Investigation into the circumstances surrounding the death of a man, a prisoner at HMP Wymott, in December 2008

Report by the Prisons and Probation Ombudsman for England and Wales

October 2010

This is an investigation into the circumstances surrounding the death of a man who died at HMP Wymott in December 2008. He was aged 68 when he died. I would like to extend my condolences to his family and friends for their loss.

This investigation was undertaken by my colleague. An independent review of the man's clinical care was conducted by a clinical reviewer on behalf of the local Primary Care Trust (PCT). I am most grateful for her assistance. I have written to the PCT outlining her recommendations.

The man had a complex medical history and was receiving regular treatment for a number of long term chronic health conditions. Unfortunately, he did not cooperate very well with his treatment plan. This compounded his problems which ultimately contributed to the decline in his overall health.

It is clear from my investigation that every effort was made to support the man. The multidisciplinary team at Wymott, which included social carers, staff from the elderly and disabled community and healthcare staff, worked together to provide him with what I believe was the best possible package of care. The clinical reviewer found that he received appropriate healthcare to a consistently high standard whilst in custody at Wymott. This compared extremely favourably with what could have been expected in the community. The level of support provided by the social carers was excellent and is an example of effective collaborative working between carers, prison and healthcare staff and the man.

I must apologise for the delay in issuing this report, although this has not delayed the giving of feedback to the prison itself.

I would also like to thank the Governor and staff at Wymott for their full and ready cooperation during the course of my investigation. I am particularly grateful to staff from the Business Development Unit at Wymott for their assistance as liaison officers to the investigator. I make one recommendation to the Governor and also highlight one example of good practice. I am pleased to see that the recommendation has been accepted.

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.

Jane Webb
Acting Prisons and Probation Ombudsman October 2010

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SUMMARY

The man was convicted on 20 January 2006 at Crown Court and on 6 April he was sentenced to five years imprisonment. He had never been in prison before until he was received into custody that day. He spent most of his time located in the healthcare units of HMP Wymott and HMP Preston, the elderly and disabled community at Wymott or in hospital. He was 68 when he died in his room at Wymott. He had a long history of chronic medical problems, which included diabetes, heart problems, neuropathy and depression and was well known to community health services.

The man was a large gentleman who struggled with his mobility throughout his time in custody. Regrettably, despite advice from staff, he adopted an unhealthy lifestyle which worsened his already poor health. For the most part he seemed unwilling to take responsibility for his health.

Throughout 2006 and 2007, the man was seen frequently by healthcare staff. Between April 2006 and July 2008, he had at least 110 contacts with healthcare staff and treatment from them. They included a number of secondary care appointments for the management of his diabetes, particularly his insulin and blood glucose levels, dermatology clinics and dental appointments.

The man had a number of investigations at hospital which included a CT scan (computed tomography which produces a three dimensional image for clinical investigation), but found no abnormalities. He continued to complain of persistent dizziness so further investigations continued.

The man was transferred to HMP Preston's healthcare inpatient facility on 16 July for an assessment of his care needs, particularly the reasons for his falls and blackouts. Healthcare staff observed that he gained weight and his mobility levels fluctuated. Their observations suggested that he was able to walk much better when he was on his own and their investigations found no specific reason why he fell frequently. He returned to Wymott on 6 August.

In August 2008, carers from a local agency were employed by the prison to support the man. They found that he needed a lot of help and support. They assisted him to get ready for bed and to maintain personal hygiene. The carers identified his main problems as poor mobility and limited ability and motivation to attend to his personal hygiene.

Between 7 August and 24 September, the man received at least 36 further contacts/episodes of medical care and treatment. His treatment regime was carefully planned and clinical observations and investigations were carried out regularly. His ability to care for himself fluctuated and he continued to need a great deal of assistance from staff. He was referred to physiotherapy to see if this would help him improve his mobility.

On 14 August, the man was assessed by a community occupational therapist who found that he was able to mobilise within his room and the corridor

outside. She assessed his main problems as reduced mobility, risks presented by moving and handling, likelihood of damage to skin and underlying flesh and risk of pressure sores. He was particularly vulnerable to these problems because of his poor health, specifically ischaemic heart disease and diabetes.

Between 24 September and 14 October the man received at least six contacts/episodes of medical care and treatment. His condition was stabilised and the multi-disciplinary team agreed a care package whilst he remained in prison.

The man transferred to Preston a second time and, between 17 October and 21 November, received at least 24 more contacts with healthcare staff. Healthcare staff provided comprehensive nursing and medical care and carried out a detailed clinical assessment.

On Christmas Day, the man suffered breathing problems and complained of chest pain so he was taken to hospital by ambulance. The next day, he was discharged from hospital and returned to Wymott. Healthcare staff noted that he seemed less alert on his return, although he appeared to know where he was.

At approximately 8.40am in December 2008 an officer, who was accompanied by a carer, unlocked the man's room. They went into the room and found that he did not respond to them, was cold to the touch and appeared to have died. The officer immediately radioed the control room with an urgent message broadcast.

Healthcare staff received a radio call to go to the man's room and, although the call was not given an emergency alert, two nurses went immediately. They were followed by another two nurses who brought emergency equipment with them.

The nurses were of the opinion that the man had died sometime previously. He was lying in bed but showed no signs of life. All four nurses agreed that any resuscitation attempt would be futile, therefore they took the decision not to commence cardio pulmonary resuscitation (CPR).

A paramedic arrived soon afterwards. He too examined the man but did not attempt resuscitation. The paramedic found no signs of life and completed the standard form 'Diagnosis of the Fact of Death' (key indicators for cardio pulmonary arrest and fact of death) at 9.05am. A doctor, who had been called at home, arrived at the man's room at approximately 9.20am and certified the death.

The Duty Governor contacted the man's son at 9.45am to inform him that his father had passed away.

I make one recommendation which asks the Governor of Wymott to consider providing prison staff working within the elderly and disabled community with

training to raise awareness of how staff should respond to the health problems experienced by prisoners in that community.

