Circumstances surrounding the death of a man at HMP Wymott in June 2008

Report by the Prisons and Probation Ombudsman for England and Wales

December 2008

This is the report of an investigation into the circumstances of the death of a man on 13 June 2008. The man was a prisoner at HMP Wymott and had been in custody for ten months at the time of his death. At 1.45pm, on 13 June, staff discovered the man collapsed in his cell after having a suspected heart attack. He was taken to Chorley and South Ribble District General Hospital where the medical team pronounced him dead at 2.55pm. The man was 68 years old.

I would like to offer my condolences to the man's family and friends for their loss.

The man was serving a sentence of two years and nine months. Shortly before his admission into prison custody, he had been receiving treatment for suspected cancer of the prostate and was awaiting further treatment. For a number of years, he had also been diagnosed with chronic obstructive pulmonary disease (COPD) which required him to use inhalers to aid his breathing, and ischaemic heart disease that had resulted in three previous myocardial infarctions (heart attacks).

My colleague conducted this investigation. I would like to thank the former Governor of Wymott and her staff for their participation. Particular thanks go to the liaison officer for making all the practical arrangements.

Central Lancashire Primary Care Trust (PCT) was commissioned to undertake a review of the man's clinical care. A Healthcare Manager at HMYOI Thorn Cross, completed the review.

I make four recommendations in this report, mostly relating to family liaison matters, and endorse (and in one case extend) a further five recommendations made by the clinical reviewer.

Stephen Shaw CBE
Prisons and Probation Ombudsman **December 2008**

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SUMMARY

The man was sentenced to two years and nine months in custody on 31 July 2007. At the time of his imprisonment he was in poor health and had a number of chronic illnesses for which he was receiving treatment. The health screen carried out on his arrival at HMP Manchester also highlighted that he had recently been referred to a hospital in Salford by his general practitioner (GP) for suspected prostate cancer and was awaiting an appointment.

The appointment was followed up by his solicitor who wrote to the Governor confirming the man's appointment at the hospital and requesting that it be honoured. However, the information was not passed on before the man's transfer to Wymott on 17 August 2007.

As is the normal course of events, on his arrival at Wymott a medical screen was completed. During the screen the man drew attention to his missed appointment at the hospital. The medical department at Manchester had not informed Wymott about the outstanding appointment, and attempts by nursing staff to contact Hope Hospital regarding the appointment were unsuccessful.

For reasons that remain unknown, the man refused to attend an appointment with the prison GP on 24 August and it was rescheduled for 28 August. On this date, the prison GP discussed with the man the problems he had with his prostate. Following the appointment, the GP discussed the man's treatment with a nurse and asked for an urgent referral to be made to the Urology Department of the local hospital under the NHS two week rule for cancer patients.

In the meantime, the healthcare department at Wymott made contact with the consultant's secretary at the hospital and informed her that the prison GP had arranged for the man to attend a local hospital. Although the hospital was still prepared to see the man if required, following discussions the prison GP decided that he should be treated locally and an appointment was received for him to attend Chorley and South Ribble District General Hospital (hereafter Chorley Hospital) on 18 September.

The man went to the appointment on 18 September, as well as to subsequent appointments, and a diagnosis of prostate cancer was made in late November. He was apprehensive about undergoing treatment but medical staff, both at Chorley Hospital and the prison, continued to encourage him to do so. In addition, the man was regularly seen by prison healthcare staff about his other health problems. In October, he complained of having a 'wheeze' on his chest but a chest x-ray showed no abnormalities. In November, the man moved to the elderly prisoner wing at Wymott, which provided a quieter and less hectic atmosphere. Over the following couple of months, he reported no further problems.

On 20 January 2008, a nurse saw the man in his cell after he complained of breathing difficulties. The prison doctor saw him the following day and diagnosed a bad chest infection. Over the next few days, nursing staff saw the man a number of times as his breathing problems continued. This resulted in him being sent to Chorley Hospital on 25 January where he was admitted. He remained in hospital for

a week while his breathing was stabilised and he was then discharged back to the prison. The man reported no further problems relating to his breathing during the next two months.

On 1 April, a nurse saw the man in his cell as he was again experiencing breathing problems and tightness in his chest. Following the assessment, an emergency ambulance took him to Chorley Hospital where he was admitted to the Coronary Care Unit (CCU). The man remained in hospital for 14 days during which time he started a course of warfarin. On his return to the prison, his new medication meant that he required regular blood tests to check its effectiveness. Both nursing staff and doctors saw him regularly for the tests and the prostate treatment.

