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 June 2014, while a prisoner 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, who died of heart failure in June 2014, while a prisoner at HMP Wymott. He was 67 years old. I offer my condolences to his family and friends.

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

The man was sentenced to nine years in prison in March 2012 for serious sexual offences and had been at HMP Wymott since February 2013. He had treatment for diabetes, chronic obstructive pulmonary disease (COPD) and a heart condition and healthcare staff also gave him advice to help him give up smoking.

The man lived in the elderly prisoners unit at Wymott and healthcare staff saw him frequently to treat his health conditions. He also had treatment in hospital. In 20 June 2014, he stopped taking his anticoagulant medication in an ill-advised protest at not getting his medication the day before. A nurse warned him of the risks, but he still refused to take it. He collapsed with chest pains several days later and went to hospital by emergency ambulance, where he was pronounced dead.

The clinical reviewer concludes that the man's standard of healthcare in prison was equivalent to that he could have expected to receive in the community. Although the clinical reviewer says that missing the dose of medication on 19 June did not lead to his death, this should have been avoided. I am concerned that staff did not follow appropriate emergency procedures and call an ambulance immediately, when he complained of chest pains. I am also concerned that restraints were used without proper justification when he went to hospital just a few weeks before he died, a matter I have raised with Wymott a number of times before. However, I am pleased to note that he was not restrained when taken to hospital the day he died.

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 **January 2014**

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SUMMARY

1. The man transferred to HMP Wymott from HMP Leeds in February 2013. He was serving a nine year sentence for serious sexual offences. He had a history of heart failure, chronic obstructive pulmonary disease (COPD), circulation problems, diabetes and arthritis.

2. After initial health screens, healthcare staff saw him frequently to manage his chronic obstructive pulmonary disease (COPD) and diabetes. Staff tried to help the man to give up smoking cigarettes but he did not succeed. In March 2013, healthcare staff recommended that he should go the regional inpatient unit for prisoners at HMP Preston, which could meet his clinical needs better, but he refused to go.

3. The man sometimes refused medication in order to protest about aspects of his treatment. One of his medications was warfarin, which he took to daily, to prevent blood clots. On 19 June, there was no warfarin for him when he went to collect it. The next day he refused to take his warfarin as a protest about it not being available the day before. A nurse advised him of the risks of doing so. On 22 June, he collapsed in the wing dining room after complaining of chest pains. He was taken to hospital by ambulance, but he died shortly after arrival.

4. The clinical reviewer concluded that the care the man received at Wymott was equivalent to that he could have expected to receive in the community. Although the clinical reviewer commented that the failure to deliver his medication and his subsequent refusal of warfarin was not the cause of his death, it should have been avoided. We are concerned that there are ongoing issues about supplies of medication and that there are no contingency plans to ensure essential medication is always available. We are also concerned that, despite his lack of mobility and poor health, he was restrained without proper justification for hospital visits.

5. Once staff realised that the man was having chest pains, they used a medical emergency code but the control room did not call an ambulance immediately, as national instructions require. We make three recommendations.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at HMP Wymott informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.

7. NHS England commissioned a clinical reviewer to review the man's clinical care in prison.

8. The investigator obtained copies of the man's medical records and relevant extracts from his prison record. The investigator and the clinical reviewer interviewed three members of staff at Wymott on 21 August 2014. The investigator later interviewed two further members of staff by telephone.

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

10. One of the Ombudsman's family liaison officers contacted the man's ex-wife, his nominated next of kin, to explain the investigation. She did not have any specific issues for the investigation to consider.

11. The man's next of kin received a copy of the draft report. They pointed out factual inaccuracies in the annexes of the report. These have been amended accordingly.

12. The draft report was issued for consultation with the prison service. There were no factual accuracies and the action plan has been added to the end of this report.

HMP WYMOTT

13. HMP Wymott is a medium secure prison holding over 1,100 sentenced men.

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 it was 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 included those for chronic diseases. Some pharmacy services were poor and prisoners did not always receive their medication on time. Inspectors noted numerous occasions when medicines were not available. There were good palliative care and end-of-life procedures.

