

**Investigation into the circumstances surrounding the death of  
a man at HMP Wymott in February 2005**

**Prisons and Probation Ombudsman for England and Wales**

**October 2005**

The man who is the subject of this report died from natural causes in February 2005 at HMP Wymott. 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. I offer my sincere condolences to the man's family and friends.

The investigation was carried out by two of my investigators. I would like to thank the Governor of Wymott for making the necessary facilities available to them.

In the course of the investigation, I asked the Chorley Primary Care Trust to undertake a clinical review of the care and treatment received by the man from Wymott. I am most grateful to them for their assistance.

The clinical review raises concerns about the medical care the man received whilst in prison custody. My report makes recommendations for the prison in partnership with the Primary Care Trust.

This report has been anonymised for publication on the Prison and Probation Ombudsman website.

**Stephen Shaw CBE**  
**Prisons and Probation Ombudsman**

**October 2005**

## **Contents**

Summary	4
HMP Wymott	5
Conduct of the Investigation	6
Key Findings	7
Recommendations	12

## Summary

1. The man died in February 2005 whilst in custody at HMP Wymott. He had been taken ill on B wing at approximately 12:00 noon, complaining of breathlessness and feeling sick. He was taken to his cell where he began to lose consciousness. Medical staff attended and attempted unsuccessfully to resuscitate him. The man was pronounced dead at 1:33pm.
2. Following a post mortem, the Consultant Pathologist, concluded that the man died of (a) *Pulmonary Embolism* (b) *Deep vein thrombosis*.
3. The clinical review carried out by Chorley and South Ribble Primary Care Trust, examined the man's medical records. The main concerns identified were regarding the man's mental health status and also that he was on suicide watch on more than one occasion. The review also notes: "*it would appear that the man did not come forward to discuss his problems as often as he might and that it was often following a letter or phone call from his wife or mother that he was seen by health care staff. However, a history of health problems has been noted. These included diabetes (managed by diet alone, not obviously monitored during his time in prison), depression, arthritis or osteoporosis of the arms, and a possible previous diagnosis of bowel cancer.*"
4. The clinical review raises concerns about the medical care given to the man whilst in custody.

## **HMP Wymott**

5. Wymott prison is a Category C training prison, located near Leyland in Lancashire. Half of the prison provides accommodation for vulnerable prisoners. (Vulnerable prisoners are those who have requested to be isolated from the normal accommodation areas of the prison, usually for their own safety and protection.)
  
6. In December 2003, the prison was inspected by HM Chief Inspector of Prisons. The inspection found that 81 per cent of the 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.

## **Conduct of the Investigation**

7. On 24 February, my investigator met with the Acting Deputy Governor at Wymott who briefed him of the circumstances surrounding the death of the man. He provided the records relating to the man, escorted him to the area where the man had been taken ill and to the cell where he died. The initial findings of the investigation were fed back to the Acting Deputy Governor at the end of the visit.
8. My investigators forwarded the man's medical record to the Chorley and South Ribble Primary Care Trust, in order that a clinical review could be carried out. The PCT raised concerns about the healthcare the man received during his stay in prison. These have been discussed with the prison's Healthcare Manager.
9. One of my Family Liaison Officers and the investigator met with the man's wife to talk about his care and treatment whilst he was in custody. The man's wife raised concerns about the medical care he received whilst in prison and also about his location.

## Key Findings

10. An examination of the wing Observation Book shows that, on 28 January 2005 at 11:00pm, the prison received a telephone call from the man's wife to say that he had told her that he would kill himself, as he was "*unable to go on any more*". A member of the wing staff saw the man, and an F2052SH document was opened to monitor him. F2052SH is a document used by the Prison Service and can be opened by any member of staff who is concerned about a prisoner who may be suicidal or intending to self-harm. It requires prison staff to monitor and record their observations and conversations with the prisoner. Once it has been opened, the prisoner is invited to meet with a multi-agency prison team to discuss their concerns. An action plan is developed, which is reviewed periodically. The man had not seen his family for six months, and this was making him feel depressed. He was advised to speak to his Personal Officer, or other wing staff, to discuss a transfer nearer to his home. The investigation has not established if the man did speak to anyone about this advice.
11. Three weeks later on 19 February, at approximately 12:10pm, another prisoner approached two Officers to inform them that the man was feeling unwell. One of these officers said that they responded immediately to the information. The other of the two officers saw the man leaning against a cupboard and noted that he was very pale. The man complained of breathing difficulties and the officer requested "Code Blue" assistance from the prison Healthcare Department, via the prison radio system. Code Blue is the term used to describe a patient with breathing difficulties. It is used by a number of prisons to alert healthcare staff to the type of incident and the medical response required. This is good practice.  
  
