

FINAL REPORT

**Investigation into the circumstances surrounding the death of a man, a prisoner
at HMP Wymott, at the Royal Preston Hospital on 21 December 2004**

Prisons and Probation Ombudsman for England and Wales

May 2005

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The man, who had been a prisoner at HMP Wymott, died on 21 December 2004 in the Royal Preston Hospital. This is a report into the circumstances surrounding his death. The loss of any family member is distressing, but especially so whilst they are in custody and I offer my sincere condolences to his family and friends.

The investigation was carried out by a member of my office. I would like to thank the Governor of Wymott for making the necessary facilities available to my investigator.

In the course of the investigation, I asked the Chorley Primary Care Trust (PCT) to undertake a clinical review of the care and treatment received by the man from HMP Wymott and the Royal Preston Hospital. I am most grateful for the review.

The principal issues raised in this report concern the relationship between Wymott and the man's family. Although some aspects were handled well, others were less so. I have been pleased to learn that the prison plans to train a member of the senior management team as a Family Liaison Officer. I hope this will ensure that the difficulties and insensitivities on which I report here will not recur.

My report makes seven recommendations for the prison. The clinical review makes no recommendations.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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Summary

1. A prisoner at HMP Wymott died at the Royal Preston Hospital on 21 December 2004. The Consultant Pathologist carried out the post-mortem and gave an opinion that the cause of death was (a) Respiratory and Renal failure, (b) Systemic Vasculitis.
2. The clinical review was carried out by the Director of Public Health on behalf of the Chorley and South Ribble PCT. The Director found that the healthcare staff at various prisons responded appropriately to the man's symptoms. The review shows that he developed problems with his prostate in 2002, but that there was no suggestion of failing renal function until he was admitted with a hypertensive crisis in December 2004. The review concludes, *unfortunately from that point onwards there is very little information available as to the cause of the man's steady deterioration and death in December 2004.*
3. One of my office's Family Liaison Officers and my investigator met with the man's sisters and brother in law on 17 January. His family raised a number of issues regarding his care and treatment, and at the time of our visit believed that he might have been "*given a good hiding*" in the hospital, as he died so suddenly. The investigation found no evidence to support this. As the clinical review only deals with care and treatment whilst in prison custody, his family have been advised to raise any concerns regarding hospital care directly with the hospital management.
4. The report raises some concerns about the way the man's family have been treated by HMP Wymott.

The man

5. He was born in Stockport on 6 April 1949 and was from a family of three girls and two boys. He had been educated locally and after leaving school he worked in a number of positions, with his latest employment prior to his imprisonment as a driver. He had been married on three occasions and had two children.
6. On 8 May 1987, he was found guilty at Manchester Crown Court of the murder of his wife and was given a life sentence, with a tariff of 11 years. He had pleaded not guilty to the offence.
7. The man had been in custody for almost 18 years and had been allocated to a number of establishments. He had progressed through the prison system and prior to his transfer to Wymott in July 2004, he had been at HMP Kirkham as a category D prisoner, which is the lowest security level available for prisoners.
8. During his time at Kirkham he had been allowed to work outside the prison and made a number of visits to the local area, unescorted. This was a measure of the level of trust given to him. However, due to security information being received at Kirkham, a risk assessment was undertaken and approval given to re-categorise him to C, which is a level of security that would not allow free unescorted movement outside of the prison. The Prison Service's Lifer Section, approved the re-categorisation and transfer to Wymott. In the man's case this was a backward step in his prison career.
9. His custodial behaviour had previously been reasonable with only 12 adjudications recorded against him. The adjudications were in the main for minor infringement of the rules, with the last one being in 2003.

HMP Wymott

10. Wymott prison is a Category C training prison. Half of the prison provides accommodation for vulnerable prisoners.
11. In December 2003 the prison was inspected by HM Chief of Inspector of Prisons. The inspection found that 81 per cent of prisoners surveyed felt safe and that the relationships between prisoners and staff were respectful. The Chief Inspector described the prison as a good, well managed prison.

Investigation Process

12. HMP Wymott made available to the investigator documents relating to the man's entire period in custody. After examination, the Inmate Medical Record (IMR) was sent to the Chorley and Ribble PCT for a clinical review to be carried out.
13. The investigator and Family Liaison Officer met with the man's sisters. The family raised a number of issues regarding his property and treatment whilst in the Royal Preston Hospital.
14. The investigator met with the Acting Deputy Governor on 24 February. He briefed him about the family's concerns regarding the way they were treated on a visit to collect the man's property and regarding damaged property. The investigator was given to understand that the prison would be writing to the Ombudsman's office explaining what they had done to resolve the dispute with the family. To date, such a letter has not been received which is disappointing.
15. The post-mortem report was received on 8 April. The draft investigation report was completed.

Findings

16. On 17 November 2004, the man was admitted to the Royal Preston Hospital, where he remained under the prison bed watch arrangements. Bed watch is the term used by the Prison Service to describe a prisoner who has been admitted to hospital and requires a minimum of two officers to be present throughout the stay and is, in the majority of cases, handcuffed to an officer. As a category C prisoner, he was handcuffed to an officer. Prison management had undertaken regular reviews of the level of risk that he presented and had given authority on a number of occasions for the handcuffs to be removed. I welcome this. Although the removal of the handcuffs was not a permanent measure, I can confirm that he was not restrained at the time of his death.
17. The Governor has the option to undertake a risk assessment and consider requesting release on temporary licence (ROTL). In the man's case, it was highly unlikely that ROTL would have been granted initially due to the nature of his offence and the security information which caused his transfer from category D to C conditions. However, it is open to the Governor to review the position as circumstances change, including medical diagnosis. I could find no evidence to suggest that ROTL was ever considered.