At 1.45pm on the afternoon of 13 June, an officer found the man unconscious on the floor of his cell after he failed to attend for the roll check. The officer immediately called for medical assistance over his radio and, along with another prisoner who had seen what was happening, administered cardio pulmonary resuscitation (CPR). They did so until the arrival of nursing staff. Two nurses responded immediately to the emergency call but could detect no pulse or breathing from the man. The nurses continued CPR until the arrival of an emergency response paramedic at 2.00pm, who in turn continued treatment and was joined shortly afterwards by another ambulance paramedic and technician. They went on administering treatment before conveying the man to the waiting ambulance.

Due to the seriousness of the man's condition, the prison arranged for two members of staff to go in the ambulance with him but no restraints were used and the ambulance was able to leave the prison without delay. Treatment continued en route to Chorley Hospital, where on arrival the man was taken straight into the emergency room.

The escort staff remained outside the emergency room. The medical team informed them at 2.55pm that the man had been pronounced dead.

THE INVESTIGATION PROCESS

1. My investigator opened the investigation on 17 June 2008 when he contacted the prison's liaison officer. The Governor and the liaison officer provided the man's prison records for examination as well as his medical record. Notices were issued to staff and prisoners to inform them of the investigation process and to give them the opportunity to speak with the investigator. One response was received to the notices from a prisoner at Wymott who knew the man.

2. The investigator carried out interviews with six staff and two prisoners when he attended Wymott on 28 July. All interviews were either recorded or notes were taken apart from the conversation with one of the prisoners as he was unable to provide any relevant information. Copies of all other interviews are attached as annexes to this report.

3. My investigator wrote to HM Coroner to inform him of the nature and scope of the investigation and to request a copy of the post mortem report. A copy of my report will be made available to the Coroner to assist with his enquiries.

4. One of my Family Liaison Officers (FLOs) wrote to the man's daughter on 4 July. No response was received so ,y family liaison officer sent a further letter to the man's ex-wife on 1 August. The man's ex-wife contacted the family liaison officer on 5 August. She told the family liaison officer that her daughter had received the initial letter but had been away on holiday. The family liaison officer explained that the purpose of the contact was to listen to any concerns that the family had about the circumstances surrounding the man's death and to give them the opportunity to ask questions about the investigation.

5. The family's concerns were about the medical treatment offered to the man and the way the news of his death had been conveyed to them. Although the man's ex-wife had not been able to visit her ex-husband due to health problems of her own, she had spoken to him on the telephone and their daughters had been in more regular contact. I have attempted to address the family's concerns within this report, and I hope it gives them a better understanding of the events leading up to the man's death.

   Following the issue of the draft report the man's family said that they accepted that staff did respond quickly to the man on 13 June and did their best to save him. However, they also had a number of other concerns that have been incorporated into the report.

HMP WYMOTT

6. HMP Wymott is a male category C training prison near Preston. It has an operational capacity (maximum crowded capacity) of 1,074. It has facilities for both vulnerable prisoners (predominantly sex offenders), who make up over half the total population, and prisoners on ordinary location.

7. The healthcare centre provides primary care. It does not have inpatient facilities and prisoners with these needs are referred to a nearby prison or local hospital. There is a general practitioner (GP) surgery five days a week. Overnight and weekend services are covered by a local GP as part of an on call service.

8. An inspection by Ms Anne Owers, HM Chief Inspector of Prisons, was conducted in November 2006. Ms Owers concluded:

> "The 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. There remain some difficult issues to grapple with, above all how to ensure the safety of vulnerable prisoners when they are not separated from other prisoners, but, overall this is a generally positive report on an improving prison."

9. The Independent Monitoring Board (IMB) at Wymott said in their most recent published report (for 2004-2005):

> "In general, relationships between staff and prisoners are good and are often characterised by a human and respectful interaction. In spite of the difficulties presented by ongoing building work and a rapid rise in the prison roll we have seen many examples of thorough, professional work being carried out by staff at all levels."

10. Since my office took over responsibility for investigating all deaths in prison custody in 2004, there have been 13 deaths attributed to natural causes at Wymott. As a result of these previous investigations, I have made a number of recommendations relating to healthcare but commended the quality of family liaison. None of my earlier recommendations are mirrored in this report.