THE INVESTIGATION PROCESS

1. The investigation was opened on 28 December 2008. The investigator issued notices announcing the investigation to the staff and prisoners of HMP Wymott. The notices included an invitation to those who wished to contribute to the investigation to make themselves known. No prisoners or staff came forward although he spoke to a number of prisoners and staff within the elderly and disabled community and Healthcare Department.

2. The investigator made a preliminary visit to the prison on 23 February 2009. He met the governing Governor, the chair of the local branch of the Prison Officers' Association and the chair of the Independent Monitoring Board (IMB). An officer from the prison's Business Development Unit assisted the investigator as his liaison officer.

3. The investigator made a tour of the prison and visited I wing annexe of the elderly and disabled community to see the man's room. He talked to a number of staff and prisoners who knew him. I wing is a small self-contained unit which houses around 75 elderly and disabled prisoners and is known as the elderly and disabled community.

4. The investigator obtained the man's prison and clinical records. He reviewed all the relevant documents, which included his core record, clinical record, wing documentation, care plans and other custodial and clinical documents. The investigator constructed a chronology of significant events from his review of the man's case files and identified any emerging issues.

5. A number of staff were identified who had been closely involved in the man's care. The investigator arranged to interview them at the prison. They included the man's personal officer, doctor, carers, and the senior nurses who had coordinated his care, and also the occupational therapist who had assessed his needs.

6. The investigator asked the local Primary Care Trust (PCT) to organise a clinical review of the healthcare the man had received whilst in custody. The PCT commissioned a clinical reviewer to carry out the review. I am grateful to her for completing her work expeditiously.

7. The investigator returned to Wymott on 18 May to complete his interviews with staff. He also met and interviewed the man's main carer from the agency, who helped build up a detailed picture of him in his last few months. I am grateful to the carer for his assistance.

8. After my report was drafted the Family Liaison Officer was able to make contact with the man's son. As a consequence of this a meeting was arranged for him to meet my investigator and family liaison officer.

9. The meeting took place on 13 May 2010 and was attended by the man's son, my investigator and family liaison officer. The son expressed a number of concerns, which I have summarised in the Issues section of my report. I invited the Governor of Wymott to comment on these matters and I have included Wymott's response after each concern expressed by the son.

HMP WYMOTT

10. HMP Wymott is a large category C closed training prison which holds a substantial number of vulnerable prisoners. Wymott is effectively two separate prisons, each with its own range of workshops, education and training facilities. The prison opened in 1979 and new accommodation was added in 1996 with a high standard of facilities and security. Vulnerable prisoners are mainly held in the original house blocks.

11. A new residential block of two wings was opened in 2004 and this is used as the induction wing. Wymott can hold an Operational Capacity of 1144 prisoners with a Certified Normal Accommodation for 1081prisoners. There are two specialist units: a drug therapeutic community and an elderly and disabled community. Healthcare services are commissioned and provided by the Primary Care Trust. Wymott has no inpatient beds so prisoners often go to HMP Preston, which has an inpatients unit.

HM Chief Inspector of Prisons' inspection 2008

12. HM Chief Inspector of Prisons last inspected Wymott in October 2008. In her report she commented:

> "Wymott is a large category C training prison, holding over a thousand men. It has expanded 25% since its last inspection in 2003. Unlike many training prisons which have undergone similar expansion, Wymott has managed to sustain its performance and the quality and quantity of activity available to its prisoners."

13. She reported:

> "The needs of older prisoners and those with disabilities were not met. The disability policy did not reflect current practice and, although a high proportion of prisoners reported some form of disability, support was ad hoc, with no formal care plans and only limited adjustments, even on I wing, which was supposed to be a specialist unit. Staff on I wing were caring and supportive but there was insufficient input and training to make it an effective unit for older prisoners and those with disabilities. Social care workers were due to be appointed. There were few links to health services and limited activities for those unable to leave the wing."

Diversity

14. She recommended:

> "A diversity policy should be developed and implemented, covering all distinct minority groups, including gay prisoners, those with disabilities and older prisoners, and based on an analysis of their needs."

I wing

15. She reported:

> "A policy for the management of older prisoners had just been developed but had not been fully implemented. Over 10% of the population were regarded as older prisoners (over 55) and a separate unit had been established on I wing to cater for some of them, as well as those with disabilities, but the criteria for the wing were unclear. This included an annexe in the healthcare centre of six cells more appropriate for use by prisoners with physical disabilities. None of these prisoners had care plans and little had been done to make reasonable adjustments to living conditions; for example, prisoners using a wheelchair were accommodated in ordinary cells. However, prisoners on this unit were generally unlocked all day, limited low level work was available on the unit, and a communal dining and television facility had been provided. Interactions between staff and prisoners on this wing were positive.
>
> "I wing held up to 75 prisoners and was the only wing where prisoners could eat out of their cell. A stair lift allowed prisoners to access the association facilities on the upper landings. I wing also had a separate annexe in the nearby healthcare centre, with cells more suitable for use by prisoners with disabilities, but they were too isolated for such prisoners to be held there."

16. She recommended:

> "Individual care plans should be developed for older prisoners with special needs and those with disabilities. Activities for older prisoners and those with limited mobility should be improved to provide more stimulating and purposeful occupation.
>
> "Cells for prisoners with a disability or limited mobility should be adapted to meet their needs."

