PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in July 2014, while in the custody of 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, who died of multi organ-failure and lung disease in July 2014, while in the custody of HMP Wymott. He was 31 years old. I offer my condolences to his family and friends.

A review of the clinical care the man received at HMP Wymott was undertaken. The prison cooperated fully with the investigation.

The man was sentenced to five years in prison in 2010 and transferred from HMP Preston to HMP Wymott in September 2012. He was diagnosed with hepatitis C in May 2013, but remained generally well. He reported no other health concerns until June 2014, when he complained of bouts of dizziness and shortness of breath. On 30 June, nurses and a prison doctor examined him, who said he had not been well for two weeks and that his chest felt tight. His chest sounded abnormal and his oxygen saturation levels were low, so he was sent to hospital. The hospital admitted him for treatment and diagnosed pneumonia. His condition deteriorated rapidly in hospital and, in July, he suffered kidney failure. He had kidney dialysis treatment, but did not respond. He died in hospital that evening.

The clinical reviewer considers that the care the man received in prison was equivalent to the care he could have expected to receive in the community. I agree. However, I am concerned that the prison did not clearly establish with him, his wishes about contacting his family when he was taken to hospital. While it did not affect the outcome for him, the investigation also identified ongoing problems with emergency procedures at Wymott. The Governor needs to ensure that these comply with Prison Service national instructions.

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 **January 2015**

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SUMMARY

1. On 14 September 2010, the man was sentenced to five years in prison and sent to HMP Manchester. On 18 July 2012, he was released from prison on licence, but was recalled to prison just two days later breaching the conditions of his licence. He was sent to HMP Preston.

2. The man transferred to HMP Wymott on 28 September 2012. At a reception health screen, the nurse noted that he had been diagnosed with paranoid schizophrenia when he was 16. He also suffered from depression. He had mild learning difficulties and a history of drug and alcohol abuse.

3. In May 2013, the man was diagnosed with hepatitis C. He remained generally well and did not report any other significant health problems until 26 June 2014, when he had some episodes of dizziness. A nurse examined him and found no obvious cause or reason to be concerned. She advised him to rest.

4. On 30 June, the man told a nurse that he had been suffering with a cough for weeks and needed antibiotics. A nurse practitioner examined him later that afternoon. He complained of a tight chest and said that he had had a cold for about two weeks. The nurse found a wheeze in his right lung and the lower section of his left lung was abnormally silent. A prison doctor reviewed him and decided he needed to go to hospital. He went by ambulance to hospital, where doctors diagnosed pneumonia.

5. The man's condition deteriorated rapidly in hospital. On 2 July, hospital staff moved him to the intensive care unit at hospital. A few days later he suffered acute renal failure and had dialysis treatment, which was unsuccessful. He died at 11.41pm that evening.

6. We agree with the clinical reviewer, that the clinical care the man received in prison was equivalent to that which he could have expected to receive in the community. We are concerned that there was a lack of clarity about his wishes about family contact, which led to a curtailed family visit when he was critically ill. While it would not have altered the outcome for him, the investigation also identified ongoing problems with the operation of the prison's emergency protocol. We make two recommendations.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Wymott informing them of the investigation and inviting anyone with relevant information to contact her. One prisoner responded.

8. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. She interviewed six members of staff and one prisoner at Wymott in July and August. She informed the Governor's representative of the preliminary findings of the investigation, and followed this up in writing.

9. NHS England commissioned a clinical reviewer to assess the man's clinical care at the prison.

10. We informed HM Coroner for Preston and West Lancashire District of the investigation, who provided the post-mortem report. We have sent the Coroner a copy of this investigation report.

11. One of the Ombudsman's family liaison officers contacted the man's sister, his nominated next of kin, to explain the investigation. She had a number of issues she wanted the investigation to cover:

    - She was concerned that her brother had been unwell for some time and healthcare staff had not identified this.
    - She asked why he was living on the vulnerable prisoner side of the prison.
    - She was concerned that the prison had limited the time she could spend with her brother on 2 July.
    - She asked why the prison did not have up to date next of kin records.

12. The man's family received a copy of the draft report and indicated that they were satisfied with the findings.

HMP WYMOTT

13. HMP Wymott is a medium secure prison holding over 1,100 sentenced men. About half of the prison is for prisoners who are regarded as vulnerable to attack from the mainstream population, principally because of the nature of their offence.

14. Lancashire Care NHS Foundation Trust provides healthcare services at the prison. A private company provides GP services and out of hours medical cover. There are no inpatient beds, but there is 24 hour nursing cover. A nearby inpatient facility is available at HMP Preston.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Wymott was in July 2014. Inspectors found that there was excellent care for older prisoners and those with disabilities held on the specialist facility in I wing. The quality of health care was reasonably good, but undermined by long delays and poor access to GPs and the dentist. The range of clinics provided reflected the needs of the prison population and including for chronic diseases. There were good palliative care and end-of-life procedures.