KEY FINDINGS

11. The man was sentenced to two years and nine months imprisonment on 31 July 2007 and taken to HMP Manchester. On reception, the man had a health screen. The nurse who completed the screen established that his doctor had recently referred him to the hospital in Salford, for suspected prostate cancer. In addition, the nurse recorded that he had suffered for a number of years from chronic obstructive pulmonary disease (COPD), for which he was receiving medication, as well as ischaemic heart disease, which had resulted in three previous heart attacks.

12. As a result of the information supplied by the man during his health screening, a doctor at HMP Manchester wrote to a Consultant Urologist at the hospital, on 3 August 2007. He informed the consultant that the man was now in custody and asked for all future appointments to be sent via the healthcare centre at Manchester.

13. The man's solicitor wrote to the prison on 7 August (the letter was received at the prison the next day) to confirm that he was awaiting an appointment at the hospital for prostate treatment. The solicitor also attached a copy of the admission letter confirming the man was due to attend hospital on 20 August to undergo a biopsy the following day. However, the man transferred to Wymott on 17 August, three days before his appointment was due. Two months later on 16 October, HMP Manchester replied to the solicitor's letter to inform them of the transfer. My investigator was informed by the healthcare at Manchester that this response was within the agreed timescales for responding to correspondence.

14. On arrival at Wymott, the man had another health screen. He explained his previous medical history and told staff about his prostate cancer and previous treatment. He was placed on the chronic disease register for his COPD which meant that he would be seen regularly to monitor his condition. In addition, a medical risk assessment was completed that indicated that he was unfit to attend the gymnasium due to his breathing difficulties.

15. On 20 August, a nurse contacted the hospital to chase progress on the man's outstanding appointments. At this time, staff at Wymott were unaware of the dates mentioned in the solicitor's letter, as the information had not been passed on. The nurse left a message for the consultant's secretary to call her back. After hearing nothing, the nurse attempted again on 22 August to make contact but there was no reply.

16. The man refused to attend a doctor's appointment on 24 August and so it was re-listed for the following week. When he attended on 28 August, The prison GP saw him and made a note of his history of prostate problems. Following the appointment, the prison GP discussed the man's care with another nurse. As a result, the prison GP made an urgent referral for a urology appointment under the two-week rule (a system used by GPs to ensure that a patient suspected of having cancer is seen by a specialist within two weeks).

17. The same day, the administrative officer (AO) in healthcare spoke with the consultant's secretary at the hospital. She told the secretary that the prison GP had faxed an urgent referral for the man to be seen at a hospital nearer to Wymott. The secretary said that, if the man was to continue with treatment at the hospital, he could expect to be seen on either 13 or 27 September but would require a pre-operation assessment. The AO discussed this with the prison GP and phoned back the following day to confirm that the prison GP wished to continue with the treatment locally. An appointment was subsequently received for the man to attend Chorley Hospital on 18 September.

18. After attending the appointment on 18 September, further appointments were scheduled for tests to confirm the prostate cancer. All appointments were attended as planned and a diagnosis was confirmed in late November. When the man received the results, the nurse spoke with him to explore his feelings about it and discuss future appointments. She explained the support available to him, completed an assessment, and concluded that he required psychological support. Following the conversation, the nurse concluded that a referral to community specialist nurses was not necessary at that time and could be explored in the future if required.

19. In addition to his ongoing appointments and treatment for his prostate, the man was also seen regularly in healthcare as part of management of his chronic illnesses. When he was seen on 13 September, his weight had increased since his reception and he was given advice about his diet. There was a further increase when he attended on 29 September and 11 October, although he said that he did not like the food. When seen on 11 October he complained of a 'wheeze' and arrangements were made for him to have a chest x-ray while attending Chorley Hospital on 31 October for a pre-arranged appointment in relation to his prostate. The x-ray showed nothing of concern. The man continued to be seen regularly in healthcare for his blood and weight to be checked as part of his chronic disease management.

20. In November, the man was moved to I wing (a wing for elderly prisoners). He was reported to have been pleased with the move as it was a quieter atmosphere. He was employed in the workshop packing tea bags and, despite his health concerns, attended regularly. As the man was appealing against his conviction, he was not considered suitable to take part in the offending behaviour courses. Staff on I wing said that, following the confirmation of prostate cancer, the man coped well and remained positive about the treatments he would receive.

21. During the afternoon of 20 January 2008, the man had difficulty breathing and a member of staff called for assistance via the radio, using the phrase "code blue". (Prisons use a variety of methods to summon assistance via the radio in medical emergencies. This is usually done by assigning a code to signify particular problems. It helps medical staff to ensure that necessary equipment is brought when they attend emergencies. At Wymott, code blue is an indication that the prisoner has breathing difficulties and code red will indicate bleeding.)

