

A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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

## ***Our Vision***

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

This is the investigation report into the death of a man at HMP Wymott in February 2013. He was 75 years old. The cause of death was chronic obstructive pulmonary disease (COPD). I offer my condolences to his family.

The man's clinical care in custody was reviewed on behalf of the local PCT. Wymott cooperated fully with the investigation.

The man was diagnosed with COPD in 2006, three years before he went to prison in 2009. In 2012, he spent time in hospital as an in-patient. He was also monitored for a heart condition and had his blood clotting levels checked. On 5 February, because he was unwell, a doctor prescribed antibiotics. A nurse went to check him the next morning but found him dead in his cell.

The clinical reviewer has raised a number of concerns about the man's healthcare at Wymott, in particular that his COPD should have been more actively managed and monitored. She concludes that the standard of care, in relation to monitoring his COPD, was not as good as he could have expected to receive in the community. However, he was an older man in generally poor health and it is not apparent that this hastened his death.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

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

**November 2013**

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## SUMMARY

1. In 2006, before he was sentenced to prison the man was diagnosed with chronic obstructive pulmonary disease (COPD - the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease). His condition caused him mobility difficulties and other health issues and he was often short of breath. On 7 October 2009, he was remanded to HMP Altcourse. Five days later he was sentenced to six years in prison. He moved to Wymott on 30 October 2009.
2. The man received frequent treatment for COPD while in prison. In August 2012, he was taken as an emergency to hospital, where he spent six days as an inpatient. While there, he was diagnosed with acute exacerbation of COPD and suspected heart failure for which he was prescribed warfarin. He was referred urgently for suspected cancer because of a testicular lump but the symptoms were found to have been caused by a urinary tract infection.
3. After he returned to prison, healthcare staff needed to monitor the man's INR (International Normalized Ratio - a measurement of the clotting rate in the blood) to manage his warfarin. His COPD began to deteriorate, however and on 5 February 2013, he reported being increasingly breathless and generally unwell. A doctor prescribed antibiotics and listed him for a review three days later.
4. The next morning a nurse went to check the man as he had been unwell the previous day. She found him on his bed, unresponsive and with signs of rigor mortis. He was pronounced dead by the doctor at 9.20am.
5. The clinical reviewer concludes that the care the man received for his COPD was not equivalent to that he could have expected to receive in the community. We make recommendations about management of COPD, monitoring prisoners on warfarin and with high blood pressure and medicines management.

## **THE INVESTIGATION PROCESS**

6. An investigator initially led the investigation, which his colleague later completed. He received all relevant documents for the man's time in prison.
7. The local PCT commissioned a clinical reviewer to produce a clinical review into the care provided for the man while he was at Wymott.
8. A copy of this report has been sent to HM Coroner. This report has been delayed because we did not receive a cause of death until 16 September 2013.
9. One of our family liaison officers contacted the man's family by letter to explain the purpose of the investigation and to give them an opportunity to raise any concerns. At the time of writing this report, the family had not contacted us.
10. The man's family received a copy of the draft report. They pointed out some factual inaccuracies and omissions. This report has been amended accordingly. The family also raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

## **HMP WYMOTT**

11. HMP Wymott is a category C prison holding over 1,100 adult male, sentenced prisoners. I wing is a specialist unit for older prisoners who are given additional support to help them with their social care needs. Healthcare services at Wymott are commissioned and provided by the NHS. A private company provides general practitioner (GP) services and out of hours medical cover. Clinics are run every weekday morning and two afternoons each week. There are no inpatient beds, but nursing cover is provided 24 hours a day.

## **HM Inspectorate of Prisons**

12. The most recent inspection of Wymott was a short follow up inspection in November 2011 of a full inspection in October 2008. Inspectors commented that care for older prisoners and those with disabilities had improved considerably. They were supported on the specialist unit based on I wing by healthcare staff and specialist social care workers. Care plans were made when necessary and adjustments put in place when required.
13. Inspectors noted that staffing levels in the healthcare centre were adequate, but that prisoners waited too long to see the GP.

## **Independent Monitoring Board**

14. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure prisoners are treated fairly and decently. In their most recent annual report, for 2011/12, the IMB identified some concerns about care for the elderly and disabled prisoners on I wing, including the lack of formal training for staff in dealing with elderly and infirm prisoners. The IMB also noted the need for wheelchair access to the outside area. The IMB welcomed improvements on I wing, such as the opening of the day centre and the employment of carers. The IMB reported that there had been a reduction in the waiting time to see a GP, helped by the appointment of a nurse practitioner. The IMB repeated previous concerns about pharmacy services and problems with prisoners not getting repeat prescriptions in time.