Independent Monitoring Board

16. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published report for the year to May 2014, the IMB noted that the vulnerable prisoners are held in separate accommodation that has its own range of workshops and education and training facilities. Waiting times for GP appointments was an issue, but the IMB noted that the triage system operated by the nurse-practitioner had ensured that urgent cases were seen promptly. They commented that management and staff have worked hard to maintain Wymott as a prison that holds prisoners with safety, decency, respect and security.

Previous deaths at HMP Wymott

17. The man was the sixth prisoner to die from natural causes at HMP Wymott since June 2012. We have raised the issue of the use of emergency codes before.

KEY EVENTS

18. On 14 September 2010, the man was sentenced to five years in prison for grievous bodily harm and assisting an offender. He was sent to HMP Manchester and later to HMP Risley.

19. On 18 July 2012, the man was released from prison on licence. However, he did not comply with the conditions of his licence and was recalled to prison two days later. On 21 July, he was sent to HMP Preston.

20. The man transferred to HMP Wymott on 28 September 2012. At a reception health screen, a nurse noted that he had a history of paranoid schizophrenia since the age of 16 and suffered from depression. He had mild learning difficulties and a history of drug and alcohol abuse. She referred him to the mental health team.

21. The prison mental health team reviewed the man frequently. There were no other significant entries in his medical record about his physical health, until 30 April 2013, when he asked for BBV (blood borne virus) screening as he was concerned about his previous drug use. Test results received on 17 May confirmed the presence of the hepatitis C anti-body in his blood. On 26 May, a second blood test confirmed the diagnosis.

22. On 29 July, a nurse referred the man to the gastroenterology department at hospital to discuss the management of his hepatitis C. On 8 August, he told a nurse that he had been surprised by his diagnosis of hepatitis C, but accepted and understood it.

23. There were no further significant entries about the man's physical health until 8 October, when a consultant gastroenterologist saw him at hospital. The consultant discussed drug treatment therapies and possible long-term health problems arising from hepatitis, such as cirrhosis of the liver. He referred the man for a scan of his abdomen. As the treatment programme was long, the doctor recommended that he did not start any treatment until after his release from prison the next year. An ultrasound scan of his abdomen on 20 November showed that his liver, gallbladder, kidneys and aorta were normal.

24. On 26 November, the man asked to be kept apart from the general prison population under Prison Rule 45 after he had got into debt with other prisoners. (A prisoner can request to be held kept separate under Rule 45 for number of reasons such as their offence, risk of bullying etc.) He moved to a vulnerable prisoners' wing, later that day.

25. A doctor examined the man on 13 June 2014, when he had an itchy rash on his legs and back pain. He mentioned no other health concerns. The doctor prescribed shampoo and creams to treat his rash and pain relief for his back pain.

26. On 26 June, another prisoner, who lived in the cell next to the man, saw him at the door of his cell. He thought that he looked unwell and asked how he was feeling. The man then sat on the landing floor with his back against the wall. He said he did not feel well and asked the prisoner to call for help. The prisoner pressed the alarm and two officers responded. They radioed a code

blue emergency (which indicates a life-threatening situation such as when a prisoner is unconscious, not breathing or has difficulty breathing) and asked for healthcare assistance. No one called an ambulance which should happen automatically when a code blue is called.

27. Two nurses attended and found the man lying on the floor. He explained that he had felt dizzy when he was leaving his cell so had sat on the floor. He did not report any other symptoms. One nurse examined him and found his blood pressure, pulse and oxygen saturation were within normal limits. She helped him to get up and he walked back to his cell unaided. The nurses reported that the incident was under control and an ambulance was not needed.

28. Thirty minutes later, an officer found the man sitting on the floor again. Both nurses came back and examined him again. One nurse said he appeared no different from earlier and did not say he had any new symptoms. She noticed that his cell was quite warm and advised him to rest and drink plenty of fluids.

29. At 8.30am on 30 June, the man told a nurse at the medication treatment hatch that he had been suffering from a cough for the past few weeks and was having trouble sleeping. He asked for antibiotics. The nurse arranged for the nurse practitioner to see him that afternoon, as she was unable to give him any medication unless it was prescribed for him. She commented that he looked a little jaundiced.

30. At 3.30pm, a nurse practitioner examined the man, who said that he had been feeling unwell for about two weeks after he had developed a cold. He said his chest felt tight. She measured his oxygen saturations (the levels of oxygen in the blood), which were low at 86%. She noted he had a wheeze in the upper part of his left lung and on the right-hand side. She was unable to hear any chest sounds on the lower part of his left lung. Although his oxygen levels were low, she noted that he remained very talkative, which is unusual for someone with breathing difficulties.

