Investigation into the circumstances surrounding the death of a man at HMP Wymott in October 2009

Report by the Prisons and Probation Ombudsman for England and Wales

January 2011

This is the report of an investigation into the death from natural causes of a 73 year old man at HMP Wymott on 5 October 2009.

I extend my sincere condolences to all those affected by his loss. I have considered how the man's family were told of his death and remind the Governor of the national guidance about contacting the next of kin. I also apologise for the delay in issuing this report and for any additional distress that this may have caused.

A clinical review of the man's care and treatment has been carried out by Central Lancashire Primary Care Trust.

I should like to thank the Governor of Wymott, and his staff for their co-operation.

The man died suddenly and unexpectedly. His cause of death was a haemopericardium following a ruptured myocardial infarct (collection of blood in the pericardial sac surrounding the heart following rupture of a major blood vessel).

The clinical review found that it would not have been possible to anticipate the man's death. The review also found that, although his clinical care was equitable to what he would have received in the outside community, more attention should have been given to following up test results and advising prisoners about managing their own health.

Jane Webb
Acting Prisons and Probation Ombudsman **January 2011**

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SUMMARY

The man was a licence recall prisoner who returned to prison custody on 5 July 2008. He was initially taken into HMP Leeds before being transferred to HMP Wymott six weeks later. He was then 72 years of age.

During the healthcare reception screening at Wymott, the man reported having type II diabetes (type II, non insulin dependent and often age related) and hypertension (high blood pressure). He was receiving medication for both conditions. He reported that he smoked and was overweight (he was six feet tall and he weighed 17 stones). His blood pressure was within the normal range.

The man had lost a leg in an accident as a young man and, although he possessed a mobility scooter, he seemed to manage without it. The reception nurse noted that she considered him to be fit for his age.

The man moved to I wing in October 2008 and he settled in well. He appears to have remained well, consulting clinical staff only rarely. The man was checked from time to time to monitor his diabetes, weight and blood pressure. He managed to lose some weight, but his blood pressure increased each time it was tested and nothing seems to have been done to attempt to deal with the problem.

In the late afternoon of 5 October, the man was in the I wing dining room eating his evening meal. Another prisoner alerted staff that something seemed to be wrong with him. The staff saw that the man was having difficulty breathing so they radioed for emergency assistance. By the time nursing staff arrived the man had stopped breathing. Staff started cardio pulmonary resuscitation (CPR) and continued until ambulance paramedics arrived and they also tried to treat him. Unfortunately, all the efforts to resuscitate the man proved unsuccessful and he was pronounced dead at around 6.45pm.

Prison Service Order 2710 contains instructions about meeting the next of kin to tell them of a death. On this occasion the Duty Governor thought that the man was estranged from his family and decided to telephone rather than visit. In the event, no reply was received and the police were asked to give the information. The man's family eventually learnt of his death in the early hours of the following day.

At post mortem, the man was found to have died from a haemopericardium following a ruptured myocardial infarct (meaning a heart attack). The post mortem examination also revealed presence of atherosclerosis (thickening of the arteries caused by fatty deposits).

The clinical advice obtained in this case included that the man's pre-existing conditions of diabetes, hypertension and atherosclerosis increased his risk of heart and circulation problems. Even so, there appears to have been no sign he was about to suffer a heart attack. The clinical review found that the man's care was adequate. However, the review also found that improvements could have been made in the area of chronic disease management.

THE INVESTIGATION PROCESS

1. The Ombudsman's investigator first visited HMP Wymott on 22 January 2010 when he spoke with a representative of the Independent Monitoring Board. He also spoke with the man's personal officer and with a healthcare nurse.

2. The investigator was shown around I wing including the dining area where the man collapsed and died. Notices were issued to staff and prisoners informing them about the investigation and inviting them to contact the investigator if they wished to be involved in the investigation. The investigator subsequently spoke by telephone with a third member of staff in addition to the two with whom he had previously spoken. No prisoners came forward in response to the published notices.

3. The investigator contacted the Coroner, to whom a copy of this report will be sent to assist his enquiries.

4. Lancashire Primary Care Trust (PCT) agreed to review the man's clinical care and treatment at Wymott. The main review was carried out by a nurse. The investigator sought clarification on a number of matters relating to the man's care and treatment which led to the PCT's Medical Director writing a supplementary report. The delay in the issue of my report was due, in part, to the request for this additional information.

5. One of the Ombudsman's Family Liaison Officers wrote to the man's son to inform him of the scope of the investigation and to give him the opportunity to ask any questions or to raise any concerns he wished to be considered as part of the investigation. He did not respond with any specific issues that he wished to be explored.