22. A third nurse answered the radio call and saw the man in his cell. On examination, he was pale and appeared breathless. The third nurse gave him oxygen via a mask as well as an inhaler. She remained with him for quite a while. When he appeared to settle, the oxygen was removed. However, he remained unwell so the nurse arranged for him to be seen by the prison doctor the following day.

23. When the prison doctor saw the man in his cell the following morning, she confirmed that he had a very bad chest infection and prescribed antibiotics. Later that day, a member of staff again called a code blue as the man had become breathless. On attending his cell, the fourth nurse found the man to be displaying the same symptoms as the previous day. The fourth nurse put the oxygen mask on him and reassured him in an effort to calm him down. After a while, he began to settle and the fourth nurse gave prednisolone (commonly used to treat asthma and other breathing related illnesses) and the antibiotics prescribed earlier in the day.

24. The man was still having breathing problems when the prison doctor saw him the next day. As a result, she prescribed nebulised salbutamol. (A 'nebuliser' is a small plastic container that is filled with a medicine solution, in this case salbutamol. A compressor, usually electric, is used to blow air or oxygen through this solution to make a fine mist of medicine. This mist is breathed into the lungs through a mouthpiece or mask.) The man settled over the next few days, but on 25 January the prison doctor went to see him in cell as he was again experiencing problems. When the doctor arrived, a nurse had already requested an ambulance. The prison doctor recorded that the man had sudden dyspnoea (shortness of breath) with ischemia (restriction in blood supply) brought on by hypoxia (a deficiency in oxygen). Staff reassured him and he was placed on a nebuliser. He was then taken to Chorley Hospital by ambulance where he was admitted.

25. The man remained in hospital for a week while his breathing was brought under control. He was discharged back to the prison on 31 January and returned to I wing. On his return, officers recorded that he was still not breathing perfectly but it appeared under control with medication. When the prison doctor saw the man on 1 February, she recorded that he appeared much better since his hospital visit and had not smoked since returning. She also discussed the side affects of the medication he was due to receive for his prostate cancer as he had previously refused to take it. However, following an appointment with the specialist that day he had decided to go ahead. The man had no further reported breathing problems over the next two months.

26. On 1 April, staff called a nurse to see the man in cell at 4.00am owing to further breathing difficulties. When another nurse arrived, she recorded that he was complaining of tightness across the right side of his chest. He also said that he had been feeling ill for a few days but did not want to trouble anyone. His pulse was erratic and he appeared distressed. The nurse asked staff to call an ambulance. The ambulance arrived at 4.20am and departed with the man at 4.30am to Chorley Hospital.

27. When the nurse attended for duty on the evening of 1 April, she was informed that the man had been admitted to the Coronary Care Unit (CCU) and was very ill. While the man remained in the CCU, the Head of Healthcare kept in regular contact with Chorley Hospital to get updates on his condition. On 14 April, the man was discharged from hospital. The discharge letter showed that he had been treated for a chest infection and assessed by a heart failure nurse. As a result he was given new medication, which included warfarin. The hospital also notified the prison of dates for the man to attend the hospital for routine follow up appointments. Taking warfarin would require the man to have regular INR (International Normalised Ratio) tests to check that his blood was clotting correctly.

28. the fourth nurse saw the man in healthcare on 17 April to carry out his first INR test. The prison doctor saw him again later in his cell as a routine follow up appointment. She recorded in his medical record that he was anxious, as he was becoming breathless even with minimal exertion. The prison doctor advised him to try gently walking several times a day and not to just sit in a chair for long periods. She also said that he should aim to eat his meals in the dining room. During her visit, the prison doctor also discussed the man's prostate treatment. The man told the prison doctor that he did want the zoladex tablets (a drug used to treat prostate cancer) yet.

29. The man continued to have regular INR tests. On 6 May, he told a nurse that he was worried. When she enquired why, he said that on his discharge from hospital in April he had been told that he should sleep upright. The nurse noted that on 17 April a request had been submitted for a minimum of five pillows, but the man said that he had still not received them. The following day, the nurse spoke to the Disability Liaison Officer at Wymott, and was told that the pillows were on order but had not yet been received.

