcare team, but the nurse had decided to check on him as a matter of courtesy, to follow up on his previous poor presentation.
34. The man confirmed that he was no longer vomiting, was drinking and eating again, and was feeling better. The nurse considered that the man appeared brighter and observed no visible deterioration between 4 and 5 October. However, she did observe bruising around the man's eye which he could not explain. This was the first time that a member of healthcare staff had noticed any bruising. The man told the nurse that he had neither recently fallen, nor been assaulted. He was unaware of the bruising until the nurse pointed it out to him.
35. When my investigator spoke with the man's friend and fellow prisoner he said that the man had told him that he had fallen over, banged his head and sustained a black eye a couple of days prior to his death. Whether this relates to the report of a collapse which one of the nurses received on the evening of 3 October is unclear. On that occasion, the nurse arrived in the man's cell to find him kneeling deliberately on the floor as a result of stomach pain. However, the original call over the radio had related to an apparent collapse.
36. Although the man's friend seemed to believe that the bruising around the man's eye was the result of a fall, the man did not inform either nurse of any such fall over the weekend. Additionally, the post mortem report establishes that the bruising around the man's left eye was spontaneous, and that there was no evidence of an external trauma to the head from either a fall or an assault which would have accounted for it. The author of the independent medical report comments that the appearance of the spontaneous bruising

37. The nurse who checked the man on 5 October told my investigator that, when she returned to the healthcare centre, she listed the man for blood tests as the doctor said she had also done on 2 October. The nurse was unable to say during interview whether she had noticed if the man was already listed as a result of the doctor's actions. She requested the tests because she was concerned that the man could not explain the bruising around his eye. The blood tests were scheduled for 10 October. In the nurse's opinion, this was a realistic and standard timeframe for tests to take place. Following the results of the tests, the man would have been referred to the doctor as appropriate. No other medical staff assessed the man again before he collapsed later that day.
38. The man was locked in his cell at about 12.25pm. One of the required daily roll calls to account for all prisoners was taken at approximately 12.30pm. It is unclear exactly when the man collapsed after this check. No routine checks of cells were carried out over the lunchtime period and the man did not press his in-cell alarm at any time.
39. At approximately 2.05pm, the man's cell was unlocked by an officer after the lunch period. Cells would normally be unlocked at about 1.45pm but, as the officer had to escort some of the prisoners to the visiting area, the regular unlock was delayed by 20 minutes. All landings have to be unlocked simultaneously, so the officers on other landings waited for each other before starting to release the prisoners from their cells.
40. The officer did not look into the man's cell when he unlocked it, and therefore did not notice that he was in any distress. He was unaware that the man had had any interaction with healthcare staff in recent days. Both a Senior Officer and the officer told my investigator that the unlock after the lunch period is not one of the occasions during the day when staff are required to count prisoners. Wymott's Local Security Strategy confirms this. The officer also indicated that the man was neither considered to be at risk of self-harm or suicide, nor to be an especially vulnerable or volatile prisoner, and there was therefore no particular reason to check him.
41. At 2.10pm, a prisoner who was a friend of the man went to his cell to give him some water. The prisoner was concerned about his friend's health because the man had been telling him that he had been feeling unwell for just over a week. The prisoner looked through the observation flap of the man's cell to check if he was asleep, and saw him lying on the floor. At first, because the room was quite dimly lit, he assumed that the man was looking for something he had dropped under the bed. The prisoner stepped inside, and found the man lying by his bed with his eyes shut. Realising that something was wrong, the prisoner then went to call two officers who were standing on the far staircase on G wing.

