A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

Investigation into the death of a man at HMP Wymott in January 2013

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution
to safer, fairer custody and offender supervision'*

This is the report of an investigation into the death of a man at HMP Wymott in January 2013. He was found lying on his bed not breathing. He was 73 years old. I offer my condolences to his family and friends.

An investigator was appointed. A clinical reviewer carried out a clinical review of the man's healthcare at Wymott. The prison cooperated fully with the investigation.

The man had been in prison for over 33 years. He was diagnosed with heart disease and high blood pressure in 1994. In 2005, vascular problems were identified that required six monthly visits to a consultant vascular surgeon. He also developed chronic kidney disease. In July 2009, he moved to the older prisoners' wing at HMP Wymott because he needed the increased support available there. He had a long history of not taking his medication and not following medical advice. Despite this, he did not appear particularly unwell in the period before he died and his death was unexpected.

The man had been prescribed a higher dose of blood pressure medication in November 2012 but he did not receive it before he died. It is not possible to say what effect this had, as he had a number of health problems and often did not take his medication. However, such confusion could have been avoided had electronic prescribing been in place - something we have previously recommended to Wymott.

Nevertheless, the clinical reviewer concludes, and I agree, that the general standard of the man's healthcare at Wymott was equivalent to that which he would have expected in the community.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **July 2013**

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SUMMARY

1. In 1979, the man was sentenced to life imprisonment for murder. He spent time at a number of different prisons during his sentence. He was diagnosed with heart disease and high blood pressure in 1994. In 2005, he was diagnosed with vascular problems that required six monthly visits to a consultant vascular surgeon. He also developed chronic kidney disease. He had a history of heart attacks and stroke.

2. In July 2009, the man transferred to I wing at HMP Wymott, a wing for older and disabled prisoners. In addition to regular wing staff, the prison employs two social carers to help with such tasks as bathing and dressing. Nurses visit three times each day.

3. The man had a long history of non-compliance with prescribed medication and often did not follow medical advice. He discharged himself from hospital on several occasions and frequently chose not to attend various prison clinics or to have regular blood tests. Twice at Wymott he signed disclaimer forms to confirm that he did not wish to have treatment or tests.

4. On 29 November 2012, a prison GP examined the man and found his blood pressure was very high. He said that he had not been taking his blood pressure medication for some months. The GP wrote two new prescriptions – one for blood pressure medication at his regular dose and one at a higher dose. The latter prescription did not reach the pharmacy. It is not clear why.

5. The same GP reviewed the man's blood pressure on 13 December 2012. He said that he had started to take his medication and was feeling better. A locum GP reviewed his notes on 25 December and noticed the discrepancy in the prescriptions written on 29 November. He continued his prescription for the lower dose. Another GP reviewed his notes on 15 January. His blood pressure was lower but still too high so the GP wrote another prescription for the higher dose. He was due to receive this on 18 January.

6. In January, the man got up as usual and one of the social carers helped him have a bath. He appeared well. At about 9.45am an officer passed his cell and saw him lying on his bed not breathing. The officer raised the alarm and began cardio-pulmonary resuscitation. Nurses attended promptly but, sadly, he could not be revived.

7. The clinical reviewer is satisfied overall that the man received care equivalent to that he would have expected in the community. However, the investigation raises concerns about the prescribing system at Wymott and we repeat a recommendation from an investigation into a death in 2011 that electronic prescribing is introduced as a priority.

THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at Wymott informing them of the investigation and inviting anyone with information to contact her. No response was received.

9. The local Primary Care Trust (PCT) commissioned a clinical reviewer to carry out a clinical review of the man’s medical care at Wymott. The investigator and clinical reviewer interviewed three members of staff. The officer who discovered the man was on long term sick leave at the time of writing and was not interviewed. The clinical reviewer spoke to the Head of Healthcare at Wymott by telephone. Feedback was given to the Governor after the interviews.

