

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in May 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 in May 2014, from multi-organ failure following a gastrointestinal bleed, while in the custody of HMP Wymott. He was 40 years old. I offer my condolences to his family and friends.

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

The man was serving a 30 month sentence. He had poor general health due to many years of opiate drug and alcohol abuse and began to cough up blood in May 2013. Prison doctors referred him to a gastroenterology clinic twice, but he refused to attend. He moved to Wymott in August 2013. In October 2013, he eventually agreed to have investigative tests at the gastroenterology clinic at a hospital. He was due to have had an endoscopy on 6 May 2014, but refused to go and said that his symptoms had resolved.

On 26 May, another prisoner found the man covered in blood in his cell and he was taken to hospital. Doctors found that he had a significant gastrointestinal bleed. His condition remained serious and he died a few days later. His family were informed and were with him when he died.

The clinical reviewer found that healthcare staff could not have foreseen the gastric bleed and would not have been able to prevent it. I consider that the man's clinical care at Wymott was equivalent to that he might have expected to receive in the community. However, I am concerned that the prison did not call an ambulance as soon as officers radioed an emergency code and I am not satisfied that the officer who unlocked his cell on 26 May, properly checked his welfare. I also consider that the prison should have made more active attempts to inform his family that he was seriously ill in hospital.

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

March 2015

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SUMMARY

1. The man was remanded to HMP Liverpool on 26 April 2013 and in May was sentenced to 30 months in prison. He was dependent on heroin and alcohol and had associated health complications including leg ulcers. The integrated drug treatment system (IDTS) team appropriately monitored him and healthcare staff effectively treated his leg ulcers.
2. In May 2013, the man complained of bringing up blood, passing blood in his stool and weight loss. A doctor referred him to a gastroenterology clinic but he refused to attend. Another doctor saw him in June with the same symptoms, but he again refused to go to hospital for tests.
3. After the man moved to Wymott on 8 August 2013, doctors carried out a number of blood tests and referred him once again to a gastroenterology clinic. He attended an appointment at hospital on 22 October and doctors referred him for additional tests.
4. On 18 February 2014, the man attended a follow-up appointment at the gastroenterology clinic. He said he had had two episodes of fresh blood stains on his pillow in the mornings, but did not know if it had come from his nose. A doctor referred him for an endoscopy to try and establish where the blood was coming from. He missed his first appointment to have the endoscopy on 8 April (it is unclear why) and it was rebooked for 6 May. However he refused to go and said his symptoms had gone. He signed a disclaimer to that effect.
5. On 26 May, another prisoner saw the man sitting in his cell covered in blood. He alerted officers who called an emergency code. The control room asked for further information before calling an ambulance, five minutes later.
6. Paramedics took the man to hospital where doctors sedated him and found he had a significant gastrointestinal bleed. They moved him to the intensive care unit. The prison attempted to contact his family but could not reach them at the time. The prison did not try to contact his family again until the day of his death, when his condition deteriorated and hospital staff asked that they should be informed. They were with him when he died at 11.20pm.
7. The clinical reviewer considered that the endoscopy appointment the man refused to attend would have been crucial in identifying any significant gastric problems. However, healthcare staff could not have foreseen his gastric bleed. We are concerned that control room staff did not call an ambulance automatically when the emergency code was received, in line with national instructions and that it does not appear that officers checked his welfare when he was unlocked on the morning of 26 May. We also consider that prison staff should have made more effort to contact his family after he was taken to hospital. We make three recommendations.

THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at Wymott informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
9. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. She visited Wymott on 9 June and met the Governor, the Head of Healthcare, two prisoners on the man's wing and wing staff involved in his care. She interviewed five members of staff and one prisoner during August and September. She informed the Governor of the preliminary findings of the investigation.
10. NHS Lancashire commissioned a clinical reviewer to review the man's clinical care at the prison.
11. We informed HM Coroner for Preston and West Lancashire District of the investigation, who provided a copy of the post-mortem. Our investigation was suspended for several weeks until the Coroner could establish the cause of the man's death. We have sent the Coroner a copy of this investigation report.
12. One of our family liaison officers contacted the man's family about the investigation. They asked for clarification as to exactly what happened, including whether he had a chest infection and received any medication for this. They were also concerned that two prison officers were present at his bedside in hospital, even though he was unconscious.
13. The man's family received a copy of the draft report. The solicitor representing them wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.
14. The draft report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been added to the end of this report

HMP WYMOTT

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

HM Inspectorate of Prisons

16. The most recent inspection of Wymott was in July 2014. Inspectors commented that the environment and living accommodation were well maintained and equipped, and prisoners felt respected in their dealings with staff. 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, including for chronic diseases.

Independent Monitoring Board

17. 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 the year to May 2014, the IMB reported that a triage system operated by the nursing team ensured that in urgent cases a GP saw prisoners promptly, but there was an increasing wait time for non-urgent cases. The IMB noted that crowded conditions in the healthcare waiting room and the limited availability of escort staff caused some distress to prisoners.

Previous deaths at Wymott

18. The man's was the second death from natural causes at Wymott since the start of 2013. There were no similarities with the circumstances of the previous deaths. There have been four deaths since. We have made recommendations in other cases about Wymott's emergency protocol and delays in calling ambulances and about unlock procedures.

KEY EVENTS

19. The man was remanded to HMP Liverpool on 26 April 2013, charged with burglary with an offensive weapon.
20. Staff noted the man was heroin and alcohol dependant. A doctor prescribed methadone and he completed an alcohol detoxification regime. Due to many years of intravenous drug abuse, he suffered from leg ulcers, which nurses regularly cleaned and dressed to ensure they did not become infected.
21. Integrated drug treatment system (IDTS) staff reviewed the man regularly and advised him of the dangers and implications of using illicit drugs while taking methadone, which he said he understood. Staff regularly reviewed and amended his dose of methadone according to his needs, although he sometimes used illicit drugs.
22. On 9 May, the man told a prison GP that he had been bringing up blood for around six weeks and had lost weight. She referred him for blood tests and to a gastroenterology clinic. She prescribed lansoprazole (used to reduce stomach acid). Records show his symptoms subsided and he stopped taking lansoprazole.
23. On 21 May, the man was sentenced to 30 months in prison. On 26 May, he refused to attend the gastroenterology clinic. There is no record of his reasons for refusing.
24. On 28 June, the man told a prison GP that he had been passing bloody stools, was experiencing stomach pain and feeling generally unwell. The GP said that he would have to go to hospital for tests. He refused to go as he would not be able to smoke in the hospital. Against the GP's advice, he signed a disclaimer not to attend hospital.
25. On 8 August, the man transferred to HMP Wymott. At a reception screen, a nurse noted that he appeared physically unwell. His blood pressure and pulse were high and he had a swollen abdomen. He said he had been experiencing breathlessness for about four months, which she said could have been due to the swelling. She referred him to see a doctor (it was a bank holiday weekend, so she made the appointment for the Tuesday).
26. On 9 August, a member of the IDTS team saw the man, and a doctor continued his methadone prescription and warned about the risks of taking illicit drugs in addition. He said he understood and planned to "get his head together" at Wymott. The IDTS team reviewed him regularly, although he still continued to use illicit drugs occasionally.
27. A prison GP reviewed the man on 12 August. He said he had been experiencing intermittent abdominal swelling. The doctor noted he did not have any free fluid in his abdomen and his blood pressure and pulse were normal. The GP referred him to hospital for a blood test as he was not able to get a blood sample. (His veins were so damaged by drug use it was difficult to obtain blood samples.)