42. A minute later, the two officers entered the man's cell (the prisoner was asked to remain outside). They found the man lying on the floor. He was bleeding from a fresh cut above his left eye. The officers also noticed the bruising around his eye, something already recorded by the nurse earlier that morning. The officers found that the man's breathing was laboured and that he was unable to respond to them verbally. The officer relayed this information by radio to healthcare staff, who were summoned, as were the prison's operational manager and the Duty Governor.
43. The situation was correctly identified by staff at this stage as a 'code blue' emergency. During interview, the nurse who checked the man that morning confirmed that the use of the term 'code blue' indicated that the man had been found in a state of collapse. She said that she was therefore appropriately prepared for dealing with the emergency when she arrived on G wing.
44. The prison's Control Room Daily Log Sheet confirms that an officer made the initial call on his radio at 2.12pm. Prison records show that two nurses proceeded towards G wing upon receiving the call. The Duty Governor was informed of what had happened at the same time. He instructed that the man's cell should initially be treated as a 'scene of crime', because there was a possibility, from the evidence available at that stage, that the man had been assaulted. The subsequent post mortem report makes it clear that there was no evidence of an assault. Spontaneous bruising appeared on the man's face as a result of the leukaemia, and he sustained a cut to his head as he collapsed in his cell.
45. Very shortly after he had been alerted on his radio to the unfolding situation, another officer went to the man's cell, followed almost immediately by a colleague who was close by on H wing. Two of the officers placed the man in the recovery position to make sure that his airway remained unobstructed. One officer applied pressure to the man's head injury in order to stem the flow of blood from the wound above his left eye.
46. At 2.14pm, an officer contacted the prison's Control Room to request that an ambulance be called. A minute later, at 2.15pm, a Senior Officer attended the man's cell and instructed an officer to begin recording a log of events relating to the man's collapse. The Head of Wymott's Offender Management Unit also arrived on G wing at the same time.
47. Two officers continued to maintain the man in the recovery position on his left side for approximately seven minutes. Two nurses then arrived on G wing at 2.19pm and took over the man's treatment. Another nurse had collected an emergency bag from the treatment room on the wing en route. This bag contained the equipment necessary to initially treat a prisoner who had collapsed. Two officers remained in the cell to assist the nurses.
48. The man's breathing was laboured, irregular and noisy. His pulse was also irregular. He remained unconscious throughout, and an airway was inserted. To allow this procedure to take place, the man was moved out of

49. The man was given oxygen and staff continued to manage his airway and assist his breathing with an ambu-bag until the ambulance arrived. (An ambu-bag is a hand held device with a mask attached, which is used to help patients who are having trouble breathing.) A towel was placed under his head, and defibrillator pads were prepared but in the event they were not required. The nurses contacted the Nursing Supervisor and asked her to bring the man's medical records and prescription chart from the healthcare centre to G wing. She arrived with a colleague at 2.27pm.
50. At the same time, the Control Room was informed by staff working with the man in the cell that his condition had deteriorated, and that an ambulance was required urgently. Control Room staff then called for an ambulance for a second time, and were informed that paramedics were two minutes away from Wymott. Prison records indicate that the ambulance arrived at the gates of Wymott at 2.31pm, and that paramedics reached the man's cell on G wing three minutes later.
51. The paramedics, with the assistance of two officers, then transferred the man from his cell to the waiting ambulance. The prison's healthcare staff handed over to the paramedics at this stage.
52. As the man was being transferred to the ambulance, the Duty Governor instructed the Nursing Supervisor to accompany the paramedics to the Royal Preston Hospital in order to assist them. The Control Room recorded that the man was still breathing but remained unconscious as he left Wymott in the ambulance at approximately 3.06pm. The Duty Governor notes in his statement that there was no delay in the escort leaving the prison.
53. During the journey to hospital, the ambulance stopped en route to allow emergency treatment to be administered. The Nursing Supervisor was required to work under the direction of a paramedic on several occasions as a result of the man's deteriorating condition. Two prison officers also travelled in the ambulance as escorts, along with the Nursing Supervisor and the paramedics.
54. The man's Prisoner Escort Record (PER) indicates that no handcuffs were used to restrain him during the transfer from Wymott to the hospital because it was evident that he was in a critical condition. The hospital's own risk assessment confirms that no handcuffs were evident upon arrival at the Royal Preston Hospital.
55. The man arrived at the hospital's Accident and Emergency Department at 3.40pm and was transferred into the care of hospital staff. The PER indicates that he was taken to the resuscitation room where he received emergency treatment. At 3.50pm, the prison's bedwatch log, which is completed by the escorting officers when a prisoner is taken to hospital,

56. The escorting officers at the hospital then spoke with the Head of the Offender Management Unit, to advise her that the man's next of kin should be called. They also told her that the man had sustained a significant head injury, and that hospital staff were concerned at this stage that there was a possibility that he had been assaulted.
57. The Head of the Offender Management Unit consequently arranged for the clothes which the man's friend was wearing when he found him to be secured, and she reported the incident to the police. The man's cell had already been sealed with a padlock. (Although prison staff took these precautions, and the police conducted an investigation later that evening, it was established that it was the man's ill health that had resulted in him falling and injuring his head.)
58. At 4.40pm, the escorting officers at the hospital were informed by nursing staff that the man was very unwell. The bedwatch log indicates that the man was taken for a CAT scan at 4.50pm, from which he returned an hour later. This procedure assists medical staff in diagnosing tumours.
59. A short while later, at 6.10pm, having been notified by prison staff, the man's mother and sister arrived at the hospital. At 6.20pm, the escorting officers were informed by nursing staff that the man had been diagnosed with advanced stage leukaemia that may well have caused him to collapse in his cell and hit his head as he fell.
60. At 7.10pm, the man was moved to the Intensive Care Unit at the Royal Preston Hospital. Within the hour, the escorting officers were told that it was likely that treatment would be withdrawn that night due to the severity of the man's condition. At the request of the man's family, his life support machine was switched off at 10.26pm. The man was declared dead a short while later, at 11.05pm.