10. One of our family liaison officers informed the man’s nominated next of kin in Australia about the investigation. His family have been sent a copy of this report.

HMP WYMOTT

11. HMP Wymott is a category C prison holding up to 1,174 adult male, sentenced prisoners. I wing, where the man lived, is a specialist unit for older prisoners who are given additional support to help them with their social care needs. Healthcare services at Wymott are commissioned and provided by the NHS. A private company provides general practitioner (GP) services and out of hours medical cover. Clinics are run every weekday morning and two afternoons each week. There are no inpatient beds, but nursing cover is provided 24 hours a day.

HM Inspectorate of Prisons

12. The most recent inspection of Wymott was a short follow up inspection in November 2011 of a full inspection in October 2008. Inspectors commented that:

> "There had been considerable improvements in the care of older prisoners and those with disabilities. I wing continued to operate as a specialist unit, and older prisoners and those with disabilities were supported by health services staff and specialist social care workers. Formal care plans were drawn up for those who needed them and a range of adjustments had been implemented as required. A day care centre had been developed and provided a range of activities for older prisoners and those with disabilities."

13. In relation to healthcare, inspectors noted that staffing levels were sufficient, but that that prisoners waited too long to see the GP.

Independent Monitoring Board

14. Each prison has an Independent Monitoring Board (IMB) made up of unpaid volunteers from the local community who monitor day-to-day life in the prison to help ensure that proper standards of care and decency are maintained. The most recent Wymott IMB annual report for 2011 – 2012 identified some concerns about care for the elderly and disabled prisoners on I wing, including the lack of formal training for staff in dealing with elderly and infirm prisoners and the need for wheelchair access to the outside area. The Board welcomed improvements on I wing, such as the opening of the day centre and the employment of carers.

15. The IMB noted there was a failure to appoint a permanent GP, but waiting times had reduced with the appointment of a nurse practitioner and better oversight of the appointment system. The IMB repeated previous concerns about pharmacy services and problems with prisoners not getting repeat prescriptions in time.

Previous deaths at Wymott

16. Since the Ombudsman took responsibility for investigating deaths in custody in April 2004, we have investigated 35 deaths at Wymott, of which the majority were due to natural causes. This is, in large part, due to its older population profile compared to most prisons. This report repeats a previous recommendation about the need for electronic prescribing made following an investigation into a self-inflicted death there in April 2011. Although the recommendation was accepted, this has not yet been introduced.

KEY EVENTS

17. In 1979, the man was sentenced to life imprisonment for murder. In 1994 he was diagnosed with heart disease and high blood pressure. In 2005 he was diagnosed with vascular disease (a form of cardiovascular disease affecting the blood vessels), which was managed by six-monthly appointments with a specialist at hospital. He had a stroke at HMP Garth in 2007 and was treated in hospital. He was also diagnosed with renal artery stenosis (narrowing of the blood vessel leading to the kidneys – an element of chronic kidney disease) but the records do not make clear when. He smoked heavily throughout his life.

18. On 27 July 2009, the man transferred from HMP Lancaster Castle to HMP Wymott because he was becoming increasingly frail and needed the extra support available on I wing. A social care assessment concluded he was fully mobile, although noted he had fallen several times. In addition to his history of heart disease and stroke, he had a blocked artery in his lower leg, arthritis in his spine, a cataract in one eye and – at various times - both high and low blood pressure. He was prescribed ramipril (used to treat high blood pressure) and tramadol (for the pain due to the blocked artery in his lower leg).

19. On 1 October 2009, the GP saw the man who complained of feeling weak. He was found to have high blood pressure and admitted that he had not been taking his ramipril. In January 2010, he refused to attend a hospital appointment for a scan. The prison continued to monitor his blood pressure and gave him advice on how to lower his risk factors for heart disease, but he said he was "too old to change". In March 2010, he refused to attend hospital for another scan. He signed a disclaimer to say that he did not want treatment and no further appointments were made.