**It is good practice that the prison uses different emergency codes, which enable staff to determine how to respond to an alarm.**
12. Three nurses responded to the call and found the man at the top of the stairwell in B wing, complaining of breathlessness. Two of the nurses assessed the man's condition, and the third went to the medical treatment room on B wing to collect oxygen.
13. One of the nurses who assessed the man, in his report, noted that he was: "*complaining of breathlessness and a degree of epigastric discomfort. His Glasgow Coma Scale was 15. The man mentioned he had a similar episode a week ago, but had not mentioned it to anybody. Concurrently oxygen was administered at a rate of 15 litres per minute, via facial mask. On examination by another nurse, the man's blood pressure was found to be 130/60, his temperature was 36.5 and his capillary refill was within normal limits.*"

14. As it was lunchtime, and the area was busy with prisoners, the nurses decided to move the man in a wheelchair to his cell which was a short distance away. When they arrived at the cell, the man moved himself onto the bed and the nurses remained with him.
15. At 12:31pm, one of the nurses was unable to obtain an Electro Cardio Graph (ECG) reading and so an ambulance was called. The man complained of feeling faint, his skin became clammy and he was unresponsive. Two of the nurses commenced Cardio Pulmonary Resuscitation (CPR), although they did not move him off the bed as there was not enough room in his cell to place him on the floor.
16. The prison healthcare department has “grab bags”, which contain the necessary equipment to deal with specific incidents of either breathing difficulties or blood spillage. Once they receive a call to attend a patient, they take the appropriate bag with them. My investigator asked if a defibrillator was inside the bag that was taken to the cell. He was informed that it was not, as it was not part of the usual grab bag equipment. One of the nurses said that the paramedic staff had informed him that the defibrillator would not have made any difference in the man’s case. Whilst, this may be the case, there was no way of the medical staff knowing that, and valuable time could have been wasted by having to return to the department to collect the equipment. This should be reviewed.

**The Governor in partnership with the PCT should ensure that the grab bag contains the necessary equipment to allow healthcare staff to administer emergency life saving aid.**

**The Governor in partnership with the PCT should ensure that a defibrillator is taken to any Code Red or Code Blue incident.**

17. At 12:57pm, the paramedics arrived, connected the man to a cardiac monitor and incubated him. As they were unable to locate a vein, they administered adrenaline via a tube. Throughout the paramedics’ intervention, one of the nurses continued with CPR.
18. At 1:33pm, the paramedics stopped any further attempt to resuscitate the man and pronounced him dead. The prison doctor, arrived at the cell at 1:40pm.
19. At 2:00pm, the police arrived and examined the area, leaving 45 minutes later when the cell was sealed pending the arrival of the undertakers.
20. I seek to involve the family of the deceased in all my investigations, including those where the death was from natural causes. I employ designated staff within my office as Family Liaison Officers (FLOs). The FLOs work closely with the family and the investigator, and will