Events following the man's death

61. On the following day, the Head of the Offender Management Unit telephoned the man's mother on behalf of the prison to express her condolences. The man's funeral was held on 24 October. Wymott's family liaison officer attended on behalf of his colleagues. The prison subsequently met the costs of the funeral.

ISSUES

62. A clinical review of the care the man received in custody has been carried out. The purpose of the review was to establish whether the treatment the man received in custody was equivalent to that which he would have enjoyed had he been living in the community.
63. Additionally, an independent medical report has been completed at the request of the local Primary Care Trust by an independent medical advisor. The purpose of his report was to review the circumstances surrounding the man's death and the treatment he received during his time in custody. More generally, his report also looked at the adequacy of current procedures in place for delivering healthcare to prisoners at Wymott.
64. When the man's mother spoke with my family liaison officer, she said that her son's death had come as a complete shock. Her son had visited the prison's healthcare centre, and she wanted to know why blood tests, which would have highlighted his extensive leukaemia, were not carried out. In the following section of this report, my investigator has explored this understandable area of concern.

Given the symptoms with which the man presented, could his illness realistically have been diagnosed before his collapse on 5 October?

65. Useful context has been provided by the prisoner and friend of the man who discovered him collapsed in his cell. In interview, he commented that, because of his height, slight build and pale complexion, people often thought the man looked unwell. However, the prisoner said that the man had enjoyed exercise and using the gym.
66. The prisoner had been acquainted with the man at Preston, and did not observe any visible change or deterioration in the man's condition when he met him again at Wymott. He did say that the man seemed a little more withdrawn at Wymott, but he also pointed out that the man tended to be quite a self-contained person who often spent time alone in his cell. The officers to whom my investigator spoke said that the man had been a compliant prisoner who had not come to their attention.
67. The prisoner said that, shortly after arriving at Wymott, the man began to complain of feeling tired and nauseous. He indicated that these symptoms had become somewhat more marked in the days before the man died. He also said that he had looked in on the man in the early evening on two or three occasions, and had found him sleeping. However, the prisoner also confirmed that he had not observed any sudden or visible deterioration in the man's health during the last few days of his life.
68. The man entered custody in Preston on 3 July 2008, and did not ask to be assessed by their healthcare team at any stage prior to his transfer to Wymott. He was subsequently assessed by four different members of the

69. My investigator, the clinical reviewer and the author of the independent medical report have all established that, during each examination, the professionals involved took the appropriate course of action given the symptoms with which the man presented at that time. Both the doctor and a nurse did order blood tests, which would indeed have revealed the fact that the man had leukaemia. Unfortunately, the symptoms which caused them to order these tests only became apparent a few days prior to the man's death. Consequently, the tests never took place.
70. The clinical reviewer has concluded that there was no significant oversight on the part of staff caring for the man at either Wymott or Preston which might have contributed to his eventual death. Because the man had previously spent time in custody, the clinical reviewer assumes that he was familiar with the procedure for reporting ill health, and that he would have reported additional symptoms if they had caused him discomfort. On the evidence available, she concludes that the man only began to experience these more pronounced symptoms in the last few days of his life.
71. The independent medical report similarly concludes that the healthcare staff who assessed the man at Wymott made appropriate decisions on the basis of the evidence available to them at the time. He comments that record keeping amongst healthcare staff was of a good standard, and that all members of the team were appropriately trained to carry out their duties.
72. The author of the independent medical report has found no evidence from the medical records held by the man's GP to indicate that he had reported experiencing any chronic health problems such as leukaemia before he entered custody in July.
73. With regard to the doctor's assessment of the man on 2 October, the author of the independent medical report agrees that she acted reasonably in prescribing antibiotic medication to treat what was presumed to be a simple bleeding of the gums. With the benefit of hindsight, he confirms that it is possible to link the symptom of bleeding gums with the leukaemia which we now know caused the man's death. However, he is of the opinion that the doctor's decision on treatment at the time, without the benefit of hindsight, 'was entirely reasonable'. Similarly, the clinical reviewer is of the opinion that the doctor acted appropriately in light of the symptoms which the man reported to her.
74. As regards the nurse's actions on 3 October, the author of the independent medical report believes these to have been reasonable and appropriate given the symptoms with which the man presented. He endorses the nurse's presumption that the man's stomach pains were most likely a side effect of the antibiotics prescribed the day before.

