Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Thomas Garside a prisoner at HMP Wymott on 7 March 2016

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Thomas Garside died of a heart attack on 7 March 2016, while a prisoner at HMP Wymott. He was 68 years old. I offer my condolences to Mr Garside's family and friends.

Mr Garside was blind and had a number of chronic health conditions. I consider that he received good care in prison, equivalent to that he could have expected to receive in the community. He received appropriate social care to help him with daily living and healthcare staff monitored his health conditions in line with national guidance. A nurse quickly arranged for Mr Garside to be taken to hospital on 7 March when he complained of breathlessness, and I am satisfied that there is nothing staff at Wymott could have done to prevent his death.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **September 2016**

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Summary

Events

1. On 10 April 2008, Mr Thomas Garside received an indeterminate prison sentence for sexual offences. Mr Garside was blind and suffered from arthritis, lung disease, diabetes, heart problems and mental health issues. He received appropriate medication and treatment for these conditions. On 9 December 2015, he was transferred from HMP Risley to HMP Wymott, as Wymott was better able to meet his social care needs.

2. Later in December, Mr Garside was admitted to hospital and treated for unstable angina. At Wymott, Mr Garside received daily social care support and healthcare staff monitored his conditions. In February 2016, test results showed no abnormalities with his heart or lungs.

3. In the early hours of 7 March, a nurse assessed Mr Garside who said he felt breathless. The nurse arranged an ambulance to take him to hospital. Shortly after he arrived at the hospital, Mr Garside suffered a heart attack. He did not recover and died later that day.

Findings

4. We are satisfied that Mr Garside‘s care was at least equivalent to that he could have expected to receive in the community. Prison healthcare staff monitored his medical conditions in line with national guidance and made sure he received his medication. He received appropriate social care support.

5. When Mr Garside said that he was breathless on 7 March, a nurse sent him to hospital promptly. We are satisfied that there was nothing staff at the prison could have done to prevent Mr Garside’s death.

The Investigation Process

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

7. NHS England commissioned a clinical reviewer to review Mr Garside’s clinical care at the prison.

8. We informed HM Coroner for Preston and West Lancashire District of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.

9. One of the Ombudsman’s family liaison officers contacted Mr Garside’s daughter, to explain the investigation. His daughter did not have any specific matters she wanted the investigation to consider.

10. Mr Garside’s family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

11. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Wymott

12. HMP Wymott is a medium security prison holding over 1,100 adult men. Lancashire Care NHS Foundation Trust provides healthcare services at the prison, including GP services and out of hours medical cover. There are no inpatient beds, but there is 24-hour nursing cover.

HM Inspectorate of Prisons

13. The most recent inspection of Wymott was in July 2014. Inspectors reported that the quality of health care was reasonably good, but undermined by long delays and poor access to GPs. The range of clinics provided reflected the needs of the prison population and included clinics for chronic diseases. Pharmacy services needed improvement to ensure that prisoners received their medication on time. Inspectors reported that the wing for older prisoners and those with disabilities provided excellent care.

Independent Monitoring Board

14. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to May 2015, the IMB reported ongoing problems with the supply of medication and a severe shortage of nurses. The IMB was also concerned about difficulties in prisoners getting GP appointments, unclear waiting times and that the process for notifying prisoners of their appointments was ineffective.

Previous deaths at HMP Wymott

15. Mr Garside was the ninth prisoner to die from natural causes at Wymott since January 2014. There were no significant similarities with the circumstances of the other deaths.

Key Events

16. On 10 April 2008, Mr Thomas Garside received an indeterminate prison sentence, for sexual offences, with a minimum period to serve of nearly two years before he could be considered for release. The Parole Board had never considered he was suitable for release. He spent most of his time in prison at HMP Risley.

17. Mr Garside was blind and suffered from arthritis, lung disease, diabetes, heart problems and mental health issues. At Risley, Mr Garside made many complaints about agency staff who provided social care. The agency decided they could no longer supply carers for Mr Garside and, on 9 December 2015, he was moved to HMP Wymott, which has directly employed social care staff.

18. When he arrived at Wymott, a nurse assessed Mr Garside, noted that he was blind and needed help to wash, eat and dress. He was given a cell on a specialist wing for elderly and disabled prisoners. A GP prescribed his medications to treat water retention, excess stomach acid, diabetes, respiratory problems, high blood pressure, depression and unstable angina (a GTN spray).