31. The nurse brought a nebuliser from another room. (A nebuliser is a machine that creates a mist of medicine, which is breathed in through a mask or mouthpiece.) While using the nebuliser the man's oxygen levels increased to 93%. A doctor examined him and noted his condition appeared to be improving. However, as soon as he stopped using the nebuliser, his oxygen levels began to drop. The nurse and doctor decided that he needed hospital treatment and the prison's control room called an emergency ambulance at 4.27pm. The control room called again at 5.15pm and the ambulance arrived at 5.28pm. Paramedics examined him and took him to hospital at 6.00pm. Two officers accompanied him and used an escort chain to restrain him. (An escort chain is a long chain with a handcuff at each end, one attached to the prisoner and the other to an officer.)

32. The hospital admitted the man for observation and tests, after which doctors diagnosed pneumonia. His condition deteriorated rapidly in hospital and, on 2 July, doctors moved him to the hospital's critical care unit. Officers removed the escort chain that morning and it was not used again. His consultant informed the prison that they were moving him, under sedation, to another hospital's intensive care unit that day, to receive one to one nursing care.

33. The man's condition continued to deteriorate at hospital and he suffered acute renal failure. A few days later he had dialysis treatment to remove toxins from his body, but he did not respond to the treatment. He died at the hospital at 11.41pm that evening.

Family liaison

34. The man had listed his father as his next of kin. A custodial manager had tried to contact the man's father when he became seriously ill on 2 July but had been unsuccessful. The same day, he contacted the man's sister to let her know that her brother was seriously ill. He asked for up to date contact information for their father and learnt that his father had died in September 2013. His sister and brother-in-law visited him at the hospital on the evening of 2 July.

35. At 4.00am on Friday 4 July, a nurse from the hospital contacted the man's sister to inform her that his condition had deteriorated. At 12.30am the next morning, another hospital nurse telephoned her to inform her of her brother's death.

36. At 10.30am that morning, the deputy governor spoke to the man's sister to offer condolences and support. She had a number of questions about his health conditions, so the deputy governor arranged for her to speak to the prison's primary care manager.

37. The prison family liaison officer contacted the man's sister to offer support and guidance. The funeral was held on 29th July. The prison contributed towards the funeral costs, in line with national policy.

Support for staff and prisoners

38. A Governor's Notice informed staff and prisoners of the man's death and offered support. A senior manager spoke to the staff who had been escorting him at the hospital and a member of the care team offered them support.

Post-mortem

39. The post-mortem report found that the cause of death was multi-organ failure with empyema (a build up of inflammatory fluid around the lung) and bronchopneumonia.

ISSUES

Clinical Care

40. After the man's death a prisoner at Wymott told us that he was concerned that the man had suffered a "hacking cough" for some time before his death, but he was not sure that he had told anyone about it. The man's sister told us that he had phoned her about five or six weeks before his death and said he felt unwell and had had a cold for a few weeks. Prisons record all prisoners' telephone calls, apart from legally privileged calls. The investigator listened to all the calls he made in the two months before his death, but did not find any where he said that he was unwell. (It is possible that he could have used an illicit mobile phone to call his sister.)

41. The first record of the man reporting he was unwell was 13 June, when he told a doctor that he had itchy legs and back pain. The next time was 26 June, when he had two episodes of dizziness. The clinical reviewer was satisfied that nurses saw him promptly at the time, examined him and took appropriate observations, which did not indicate any problems. He did not mention a cough or any other symptoms at the time.

42. It was not until 30 June, that the man reported that he had been feeling generally unwell for two weeks and had a cough that had got steadily worse. A nurse and a doctor examined him that afternoon. They were concerned about his health and arranged for an ambulance to take him to hospital. The clinical reviewer considered that the healthcare staff acted appropriately and arranged a timely admission to hospital. We are satisfied that he did not report any ongoing cough or chest problems until 30 June and healthcare staff at the prison responded quickly when he did.

43. The man had been diagnosed with hepatitis C in 2013. The clinical reviewer considered that his final illness was not related to his hepatitis C condition. His primary cause of death was multi-organ failure, which the clinical reviewer described as the progressive impairment of two or more organ systems, and is caused by the immune system's uncontrolled inflammatory response to a severe illness. Sadly, his immune system was unable to respond to his illness.

44. The clinical reviewer considered that the care the man received in prison was equivalent to that he could have expected to receive in the community, and in some aspects it was better, as he was usually able to see a healthcare professional the same day if he needed to. We are satisfied that he received an appropriate standard of healthcare at the prison.