## **Previous deaths at Wymott**

15. Since the Ombudsman took responsibility for investigating deaths in custody in April 2004, we have investigated 35 deaths at Wymott, of which the majority were from natural causes. This is, in large part, as a result of its older population profile compared to most prisons.

## KEY EVENTS

16. The man was remanded in custody on 7 October 2009. On 13 October, he was sentenced to 6 years imprisonment for sex offences. He first went to HMP Altcourse, which is a local prison, before being transferred to HMP Wymott to continue his sentence.
17. At a reception health screening in HMP Altcourse, the man told the nurse that he had suffered from COPD since 2006 and that his breathing difficulties affected his mobility. He smoked cigarettes. He was prescribed inhalers and he was referred to the mental health team because he had recently tried to commit suicide. However, he said that he no longer had thoughts of harming himself.
18. On 30 October he transferred to HMP Wymott. At the health screen staff again identified that he had COPD, emphysema and heart problems.
19. On 9 June 2010, the man was diagnosed with exacerbation of his COPD, possibly linked to hay fever. He was given a repeat prescription of Spiriva (an inhaler).
20. Over the next year, the man's condition was monitored and he gave blood samples at various times. On 23 June 2011, he felt ill and was short of breath. A nurse advised him to use his inhalers and to contact healthcare if his breathing worsened.
21. A social carer conducted an initial assessment on 24 June and 5 September with the man. This concluded that he needed help with his daily living activities. He engaged with the carers but did not always accept help as he preferred to remain independent.
22. In October 2011, the man's blood pressure was recorded as being elevated but no record was made of the reading. There is no evidence that further follow up readings were taken.
23. On 12 January 2012, the man attended the prison healthcare centre for a review. He gave staff details of the medication he had been prescribed in the community and they requested his past medical records. He had given this information when he first came to prison in 2009. His records had been requested at the time but had not been received and staff had never chased them up. The records were received on 25 January.
24. Over the next few months, the man twice complained of increased breathlessness and saw healthcare staff. On 30 June, he complained of swollen legs and, on 3 July, a swollen testicle. On 15 August, staff called an ambulance as he was struggling to breathe. He stayed in hospital as an inpatient until 21 August, and was diagnosed with acute exacerbation of COPD and suspected heart failure. The hospital prescribed warfarin (a drug used to prevent blood clotting) and digoxin (a drug used to treat heart conditions).

25. The man was referred urgently for a cancer check, as he had a lump on his testicle. The results showed that he did not have cancer. The urologist stated that the swelling began after an apparent urinary tract infection and diagnosed a hydrocele (a build up of fluid in the testicle).
26. On 4 September, the man had a heart scan. The consultant cardiologist wrote to the prison on 10 October, stating that his atrial fibrillation (an abnormally fast heart rate) needed to be better controlled. On 30 October, his medication was changed on the advice of the cardiologist.
27. After his return from hospital in August, the man needed to have his INR (International Normalized Ratio - a measurement of the clotting rate in the blood) tested regularly. He missed two test appointments on 30 October and 13 November but no reason was recorded. His INR was tested on 20 November and was within the appropriate range (2.5). When he was tested on 18 December, his INR had risen to 4.5, and his dosage of warfarin was changed to bring it back into normal range. His medical records indicate that his INR returned to normal levels although daily recordings of his INR rate were not recorded.
28. In December 2012, the man suffered from increased breathlessness. He was diagnosed with exacerbation of COPD. His INR began to be monitored more frequently. On 21 December, he refused to attend a booked hospital appointment because he felt unwell. On 23 December, the GP diagnosed a chest infection. On 24 December, he refused to attend hospital for a chest x-ray to eliminate the possibility that he had cancer and signed a disclaimer form. The missed hospital appointment was rearranged for 28 December, but again he did not attend. He went to hospital for an X-Ray on 4 January 2013.
29. At the end of January, the man's INR fluctuated and, on 29 January, his dose of warfarin was changed. On 5 February, it was changed again in response to his INR reading. That day, he also said that he had been experiencing breathlessness for the previous two days. The GP examined him and diagnosed exacerbation of COPD, prescribed antibiotics and told him to continue using a nebuliser (a device to deliver medication as a mist inhaled into the lungs). The GP noted there should be a review if he felt chest pains or his condition worsened.
30. On I wing, where the man lived, sections of the wing are closed at night but prisoners are able to go in and out of each others' cells, as the doors are unlocked. During the night, three other prisoners went to see him when he said he felt ill. He did not want to press his cell bell to call staff but asked them for some water, which they got him. This was around 1.00am. It was the last time he was seen alive.
31. At 8.45am the next morning a nurse went to check the man as she knew he had been unwell the previous day. He was on his bed, had no pulse, and was unresponsive with signs of rigor mortis. An ambulance was called and he was

pronounced dead by the prison doctor at 9.20am. The nurse confirmed that she was offered support by her managers after his death