19. On 10 December, a prison GP examined Mr Garside and noted he had arthritis, a narrowing of the aortic valve in his heart, chronic obstructive pulmonary disease (COPD the name for a collection of lung diseases including chronic bronchitis and emphysema) and mental health problems. The doctor referred him to the mental health service and a nurse referred him for an urgent social care assessment. Mental health nurses saw Mr Garside frequently throughout his time in prison.

20. Over the next week, healthcare staff saw Mr Garside daily to give him his medication. On 18 December, Mr Garside complained of chest and arm pain, and was admitted to hospital, where he stayed until 24 December. Cardiologists diagnosed further unstable angina (when the heart does not receive enough blood flow or oxygen). They suggested an aortic valve replacement, which Mr Garside declined. Prison healthcare staff discussed this decision with him, and were satisfied he had the mental capacity to make decisions about his treatment.

21. Mr Garside received daily social care at the prison. He frequently complained of chest pain caused by angina and reported using his GTN spray up to eight times a day to relieve the pain. On 8 January 2016, an ECG test (electrocardiogram, which monitors the electrical rhythm of the heart) showed no recent abnormalities.

22. On 25 January, a social worker assessed Mr Garside's social care needs. The social worker assessed that he needed help to wash, dress, get about the wing, and to eat. Staff carers already helped Mr Garside to shower daily, and brought him food and drink. Mr Garside had a wheelchair but chose to remain in his cell and said he had agoraphobia (a fear of open or public spaces).

23. The results of an X-ray completed in hospital on 4 February, showed no issues with Mr Garside's heart or lungs. On 12 February, Mr Garside had an angina attack, which lasted 20 minutes, and nurses monitored him. On 17 February, an ECG showed no new abnormalities.

24. At 2.15am on 7 March, a nurse assessed Mr Garside in his cell, after he had reported being breathless. She noted he had a low oxygen level (93%); high blood pressure (146/87) and high blood sugar level (14.4) though his pulse (42) was within normal range. His temperature was slightly low and he was sweaty, with severe lower back pain. His legs were swollen but he reported no chest pain. She called for an ambulance. Paramedics attended and an ECG showed some new abnormalities. The paramedics took Mr Garside to hospital. Prison staff did not restrain him.

25. Shortly after Mr Garside arrived at the hospital, he had a heart attack. Doctors performed cardiopulmonary resuscitation and then placed Mr Garside on a ventilator. He remained unconscious and, at 8.45pm on 7 March, a doctor recorded that Mr Garside had died.

Contact with Garside's family

26. When Mr Garside arrived at hospital, hospital staff informed his daughter, who was able to visit him later that morning. A prison chaplain was the prison's family liaison officer and went to see Mr Garside's daughter at the hospital and offered support. Hospital staff informed Mr Garside's daughter when he died and the chaplain visited her the next day to offer condolences and ongoing support.

27. Mr Garside's funeral was on 14 April. The prison contributed to the costs in line with national instructions.

Support for prisoners and staff

28. After Mr Garside's death, a prison manager debriefed the staff involved in Mr Garside's care in the early hours of 7 March and offered his support and that of the staff care team.

29. The prison posted notices informing staff and prisoners of Mr Garside's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm in case they had been adversely affected by Mr Garside's death.

Cause of death

30. The coroner gave the cause of death as heart attack caused by heart disease.

Findings

Clinical care

31. We are satisfied that Mr Garside's care in prison was at least equivalent to that he could have expected to receive in the community. When Risley could no longer meet his social care needs, he was moved to Wymott, where he had help with all his daily needs and was well cared for.

32. The clinical reviewer noted that, throughout his time in prison, healthcare staff monitored Mr Garside's chronic conditions frequently and in line with national guidelines. Doctors prescribed appropriate medication and kept these under review. Mental health staff saw Mr Garside frequently and his care was of a good standard.

33. When Mr Garside reported breathlessness, a nurse quickly and appropriately assessed him and called an ambulance promptly. There was no delay in getting Mr Garside to hospital. We are satisfied that there was nothing healthcare staff at the prison could have done to prevent Mr Garside's death.

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