30. The man's personal officer, made an entry in his wing history sheet that "The man's behaviour has been somewhat unpredictable of late". (A personal officer is a prison officer who is given responsibility for a number of prisoners to deal with any issues that they might have, as well as completing reports on them.) The officer wrote, "It seems he is unwilling to accept logical arguments from strangers when an answer is not to his liking, but regular I wing staff can give the same information that is accepted unreservedly." The officer also recorded that the man was no longer working in the tea bag shop because of his respiratory problems.

31. On 1 June, the man told the nurse that he was still waiting for the pillows he had requested in April. The nurse spoke to the prison officer who worked regularly on I wing. The prison officer explained that he had offered the man additional pillows but he had said they were "not fluffy enough". Both the nurse and the prison officer went to see the man and provided him with five pillows which the nurse arranged on his bed for him. Apart from attending for regular INR tests, the man had no other reported contact with healthcare over the following two weeks.

Following the publication of the draft report the man's family were surprised that in the clinical reviewers report the provision of the pillows was described as good practice. The family felt that given the man had been told by the hospital to remain in an upright position to aid his breathing, it took six weeks for him to be provided with them. The family are shocked that no one followed up what they feel was an essential piece of healthcare equipment and not a luxury item. If healthcare staff had thought of providing the pillows in January after the man had experienced a number of episodes of breathlessness they would have been more impressed.

Events of 13 June 2008

32. At 1.45pm on 13 June 2008, the prison officer was on duty on I wing and noticed that the man had not turned up for roll check (this is a check to establish that all prisoners are in their cells). The prison officer went to his cell and, on looking through the observation panel, saw the man lying on the floor. He immediately called for code blue assistance via his radio and entered the cell. At the time another prisoner was cleaning the landing and heard the prison officer call for assistance. The other prisoner made his way along the landing to the cell. The prison officer had already gone into the cell and subsequently wrote in his statement that, "The man was blue in colour and his tongue was out." The other prisoner also went into the cell and he and the prison officer placed the man on his back. While the prison officer was requesting assistance, the other prisoner began checking for a pulse. In his statement, he said he could not find one and began to administer cardio pulmonary resuscitation (CPR). (Prior to coming into custody, the other prisoner had been employed as a paramedic so was qualified to administer first aid.)

33. On hearing the call for medical assistance, two nurses made their way to I wing. One nurse went directly to the man's cell and the other nurse went to the treatment room to collect an emergency bag and an oxygen cylinder before joining the nurse. The nurse said that, when she arrived, the other prisoner was administering CPR. She checked the man and there was no pulse or breathing. The nurse asked for an ambulance to be called urgently and took over the CPR from the other prisoner who then left the cell. While CPR continued, the other nurse inserted an airway into the man and commenced ventilation using an ambubag (a self-inflating bag used to give ventilation during resuscitation). The other nurse then attempted to cannulate (to insert a tube into a vein to allow medication to be administered) but was unable to do so as the man's veins had collapsed, so she continued with the ventilation.

34. The fourth nurse who also attended the code blue call, was asked over the radio to collect the automated defibrillator from I wing office on her way. (An automated external defibrillator is used in cases of life threatening cardiac arrhythmias, which have led to cardiac arrest.) However, when she got to I wing she found that the machine was not there and she went on to the man's cell. She informed the nurse that the defibrillator was not in the office and was told that it had been taken to healthcare to be charged. (The defibrillator machines have to be charged frequently and after use. The machine on I wing,

which would usually be located in the wing office, had been used earlier in the week so had been taken to healthcare for charging.) the nurse collected the machine from healthcare and returned to I wing. When interviewed the nursing staff were unable to give an exact time that it took for the defibrillator to be collected but given the vicinity of the healthcare wing it was felt that it was likely to have been a matter of minutes.

35. When she returned to the cell, the fourth nurse took over CPR from the nurse so that she could attach the defibrillator to the man. When the nurse connected the machine, it advised not to shock the patient. The nurse then continued with CPR while the two other nurses continued ventilation. Statements from the nursing staff indicate that at no time during treatment did the defibrillator indicate for them to shock the man. (The defibrillator will only advise the user to shock a patient if it detects heart rhythm. As it advised no shock in the man's case, this indicates that there was no output.)

36. A rapid response paramedic arrived at the prison at 2.00pm and went straight to I wing. He attached the man to his own defibrillator which showed that he was asystole (a state of no electrical cardiac activity). The paramedic then managed to cannulate the man while the nurses continued CPR. The paramedic administered adrenaline and atropine and CPR continued until an output was noted. An ambulance paramedic and technician who had arrived at the prison at 2.04pm joined the rapid response paramedic. They continued treatment before transferring the man to the ambulance.