28. On 17 August, wing staff told healthcare staff that the man had been vomiting. He said he was eating but not drinking very much. He did not have any pain anywhere and his clinical observations, including blood pressure and temperature, were normal. His cell mate said he was vomiting every night, but he denied this.
29. A GP saw the man the next morning. He said that his antidepressant was making him feel ill and he felt like he was going mad. The GP said it was more likely to be his painkillers (prescribed for the pain due to leg swelling), which had recently been increased. The GP agreed to reduce his antidepressant and continue with the pain relief and see if there was any difference in how he felt. The next day, he told a nurse that he was concerned the pain relief was making him feel unwell and the doctor reduced the dose.
30. On 21 August, healthcare staff noted that the man appeared over sedated when he was due to go to hospital for blood tests so he did not go. He said it was because of the antidepressant and pain relief he was taking, but could not give explain why he was still taking them if they made him unwell. He eventually admitted he had taken illicit opiates and had been selling his antidepressants. A GP reviewed him and stopped his antidepressant and pain relief prescription. She also reduced his methadone dose. The next day, staff noted he was back to his normal self and said he felt great. He told a nurse that he planned to be drug free by the time of his release in July 2014 and wanted to go to a rehabilitation centre in the community.
31. On 27 August, the man had a blood test, and a prison GP reviewed the results. He noted that some of results were abnormal, but as he had some health complications, this was expected. The GP arranged for nurses to re-check and monitor his blood as his blood count was decreasing. The GP also referred him to a gastroenterology clinic.
32. The man attended an appointment at the gastroenterology clinic at hospital on 22 October. A consultant physician said that he thought the man had significant liver disease and liver cirrhosis (scarring of the liver as a result of long term damage or disease). He arranged an ultrasound and more blood tests. The consultant said he would review him with the results, but as he was due to released in July, and any possible treatment would be six months to a year long, it would be better to start the treatment after he had been released.
33. A prison GP reviewed the man's blood tests results of 20 November. He noted they were abnormal, but this was expected. He noted there was evidence of a reduced blood count again.
34. On 6 December, the man had an ultrasound of his liver, kidneys and spleen, which showed no significant problems. He had a blood test again on 20 December. A prison GP reviewed the results which were once again were abnormal, but as expected. The doctor noted his blood count was still dropping.
35. On 18 February 2014, the man attended a follow-up appointment at the gastroenterology clinic. A locum specialist registrar reviewed him. He said he

had had two episodes of fresh blood stains on his pillow in the mornings, but did not know if it had come from his nose. The specialist referred him for an endoscopy to try and establish where the blood was coming from.

36. A prison GP noted that the man's blood test of 10 March showed a reduction in his blood count. He told him he thought his blood count was dropping due to the anti-clotting medication he was taking. He had a history of deep vein thrombosis (DVT) in his leg and doctors had prescribed warfarin (anticoagulant) for some time, which was regularly monitored.
37. The man had an endoscopy on 8 April but did not attend. The records do not show why. Staff rebooked the appointment for 6 May, but on the day, he refused to go and said his symptoms had gone. He signed a disclaimer to that effect. There were no other significant entries in his medical record between 6 May and 25 May.
38. At 6.30pm on 25 May, an officer responded to the man's cell bell. He was holding the side of his stomach and asked if he could have something to settle his stomach. She phoned healthcare staff, who said they did not have anything available. She told him and he said he was fine and would go to sleep.
39. An operational support grade was on duty overnight and said that the man did not press his cell bell again during the night and he did not have any concerns about him. He completed the roll count to check that all prisoners were present in their cells, shortly after 5.00am. He saw nothing about him to concern him.
40. As it was a bank holiday on 26 May, prisoners were unlocked later, at around 9.10am. There were three officers on duty unlocking the prisoners, but unfortunately it has not been possible to establish who unlocked the man's cell. Officer A, who was one of the officers on duty, said he could not recall unlocking the landing, but said that when unlocking cells he would not talk to a prisoner or seek a response from them unless they were already up and about.
41. After unlock, another prisoner said that he was waiting for his morning medication. As the queue was long, he and another prisoner waited on the landing outside the man's cell. He said that he looked through the observation panel of his cell and saw him sitting on his bed covered in blood. He shouted to officers for help.
42. Officer A responded and went to the man's cell. He was sitting on his bed, covered in blood and clutching his stomach. There was a substantial amount of blood around the cell and he thought the man had harmed himself. He asked him what he had done, but he did not respond. Due to the amount of blood and the possibility that he might have had a weapon, he closed the cell door and radioed a code red emergency. (A code red is an emergency code indicating a serious situation when a prisoner is bleeding.) It was 9.38am.
43. Two officers arrived and Officer A radioed the control room and confirmed an ambulance was required. He reassured the man that healthcare staff were on their way, but he did not respond. The control room asked him for additional

information about the incident. Records show they called an ambulance at 9.43am.