Older prisoners in England and Wales: a follow-up to the 2004 thematic review by HM Chief Inspector of Prisons June 2008

17. In 2004, HM Chief Inspector published a report on the treatment and conditions of the growing number of older prisoners in England and Wales. A short follow-up report revisits the issue, four years on, to identify any changes. She comments:

> "The population of men over 60 in prison has risen slightly over that period, reaching nearly 3% of the population; at the same time, the population of women over 50 has increased significantly, reaching nearly 7% by mid-2007. It is well-known that prisoners are likely to have earlier onset of chronic health and social care needs than the general population.
>
> "There have clearly been some positive developments over the last four years. Survey responses from older prisoners are more positive than they were; healthcare arrangements have in general improved; some individual prisons, or prison staff, are carrying out good and innovative work to meet the specific needs of these prisoners.
>
> "Older prisoners are a relatively compliant population – hence the title of our previous report, *No problems – old and quiet*, taken from a prisoner's wing file. In an increasingly pressurised prison system, their needs are therefore likely to be overlooked unless there is specific provision – yet the issues they pose are likely to become more acute, as an increasing number of long-sentenced prisoners grow old and frail in prison.
>
> "The voluntary and healthcare sectors have done a great deal of important and useful work in this area. It now falls to the National Offender Management Service to make full use of that work and of the recommendations in our last report, and ensure that prisons properly reflect, and can provide for, the needs of their ageing population.
>
> "There were some good examples of provision for older prisoners organised and managed by health services staff, but this was largely done in isolation with little evidence of multidisciplinary working. It was disappointing that the social care needs of older and disabled prisoners were still considered the responsibility of health services. A lead nurse for older prisoners was not evident in all inspections, despite the requirements of the National Service Framework for Older Prisoners. However, there were some good examples of care for this older age group. But there was a complete lack of staff training in identifying the signs of mental health problems among the elderly."

The Independent Monitoring Board (IMB) Annual Report 2008/09

18. The Prisons Act 1952 requires every prison to be monitored by an independent board appointed by the Secretary of State for Justice from members of the community in which the prison is situated. The Board must satisfy itself as to the humane and just treatment of those held in the prison it monitors.

19. Wymott IMB's most recent annual report was published in May 2009. The executive summary says:

> "The Board considers that the Prison is providing a safe environment in which prisoners are treated with decency and respect and have access to an extensive programme of education and skills. The Senior Management of the Prison has set out to address those areas where prisoners are not treated decently within the limitations of what the Prison can do given its national resource allocation."

Elderly and disabled community (I wing)

20. The section of the IMB's report dealing with Statutory Reporting Areas: Healthcare and Mental Health reports:

> "A lead nurse for elderly prisoners has been designated. Care plans for elderly prisoners are now being developed and the prison has produced an elderly prisoner action plan as a response to the HMCIP Thematic Review. However due to staffing shortages and pressure of work, the lead nurse has been delayed in producing an individual healthcare plan for each elderly prisoner. A revised induction document has been designed to more fully assess elderly prisoners' medical and social needs and is implemented.
>
> "Consider the introduction of specialist training for I Wing officers to enhance the quality of care for elderly and disabled prisoners. Although I Wing is identified as the elderly and disabled community it does not appear to have attracted significant additional funding to reflect the specific requirements of that role. In the course of the year, however, the Governor was able to find sufficient funds to appoint two care workers, to install a stairlift on I Wing and to set up a daycare activity centre, all of which enhance significantly the facilities on the wing. The appointment of the care workers, in particular, provides much-needed assistance with daily living. Although the activity centre had been completed by the end of the reporting year it had not yet been commissioned.

> "The layout of I Wing creates difficulties for wheelchair users. However, the installation of the stairlift is a welcome addition, and the social environment of the wing and the good staff-prisoner relationships provide further benefits."

21. The section of the IMB's report dealing with Reports on Other Areas of the Prison: Elderly and Disabled, says:

> "The Prison now employs two careworkers located on the elderly and disabled wing and the Board welcomes this. The careworkers provide the assistance that some disabled and elderly prisoners require on a daily basis. The Board also recognises the important role that prisoners play in the care of their fellow inmates. Careworkers are developing their own day-to-day care plans under the supervision of the named nurse for elderly or disabled prisoners. However medical care plans for each prisoner have not yet been constructed. There is a growing collaboration between careworkers and Healthcare, which may lead to opportunities for improved care. At the time of writing there does not appear to be arrangements for the development of the careworker role.
>
> "Whilst the Board considers that the care provided by discipline staff for elderly and disabled prisoners on I Wing is good and that the careworkers will provide vital support it is concerned that there is no specialist training for officers; for example recognising early geriatric mental health deterioration. However the introduction of the careworkers may help to bridge this gap. The Board welcomes the development of a daycare centre for the elderly and disabled, which promises an improvement on the previously poor arrangements for association, education and work."

Previous deaths in custody at Wymott

22. Since 2004, the Ombudsman has investigated 25 deaths at Wymott, which include 22 deaths by natural causes and three apparently self-inflicted deaths. There was no link between the circumstances surrounding this investigation and the other deaths, although a number of the deaths by natural causes were also associated with chronic disease and long term conditions.

23. Four of the deaths were elderly men who were, or had been, located on I wing within the elderly and disabled community. They were all due to natural causes and associated with long term conditions such as coronary heart disease.

24. The Ombudsman investigated the death of a man at Wymott in November 2007 and recommended that the Head of Healthcare should ensure tighter monitoring and follow-up of delays and missed

appointments, particularly those of chronically ill patients. The investigator found no evidence from the circumstances surrounding the man's death that he missed any scheduled appointments because of a lack of monitoring by the prison. This was confirmed by the clinical reviewer's clinical review.

KEY EVENTS

25. The man was convicted on 20 January 2006 at Crown Court. On 6 April 2006 he was sentenced to five years imprisonment and was received into custody at HMP Altcourse the same day. It was his first time in prison as he had been bailed by the court prior to sentencing.

26. During the reception process the man was interviewed by a nurse (no name or signature on the clinical record) who admitted him to the healthcare centre. He was registered disabled and suffered from a number of serious long-term health conditions which required further medical assessment and treatment. He did not have a history of suicidal or self harming behaviour but was referred to see a mental health nurse because he reported a history of depression.

27. Healthcare staff identified that the man was an insulin dependent diabetic (diabetes which needs daily injection of insulin) with a history of heart problems. His clinical observations (pulse, blood pressure, respirations and temperature) were recorded by the reception nurse and he was seen by the prison doctor.