    Following the publication of the draft report the man's family expressed concern about the length of time it took for the defibrillator to be brought to the cell. The family asked whether this delay could have made a difference given that the paramedics managed to raise a pulse later on.

37. As mentioned in the report, CPR had been continuous from the time that the man was discovered. The defibrillator was not brought immediately but when it was it indicated that there was no output (heart beat). The defibrillator will as previously mentioned put a heart back into a normal rhythm but is unable to restart a heart that has stopped. When the paramedic connected his machine it indicated the same. Although I am unable to be certain I feel that the output noted was as a result of drugs administered by the ambulance staff and the continued CPR.

38. Due to the seriousness of the man's condition, the prison quickly arranged for staff to escort him in the ambulance. In order to allow the ambulance to depart immediately, completion of the escort paperwork that would usually accompany a prisoner was deferred. Two officers, who were escorting the man, were told that this would follow. The man was not handcuffed so that the ambulance crew could continue to treat him. The ambulance left the prison at 2.35pm.

39. Throughout the journey to Chorley Hospital, the paramedic administered CPR. On arrival at 2.45pm, a medical team was waiting and hospital staff continued to attempt to resuscitate the man. However, at 2.55pm the escort staff were

informed that the decision had been taken to cease resuscitation attempts and The man had been pronounced dead by the medical team.

40. The Duty Governor, telephoned the man's ex-wife to break the news of his death. She decided to telephone rather than arrange a visit as his family were based in the Manchester area, some distance from the prison.

41. A debriefing session was held for healthcare staff in which they were able to share their experiences. Staff who spoke to my investigator said they felt supported by the prison.

ISSUES

Transfer from HMP Manchester to Wymott

42. As mentioned earlier in this report, a letter from the man's solicitor received by HMP Manchester on 8 August 2007 indicated that a biopsy had been arranged for him at the hospital on 20/21 August. In spite of this information, the man was transferred on 17 August.

43. My investigator contacted HMP Manchester and spoke to the healthcare department. The investigator asked why the man had been transferred only three days before a scheduled hospital appointment. It was explained that, at the time of the transfer, the healthcare department was unaware of the appointment. As a result, they were unable to inform the receiving establishment so that the appointment could be attended. The explanation given was that the letter had been addressed to the Governor and not healthcare. As a result, it would have been dealt with alongside other post and not flagged as urgent.

44. The clinical reviewer says in her report:

> "It should be recognised that this was quickly rectified by healthcare staff at Wymott and an appointment went ahead in Lancashire on 18 September. This 28 day delay is unlikely to have had a major effect on the outcome of the care in relation to the prostate cancer in these circumstances. However, it is not possible to estimate the effect on the man psychologically."

45. The clinical reviewer goes on to say:

> "By contrast, it is commented that the man was known to be a nervous prisoner who doubted his ability to cope with his sentence. The transfer from a busy local prison to a prison with a more stable population would likely have been of great benefit to the man and was perhaps a factor in the decision to transfer him."

46. I am satisfied that, had the letter from the man's solicitor been addressed to the healthcare department, or indeed marked as urgent, the necessary actions would have been taken to ensure the appointment was attended. The man may still have been transferred as this would appear to have been to his benefit. Again, had the information been known to Manchester healthcare staff then it would, in all likelihood, have been passed on to their colleagues at Wymott. I therefore make no recommendations. That said, I am concerned that correspondence appears to take a very long time to be passed from one part of HMP Manchester to another. The Governor of Manchester, to whom this report will be copied, might wish to consider how the transfer of mail can be expedited.

47. The clinical reviewer says that the thorough assessment the man received on his reception at Wymott ensured his prostate problems were picked up quickly, and delays were minimised by using the 14 day rule in respect of appointments for cancer sufferers.

The man's family commented following the publication of the draft report that they could not understand how the man's appointment was not known to healthcare staff. They point out that it was noted on both the initial health screen and had been picked up by the doctor at HMP Manchester who sent a letter to the consultant at the hospital. They also mention that when the man was seen prior to his transfer to Wymott healthcare staff had another opportunity to discover the outstanding appointment.

The man's family feel strongly that he should not have been transferred when he was in the middle of treatment. They say that the man had confidence in the hospital and that if he had continued treatment there he may have been persuaded to accept a difficult course of medical treatment. It would have also made it easier for his family to visit in order to improve his morale.