Independent Monitoring Board

16. Each prison 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 latest published annual report, for the year ending May 2013, the IMB commented that it was unclear whether a review of pharmacy services by Lancashire Care Foundation Trust had brought improvements to the service after problems in the past. It also highlighted problems with waiting times for GP appointments, and specifically noted that it had been difficult to establish clearly what waiting times were. The report also noted that the prison had applied for funding to establish a palliative care suite to provide end of life care.

Previous deaths at Wymott

17. The man was the fifth prisoner to die from natural causes at HMP Wymott since June 2012. We have raised the issue of the proper use of emergency codes and the need for fully considered security risk assessments for the use of restraints before.

KEY EVENTS

18. The man arrived at HMP Leeds in December 2011 on remand. In March 2012, he was sentenced to nine years in prison for serious sexual offences. He had a history of heart disease, circulation problems, COPD, diabetes and arthritis. While at Leeds, healthcare staff initiated a care plan to manage his heart condition.

19. On 19 February 2013, the man transferred to HMP Wymott and lived on I wing, a specialist wing for elderly prisoners. At his initial health screen, staff recorded that he had damage to the left and right ventricles of the heart, chronic obstructive pulmonary disease (COPD – lung disease), type one diabetes and angina. He was prescribed medication for his conditions, including warfarin (an anticoagulant drug to prevent blood from clotting) and he had an oxygen cylinder to help with his breathing difficulties. His mobility was very limited due to his poor health. A prison GP examined him the next day and noted that he was a very ill man with a poor long term prognosis.

20. Clinical staff encouraged the man to improve his health generally through exercise. Despite help, he did not give up smoking. During his first few months in at Wymott, records show his mobility improved slightly and he needed to use oxygen less. However, he remained short of breath when climbing stairs or walking more than a few metres and sometimes used a wheelchair. Healthcare staff saw him frequently for his chronic conditions and sent him to hospital when his condition deteriorated or he required specialist care to treat COPD. The hospital admitted him several times and discharged him with advice about controlling the symptoms of his various health conditions.

21. In March 2013, healthcare staff considered whether the man needed palliative care because of his poor health and frequent hospital admissions. Palliative care includes the treatment of pain and symptoms when active treatment is no longer possible. However, on 21 March, a nurse recorded in his medical record that he had not yet reached a palliative stage. The nurse spoke to him and advised him that his health needs could be better met at the regional inpatient unit at HMP Preston. She explained to him that if he did not go to Preston he was at greater risk of heart failure or having a heart attack. He did not want to go and said that he would refuse his medication if staff forced him to move to Preston. He signed a disclaimer to say that he was aware of the potential risks to his health. Nurses continued to try to persuade him that a transfer would be in his best interests, but he continued to refuse.

22. On 21 May 2014, the man complained of chest pains and went to hospital by emergency ambulance. He was treated for exacerbation of his COPD and returned to the prison the next day. On 2 June, he told a nurse that he had had a bad weekend with his COPD and requested further medication. A nurse informed the GP, who reviewed his medication and prescribed some more.

23. On 3 June, the man went to the cardio-respiratory unit at the hospital for an appointment to treat his COPD. He was very ill and not mobile. Two officers escorted him and used handcuffs to restrain him.

24. On 19 June, the man did not receive his prescribed warfarin as it was not available at the time. The next day, he told a nurse that he would not take his warfarin anymore. This was not the first time he had refused his medication. Since April 2013, he had occasionally refused his medication as a protest when he wanted to complain about aspects of his treatment (such as receiving the wrong wages). He had always resumed taking his medication once his complaint was resolved. He had also occasionally refused to attend prison healthcare appointments and on several occasions would not go to hospital.

25. Two nurses spoke to the man about the importance of taking his medication. On 21 June, he did not receive his prescribed pain relief medication due to a pharmacy problem and continued to refuse to take his warfarin in protest. A nurse told him that if he did not take warfarin there was an increased risk that his blood would clot.

26. At approximately 4.30pm, a nurse saw the man to give him his medication in his cell, because of his poor mobility. She told another nurse, who was issuing medication to other prisoners on the wing, that there were no problems with him and he was not unwell.