20. In May 2010, the man refused to attend his six monthly hospital appointment with a vascular specialist. On 16 September 2010 he was taken to hospital after collapsing on I wing. He refused treatment and discharged himself the next day against the advice of doctors. The hospital believed he had suffered a femoral thrombosis in his left leg (a blood clot in a deep vein). He consistently refused to have blood samples taken for testing and in February 2011, he signed a disclaimer confirming that he did not wish to have blood tests.

21. In October 2011, a nurse wrote in the man's medical record that his cell needed checking regularly for dirty clothes and old medicine. In November 2011, he did not attend an appointment for the chronic heart disease clinic at Wymott.

22. In January 2012, the man did not attend a chiropody appointment. On 16 April 2012, he had a fall in his cell and banged his elbow but was otherwise unhurt. In July, he developed an ear infection after blocking his ears with cotton wool. At the same time, he was also found to have shingles.

23. On 11 October 2012, the man attended healthcare for a vaccination against flu. The nurse manager found that he had an irregular pulse and high blood pressure. He told her he had not taken his ramipril that day. She explained to him the importance of taking it because of the risk of stroke and he told her he understood the risks. She referred him for an ECG (electrocardiogram – a test recording the rhythm and electrical activity in the heart).

24. The man had the ECG on 17 October. He said he felt well and no different than usual and had no chest pain or shortness of breath. On 19 October, his full blood count, cholesterol and thyroid function was checked and found to be normal. The levels of urea and electrolytes in his blood were abnormal but consistent with his history of chronic kidney disease. He gave blood for further tests on 9 November.

25. A prison GP saw the man on 29 November. The doctor noted that his ECG result had come back abnormal and that he had previously had a number of heart attacks. He had no chest pain or difficulty getting upstairs. He told the doctor that he had not taken ramipril since July because he did not need it. The doctor recorded that he was non-compliant with his medication. His blood pressure was very high and the doctor prescribed ramipril again. The doctors appears to have completed two different prescription charts – one for ramipril at 5mgs per day and one for ramipril at 7.5mgs per day. The prescription chart for the higher dose of ramipril did not reach the pharmacy. It is not clear why.

26. A nurse reminded the man the same day about the risks of not taking his ramipril and booked him for a blood pressure review. He provided a urine sample as requested but did not attend the clinic on 5 December. The doctor saw him again on 13 December. He noted that he had started taking his ramipril and reported feeling better. His blood pressure was slightly down from 29 November but still very high and his pulse was irregular. The doctor decided that he should have his blood pressure checked fortnightly and a GP review every two months.

27. On 17 December 2012, the man was diagnosed with chronic kidney disease stage 3A, indicating moderately reduced kidney function. (Renal failure is measured in five stages with the end stage being stage 5 – high blood pressure is a symptom at stage 3.) He did not attend nurse clinics on 5, 13 and 19 December. The acting Head of Healthcare said that a locum GP reviewed his ramipril prescription on 25 December. He noticed the two different prescriptions written by the prison doctor on 29 November and continued the prescription for ramipril 5mgs daily because he had never received the higher dose. He set up a task (an electronic referral) on his medical record for the next GP to review his ramipril prescription. The next GP was also a locum but had never worked in Wymott before and was unfamiliar with the electronic task system. He did not see the task and the prescription was not reviewed.

28. The man did not attend a scheduled blood pressure check on 28 December. His blood pressure was next checked on 7 January 2013 and found to be high

but lower than when checked by the doctor on 29 November. His pulse was normal.

29. The man refused another scheduled blood pressure check on 11 January. A doctor reviewed his notes on 15 January at the request of the nurse manager. He noted that his blood pressure was still running higher than the ideal range for a man with his medical conditions. The doctor increased his ramipril prescription from 5mg to 7.5mg daily but did not see him in person. He was due to receive the new dose of ramipril on 18 January.