HMP WYMOTT

6. HMP Wymott is a category C training prison near Preston for adult male prisoners serving sentences longer than six months. It has an operational capacity of just over 1,000. It has facilities for both vulnerable prisoners (who have to be kept separate from the rest of the prison's population, usually due to the nature of their offence), who make up over half the total population, and prisoners on ordinary location.

7. Commissioning healthcare within Wymott is the responsibility of the Central Lancashire Primary Care Trust. The prison does not have inpatient facilities. There is a general practitioner (GP) surgery within the prison which prisoners can access five days a week. Overnight and weekend doctors' services are covered by the same provider and nurses are on duty 24 hours a day.

8. The most recent inspection of Wymott by Her Majesty's Chief Inspector of Prisons was a full announced inspection in October 2008. The Inspector's findings included:

   "Overall, this is a very positive report on a prison that has managed to progress despite a considerably increased and very varied population …

   "I wing (where the man lived) held up to 75 prisoners and was the only wing where prisoners could eat out of their cell (the wing has a dining room that can accommodate the full prisoner complement). A stair lift allowed prisoners to access the association facilities on the upper landings …

   "All the interactions we observed between staff and prisoners were positive and respectful. Prisoners and staff were relaxed with each other …

   "Despite [deficiencies in the written personal officer policy] some good personal officer work took place … [92 per cent] of vulnerable prisoners said that they had a personal officer … and 69 [per cent] of vulnerable prisoners … said that they found their personal officer helpful …"

9. In its report for the year from 1 June 2008 to 31 May 2009, the Independent Monitoring Board (IMB) at Wymott wrote in its summary that:

   "The Board considers that the Prison is providing a safe environment in which prisoners are treated with decency and respect and have access to an extensive programme of education and skills. The Senior Management of the Prison have set out to address those areas where prisoners are not treated decently within the limitations of what the Prison can do given its national resource allocation."

10. In relation to I wing, the IMB wrote that:

   "Although I wing is identified as the Elderly and Disabled Community it does not appear to have attracted significant additional funding to reflect the specific requirements of that role. In the course of the year, however, the

Governor was able to find sufficient funds to appoint two care workers, to install a stair lift on I Wing and to set up a day care activity centre, all of which enhance significantly the facilities on the wing. The appointment of the care workers, in particular, provides much-needed assistance with daily living. The layout of I Wing creates difficulties for wheelchair users. However, the installation of the stair lift is a welcome addition, and the social environment of the wing and the good staff-prisoner relationships provide further benefits."

11. Since my office took over responsibility for investigating all deaths in prison custody in 2004, there have been 22 deaths attributed to natural causes at Wymott. This high number is unsurprising given the number of older prisoners held at Wymott. On more than one occasion in the past my office has either recommended or reminded Wymott about the need to follow the published guidance when notifying families about a death. I again make such a recommendation in this report.

KEY FINDINGS

12. The man was born in Leeds on 5 August 1936. He was the youngest of five children and reported having had a happy childhood despite the deprivations suffered during the war time years.

13. He left school at the age of 15 and became a jeweller's apprentice. At the age of 18 the man began National Service. During his period on National Service, he sustained a serious leg injury that resulted in a below-knee amputation. On returning to civilian life, the man took a driving job and subsequently became a taxi driver. He pursued that occupation for around 40 years.

14. The man was married twice and had one other long term relationship. He had nine children: three from each of these relationships.

15. The man was first remanded into prison custody on 16 September 2000 and remained in custody at HMP Leeds while awaiting trial. In January 2001, he was convicted of a number of offences of a sexual nature and was subsequently sentenced to eleven years imprisonment.

16. The man was transferred to HMP Wakefield in the summer of 2002 and, having remained there for over two years, was transferred to HMP Bullingdon in Oxfordshire. He was released on licence in September 2007, but ten months later he transgressed his licence conditions and was re-arrested.

17. Upon being re-arrested, the man was taken into HMP Leeds where he arrived on 5 July 2008 and received a health screening assessment (this is a standard assessment that all prisoners receive when arriving at a new establishment). In response to a question about any existing medical conditions or problems, the man reported that he had type II diabetes and hypertension. He was receiving medication for both conditions. The man also mentioned the below the knee amputation that he suffered following an accident many years previously. He said that he had difficulty using stairs and used an electric mobility scooter to move around. In answer to a question about heart problems in his family, the man said that a brother and a sister had such problems. He reported that he smoked 40 cigarettes a day. There is no evidence that he was given advice about reducing or stopping smoking. His weight was recorded as 17 stones (108 kilograms) and he was noted to be six feet tall. The man's blood pressure was 122/74 (this is considered to be around an optimal level).