Emergency protocol

45. On 30 June, a nurse asked for an emergency ambulance. An operational support grade called the ambulance at 4.27pm but the ambulance did not arrive until 5.28pm, after a further call from the prison. The investigator read a transcript of the OSG's call and who did not have the information to answer a number of questions put by the ambulance operator. These appeared to be

standard questions developed for a community situation, rather than for the prison context, where the prisoner had been assessed by a nurse and a doctor and the person who calls the ambulance is not with the prisoner who needs emergency help. (For example the OSG was unable to say whether the man was changing colour or if he was alert at the time.)

46. The investigator spoke the Head of Risk and Safety at North West Ambulance Service. She said that an ambulance service operator appropriately triaged the emergency call. Based on the responses given by the prison, the man was coded as Green 1 (serious but not immediately life threatening). She noted that prison staff were unable to answer all the questions the emergency operator asked.

47. Prison Service Instruction (PSI) 3/2013, issued in February 2013, requires prisons to develop a local emergency protocol agreed with the local healthcare commissioner and ambulance trust. We consider that the local protocol should include how emergency calls for an ambulance are handled within the prison context.

48. Although it did not affect the outcome for the man, we note that officers radioed a code blue emergency when he had an episode of dizziness on 26 June, but the control room did not call an ambulance automatically, as required by PSI 3/2013. In this case, it appears that the staff misused the code, to call healthcare staff urgently, rather than because there was an immediate life-threatening emergency.

49. Wymott's local policy does not clearly set out that the control room should call an ambulance immediately as the national instruction requires. PSI 03/2013 makes it clear that it should not be a requirement for healthcare staff to attend before calling an ambulance. It says that it is better to request an ambulance that can be cancelled later, if healthcare staff assess that one is not required.

50. We have made several recommendations to Wymott about their local emergency protocol, which does not meet the requirements of PSI 03/2013. The prison needs to ensure that staff use emergency codes appropriately and follow the national instructions. We are satisfied that the delay in the ambulance arriving, did not affect the outcome for the man and the priority the ambulance service gave the emergency call might well have been appropriate. However, the incident suggests there is a need for better communication between the person at the scene reporting the incident and the person making the emergency call as well as some discussions with the ambulance service so that they understand that the person making the call will not have all information immediately. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies including appropriate use of emergency codes. Wymott's medical emergency response code protocol should be consistent with the national instruction and agreed with the North West Ambulance Service to ensure there are no delays in calling, directing or discharging ambulances.

Family liaison

51. The man had not notified the prison that his father had died and that his next of kin details were therefore out of date. Had the prison tried to notify his father when he was first admitted to hospital on 30 June, this might have been established earlier. However, it appears that he did not want the prison to inform his family of his hospital admission at that stage.

52. The man's sister and brother-in-law visited him at hospital on 2 July. His sister was concerned that when she arrived the escorting officers had to obtain permission to allow her to visit, and then she was told she could visit her brother for only one hour.

53. The records show that the man's sister and her husband arrived at the hospital at 4.00pm. They were not able to see him immediately as his consultant told the escorting officers that the visit would need to be delayed as he was about to go for X-rays. She was eventually able to visit him at 6.00pm.

54. A custodial manager at the prison told the investigator that when the man's sister and brother-in-law arrived at the hospital, the ward sister told the escorting officers that she had read in his hospital notes that he had said he did not want his family informed of his situation. The officers therefore contacted him for advice about what to do. By this stage, the man was too ill to be able to say whether he wanted his family to visit or not, and he agreed a one hour visit.

55. Prison Rule 22 requires prisons to inform the next of kin of seriously ill prisoners as soon as possible. When the man was admitted to hospital, he was still able to communicate and the prison should have established and noted his wishes about family contact on his prison record at the time if he did not want them contacted. In the absence of information to the contrary, the assumption should be that families are informed and allowed to visit. He had been in contact with his sister throughout his prison sentence. It is possible that he told the hospital that he did not want his family informed of his situation because he did not want to alarm them at the time. However, the prison informed his sister on 2 July that he was critically ill. Once they had done this, and a visit allowed, we consider it was insensitive to restrict his sister's time with him. We make the following recommendation:

The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible and that they are able to visit them in hospital without unnecessary restriction. When prisoners do not want family contact, this should be discussed with them and noted clearly on their prison record.

RECOMMENDATIONS

1. The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies including appropriate use of emergency codes. Wymott's medical emergency response code protocol should be consistent with the national instruction and agreed with the North West Ambulance Service to ensure there are no delays in calling, directing or discharging ambulances.

2. The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible and that they are able to visit them in hospital without unnecessary restriction. When prisoners do not want family contact, this should be discussed with them and noted clearly on their prison record.