30. The man's wing record and social care evaluation sheets for his time on I wing show that he was mobile and self-caring but needed frequent encouragement and help to keep himself and his cell clean. He did not mix much with other prisoners and spent most of his time in his cell. On 13 December 2012, an officer wrote on his history sheet that he had had a good month. He said the man appeared more active and had spent more time out of his cell and had visited other prisoners on the wing. The officer reported that the man had told staff for the first time that he would consider doing some offending behaviour courses.

January 2013

31. At about 9.43am, an officer found the man lying on his bed looking very ill and he called one of the social carers into the cell. In his statement to the Governor after the incident, he said that he radioed an emergency 'code blue' (to indicate a person with breathing difficulty). He first put him into the recovery position but then turned him on to his back and started cardio-pulmonary resuscitation (CPR). Two nurses arrived at about 9.48am and took over.

32. Both nurses were giving out medication in the segregation unit when they heard a call for assistance on I wing over the radio. Nurse A was the designated emergency response nurse that day. She told the investigator that she heard a call for the emergency response nurse to go to I wing but the call did not say code red (bleeding) or code blue to indicate an immediate response was required. The nurses therefore began to put away their medication instead of leaving immediately. While they were doing this, another call came over the radio, this time asking for an immediate response. Both nurses then went immediately to I wing. She went directly to the man's cell and Nurse B went to I wing treatment room to collect the emergency bag, oxygen and defibrillator.

33. Nurse A said she arrived to find the man on the bed and an officer doing chest compressions. The social carer told her that he had only got out of a bath a few minutes before and had seemed perfectly well. She checked for signs of life but did not find any. She said he appeared dead. As she knew that he had been seen alive minutes earlier she began CPR. Nurse B arrived quickly with the emergency bag and they gave him oxygen using an ambu-bag and attached a defibrillator. Nurse A said that when she arrived on the wing she

was told that an ambulance had been called. The nurses were joined by others from the healthcare department.

34. A doctor arrived at the man's cell at about 9.54am. He said he saw nurses performing CPR and that an airway had been inserted to give him oxygen. He was attached to a defibrillator. The doctor said he looked vacant, was cold to the touch and was not breathing. He felt for a pulse but could not find one. He said that the defibrillator gave him seven electric shocks and staff continued CPR between the shocks. After the seventh shock he re-assessed the situation and pronounced him dead.

Support for staff and prisoners

35. A chaplain said a short prayer in the man's cell and then gathered together those prisoners who were present on the wing to offer support. The nurse manager arranged for the staff involved in the resuscitation attempt to go to the staff room with the option of staying there as long as they needed. They talked together about what happened and then returned to their shifts. The staff interviewed told the investigator they were happy with the level of support provided. All prisoners being monitored as at risk of suicide and self harm were reviewed in case they had been adversely affected by the man's death. Notices were put up throughout the prison about his death.

Family liaison

36. The Deputy Governor rang the man's daughter in Australia to break the news of his death. She said she would tell the rest of his family. At 11.30am the Deputy Governor spoke to the man's ex-wife. She spoke to his daughter again the next day. The Governor wrote to his family on 18 January. The prison offered assistance with the arrangements and expense of his funeral. Prison staff attended the service.

Post-Mortem

37. A post-mortem examination at hospital on 21 January concluded that the man died of ischaemic and hypertensive heart disease. The pathologist explained that this could lead to cardiac dysfunction and sudden death.

ISSUES

38. Overall the clinical reviewer was satisfied that the standard of care the man received was equivalent to that he would have expected in the community but her investigation identified an issue with prescribing at Wymott.

Prescribing

39. The man had a long history of not taking his medication and ignoring medical advice. On 29 November 2012, he told a doctor that he had not taken his ramipril since the previous July. The doctor wrote two prescriptions and completed two different prescription charts – one for ramipril at his usual dose and one at an increased dose. The doctor no longer works at Wymott and he was not interviewed, so we have been unable to establish why there were two and which prescription he intended to be used. The prescription at the higher dose did not reach the pharmacy. (It could be assumed that, as it did not, the doctor decided to continue with the standard dose.) The two prescriptions were noted by a locum GP on 25 December, who continued the prescription at the lower dose and 'tasked' another GP to review the notes. The succeeding GP was not familiar with SystmOne (the electronic medical record) and missed the task. A doctor reviewed the notes on 15 January and wrote a prescription for ramipril at the higher dose but he did not receive it before he died.