18. On 15 August, the man transferred to HMP Wymott where he received a further health screening assessment. He reported similar information to that which he reported when he arrived in Leeds. At the end of the process, the nurse referred the man to the diabetic clinic. She also noted his assessment form to indicate that she considered him "fit for his age" (he was then 72 years old).

19. In early October, the man had a blood test after fasting, which detected a high level of fasting glucose. Although a nurse noted in his clinical records that the results should be discussed with a doctor, there is no evidence to show whether this happened.

20. The man moved to I wing on 6 October, when an officer was appointed as his personal officer[1]. The officer told my investigator that he spoke with the man several times per day when he was on duty. The officer said that, despite having a false leg, the man was able to walk and could use the stairs without any great difficulty. The officer could not recall the man using a wheelchair or a mobility scooter. He complained at times that his false leg chaffed his leg stump but, other than that, he seemed to be a well man who rarely consulted healthcare.

21. The man went to a diabetic clinic on 20 October. Urine testing again revealed a high level of glucose as well as high levels protein, blood and nitrates. The nurse noted that the man's urine appeared concentrated and she questioned whether he should be reviewed by a doctor for a prescription of antibiotics. His weight was recorded as 100 kilograms. His body mass index (BMI) was calculated at 29.9. Using NHS guidelines this meant that he was technically overweight. His blood pressure was found to be 138/71 (this is a slightly elevated level). The nurse discussed with the man an aim to lose weight and recommended that he should consider going to the gym. The man's own stated aims appeared to be a desire to reduce his sugar intake, lose weight and reduce the amount that he smoked.

22. An entry in his clinical records two days later showed that the man had been diagnosed with a urinary tract infection and he was prescribed antibiotics.

23. On 5 November, the man's weight was recorded as 99 kilograms and his blood pressure as 156/79. This is a high reading for blood pressure and a note was made in his records for a further check in two weeks time. (Despite the apparent plan for his blood pressure to be re-tested in a fortnight, it was not until eight months later that a test was next recorded.)

24. In February 2009, an entry in the man's clinical records refers to a consultation three weeks earlier. It concerned a septic arm infection that was noted to have cleared up so that no action was needed. Little else is recorded in his clinical records during 2009, apart from a number of on-going prescriptions for medication to help manage his diabetes as well as medication commonly prescribed to older patients to limit chances of a heart attack. Otherwise, it seems that the man remained relatively fit and well.

25. Entries made by the man's personal officer in his records show that he settled in well on I wing and got on well with the other prisoners. The officer told my investigator that it had long been his practice to periodically check with prisoners whether their next of kin details were up to date. It was through such a check that the officer discovered that the man wanted to change his nominated next of kin from his brother to his son.

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[1] When prisoners arrive at a prison they are usually allocated a personal officer. Among other things, the personal officer is a prisoner's first port of call if they have questions, complaints or need advice.

26. The man attended another diabetes clinic on 13 July. On this day his weight was recorded as 102 kilograms and his blood pressure was 165/89 (this, again, is a high reading and higher than the previous reading). There is no mention in his clinical records about any plan to deal with this.

5 October

27. At just after 6.00pm on 5 October, the man was in the I wing dining room eating his evening meal as usual. There were three officers supervising the serving of the food when a prisoner alerted them that something was wrong with the man. All three officers went to the man and saw that he was having difficulty breathing. One of the officers issued a radio message to notify a code blue alert (a code blue alert indicates that a prisoner is having breathing difficulties and emergency healthcare assistance is needed). A few minutes after that another officer radioed for an ambulance as it seemed to him that the man was deteriorating. The man was still sitting in his chair, supported by an officer.

28. A Principal Officer (PO) arrived in the dining room and the officer told him that the man was still breathing. At the same time a nurse arrived and she examined the man. She found that he was not breathing and had no pulse. The nurse asked the officers to move the man to the floor and she started cardio pulmonary resuscitation (CPR). Another nurse and an officer assisted the first nurse with CPR. The man was checked with a defibrillator[2] which advised that CPR should continue. Shortly afterwards, ambulance paramedics arrived and also tried to treat him. The efforts to resuscitate the man continued until around 6.45pm. The decision was then made that the man could not be resuscitated and his death was pronounced.