28. The man complained of chest pain and shortness of breath on reception at Altcourse. Healthcare staff contacted his home GP in Macclesfield for further information about his past medical history. His last diabetic check showed he had 40 percent loss of sensation in his feet. The plan was for him to have an ECG (an electrocardiograph is a recording of the electrical activity of the heart) and further medical tests. He was also referred to the chiropodist and optician.

29. On 13 April, the man transferred from Altcourse to HMP Wymott. He was seen on reception by healthcare staff who confirmed that his main health problems were insulin dependent diabetes, ischaemic heart disease (reduced blood supply to the heart muscle), neuropathy (disorders of the nerves of the peripheral nervous system which may be connected to diabetes) and depressive illness.

30. The man was a large, overweight gentleman who struggled with his mobility. On admission to Wymott he was suffering from hypoglycaemia (a diabetic condition where glucose levels are lower than normal) which needed careful monitoring. The doctor recommended that he needed to be allocated a ground floor cell and he was provided with a wheelchair.

31. Healthcare staff made the appropriate referrals to specialist secondary care clinics. The man took warfarin medication (used to prevent the formation and movement of abnormal blood clots) for his heart condition and regular INR testing (tests for blood clotting).

32. Healthcare staff saw the man every day for the next week. On 18 April, he complained of chest pains. In response, the nurses took his pulse,

blood pressure, blood sugar level and oxygen saturation levels, and administered oxygen.

33. The next day, the man complained that he could not breathe. Healthcare staff visited him, took clinical observations and administered oxygen again. The doctor recorded in the medical record that he had "ischaemic type chest pain, similar to MI" (MI means myocardial infarction, which is a heart attack).

34. Healthcare staff saw the man a week later following a fall where he had banged his head and hurt his elbow. They could not find any injuries when they examined him. On 11 May, the doctor saw him about his psoriasis (a skin condition).

35. Wing staff were given a box of insulin needles on 2 June, which had been found between the gates of the adjoining wings by another prisoner. The man said he had put the box of needles and some co-codamol (pain killer tablets) on his window ledge and later found they had been removed. Staff decided to monitor his use of his medical equipment more carefully.

36. On 27 June, healthcare staff attended a 'code red' alert (code red is a radio alert to indicate a medical emergency where a patient is found to be bleeding). The man had fallen and sustained a graze and bruise to his forehead. Healthcare staff examined him and found he had:

> "Full movement of limbs, pupils equal and reacting to light and coherent with his speech, and orientated to time, place and person." (These observations are made to aid clinical assessment and diagnosis following a head injury.)

37. The man was seen by healthcare staff for his regular INR reading (INR is a measure to determine the clotting tendency of blood) on 3 July. The nurse recorded in his medical record:

> "He tells me he had stopped taking his warfarin over the weekend in order to get his INR reading up. I attempted to explain that the warfarin would increase the INR reading. He did not appear to understand. I advised him to take the warfarin as prescribed and I will repeat INR on Thursday morning."

38. The man was brought to the healthcare centre for his third hepatitis B vaccination on 13 July. Staff noted his feet were very swollen due to oedema (this is a build-up of fluids in the circulatory system usually due to cardiac problems such as poor circulation), and he was short of breath. Healthcare staff referred him to the doctor for review. A few days later, on 16 July, staff observed that his ankles were still swollen.

39. The man was seen by healthcare staff on 29 August after complaining he had suffered a dizzy spell, blacked out and fallen. Healthcare staff

examined and treated him accordingly. He was reviewed in the doctor's clinic on 7 September. The doctor recorded in his medical record:

> "Says left with some memory loss but otherwise recovered. Pulse regular today. Says not like a hypo. Probable TIA (transient ischaemic attack which is like a mini stroke where the patient generally makes a full recovery). Continue current medication, but if recurs frequently consider referral."

40. The next contact with healthcare staff was on 12 January 2007, when the diabetic specialist nurse gave advice to the man and the healthcare team regarding a planned medical procedure (the diabetic nurse was one of several secondary care specialists involved with his medical care.)

41. The man was seen by the doctor on 19 March for a possible urinary tract infection after he had complained of blood in his urine. When his urine sample was tested it was "nil for blood". He was prescribed a week's course of antibiotics.

42. During July, the man developed a wound to his knee so healthcare staff implemented a wound care plan. Treatment included regular cleaning of the wound and renewal of the dressing. The doctor prescribed antibiotics and steroid cream to be applied each day.

43. The man did not follow his care plan properly. Healthcare staff told the investigator that he was generally uncooperative when they tried to encourage him to change his unhealthy lifestyle or when he needed to attend hospital appointments. They tried to discourage him from overeating, especially sugary and fatty foods.

44. On 15 August, the man was due to have an endoscopy (which looks inside the body using an instrument called an endoscope). Because he had not taken his preparatory medication before the procedure, he could not attend his appointment. Another appointment was made.

45. The man had a hospital appointment on 11 September at hospital to see his physician. However, healthcare administration staff recorded in his medical record:

> "The appointment is in the diary; it is written on LIDS system (prisoner movement log) and is written above (in his medical record); it is also on the escort sheet. The patient has not attended an appointment since 12 June 2006."

46. There were not any prison-related reasons why the man did not attend appointments as escorts for hospital appointments were available.

47. The man continued to disregard healthcare staff's advice and they believed that he was unwilling to take responsibility for his health. He resisted any attempts by staff to improve his diet and would only partially comply with his care plan. Occasionally, he did cooperate and he reluctantly accepted a flu vaccination on 22 October.

48. An appointment was made for the man to go to the dermatology clinic at hospital on 17 April 2007. Healthcare staff made a note that it was important he attended the clinic. He ultimately did not go but the reason for this is not known as nothing of note was recorded in his medical record.