The Governor should remind staff that consideration should be given to ROTL in the case of prisoners on bed watch and the risk assessment results kept and reviewed as circumstances change.

18. The death in custody incident log sheet is not dated and a number of sections relating to contacting the family are not ticked as being actioned. There is though a letter from the Governor offering the man's family a visit to the establishment and contact number, which they declined.

The Governor should remind staff of the need to ensure that the Death in Custody incident log is completed correctly.

19. The bed watch records are comprehensive and well documented. There is though a need to remind bed watch staff that they should print their names, sign the entries and date the pages. A signature on its own is not sufficient.

- **The Governor should remind staff to print their names, sign and date the page entries in bed watch records.**
- **The Governor should remind senior staff that the Duty Manager should check the entries at the time of any visit.**

20. The entries and concerns raised by staff regarding the man's health demonstrate a caring attitude by those on the bed watch. A number of entries clearly show that staff were concerned about the use of restraints and would take the trouble to speak to a Duty Manager at the prison for guidance. This is welcome. Due to the length of time the man was in hospital, a large number of bed watch record books have been compiled.

21. The man's family raised concern that they were not contacted by the prison regarding his condition. The record for 19 November shows that the prison and chaplain attempted to contact the next of kin, but were unable to do so. The prison then contacted the local police for their assistance in notifying the family of his condition. I welcome the efforts made by the prison.
22. The family requested the return of his property (mobile phone, driving licence, wallet, battery, bag, two bankbooks, cigarette lighters and money) and had been advised by a member of the prison management that the items were subject to probate. The manager concerned acted in what he believed were the best interests of anyone who might have a claim on the property, but without obtaining clear advice and guidance. The manager concerned had advised the family that they should ask their solicitor to write to the governor, explain that the items were not subject to probate, and then the items would be returned. An assumption was made that the family had a solicitor and/or the means to employ one. Prison management should have taken the lead and clarified the exact position. In this way, the correct guidance could have been given to the family.

The Governor should ensure that the property of a deceased prisoner is dealt with as per Prison Service Order 2710 (PSO 2710) "Follow up to Deaths in Custody", and insert clear instructions into his contingency plans.

23. The family made a complaint to a prison manager regarding damage to a CD player, which had been packed by prison staff and only noticed to be broken when they returned home. They said that they had spoken to the manager dealing with the withheld property, and that he had asked them to write formally to the governing Governor. He said that the Governor would then investigate the complaint. Having made the complaint they should not then have been required to write to the Governor. The prison should deal appropriately with the complaint without any further delay.

The Governor should resolve the outstanding issues of the broken CD player and missing property.

24. At the invitation of a senior manager, the man's family were invited to collect his property from the prison. They arrived at the prison as arranged and were asked to wait in a room where other members of the public visiting prisoners were held. They were kept waiting for over one hour before being allowed entry into the establishment and were not greeted by a senior member of staff. This was very regrettable in itself. In addition, the property was not washed or folded as per the instructions in PSO 2710 and had been packed into nine plastic HMP bags which were then sealed with HMP tags. This was extremely insensitive.

The Governor should remind all staff that bereaved families visiting the prison are to be treated with sensitivity and courtesy.

25. During a visit to the establishment on 24 February, my investigator briefed the Acting Deputy Governor regarding the investigation findings. The investigation team were informed that the Senior Manager dealing with the man's family

would write to the Ombudsman's office with an account of what the establishment had done to resolve the breakdown between family and prison. At the time of completing the report on 8 April, no correspondence has been received from the prison. This is disappointing.

26. The establishment has not dealt with the family well and has presented an impression (no doubt, unintended) of not caring for the relatives of prisoners and of being insensitive to bereaved families. The investigator understands that the Governor has recently appointed a member of his management team to be trained as a Family Liaison Officer for any future deaths in custody. This is welcomed.
27. A member of the Senior Management Team visited the family following the man's death and offered condolences and continued support. The Governor wrote to the family offering his condolences and support, plus a contact telephone number. The family said that they had attempted to contact the Governor since the initial visit, but had been unable to speak to him. The investigation could find nothing to suggest that the Governor was not prepared to speak to his family.
28. The family believe that whilst in hospital he was given the Last Rites by the hospital chaplain and raised concern that they were not notified by the hospital or prison that this had taken place. The investigation has been unable to confirm this.
29. At the time of visiting the family, they said that they had not been assisted with funeral costs by the establishment. However, the investigator understands that arrangements are in place to contribute the outstanding portion of the funeral expenses, once the level of assistance to be given by the Department for Work and Pensions is established. Although I make no formal recommendation in this regard, the Governor will wish to consult with the Safer Custody Group in NOMS regarding best practice in this area.

Recommendations

For the Prison

1. The Governor should remind staff that consideration should be given to ROTL in the case of prisoners on bed watch and the risk assessment results kept and reviewed as circumstances change.
2. The Governor should remind staff of the need to ensure that the Death in Custody incident log is completed correctly.
3. The Governor should remind staff to print their names, sign and date the page entries in bed watch records.
4. The Governor should remind senior staff that the Duty Manager should check the entries at the time of any visit.
5. The Governor should ensure that the property of a deceased prisoner is dealt with as per Prison Service Order 2710 (PSO 2710) "Follow up to Deaths in Custody", and insert clear instructions into his contingency plans.
6. The Governor should resolve the outstanding issues of the broken CD player and missing property.
7. The Governor should remind all staff that bereaved families visiting the prison are to be treated with sensitivity and courtesy.