75. The author of the independent medical report considers that another nurse made an appropriate decision in listing the man for blood tests after she noticed spontaneous bruising around his right eye on 5 October. This nurse had checked on the man that day as a matter of courtesy. He had not asked to see a member of the healthcare team, but she wished to follow up on her examination of him during the previous day.
76. With the benefit of hindsight, the author of the independent medical report does highlight that a link between spontaneous bruising and bleeding gums could have been made on 5 October. Making this link would have led staff to consider the possibility of a diagnosis such as leukaemia. Had they done so, they might then have ordered emergency blood tests on the same day. However, a potential delay ordering blood tests would not have made any difference to the eventual outcome. The man's leukaemia was far too widespread at this stage, and he collapsed in his cell just a few hours later.
77. The author of the independent medical report suggests that the link between bleeding gums and the appearance of spontaneous bruising in the man's case provides a learning opportunity for the staff at Wymott. He recommends that the Head of Healthcare should ensure that the man's case is reviewed, something which has not happened thus far. He suggests an increased emphasis on these types of case reviews, or learning opportunities, within the healthcare team at Wymott, so that lessons can be learnt for the future. I endorse his recommendation.
78. Wymott's healthcare centre is currently undergoing some renovation. Consequently, the working environment is under some pressure. The author of the independent medical report points out that these changes have delayed appointments offered to prisoners. However, he does not consider that the changes affected the treatment which the man received.
79. Nonetheless, the author of the independent medical report is of the opinion that the completion of alterations to the clinical accommodation at Wymott, the full installation of electronic patient record keeping, and the reduction of GP waiting times, remain a priority. He recommends that these issues are addressed within the next three months. I note that my earlier investigation into the death of another prisoner at Wymott, completed in June 2008, raised some of the same matters. At the time, the electronic patient record keeping system was scheduled to be completed in September 2008.

The Governor of Wymott should review the progress made in relation to the ongoing improvements to the healthcare centre at Wymott. He should work with the Head of Healthcare to ensure that changes and works are completed as soon as possible and do not impact negatively on the levels of patient care.

80. In the longer term, the author of the independent medical report recommends that Wymott should ensure that the prisoners within its care have access to a chronic disease management clinic. He suggests that all healthcare staff should receive the relevant training to run these clinics.

Why did staff not discover that the man had already collapsed in his cell when they unlocked on G wing after lunch on 5 October?

81. The man was locked in his cell on G wing over the lunchtime period on 5 October, as were all the other prisoners. An officer has confirmed that he unlocked the man's cell at about 2.05pm. The officer told my investigator that unlock would normally take place at approximately 1.45pm, but that he was delayed because he was taking prisoners to the visiting area. When he unlocked the cell, the officer said that he did not look through the observation flap which is built into the cell door, and therefore did not see the man in a collapsed state on the floor.
82. Wymott has developed its own Local Security Strategy, which is based upon the Prison Service's National Security Framework. Within this document, it is clearly stated how often and when all prisoners must be accounted for. (In other words, the number of times a roll call is to be conducted during each 24 hour period is clearly laid out for all staff.) These regular checks both ensure security and allow staff to confirm that each prisoner is safe. On this occasion, Wymott's Local Security Strategy was correctly implemented. It instructs that prisoners must be accounted for six times each day, at approximately 6.00am, 7.45am, 12.15pm (at the lock up for lunch), 5.00pm, 8.15pm and 9.15pm.
83. There is therefore no requirement to make a visual check on a prisoner during the unlocking of cells after the lunch period. For this reason, the officer did not look through the observation flap when he unlocked the man's cell. He simply went on to unlock the other cells. Within a few minutes, a fellow prisoner had found the man. Given the man's eventual diagnosis of widespread leukaemia, the minutes during which he lay undiscovered in his cell were not pivotal to his subsequent death. Additionally, whilst the short delay in finding the man after the unlock was most unfortunate, there was no actual obligation for a member of staff to check on him at that time and there should be no criticism that they did not do so.
84. That said, the Senior Officer did tell my investigator that he always looks briefly through the observation flap when he unlocks, as he was used to doing so as a matter of habit when he worked on another wing with more volatile, higher risk prisoners. He suggested that it would be a workable and realistic aim for staff to observe prisoners very briefly during the unlock after lunch. He pointed out that each observation would take a matter of seconds. Although such a policy would not have changed the outcome so far as the man was concerned, there may be situations when a few minutes