49. The man's health, specifically his long term conditions, was subject to regular review by the healthcare team. A review on 9 October 2007, noted that he had been a diabetic for the past 12 years maintained on insulin for the past three years. His medical history included coronary heart disease, hypertension (high blood pressure), rheumatoid arthritis, diabetic neuropathy (nerve damage as a consequence of diabetes). His other health problems included carpal tunnel syndrome (a medical condition in which the median nerve is compressed at the wrist, leading to paresthesias, numbness and muscle weakness in the hand) which had led to a loss of feeling in his hands and feet.

50. Healthcare staff advised the man to keep a careful check on his health by taking a healthy diet which should be low fat, high fibre and no sugar but with plenty of fruit and vegetables. They advised him against consuming 'diabetic foods' and suggested he take regular exercise such as walking up and down the wing.

51. A diabetic nurse saw the man on 22 November. They discussed his insulin levels and sugar testing regime with the aim of improving the way he managed his diabetes.

52. The nurse explained to the man that each morning he should take a fasting glucose test (test sugar level before any food is taken) before breakfast and record this in his home monitoring diary. He did not comply with the advice.

53. On 3 March 2008, the man was seen by healthcare staff while collecting his medication. He complained of "feeling unwell" and "felt unsteady". His clinical observations were taken and he was advised to rest, take plenty of fluids and some paracetamol and to contact healthcare staff if he became worse.

54. The following day healthcare staff followed this up with a visit to the man's cell and noted:

> "Gross obese man sat eating a packet of crisps. Some peripheral ankle oedema, bases clear. No sacral oedema. Has had chair all day. Advised fluids and weight reduction."

55. Prison doctor A visited the man in his cell on 18 March. He noted:

> "Cell visit; patient conscious and orientated; (clinical observations taken); no bowel/bladder complaints; no chest pain/shortness of breath; says had "falls" last few days.
> On examination obese person; temperature normal; left ankle – mild oedema; right ankle red; knees mild arthritis.
> Plan – stop warfarin for 48 hours, then re-start; fluids; re-assess in three days if not better; then refer for OT (occupational therapy) falls assessment; chase blood results."

56. On 4 April, the man was seen by healthcare staff after he had blacked out the previous night and fallen to the floor. He told staff he had hurt his head, hip and elbow on his right side. Staff examined him and found he had "normal range of movement". He told staff he felt unwell so he was added to the doctor's list for review that afternoon.

57. The same day a nurse recorded in the man's medical record "Overweight, enforced inability. I have talked to him about the need to reduce eating. Told (him) he will live longer and feel a lot better."

58. On 9 June, the man received notification that his application for leave to appeal against his sentence had been refused. The officer who was the man's personal officer told the investigator that he was very disappointed and seemed to go downhill from that point. The officer said he had been confident his appeal would be successful but she had encouraged him to be more realistic and not to count on it.

59. Healthcare staff were alerted by radio to a 'code blue' emergency on 1 July 2008 (code blue is a radio alert to indicate a medical emergency where a patient is found to be either not breathing or severe difficulty breathing, e.g. an asthma attack).

60. When they arrived at his cell they found that the man appeared to have fainted. They examined him but could see no obvious injuries. His clinical observations were within 'acceptable limits' (his pulse and respirations were recorded as normal and caused no undue concern).

61. Prison doctor B concluded that the man could have suffered from postural hypotension which caused him to collapse (that is when the blood pressure quickly falls on standing up, causing faintness and sometimes collapse).

62. The man was seen again later that day as I wing staff remained concerned. After examining him, healthcare staff reassured him and the staff.

63. On 6 July, healthcare staff were again called to see the man following another report that he had fallen. When they arrived, he was sitting in

a wheelchair in his room. They advised him to rest in bed and arrangements were made for the doctor to see him the following day.

64. On 9 July healthcare staff requested an occupational therapy assessment from the local social services department. They were informed of a current waiting time between 12 and 14 weeks but were assured that an appointment would be made in due course. (Ultimately, the local PCT arranged the occupational therapy assessment.)

65. The man was referred for admission to HMP Preston's healthcare unit on 14 July. The plan was to admit him for observation and assessment of his physical health, particularly to identify the reason for his falls. He would be admitted to Preston for a short period of time and then return to Wymott, with a more informed and developed plan of care.

66. Healthcare staff continued to go to the man on numerous occasions, usually when he felt unsteady or unwell or following reports that he had collapsed or fallen. On 15 July, he complained that he felt much worse. A BM test (blood sugar level) was taken and showed a high level of blood sugar. This was a frequent problem for him and healthcare staff responded promptly by providing appropriate medical intervention.

Admission to HMP Preston

67. The man transferred to Preston's healthcare inpatient facility on 16 July to assess his care needs and try to identify the reasons for his falls and blackouts. Prison doctor B worked at both Wymott and Preston so he knew him well. He reviewed his treatment plan and medication regime and the nurses implemented a nursing care plan to stabilise his heath problems, identify the reasons for his collapses, and encourage him to take more responsibility for his health.

68. The next day, healthcare staff at Preston recorded in his medical record:

> "The man has been observed walking around his room with the use of one walking stick, without any difficulty, appeared quite agile. He was able to change the channels on the TV which is mounted high on a wall. Also, he was capable of carrying his food tray across the room. Prison doctor B notified, this man should not be using a wheelchair as he has (does not) appear to have any mobility problems that warrants its use."

69. Later that evening, the man was found on the floor by staff and told them that he had fallen. They helped him back onto his chair and made him comfortable. They took his clinical observations, which were within normal limits and found no cause for concern.

70. The man fell out of bed several times that week but did not sustain any injuries. Healthcare staff assisted him back to bed or back to his chair on each occasion.

71. A referral for physiotherapy was made on 20 July to help the man with his mobility. The next day he was seen by the prison doctor who recorded in his medical record that the man had difficulty moving about after a fall three days previously.