29. When it became apparent that a medical emergency was developing, the serving of the evening meal was suspended and the other prisoners were escorted out of the dining room. The remaining meals were then served elsewhere. The other prisoners were told later of the man's death.

After the man's death

30. Before his death, the man had nominated one of his sons as his next of kin. He had previously named one of his brothers as next of kin and his contact details were still held on file. Both family members live in Leeds, which is about 60 miles from the prison. Between 7.15pm and 9.05pm, Wymott's Acting Deputy Governor, made repeated attempts to telephone the man's son and brother but failed to obtain an answer. She then contacted the police force local to the son's home. The police were able to make contact with the man's son in the early hours of 6 October.

31. The investigator spoke to the Deputy Governor to ask why her initial approach was to try to telephone the man's family, given that that is not advised in Prison Service Order 2710 (the Prison Service Order that sets out the actions to be

[2] A defibrillator checks for electrical activity in the heart and issues audible instructions about treatment of the patient.

taken following a death in custody). The Deputy Governor said that, on checking the man's records, she saw that he had never received visits from either his son or brother. She thought, therefore, that he was estranged from his family.

32. Another factor which the Deputy Governor took into account was that by that time of the day, prisons have moved to reduced evening staffing levels. Based on those factors, she thought that telephoning was a reasonable option. The Deputy Governor added that if there had been evidence of more contact between the man and his family, she would have considered other options.

33. Wymott contributed to the man's funeral expenses. Chaplaincy staff visited I wing two days after his death, spending time with the prisoners on the wing and offering support.

The man's cause of death

34. After post mortem examination, the pathologist listed the man's cause of death as:

    1a. Haemopericardium.

    1b. Ruptured acute posterior myocardial infarct.

    1c. Right coronary artery atherosclerosis with thrombus.

    2. Diabetes mellitus and hypertension.

35. In the conclusion section of her report the pathologist wrote:

    "This elderly man was known to suffer with multiple medical problems. He was found at post mortem to have suffered an acute myocardial infarct affecting the posterior aspect of the heart. A complication of myocardial infarction is rupture of the myocardial infarct with formation of a haemopericardium, which results in sudden death due to cardiac tamponade. This complication had occurred ... "

36. The Medical Director and Director of Clinical Quality and Assurance at Central Lancashire Primary Care Trust, noted in his report that the man had three long term conditions each of which increased his risk of having heart and circulation problems. The conditions were diabetes, hypertension (high blood pressure) and atherosclerosis (thickening of the artery walls through build up of fatty materials such as cholesterol).

37. It is likely that the man suffered a thrombus (a clot) which broke away from the fatty build up in the arteries. This thrombus caused a blockage in the flow of blood feeding the heart muscle resulting in some of the heart muscle dying. There was also a rupture in one of the heart's major blood vessels which meant that the blood left the artery and collected in the pericardium (the sack that surrounds the heart muscle). This condition is known as a haemopericardium which, in his case, resulted in sudden death due to cardiac tamponade (where the functioning of the heart is compromised by the haemopericardium).

.ISSUES

The man's clinical care and treatment

38. As previously mentioned, the main clinical review into the man's care and treatment was carried out by a nurse and a supplementary review was carried out by the PCT Medical Director.

39. Focussing on the clinical condition that caused the man's death, the PCT Medical Director explained that most patients who develop haemopericardium do so without warning and the sudden onset means that the condition is nearly always fatal. He went on to say that, in the man's case, there appear to have been no signs or symptoms before his collapse. Given the circumstances the PCT Medical Director considers it unlikely that staff at Wymott could have anticipated the onset of the condition.

40. The clinical reviewer also found no evidence to suggest that the man experienced any signs or symptoms that would have enabled the nursing staff to detect, in advance, an acute life threatening event.

41. However the clinical reviewer has criticised some aspects of the man's care and treatment. She explains that she can find no clear evidence of closer monitoring of the man's diabetic assessments despite his rising blood pressure readings. The first evidence of an elevated blood pressure reading was in October 2008. When re-tested a month later, the man's blood pressure was found to have risen further and the plan was to re-test in a fortnight. This did not happen. Another eight months went by before his blood pressure was next recorded when the reading was even further elevated. The clinical reviewer has also criticised the absence of any apparent treatment plan following the man's final diabetic assessment in July 2009.

    I recommend that the healthcare manager reviews the processes for chronic disease management to ensure that abnormal test results are followed up as appropriate.

42. The clinical reviewer has also pointed out that there is no evidence that the man was supported in his apparent aims to reduce his smoking and to increase his activity levels.