40. It is not possible to say whether not receiving ramipril at the higher dose was a factor in the man's death or, indeed, whether the doctor intended he should have received the higher dose. He had a history of non-compliance with prescribed medication and a number of medical conditions. High blood pressure is a symptom of chronic kidney disease at stage 3 and a risk factor for heart attacks and strokes. However, it is important that prisoners receive medication at the dose prescribed by the GP. If they have capacity, it is their decision whether they take it or not. Towards the end of his life, he appeared to be more compliant with his prescription and his blood pressure was found to have come down at successive tests on 13 December and 7 January 2013.

41. The current prescribing process at Wymott is that the GP writes a handwritten prescription that is dispensed at a pharmacy which is not on the prison site. New prescriptions are documented on a prescription chart but not on the electronic SystmOne record. This makes it difficult for different GPs to see changes in prescription because they typically only review the electronic record. In an investigation into a self-inflicted death at Wymott in April 2011, we found that a prescription for an anti-depressant had not been delivered to the pharmacy and the prisoner had died without receiving it. We recommended that Wymott introduce electronic prescribing as soon as possible. This recommendation was accepted in January 2012 and, at the time, the prison told us that electronic prescribing was being trialled at Garth (a neighbouring prison) and would be introduced at Wymott once an audit had taken place. It remains outstanding.

42. As there appeared to be some confusion about which prescription the man should have had and the level of medication, we repeat this recommendation here. We also think that it is important to ensure that all new GPs at Wymott, including locums, are given induction training to ensure that they do not miss routine tasks on SystmOne. We make the following recommendations:

The Head of Healthcare should introduce electronic prescribing as a priority.

The Head of Healthcare should ensure that all GPs working in the prison understand how to use SystmOne.

The emergency response

43. In his statement after the man's death, an officer said he radioed a code blue. Nurse A said at interview that the call relayed by the control room simply said "Hotel 2 to I wing". (Hotel 2 was her radio sign.) A second call a minute or so later made it clear that she should go immediately. She said she was unsure of the nature of the emergency until she arrived at the cell because the code system was not used. She believed the code system at Wymott was misused because she was aware of a number of non-emergency incidents that had been called code blue, particularly from of I wing.

44. Prison Service Instruction (PSI) 03/2013 issued on 1 February 2013 introduced a standard approach for calling medical emergencies over the radio network. All Governors were required to introduce a Medical Emergency Response Protocol based on guidance in the PSI.

45. The investigator raised the issue of emergency response codes during feedback to the prison, and was shown a copy of a Governor's Notice to Staff which was issued on 15 March 2013 setting out guidance about what to do in an emergency in line with the PSI. We therefore make no recommendation, bur reiterate the importance of emergencies being communicated effectively using the correct emergency code.

46. In all other respects the response to finding the man in January appears to have been prompt and efficient.

RECOMMENDATIONS

1. The Head of Healthcare should introduce electronic prescribing as a priority.

   This recommendation was accepted at consultation stage and the National Offender Management Service (NOMS) responded:

   "Healthcare is currently working through the whole prison entering all prescriptions onto the electronic system."

2. The Head of Healthcare should ensure that all GPs working in the prison understand how to use SystmOne.

   This recommendation was accepted at consultation stage and the National Offender Management Service (NOMS) responded:

   "All establishments throughout the prison estate use SystmOne as the only clinical system. Most GPs that come to HMP Wymott have worked with the system elsewhere, however the GP forum and local clinical meeting support the GP in utilising the system most appropriately. Recently LCfT have trained a further 6 staff as super users on SystmOne. All GPs that require any further training can access through LCfT."