72. The man was admitted to the hospital's medical assessment unit on 25 July after healthcare staff had observed "increased confusion and slurred speech". Prison healthcare staff liaised with hospital staff to monitor him progress in hospital. He had a CT scan on 28 July.

73. On 6 August, the man had physiotherapy while in hospital to help him with his mobility. The results from his clinical tests came back and his CT scan was 'NAD' (no abnormalities detected) with no evidence of transient ischaemic attacks (mini-strokes). Hospital staff were suspicious that he was "deliberately putting himself on the floor for attention seeking". All clinical investigations had proved either "negative or unremarkable".

74. The man returned to Wymott on 6 August directly from the hospital. He continued to need a lot of support from staff to help him with his day-to-day living activities. Back in his room on I wing annexe, healthcare staff recorded in his medical record that he was unable to get undressed and get into bed. They observed that his sacrum (large, triangular bone at the base of the spine and at the upper and back part of the pelvic cavity) looked intact with no sign of redness but were not able to fully inspect at the time. They considered that his cell was inadequate for his needs.

75. The man was found on the floor of his cell by prison staff on 9 August. Healthcare staff were called and he was helped back to his chair. There was no evidence that he had sustained any injuries. The following day, he complained to staff that he was unable to move and needed more help. Healthcare staff were called and gave assistance.

76. Prison healthcare managers met PCT health professionals on 12 August to review the man's overall care management. The Head of Healthcare recorded in his medical record:

> "The man seen, sat in wheelchair. Awake and orientated. Low in mood, though no signs or symptoms of depression. Became tearful only when discussing family. He stated that he is able to transfer himself from bed to chair and chair to toilet'.
>
> "Plan:
>
> 1. To be seen daily by healthcare staff. Medication currently not in possession

2. Expedite occupational therapy assessment
3. Liaise with prison staff re: plan of care.

"Discussed:

1. Occupational therapy assessment to take place 13.08.08 or 14.08.08
2. Healthcare will see him daily to give medication
3. Healthcare will respond to healthcare needs as required
4. Personal care needs to be provided by care agency – HMP Wymott to arrange and fund
5. Healthcare to advise HMP Wymott re: outcome of occupational therapy assessment
6. Healthcare to re-arrange missed appointments with doctor."

77. Some of the man's difficulties seemed to stem from his inability to take care of himself. Healthcare management discussed his care with the Governor. The Governor decided to contact a care agency to employ carers to provide additional support for him. The intention was they would assist him with his day-to-day care needs (described by the care profession as 'daily activities of living').

78. The man was also provided with a 'litter picker' and 'back support' (equipment aids to help him dress himself and attend to his personal hygiene) and an urgent referral was made to the local PCT's community occupational therapist for assessment.

79. In August 2008, the agency employed three carers to work in the prison to support the man. They were tasked with providing care and support every day within the elderly and disabled community's I wing.

80. The carers found the man needed a lot of assistance including help to get ready for bed and with his personal hygiene, such as taking a shower or going to the toilet. (The carers' approach was one of common sense and kindness.)

81. On 14 August, the man was seen by the community occupational therapist from the PCT for "assessment of his physical capabilities within his environment". She found he was able to move from his chair to bed and move about independently within his room and the corridor outside. She noted that his bed was a bit high and that he had problems sitting up.

82. When the man fell on the floor staff were not able to pick him up safely, so the therapist suggested that a mattress should be placed on the floor by the side of the bed. If he fell out of bed onto the floor he would be cushioned and would not hurt himself. She advised the use of specialist equipment such as an 'easyreach' (an aid to assist dressing, such as removing socks).

83. The therapist saw that the man had a sore on his head following a previous fall from his bed. She also observed that there was limited space in his room and that his wheelchair did not have a pressure cushion.

84. She recommended that a pressure cushion or a better chair be provided. She noted that the width and height of the wheelchair were satisfactory. He also had two sticks which he used to help him get about. One stick had a curved handle, the other a moulded hand grip but the sticks were of different lengths. She made a number of recommendations, which included a referral to physiotherapy to see if he would benefit from exercise and a programme to build up his standing tolerance.

85. He was a large man and found difficulty in using a standard size toilet. The therapist recommended rails around the toilet. She identified that one of the main problems was moving and handling, and the risks this presented to both him and staff.

86. She suggested various items of equipment such as sliding sheets and slings so that the hoist could be used more effectively and safely. She also talked to staff about how best to help him bathe and recommended a seat in the shower.

87. The therapist told the investigator that, in her opinion, the quality of care the man received "was excellent" and that he had "very positive relationships with his carers and prison officers". She felt that the "carers were very caring and knew how to look after him". She felt the best plan for him was to "help him to help himself to get to the point where he would be able to walk out of prison himself in August".

88. In conclusion, she assessed his main problems to be:

> "Reduced mobility, the risks presented by moving and handling, compromised tissue viability (likelihood of damage to skin and underlying flesh) and the risk of pressure sores". She submitted a full assessment report for the healthcare team.

89. The man was particularly vulnerable to these health problems because his health was poor due to heart disease and diabetes. The therapist also told the investigator that he was very cooperative and did not complain during her assessment.

90. The prison possessed a hoist which was used to help staff move and handle him. It was serviced and additional items of lifting equipment were purchased so that it was fit for purpose. Healthcare staff were trained to use it and a care plan specifically for him was developed.

91. Wymott's health and safety manager compiled a risk assessment of the potentially hazardous activity of lifting, moving and handling the man

(due to his heavy weight and poor cooperation). The assessment aimed to identify actual and potential hazards, assess the risks of moving and handling him using the hoist, and develop a management plan to reduce these risks. A copy of the risk assessment and safe system of work was placed in the care plan. The carers confirmed to the investigator that they were familiar with the risk assessment and its safety systems.

92. The man was often uncooperative with his carers who told the investigator that he "could be grumpy, especially on a morning". In collaboration with the healthcare team, they agreed a care plan with him. The plan was to provide care in a safe environment but also to try to maintain his independence. It specified a number of interventions to address his problems with safety, communication, breathing, eating healthily, washing and using the toilet independently.