21. On 31 March, a FLO and one of my investigators met with the man's wife. She raised a number of issues relating to his health and asked why she had not immediately been informed of his death. The man's wife also expressed concern at the distance that he had been located from their home. I believe that the clinical review will answer her concerns regarding her husband's health.
22. With regard to the man's location, it is clear from correspondence between the Prison Service, the man's wife and a Member of Parliament, that the man's location was based entirely on the nature of his offence. This limited the number of establishments available to accommodate him.
23. The Prison Service's Resettlement Policy asks prisons to consider the location of prisoners in relation to their home circumstances and to develop family contact. However, the overriding factor of the policy is to address offending behaviour and to equip the prisoner with the necessary skills to remain offence free on release. It is unfortunate that the personal needs of the man's wife were not taken into account when allocating the man to Wymott, which was difficult for her to travel to.
24. The prison records show that the man provided the names of his parents as his next of kin, which explains why his wife was not the first contact point in the event of an emergency.
25. The man's wife was asked how the prison had dealt with her and the man's property. She confirmed that the prison Liaison Officer had been in regular contact with her, and that the majority of her husband's property and private money had been returned quickly and efficiently. However, she told the investigation team that a key ring, spectacles, and bracelet were missing. The man's wife believed that he might have passed the bracelet to another prisoner, intending him to repair it. The investigator has not been able to identify who the prisoner was. The Governor was informed about the missing property. He has written to the man's wife to confirm that they were missing, but that he would return them should they be found at a later stage. However, an examination of the cell clearance certificate for 21 February shows that the officers have recorded "glasses" as being removed from the cell.

**The Governor should clarify the items removed from the cell and, if necessary, compensate the man's wife for the lost spectacles.**

26. The man's wife was pleased that the Governor agreed to photograph her husband's cell, as she was unable to visit the prison. She confirmed that the prison had offered assistance with the funeral costs. I welcome the Governor's actions.

27. The clinical review raises one concern about the care of the man. The report notes, "*Although it is always easy with hindsight to see where omissions have been made. It is of concern that the health care staff should have tacitly accepted a diagnosis of osteoporosis as the cause of leg pain in a 38 year old man. There is no record of his legs having been examined and there is therefore no evidence that a deep vein thrombosis was ever considered or ruled out. I note that in the list of concerns raised by the man's wife was a statement that both his mother and wife had contacted the prison with concerns about leg pain and swelling in his leg. This is not recorded in the notes but may be recorded elsewhere. If this is true then the fact of swelling in his leg is very suggestive that he did in fact have a deep vein thrombosis, which, sadly, is a treatable condition if caught in time.*" The clinical review finding has been forwarded to the Governor for action.

**The Governor and Healthcare Manager of HMP Wymott should meet with senior Primary Care Trust representatives to discuss the findings of the clinical review and agree on any actions that are required. A follow up meeting should then be arranged in a further six months to review progress.**

28. Although I do not think it requires a formal recommendation on my part, medical staff should additionally be reminded of the need fully and accurately to record information in the medical notes.
29. The final paragraph of the clinical review questions whether there is a record of the man's family contacting the prison to discuss the pain and swelling in his leg. His mother provided a number of documents which show that medical concerns had been raised with the Governor of Blakenhurst, which is where the man was located at the time. The reply from the Governor said that "*the concerns you express about the man's health have been passed to the Medical Officer who will look into them*". There is no record of the man's mother being written to again by the Governor or Medical Officer of Blakenhurst to explain the man's condition or of any intervention taking place.
30. On 10 March, the man's parents wrote to my FLO to inform her that, following a telephone call from the man when he described his leg as swollen and his foot blue, they telephoned Wymott prison about their concerns. They understood that the man was seen the following morning by a doctor, informed that the pain in his leg was due to his bone disease and given painkillers and anti-inflammatory drugs.
31. The man's parents end their letter by saying that they had concerns about his medical care, and that he would still be alive had his medical condition been investigated properly
32. It is clear that the man's parents and his wife telephoned and wrote more than once to the Governors of Blakenhurst and Wymott to



## **Recommendations**

### **Operational**

- The Governor, in partnership with the Primary Care Trust, should ensure that the grab bag contains the necessary equipment to allow healthcare staff to administer emergency life saving aid.
- The Governor, in partnership with the PCT, should ensure that a defibrillator is taken to any Code Red or Code Blue incident.
- The Governor should clarify the items removed from the cell and if necessary, compensate the man's wife for the lost spectacles.

### **Healthcare**

- The Governor and Healthcare Manager of HMP Wymott should meet with senior Primary Care Trust representatives to discuss the findings of the clinical review and agree on any actions that are required. A follow up meeting should then be arranged in a further six months to review progress.

### **Good Practice**

- It is good practice that the prison uses different emergency codes, which enable staff to determine how to respond to the alarm.