The response to the man's collapse on 5 October

85. Having spoken with healthcare staff who assessed and treated the man both in the days before he collapsed and during the emergency on the afternoon of 5 October, my investigator is satisfied that all concerned acted appropriately in addressing the man's symptoms, and subsequently his collapse. The clinical reviewer says that healthcare staff at Wymott should be commended for their assessments and the follow up care administered to the man between 1 and 5 October. She also notes that both healthcare staff and prison staff demonstrated a high degree of professionalism and excellent teamwork in dealing with the man's collapse and his subsequent transfer to hospital.
86. Given the man's very poor health upon leaving Wymott in the ambulance, the decision was made that he should not be cuffed. This was an appropriate decision, respectful to the man. It also ensured that, when his relatives arrived at the hospital later that day, they were not unnecessarily distressed. I also note that staff at Wymott notified the man's next of kin promptly, allowing them to travel to the hospital immediately and to be with him.

Staff support

87. As I have reported, my investigator conducted interviews with four members of Wymott's healthcare staff, two prison officers, and the prisoner who discovered the man collapsed in his cell. I am satisfied that they have all been properly supported since 5 October. Staff thought they had been adequately debriefed, and were offered access to the local care team. All considered that their needs had been met. The prisoner who was the man's friend felt unable to continue on G wing because he was reminded of his involvement in discovering the man. Staff accommodated his wish and moved him to another wing straightaway.

Conclusion

88. The death of the man was sudden and unexpected. However, while my investigation has pointed up a number of matters that both the Governor and Head of Healthcare at Wymott may wish to take forward, I do not believe that there were any failures in the care offered to the man while he was in custody.

RECOMMENDATION

The Governor of Wymott should review the progress made in relation to the ongoing improvements to the healthcare centre at Wymott. He should work with the Head of Healthcare to ensure that changes and works are completed as soon as possible and do not impact negatively on the levels of patient care.

The prison accepted this recommendation at draft report stage and responded,

'Alterations to clinical accommodation are now complete.'

The cabling for electronic patient record keeping is in progress. Several areas have already been cabled and the wings are currently being cabled. The estimated date for completion of these works is June 2009.

GP waiting times have significantly reduced since the report was published and waiting time is now less than a week.'

THE RESPONSE OF THE FAMILY TO THE DRAFT REPORT

The man's mother has responded to the draft report, for which I thank her. In her letter, she raised several concerns. She expressed her belief that her son was prescribed the wrong medication before his death, causing him to collapse in his cell and sustain a head injury from which he did not recover.

The medication the man was prescribed appropriately in the days before he died were intended to address relatively minor complaints, namely penile ulcers and gum disease. These medications can have side effects, causing nausea and such like. The man was advised to stop taking them for the time being when he felt unwell on 3 October. These medications had no bearing on the cause of his death. The post mortem report confirms that the man collapsed in his cell as a result of a brain haemorrhage, caused by extensive and undiagnosed leukaemia. He sustained an injury to his head when he fell, but the cause of death was the haemorrhage in his brain resulting from the leukaemia.

The man's mother feels that her son should have undergone blood tests, which would have identified his leukaemia and allowed treatment to begin at a much earlier stage. She considers that a blood test would have saved his life.

The man died as a result of undiagnosed and advanced leukaemia. Blood tests had been ordered which would have revealed this form of cancer, but had not yet taken place when the man collapsed. The man was very unwell at this point, but had only started to present with symptoms in the last few days before he died, which was why no blood tests had been ordered at an earlier stage.

The man's mother believes that when her son arrived at Wymott in July, he was a fit man.

It is impossible to speculate about the length of time the man had been living with leukaemia, or how far advanced his condition was when he arrived at Wymott. Given the extensive spread of the illness by the time he died, it seems probable that it had been progressing for some considerable time, but remained undiagnosed. I have found no evidence of any causal relationship between the man's illness and his time in custody.

The man's mother believes that the filthy state of her son's cell and the poor quality of the tap water caused him to acquire a serious blood infection.

There is no evidence in any of the reports prepared by medical professionals that the man had a blood infection. He had a form of cancer, which would not have been related to either the quality of the tap water or the hygiene in his cell. My investigator visited the cell where the man stayed. It was of a comparable standard to other prison accommodation of the same build and age.