93. The man had a main carer. He told the investigator that the man could not do much for himself at first. He said the carers had to "wheel him into the shower, and wash him down". He said "they got to the point where he would wash himself with minimum assistance".

94. The carers identified the man's main problems as poor mobility and limited ability and motivation to attend to his personal hygiene. They tried to motivate him to help himself as much as possible. The main carer said "when it came to washing and showering we would wash parts of him, his back and bottom of his legs, and then tried to get him to do the rest". This strategy did seem to work because his ability to care for himself improved.

95. The main carer described how the man and the carers soon established a regular daily routine. They helped him to get out of bed and take a shower then took him back to his room for a cup of tea and breakfast. After breakfast they would encourage him to plan his day, which might include going to the unit to participate in some work or associate with the other men. Often though, he just preferred his own company, watching television in his room.

96. The carers had a positive relationship with him. The main carer described how, over several months caring for him, they developed a good rapport and enjoyed long conversations together. He told the investigator that the prison and healthcare staff "were kind to the man and couldn't have done any more for him".

97. The man had significant needs which required the carers to provide care of a very personal nature. One problem was incontinence. He was frequently incontinent of urine during the night which distressed him. He started to use a continence pad when he retired to bed at night, which made him more comfortable and able to enjoy a night's sleep.

98. On 19 August, the man fell and was unable to get up again without assistance. He had developed a large pressure sore (a lesion or wound caused by multi factors such as friction against bedclothes usually found in people with compromised health) on his heel. This was treated by community specialist nurses trained to care for wounds.

99. He was again found on the floor of his room on 22 September. Healthcare staff attended and helped him get back into his chair by using the hoist. Later that evening he was found on the floor and again staff helped him back into his chair.

100. The man fell again on 24 September and banged his head which bled profusely. Healthcare staff took his clinical observations and reassured him. They helped him back to his chair and an ambulance was called.

101. He was taken to the Accident and Emergency Department at hospital and admitted to a ward for further care. Whilst in hospital he refused to attend his appointment for an endoscopy. His behaviour in hospital was challenging. Prison bedwatch staff wrote in his F2052A (record of events) on 5 October that "his behaviour whilst in hospital has been poor, showing nurses and prison staff little respect or cooperation". These were areas of concern to his personal officer and made her feel that he was not making progress. He was discharged from hospital and returned to Wymott on 14 October.

Return to HMP Wymott

102. When the man returned to Wymott he was interviewed by his personal officer. She noted that his mobility was still poor, he was not taking his medication properly and, worryingly, large amounts of excess medication were found during a cell search. He also continued to put on weight.

103. He fell on the floor again on 15 October. Healthcare staff were called and provided assistance and medical assessment. There were no causes for serious concern.

104. Between 15 and 17 October, staff observed that his "already generally poor coping skills had deteriorated" and the man was referred back to HMP Preston's inpatient facility. He transferred to Preston on 17 October for assessment of his reduced mobility.

105. The man was admitted to the medical assessment unit at hospital on 31 October due to an overall deterioration in health. Following this episode in hospital, he returned to Wymott on 21 November. He seemed to settle back into the elderly and disabled community and his carers continued to provide care for him in accordance with his care plan and care regime.

106. He was seen again by the occupational therapist on 25 November for follow-up assessment. She found hat he had deteriorated and was no longer able to stand independently. She saw that he had cot sides fitted to his bed, which was now a standard hospital bed. The carers had to help him get on and off the bed and used the hoist to do this. They used slide sheets to move him from one position to another, as she had recommended following her first assessment.

107. The therapist saw that the carers were encouraging the man to help himself but with limited success. The shower had been fitted with a mobile shower chair which they used to transfer him into the shower. They would collect him from his room in the morning, wheel him in the shower chair to the shower room and thence under the shower. The longer term plan was to get him to the point where he could walk into the shower with minimal assistance and use the drop-down seat while he took his shower.

108. The therapist also observed that the man only had a limited range of movement in his limbs and that the carers had to put on most of his clothes. He would sit in his chair and let the carers dress him as he did not seem able to mobilise independently any longer.

109. His willingness to take his medication every day was inconsistent, which caused concern. He would sometimes take his medication, but at other times either forgot or refused it. On 27 November, his care plan was reviewed by his carers and healthcare staff, in collaboration with pharmacy colleagues. A ‘dosette box’ (system which aids the proper administration and ingestion of medicines) was introduced with the aim of encouraging him to take his medication safely.

110. The man’s care plan encouraged him to use a urine bottle during the night and to monitor his risk of developing pressure sores. The care team agreed that he should be reviewed every day by healthcare staff.

111. On 2 December he was reviewed by Nurse A, who noted:

> “Reviewed today: looks well; maintaining a safe environment; transfers and mobilises short distances with two carers support; eating well; speech good – not slurred; used large pad last night but remained continent; he advised staff at 5am that he wanted to open his bowels but no-one able to assist him so he is asking for bedpans; to review medication re; use of dosette box system; he is going over to I wing daily (from his cell on I wing annexe) which is helping with his motivation.”

112. Healthcare staff reviewed his pressure sore risk assessment on 3 December and recorded that he remained at risk of developing sores. The carers continued to follow the care plan to minimise the risk of sores developing.

113. On 6 December, healthcare staff were called to I wing annexe to see the man. He had climbed out of bed and was on the floor. He told healthcare staff that he had got out of bed to use the commode but, because the brakes were not locked, he had slipped to the floor. He complained of soreness to his elbow and side. The nurses checked for injuries but he had full movement of his elbows and arms and no bruising could be seen.

114. Healthcare staff saw him the following day in his room to find out how he was after the previous night's accident. They found him up, dressed and sitting in his wheelchair. He did not complain of any injuries from the previous night. The nurses took the opportunity to renew a dressing to his knee.