    I recommend that the healthcare manager ensures that prisoners are offered appropriate advice and support to manage their own health, including adjustments such as reducing smoking or losing weight.

43. Finally, the clinical reviewer remarks on the fact that some of the man's handwritten clinical records are difficult to read. I understand that Wymott has now introduced electronic clinical record keeping and so I make no recommendation in this regard.

Breaking the news to the man’s family

44. When the man first arrived in Wymott he named one of his brothers as his next of kin. He subsequently changed his nomination to make one of his sons his next of kin instead. Up to date information about a prisoner’s next of kin is not always available and it is an example of good practice that the man’s personal officer is in the habit of obtaining up to date information.

45. Prison Service Order (PSO) 2710, which offers guidance and instructions for actions to be taken following a death in custody, says that Governors must:

> “Arrange notification to the next-of-kin and any other person reasonably nominated by the prisoner as soon as possible in a suitable manner, giving an accurate factual account of what has happened.”

46. The accompanying family liaison officer guidance recommends that:

> “The family should be informed face to face as soon as possible after the death. Wherever possible this should be done by a dedicated family liaison officer working alongside the Chaplain, or governor or most senior individual available together with the Chaplain ...
>
> “If distance from the prison presents a problem, a dedicated family liaison officer or chaplain based in the area nearest the family home could inform the family face to face …
>
> “Asking the police to inform the family may sometimes be necessary but the decision to do so should be based on an assessment [of the family circumstances] and not chosen as an easy option …
>
> “Using the telephone is too impersonal to use in delivering news of a death to the family and should be used only as a last resort …”

47. The man died in the early evening. His records contained contact details for two family members, a son and a brother. Wymott’s Acting Deputy Governor understood that the man was estranged from his family and so she decided to telephone the family. The Deputy Governor said that she had an added reason for that decision; being the reduced evening staffing levels. As it turned out, her repeated attempts to telephone the family proved fruitless as she obtained no answer. At just after 9.00pm, about three hours after the man’s death, the Deputy Governor contacted the police force local to the man’s son’s home and it was the police who broke the news to him in the early hours on the following day.

48. Had the Deputy Governor followed the advice given in PSO 2700, she would have arranged for a visit in person from appropriately trained prison staff. She could have appointed staff from Wymott to make the visit. However, the journey from Wymott to Leeds, where the family lived, would have taken around 90 minutes. In view of the distance, it would have been entirely reasonable for the Deputy Governor to have asked another prison, such as HMP Leeds, to ask

their staff to make the visit. However, it seems that neither of the family members were actually at home that evening so any visits would have proved unsuccessful. This news would have been fed back to the Deputy Governor whose next step would have probably been to ask the police for their assistance, just as she did in any case.

49. Although it seems that the ultimate outcome about breaking the news would have been the same, I nevertheless make the following recommendation:

    The Governor should ensure that, where possible, staff adhere to national instructions on breaking the news to the next-of-kin following a death in custody.

CONCLUSION

50. The man was 73 years of age and was a licence recall prisoner who had returned to custody in July 2008. He smoked and was overweight. He had been diagnosed with type II diabetes and high blood pressure and was receiving medication for both conditions. Despite these factors, the man remained reasonably fit and well. Unfortunately, on the afternoon of 5 October 2009, he suffered a myocardial infarct leading to a haemopericardium. No one could have anticipated that this was about to happen and for the man it was an unsurvivable event.

RECOMMENDATIONS

51. The following three recommendations were made in the draft version of this report. The Prison Service response to the recommendations is included in italics following each recommendation.

1. I recommend that the healthcare manager reviews processes for chronic disease management to ensure that abnormal test results are followed up as appropriate.

   Recommendation accepted and action completed. All pathology reports are read daily by the GP and tasked to a user group to action.

2. I recommend that the healthcare manager ensures that prisoners are offered appropriate advice and support in managing their own health, including where this means making adjustments such as reducing smoking or losing weight.

   Recommendation accepted and action completed. Increased resources are in place to offer more health promotional activities such as smoking cessation and primary prevention is a high priority, with the introduction of cardiovascular risk assessments and screening for COPD. Healthcare has also introduced a healthcare forum to work alongside service users to develop the department.

3. The Governor should ensure that, where possible, staff adhere to national instructions on breaking the news to the next-of-kin following a death in custody.

   Recommendation accepted and action completed. A review has been undertaken and the Governor is satisfied that he does comply with national policy. Contact with next of kin is delivered as per the policy, however in some circumstances the next of kin is not always contactable and other arrangements have to be made to ensure that they informed at the earliest opportunity.