44. Two nurses attended with the emergency bag. The man was sitting on the bed clutching his stomach. They noted he appeared confused and disorientated, but he was fully conscious. One nurse could not find any injuries and realised he must have vomited the blood. He was not communicating but was clearly distressed. She tried to reassure him. The nurses tried to get a blood pressure reading and put in an intravenous line but this was not possible.
45. An ambulance arrived at 9.55am. Paramedics took over the man's care and prepared him for hospital. They left the prison at 10.32am and arrived at hospital at 10.55am. He was not restrained.
46. The hospital admitted the man and sedated him. Doctors found he had suffered a severe gastrointestinal bleed. He had blood tests and a blood transfusion. A doctor assessed his condition as serious but not life threatening and he moved to the intensive care unit.
47. The Head of Offender Management at Wymott tried to telephone the man's mother, his next of kin. There was no reply and she left a message. She also tried to contact his sister, but again got no reply. There is no record that prison staff made any further attempts to inform his family until the day of his death.
48. The man remained stable and sedated overnight. At 9.15am on 27 May, his breathing became erratic and hospital staff put him on a ventilator.
49. The man's condition remained the same over the next few days. A few days later the man deteriorated and he had another blood transfusion. The prison then contacted his family at the request of the hospital.
50. The man's mother, brother and sister arrived around 11.30am and hospital staff told them about his condition. They remained at his bedside. He was unconscious but prison escort staff remained with him. At 6.10pm, after his family complained, the duty manager asked the escorting staff to position themselves away from the bedside.
51. The man's son arrived at 8.30pm and hospital staff told his family that he was critically ill and had little chance of surviving. At 11.15pm hospital staff withdrew all active treatment and a doctor pronounced him dead at 11.20pm.
52. The prison appointed an officer as the family liaison officer at 8.15am on 1 June. He contacted the man's sister and arranged to meet his family at 11.00am. He offered his condolences, explained his role and gave his contact details. He remained in contact with the family. The funeral was on 19 June. The prison chaplain, a prison manager and the family liaison officer attended. The prison contributed towards the cost in line with national guidance.

Support for staff and prisoners

53. A senior manager debriefed staff involved in the emergency response and directed them to the available support services if they needed them.
54. A Governor's Notice informed staff and prisoners of the man's death and the support available. The prison reviewed prisoners identified as at risk of suicide and self-harm in case the news of his death had adversely affected them. Staff offered a prisoner additional support.

Post-mortem

55. The post-mortem report stated that the man suffered from a massive gastrointestinal bleed, a complication of liver cirrhosis. He also suffered complications from the bleed, resulting in multi-organ failure.

ISSUES

Clinical care

56. The clinical reviewer noted that the man had general poor health due to years of drug and alcohol abuse when he arrived in prison. When a doctor saw him with symptoms of passing blood and coughing, he appropriately referred him to a gastroenterology clinic for investigative tests. Despite the advice of healthcare staff, he refused to attend several appointments including his last appointment for an endoscopy. The clinical reviewer considered that this was a missed opportunity to identify significant gastric problems. He found that healthcare staff at the prison could not have done any more and would not have been able to foresee that he would have a major gastric bleed. We agree with the clinical reviewer that the care he received while at Wymott was equivalent to that he might have expected to receive in the community.

Unlock procedures

57. Officers are told in their initial training that they should check the safety of prisoners when they unlock cells. The purpose is to establish that the “prisoner has not escaped, is ill or dead”. Prison Service Instruction (PSI) 10/2011, paragraph 2.3 clarifies the responsibility of the unlocking officer:

“Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process.”