32. Staff visited the man's wife at her home at 11.27am to inform her of her husband's death. She and her stepdaughter visited the prison on 12 February to attend a memorial service. The funeral was held on 21 February and the prison contributed to the funeral expenses.
33. A consultant pathologist performed a post-mortem examination on 8 February. She found the cause of death was respiratory failure as a result of COPD. She also noted that the man had hypertensive heart disease (when the heart has been enlarged because of high blood pressure), and said that this had probably also contributed to his death.

## ISSUES

### Clinical care

#### Monitoring of the man's COPD

34. COPD is a chronic, long term illness, which can be exacerbated by cold weather and smoking. The man had been monitored by his outside GP practice since 2006. He often got breathless, especially after speaking in long sentences.
35. The man's community medical records held information that was relevant to his care and which would have helped staff manage his COPD. The records were requested after his first health screening at Wymott in October 2009 but staff did not chase them when the records were not received. The records were not requested again until January 2012, when they were finally received at Wymott. It is important that community medical records are obtained to ensure continuity of care. We make the following recommendation:

#### **The Head of Healthcare should ensure that community medical records are requested promptly and chased if they are not received.**

36. Patients with COPD are often reviewed using several common tools to provide a baseline to measure whether their condition is improving or deteriorating. These tools include the Medical Research Council dyspnoea test to measure the degree of breathlessness and spirometry to measure lung function. The clinical reviewer notes that no such tools were used to measure the man's COPD.
37. Healthcare staff often saw the man after he complained of a cough or increased breathlessness. On 9 July 2010, a nurse saw him and diagnosed exacerbation of COPD, perhaps caused by hay fever. There was no follow up review. In October 2010, a nurse completed a care plan assessment with him which should have ensured that he understood how to use his inhalers and oxygen therapy. There is no evidence that staff confirmed that he did understand. On 23 June 2011, he had another episode of COPD. The doctor came to visit him in his cell and discuss social care, but there was no further review planned. There were also no reviews after an episode of COPD on 9 February 2012 or after his stay in hospital during August 2012.
38. On 30 June 2012, the man told healthcare staff that he had swelling in his legs and a testicle. This continued for several weeks. Staff noted oedema (where fluid collects and swells an area of the body) in his feet, and that he also had athletes' foot. His medical records states that his swollen legs were treated by treating the fungal infection. However, the clinical reviewer notes that his swollen oedematous legs were likely to be an indication of developing cardiac complications.
39. The clinical reviewer has found that the care provided for the man's COPD was reactive rather than proactive. In 2004, the National Institute for Clinical

Excellence (NICE) issued guidelines for the management and review of patients with COPD in primary care. The guidelines state that patients should have a clinical assessment and annual review of their COPD, which should include smoking cessation advice. For patients with severe COPD, there should be two reviews per year. Overall, she believes that the monitoring of his COPD at Wymott was inadequate. We make the following recommendation:

**The Head of Healthcare should ensure that prisoners with COPD and other chronic conditions are managed and reviewed in line with NICE guidelines and that any deterioration in their condition is closely monitored.**

#### **Measuring and monitoring of the man's INR and blood pressure**

40. After the man went to hospital in August 2012, he was diagnosed with atrial fibrillation, a heart condition which causes an irregular, often abnormally fast heart rate. He was prescribed warfarin. The hospital suggested that his INR rate should be monitored daily and warfarin given daily, to keep his INR between 2 and 3.
41. The prison monitored the man's INR, but there is no evidence that this was done daily or every other day, even when healthcare staff noted in his medical record that it should be. From December 2012, his INR reading fluctuated. It was 4.5 on 18 December, on 2 January 2013 it was 1.6, on 8 January it was 2.4, on 22 January it was 4.0, on 24 January it was 2.3 and on 29 January it was 1.6. To address these fluctuations, his dose of warfarin was changed each time. In her review, the clinical reviewer states that the changes in his INR should have been an indication that either his health was deteriorating or that he was not compliant with his medication.
42. There are also several entries in the man's medical record which state that his blood pressure was taken. However, the readings were not always recorded, and it is not clear that his blood pressure was subsequently reviewed or whether his blood pressure was an ongoing concern.
43. It is important that healthcare staff accurately record clinical observations, as these can be key to the effective long-term monitoring of chronic health problems. We make the following recommendation:

**The Head of Healthcare should ensure that clinical assessments and observations such as INR levels and blood pressure readings, are made as required and are entered in the medical record.**

#### **The man's medication**

44. The man was prescribed warfarin after his stay in hospital in August 2012 and the dosage frequently changed to try and control his INR. On 25 September 2012, he was given warfarin to keep in his cell and self-administer, because the nurse had previously not delivered it and he had missed a dose. The

clinical reviewer notes that the frequent change of dose in his warfarin would have been confusing, and that his compliance with the medication was not checked. His medical notes from the community suggested he had a history of non-compliance with medication. A letter from a consultant cardiologist in September 2012 also questioned whether he complied with his medication.