The family ask whether it can be discounted that the decision in discontinuing treatment at the hospital, once he had been transferred to Wymott was not done on a financial basis.

48. I have no reason to believe that this was the case. The decision to move the man's treatment to Chorley Hospital was I believe based on the ability to provide the quickest appointment and clearly looked into by the prison GP. There is nothing to suggest that the man received any lesser treatment than he would have at the other hospital. It is clear that Chorley was more convenient in terms of travelling time but this would have been of benefit to the man in terms of not having to travel long distances after receiving treatment.

Healthcare provision at Wymott

49. Responsibility for the provision of healthcare at Wymott has recently been passed from the Prison Service to Lancashire PCT. The clinical reviewer has found that the healthcare policies and procedures were still being reviewed. As a result, some of the existing policies were outdated and staff did not access them on a regular basis. However, the clinical reviewer says:

> "Staff had followed correct procedures and the existing policy with regard to the care of the man. Although modernised policies will improve the way that care is delivered generally, in this instance, it is unlikely that this would have affected to any great extent the overall care package that was delivered to the man."

I have added to a recommendation made by the clinical reviewer in relation to this issue:

Publication of new policies and procedures for patients accessing primary care health services at Wymott should be a priority for the PCT.

The policies and procedures should take account of the national service framework recommendations and other relevant guidance regarding the modernisation of patient care.

50. Health services for older people at Wymott have recently been strengthened with the appointment of a nursing sister to specifically look at the needs of the older population. The clinical reviewer says in her report:

> "… the procedures and documentation used for assessments of older people is also under review and when completed should mirror the documentation used by the local health provider and be compatible with the national service framework for older people and take into account National Institute of Excellence (N.I.C.E) guidelines. This will ensure that all the documentation is evidence based and shares the same risk assessment procedure used by the Primary Care Trust. Where appropriate, patients should also be provided with a copy of their care plan."

Record Keeping

51. The clinical reviewer has commented on the standard of record keeping in her report saying, "In a small number of instances records had been stored without a date or a name attached. There should be a clear policy around record keeping. In order to improve communication systems medical/nursing documentation could be audited. This would enable managers to identify any training needs for staff." I endorse these comments and make the following recommendation:

The Head of Healthcare should consider updating training and guidance for all healthcare staff in relation to record keeping. In particular, they should be reminded of their obligations to comply with the guidelines regarding record keeping set out in the relevant Nursing and Midwifery Council Guidelines.

Medical intervention on 13 June

52. When the man was found lying on the floor of his cell, the medical response to the code blue call was relatively quick. The equipment required was easily accessible and collected en route to the man's cell. However, the defibrillator was not located in the wing treatment room where it should have been as it had been removed to the healthcare centre for recharging. Although this did not cause a significant delay in the care or treatment of the man, it has the potential to cause delays. This was also acknowledged by the clinical reviewer who says "on investigation it seems that the equipment cannot be charged in the treatment room as there is currently only one electrical plug socket available and that is occupied by the drugs refrigerator, which must remain on". The reviewer makes the following recommendation in her report which I am happy to endorse:

The equipment used in an emergency situation should be stored in the treatment room on each wing. There should be an adequate number of electrical sockets to facilitate use of the medicines refrigerator and re-charging equipment. Equipment should not be returned to the healthcare centre for recharging as this may impede the efficiency of an emergency response time.

The man's family particularly welcomed this recommendation.

53. During her review, the clinical reviewer also found that the training in basic life support and first aid in respect of a number of healthcare staff was out of date. This is a concern given that staff in healthcare are responsible for attending patients in emergency situations. In view of this, she makes the following recommendation which I endorse:

Health professionals who are responsible for attending an emergency situation should have up-date training in basic life support and first aid on an annual basis. Records of training and date for renewal should be retained by the healthcare manager to ensure compliance.

54. I note the assistance provided by the other prisoner. I do not know what actions have followed, but I believe his involvement should be formally acknowledged. I therefore recommend:

The Governor should write to the other prisoner to thank him for his assistance in the attempted resuscitation of the man.

Notifying the next of kin

55. Following the man's death, the Duty Governor took the decision to contact his next of kin by telephone. The reasons given for this decision were that prisoners on the man's wing were in a position to access Pinphones and might have been in a position to contact his family or other persons about his death. The Duty Governor therefore wanted to ensure that a member of the senior management team contacted the family at the earliest opportunity.