27. At around 5.00pm, while eating with other prisoners in the wing dining room, the man began to feel unwell. A prisoner alerted an officer that he needed medical attention and he told the officer that he was having chest pains.

28. Records show that, at 5.16pm, the officer radioed a code blue, (indicating a medical emergency such as where a prisoner is unresponsive, has breathing difficulties or chest pain). Control room staff informed the healthcare first responder and duty manager, but did not call an ambulance. The officer gave the man a wheelchair to sit in and was preparing to take him back to his cell when he belched loudly and slumped forward in the wheelchair. Shortly afterwards, he fell onto the floor and became unconscious.

29. Two nurses heard the emergency code blue and collected a bag containing emergency equipment. They arrived in the dining area at around 5.20pm. The man was pale, cyanosed (blue colouring indicating a lack of oxygen), was having difficulty breathing and unresponsive. The nurses began cardiopulmonary resuscitation and emergency treatment. An officer asked prisoners in the dining area to go back to their cells to ensure they did not impede the emergency response. A prison manager arrived shortly after the nurses and at 5.22pm control room staff called an ambulance at her request. The man's condition deteriorated further and an officer radioed the control room and told them that he had stopped breathing. The control room passed this information on to the Ambulance Service. Several minutes later, a wing manager and the deputy governor arrived and helped the nurses with

resuscitation. They attached a defibrillator, which gave him four cardiac shocks.

30. At 5.35pm, an ambulance arrived and paramedics continued emergency treatment. The ambulance left the prison at 6.12pm and took the man to hospital. He was not restrained. At 6.45pm, the deputy governor telephoned the man's nominated next of kin, his ex-wife, and told her that he had been taken to hospital and was seriously ill. They agreed that she would keep his ex-wife informed by telephone. At 7.05pm, a member of hospital staff telephoned her at the prison and told her that he had died.

31. At 7.15pm, the deputy governor called the man's ex-wife again and told her that he had died. Shortly after this the family liaison officer contacted the man's ex-wife to offer support and guidance. He also helped with the organisation of the funeral. In line with national guidance, the prison offered a contribution to the cost of the funeral, which was held on 1 July.

32. The prison issued notices informing staff and prisoners of the man's death and offering support. A manager held a debrief for the staff involved in the emergency response and offered them support.

Post-mortem

33. After a post-mortem examination, the Coroner gave the cause of death as left ventricular hypertrophy. This is a thickening of the muscle in the heart which causes it to function poorly and work harder, resulting in heart failure and death.

ISSUES

Clinical Care

34. The man arrived at Wymott in February 2013 and had timely health assessments. Healthcare staff saw him frequently because of his multiple health conditions and he often went to hospital for treatment. He refused to go to the inpatient healthcare unit at HMP Preston, which healthcare staff believed would have been more appropriate for his needs. The clinical reviewer concluded that his standard of healthcare in prison was equivalent to that he could have expected to receive in the community.

35. The man was prescribed warfarin to reduce the risk of blood clots. He received regular blood tests to review his warfarin levels. On several occasions he refused to take his medication. On 20 June 2014, he did not take his warfarin in protest at not receiving his medication the day before when it was not available. Although this is an essential medication for someone with heart failure, the clinical reviewer says that missing the dose on 19 June or subsequently did not affect the outcome for him.

36. We were told that the prison had experienced problems with receiving medication from the pharmacy since a change of contract in February 2014. Warfarin is an essential medication. The clinical reviewer considered that there needed to be a contingency plan to ensure prisoners received medication in the event of a supply problem. Wymott did not have any contingency plans.

37. We agree with the clinical reviewer's assessment that the man received care at the prison equivalent to that in the community and we are satisfied that he received appropriate support for his known health problems. However, we are concerned that there are ongoing problems with pharmacy services at the prison which need to be addressed. We make the following recommendation:

    The Head of Healthcare should ensure the prison has a pharmacy service which provides adequate, timely supplies of medication, with contingency plans to ensure prisoners receive all essential medication.

Emergency response

38. Prison Service Instruction (PSI) 03/2013 requires a code blue (or equivalent) emergency code to be used in a medical emergency, including when a prisoner has chest pain, has difficulty breathing or is unconscious. It directs that when a medical emergency code is called the control room must call an ambulance immediately. Wymott's local policy does not clearly set out that the control room should call an ambulance immediately.