45. There was no evidence in the man's medical record that the risk assessment to allow him to keep his medication in his cell was reviewed after 2009. The medication risk assessment has a variety of functions to ensure prisoners use the medication appropriately and are complying with the dosage. The clinical reviewer believes that the assessment should have been reviewed, especially as he was an unwell, elderly prisoner who might not have understood his medication regime. We make the following recommendation:

**The Head of Healthcare should ensure that in possession medication risk assessments are conducted regularly and comprehensively to help monitor compliance with medication.**

## **RECOMMENDATIONS**

1. The Head of Healthcare should ensure that community medical records are requested promptly and chased if they are not received.
2. The Head of Healthcare should ensure that prisoners with COPD and other chronic conditions are managed and reviewed in line with NICE guidelines and that any deterioration in their condition is closely monitored.
3. The Head of Healthcare should ensure that clinical assessments and observations such as INR levels and blood pressure readings are made as required and are entered in the medical record.
4. The Head of Healthcare should ensure that in possession medication risk assessments are conducted regularly and comprehensively to help monitor compliance with medication.

## ACTION PLAN: The man – HMP Wymott

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1.	The Head of Healthcare should ensure that community medical records are requested promptly and chased if they are not received.	Accepted	<p>The revised reception template that all new receptions now complete on their first day at HMP Wymott requests the last five years' medical history, to include any names of GPs they were registered with and any previous prisons. Prisoners are requested to sign a consent form to allow the prison to request these records and the administration team keep a log of all faxed requests.</p> <p>Recommendations arising from PPO investigations/reports have been fed back to staff at the monthly staff governance group (SLGG) meeting where this is a standing agenda item.</p> <p>All new and existing staff receive training on the use of the healthcare templates and the system for requesting clinical records is auditable.</p>	Completed and ongoing	
2.	The Head of Healthcare should ensure that prisoners with COPD and other chronic conditions are managed and reviewed in line with NICE guidelines and that any deterioration in their condition is closely monitored.	Accepted	All new receptions at HMP Wymott will complete a comprehensive reception screen. During this screen all past medical history and ongoing conditions are identified. If it is identified that a prisoner has a long term condition such as COPD they are referred through the clinical tasking system to the clinical lead and monitored in line with local and national guidance. Any deterioration in their condition will then be treated in line with	Completed and ongoing	

			<p>clinical guidance and their ongoing management plan.</p> <p>All new and existing staff receive training on the use of the healthcare templates.</p> <p>Lancashire Care Foundation Trust (LCFT) is currently reviewing the pathway for all Long Term Conditions within the prisons in the LCFT footprint and any changes will be implemented following training.</p>		
3.	<p>The Head of Healthcare should ensure that clinical assessments and observations such as INR levels and blood pressure readings, are made as required and are entered in the medical record.</p>	Accepted	<p>All clinical measurements and observations are recorded with read codes to allow clinicians to compare recent measures and ensure any deviations are promptly actioned. The read code formulary has been reviewed and we continue to raise awareness of any new codes within staff meetings. Five staff from LCFT have been trained as SystmOne super users including IT staff who are developing a training package for new and existing staff. There is on-going training for SystmOne to support other staff and to ensure appropriate use of the clinical system and this recommendation.</p>	Completed and ongoing	
4.	<p>The Head of Healthcare should ensure that in possession medication risk assessments are conducted regularly and comprehensively to help monitor compliance with medication.</p>	Accepted	<p>The medication in possession risk assessment (MIPRA) was developed as an electronic tool on SystmOne. This allows quantitative data to be used when reviewing individual risk. All vulnerable patients are monitored and supported with their medication highlighting any issues promptly with a review of the MIPRA. The outcome supports compliance of medication.</p> <p>All new and existing staff receive training on the use of this template. There is an operating protocol available for all staff to use and staff are given detailed time to complete reviews.</p>	Completed and ongoing	

			Use of the MIPRA is also a standing agenda item on the staff governance group meeting.		
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