58. It has not been possible to establish which of the three officers on duty on 26 May unlocked the man’s cell and whether they checked on his welfare at the time. Officer A, who was one of the officers on duty, said he could not recall unlocking his landing, but said that when unlocking cells he would not usually talk to a prisoner or seek a response from them unless they were up and about. As none of the officers accepted that they had unlocked his landing, we do not know whether the person who did so checked his wellbeing at the time. In another investigation into a death at Wymott in March 2014, two months before his death, we found it was not the general practice at Wymott to check on prisoner’s welfare when they are unlocked. We do not know whether he was unwell at the time his cell was unlocked but he was very ill shortly afterwards. We consider it is important that officers check prisoners’ welfare when unlocking cells. We repeat our previous recommendation:

The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

Emergency response

59. Prison Service Instruction (PSI) 03/2013 required Governors to have in place a medical emergency response code protocol. This protocol should state how staff communicate the nature of a medical emergency, using agreed codes, and ensure that control room staff call an ambulance immediately. HMP Wymott's local policy does not clearly set out that the control room should call an ambulance immediately as the national instruction requires.
60. When Officer A called an emergency code, the control room staff asked for further information, before they called an ambulance. This resulted in a five minute delay. A code red signifies a life threatening situation and the control room should have requested an ambulance automatically. It does not appear that the delay would have made any difference to the outcome for the man, but in other circumstances it could be crucial. We have made several recommendations to Wymott about their emergency protocol, which does not meet the requirements of PSI 03.2013. 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.

Liaison with the man's family

61. PSI 64/2011 Safer Custody requires:
- “Where prisoners have a terminal illness or suffer an unpredicted and/or rapid deterioration in their physical health, prisons must have in place procedures for supporting the prisoner, engaging with their next of kin or nominated person and providing support for staff.”
62. As well as the procedures in PSI 64/2011 – Prison Rule 22(1) states:
- ‘Notification of illness or death
- ’22 – (1) If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed.’
63. When a seriously ill prisoner is taken to hospital, his next of kin should be informed as soon as possible. The Head of Offender Management tried to telephone the man's family as soon as he went to hospital, in line with Prison Rule 22. Unfortunately she got no reply and left a message. She said that after she went off duty, she did not make any further attempts to contact his family. There is no record that anyone from the prison made any further effort to contact his family after that, until the hospital advised them to do so on the day of his death. We understand his family were on holiday at the time, but his nephew was staying at the house and he could have passed on a message if someone had tried to contact them again. We consider that the prison should have made additional efforts to contact them after 26 May. This

might have allowed them the opportunity to see him before his condition deteriorated significantly. We make the following recommendation:

The Governor should ensure that active efforts are made to inform families when seriously ill prisoners are admitted to hospital.

64. The man's family were upset that escorting officers remained at his bedside until they complained about this. When they did, the duty manager asked the officers to leave the bedside to allow his family some privacy with him before he died. While it would have been better for the officers to have acted with greater sensitivity earlier, we are satisfied that a manager took appropriate action once the matter was raised.

RECOMMENDATIONS

1. The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.
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 should ensure that active efforts are made to inform families when seriously ill prisoners are admitted to hospital.

ACTION PLAN

No	Recommendation	Accepted / Not accepted	Response	Target date for completion and Function Responsible
1	The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.	Accepted	A Notice to Staff (05/2015) was issued on 8 January 2015 reminding staff of the correct procedure to follow when unlocking cell doors at any time.	Completed Head of Residence
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) was issued on 7 November 2014 regarding the correct protocol for emergency codes and the calling of emergency ambulances. This NTS is consistent with instructions in PSI 03/2013.	Completed Governor
3	The Governor should ensure that active efforts are made to inform families when seriously ill prisoners are admitted to hospital.	Accepted	Instructions have been issued to duty Governors and orderly officers regarding the notification of the next of kin and visiting arrangements for seriously ill prisoners. These instructions also provide guidance for recording when prisoners state that they do not want their families to be contacted.	Completed Head of Safer Prisons