39. On 22 June, an officer radioed a code blue at 5.16pm. The officer who received this message in the control room told us she did not call an ambulance at this point as she did not believe this was required by the emergency response protocols. Her understanding of the protocols was that

when an ambulance is required, the person calling the code blue should explicitly state this. She told us that usually a manager would explicitly request an ambulance.

40. Paragraph 5.2 of PSI 03/2013 states:

> "Local procedures must ensure that staff understand they should not delay summoning emergency assistance. For example, it must not be a requirement for a member of the prison healthcare team or a Duty Manager to attend the scene before emergency services are called."

41. The control room did not call an ambulance until prompted by a manager, at 5.22pm, six minutes after the code blue was called, which is too long. While there is no evidence the delay affected the outcome for the man, in other emergencies this could be crucial. We make the following recommendation:

The Governor should ensure that the local emergency protocol meets the requirements of PSI 03/2013 and that the control room calls an ambulance as soon as an emergency medical code is called.

Restraints, security and escorts

42. When prisoners have to travel outside prison, such as to a hospital, a risk assessment is conducted to determine the nature and level of any security arrangements, including any restraints.

43. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity and maintain their dignity. The level of restraints used should be necessary in the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes account of factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process. It also deemed that restraining by handcuffs of a prisoner receiving chemotherapy (and by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.

44. The man went to hospital many times and was always restrained despite his poor mobility. On 3 June, only three weeks before he died, he was taken to hospital. His level of security risk is not clearly shown on the risk assessment document. At the time he was very ill and not mobile. Two officers escorted him and used handcuffs to restrain him. The healthcare section of the risk assessment recorded only that he was diabetic and made no mention of his poor mobility or chronic medical conditions including COPD. There was no

mention of whether his condition impacted on his risk of escape, as the court judgement requires.

45. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances which must be fully considered, taken into account and balanced against the security risks. The man had a number of chronic medical conditions that meant his mobility was limited to several metres without severe shortness of breath. Records show that he often needed to use a wheelchair. We are not satisfied that the use of restraints was justified by fully considered risk assessments that took into account his risk and condition at the time, in line with the 2007 High Court judgement. This is a matter we have raised with Wymott a number of times before. However, we are pleased to note that he was not restrained when taken to hospital as an emergency on 22 June.

46. Ultimately, it is the Governor's responsibility to ensure that the process is managed properly, but the Head of Healthcare also needs to ensure that healthcare staff understand their responsibilities and have appropriate and considered input into the risk assessment process. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

RECOMMENDATIONS

1. The Head of Healthcare should ensure the prison has a pharmacy service which provides adequate, timely supplies of medication, with contingency plans to ensure prisoners receive all essential medication.

2. The Governor should ensure that the local emergency protocol meets the requirements of PSI 03/2013 and that the control room calls an ambulance as soon as an emergency medical code is called.

3. The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

ACTION PLAN

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible
1	The Head of Healthcare should ensure the prison has a pharmacy service which provides adequate, timely supplies of medication, with contingency plans to ensure prisoners receive all essential medication.	Accepted	Lancashire Care Foundation Trust and the pharmacy supplier have recently appointed a pharmacist to work at HMP Wymott for 2.5 days a week (contactable five days a week) to oversee the pharmaceutical service.	31/01/15 Head of Healthcare
2	The Governor should ensure that the local emergency protocol meets the requirements of PSI 03/2013 and that the control room calls an ambulance as soon as an emergency medical code is called.	Accepted	A Notice to Staff (234/2014) has been issued regarding the correct protocol for emergency codes and requesting emergency ambulances.	Completed
3	The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.	Accepted	The Head of Healthcare will remind all Healthcare staff of the legal position that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. A Governors Order (05/2014) was issued in September 2014. The order instructs staff to ensure that the new escort risk assessment forms are used with immediate effect when completing all escort risk assessments.	31/12/14 Head of Healthcare

			The hospital escort risk assessment states: “A new risk assessment is required for every escort / appointment”. The Healthcare section within the assessment records the current condition and risks posed by each prisoner.	