Following the publication of the draft report the man's ex-wife said that she did not accept the reasons given for the way in which she was informed. She said that she felt her husband was a private person who would not have given his phone numbers to anyone. The man's ex-wife feels that the prison misread the situation and she would like them to learn from it.

56. However, the call was taken by the man's ex-wife who was on her own at the time. The man's ex-wife did not feel adequately cared for as there was no attempt by the prison to check whether she had support after the news was broken. While the man's ex-wife appreciated that the prison wanted to relay the news quickly, she would have preferred the police go to her home as this would have provided her with some human contact at a distressing time.

57. Wymott could have asked a nearby prison to assist them in breaking the news, or indeed to provide follow up support even after the news had been broken. The prison has one trained family liaison officer (FLO) who would normally visit a prisoner's family along with a prison manager or member of the chaplaincy to break such news. However, at the time of the man's death the FLO was on annual leave. In my view, the prison should have considered alternative ways of offering more immediate support, rather than waiting for their FLO to return from holiday.

58. The Duty Governor acknowledged in the hot debrief (where those involved are brought together by those involved to discuss their roles and to highlight any issues that arose) following the death that the method used in notifying the next of kin was less than perfect. The Governor sent a letter of condolence to the family and an offer of assistance with funeral costs was made. I make the following recommendations in relation to this issue.

The Governor should ensure that Wymott's contingency plans for dealing with a death in custody clearly state that next of kin are informed in person wherever possible, and provide guidance about alternative means of notification in the event that no one is available from the prison.

The Governor should increase the number of trained FLOs at Wymott.

59. The man's family also mentioned that they had been disappointed not to have been notified that he had been admitted to hospital on the two previous occasions. Prisons do not automatically notify next of kin when prisoners are taken to outside hospital. However, if a prisoner is likely to be admitted for more than a short time, such as two days, the prison should ask if they wish their next of kin to be told unless there are security reasons for not doing so.

The Governor should ensure that when a prisoner is admitted to outside hospital for more than 48 hours they are asked as part of the management check whether they wish their next of kin to be informed. This should be recorded on the bed watch documentation.

The man's family particularly welcomed this recommendation.

Staff Support

60. My investigator was told by the staff he interviewed that they had been properly supported following the man's death. Healthcare staff reported that a debriefing session had taken place which had served to relieve anxieties that they may have had.

Conclusion

61. The man was an elderly and had entered prison with chronic health problems. These were probably worsened by the stress of finding himself in custody at the age of 68. I understand he was a worrier and the confusion over his original appointment at the hospital is unlikely to have improved this. However, I believe that nursing staff made every attempt to alleviate his distress. The move to Wymott also provided him with the opportunity to be located on the elderly prisoner wing, and the quieter surroundings would have been of benefit to him.

62. In relation to the healthcare the man received, the clinical reviewer concludes as follows:"The level of service provision arguably exceeded the provision offered in the general community as the man was able to access health professionals as he needed within minutes."

RECOMMENDATIONS

1. The Governor should write to the other prisoner to thank him for his assistance in the attempted resuscitation of the man.

2. The Governor should ensure that Wymott's contingency plans for dealing with a death in custody clearly state that next of kin are informed in person wherever possible, and provide guidance about alternative means of notification in the event that no one is available from the prison.

3. The Governor should increase the number of trained FLOs at Wymott.

4. The Governor should ensure that when a prisoner is admitted to outside hospital for more than 48 hours they are asked as part of the management check whether they wish their next of kin to be informed. This should be recorded on the bed watch documentation.

5. Publication of new policies and procedures for patients accessing primary care health services at Wymott should be a priority for the PCT. The policies and procedures should take account of the national service framework recommendations and other relevant guidance regarding the modernisation of patient care.

6. The Head of Healthcare should consider updating training and guidance for all healthcare staff in relation to record keeping. In particular, they should be reminded of their obligations to comply with the guidelines regarding record keeping set out in the relevant Nursing and Midwifery Council Guidelines.

7. The equipment used in an emergency situation should be stored in the treatment room on each wing. There should be an adequate number of electrical sockets to facilitate use of the medicines refrigerator and re-charging equipment. Equipment should not be returned to the healthcare centre for recharging as this may impede the efficiency of an emergency response time.

8. Health professionals who are responsible for attending an emergency situation should have up-date training in basic life support and first aid on an annual basis. Records of training and date for renewal should be retained by the healthcare manager to ensure compliance.

Following the publication of the draft report, the Prison service accepted in full all of the recommendations. They also produced an action plan that indicates a target date of December 2008 for all recommendations to be implemented.