115. The man seemed in better spirits and more motivated in early December. The carers were managing to move him by using transfer sheets and no longer had to use the hoist. The nurses continued to advise him to use his bed pan and urine bottle during the night so that he need not get out of bed.

116. Nurses took swabs from his nose and perineum *(*between the pubic area and coccyx) to test for MRSA status (Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for infections which are difficult to treat). The test result came back positive for MRSA.

117. Healthcare staff reviewed the man again on 9 December after he complained that his rib cage and abdomen were bruised. They saw some superficial bruising and again advised him not to climb out of bed during the night but to use his urine bottle and bed pan instead.

118. The man received an IEP (incentives and earned privileges scheme) warning about inappropriate behaviour and comments towards one of the female carers on 10 December.

119. A few days later, on 15 December, the carers cleaned the man's room and found medication which he should have taken. They also found uneaten food, which was removed. Staff recorded in the wing observation book that he complained he was unhappy about the food he had purchased being removed and he intended to inform his solicitor.

120. The man's main carer continued to assist him with personal hygiene and observed there were:

> "no signs of pressure area development, but oedema evident in both lower legs; noted urine very concentrated and pungent; advised Healthcare and requested MSU (mid stream urine sample) for C & S (culture and specimen pathology testing). Advice provided to consume a diabetic appropriate diet –

> ignored by the man. Fluid balance completed. Patient interactive – appears in good mood. Note periods of confusion and pain when passing urine."

121. The man was seen by the nurses on 16 December. They reviewed the pressure wound to his knee and noted that the wound was dry with no sign of infection or discharge. He told staff on 21 December that he had not slept all night as he had chest pains. Staff made clinical observations and assessments and continued to monitor his health.

122. The next day, staff decided to keep the key to his locker, which was where he kept his food, in his file so that his consumption of sugary drinks and snacks could be better controlled. He was not happy with this decision, although he said he understood the reason for it.

123. The same day, nurses noted that recent swabs taken from the man's knee wound and perineum were confirmed as MRSA positive. They formulated an appropriate care plan and informed the doctor.

124. Later that day, healthcare staff were asked to see him again. They found him sitting on the floor. He complained he had "loose stools" and had needed help to go to the toilet. As his carers had left for the day he had tried to go to the toilet himself but had fallen. He explained that while he was walking back from the toilet using his Zimmer frame he had slipped on the floor. The nurses examined him but could not find any injuries or cause for serious concern.

125. Healthcare staff recorded their examination in his medical record. He was able to:

> "Move his legs and there was no pain, no external rotation, no limb shortening, and able to move hands and arms. Adamant he couldn't get up off the floor."

126. The staff helped him back to bed and put the cot side in place on his bed. They left him with a drink and clean urine bottle for the night, making sure he could reach his call bell and remote control for the television. He said he was comfortable as the staff left his room.

127. Three days later, on Christmas Day, healthcare staff saw the man following a code blue radio alert. He was having difficulty breathing and complained of chest pain. The nurses carried out the appropriate tests, including an ECG, which showed as 'normal', but they found his oxygen levels to be low, so oxygen was administered.

128. He was given his GTN medication (glyceryl trinitrate is used to treat angina and heart failure), which eased his chest pain after five minutes. However, the pain returned so more GTB was administered. The nurses recorded another ECG reading which was transmitted to 'Heartview' (a telelink ECG diagnostic company) for diagnosis.

Heartview responded that the reading was 'abnormal' so an emergency ambulance was called. The nurses continued to administer oxygen until the ambulance arrived. He was subsequently taken to the Accident and Emergency Department at hospital.

129. The next day, 26 December, the man was discharged from hospital and returned to Wymott at 5.30pm. Nursing staff observed that he seemed less alert than prior to his admission to hospital but knew where he was and had no difficulty talking to them. A review was planned for the next morning. The carers then helped him settle into bed.

130. At approximately 8.40am the next day, Officer A, who was accompanied by carer, unlocked the man's room. They went inside and found that he did not respond to them, was cold to the touch and appeared to have died. The officer immediately radioed the control room with an urgent message broadcast.

131. A Principal Officer (PO) was in charge of the prison. He was in the central detail office with another PO and a SO when a radio call came through at approximately 8.45am which asked him to contact the control room.

132. At the same time, an OSG came into the central detail office and advised there had been an 'urgent message broadcast' (emergency request call). PO A instructed, by radio, for an ambulance to be called immediately and for "Oscar 2 (SO B) and healthcare staff to attend the scene immediately".

133. When PO A arrived on I wing annexe he was met by Officer A and the carer who briefed him and took him to the man's room.

134. Nurse B was called on her radio (Hotel 1) at approximately 8.45am to go to I wing annexe. The message relayed was that the man had "passed away". Although the call was not a blue or red emergency call, Nurses B and C went immediately to the room (I-15/01). They were closely followed by two other nurses who brought the emergency equipment.

135. The man showed no signs of life when the nurses examined him in his bed. Nurse B wrote in her statement:

> "On arrival it was apparent that the man has passed away for some time. He was very cold to the touch and lividity (where blood has visibly settled to parts of the body) was present, no cardiac output was detected. The ambulance crew had already been called. All four nurses present agreed that any resuscitation attempt would be futile, therefore CPR (cardio pulmonary resuscitation) not started. Fast response paramedic

arrived and confirmed death. No resuscitation attempt was made by paramedic."

136. Nurse C wrote in her statement:

> "On arrival we found the man lying on his bed. He was very cold to touch and lividity was evident. There was no cardiac output detected and we felt from the presentation that he had been dead some time. It was agreed by all four nurses on duty that resuscitation would be futile so no CPR attempt was made. The paramedics had already been called. We returned to the healthcare department and telephoned the prison doctor B (duty doctor). When the fast response paramedic arrived he confirmed death and we heard that he stood down the ambulance which was en route to the prison."

137. Prison doctor B arrived soon afterwards at approximately 9.20am and certified the man's death. Police also attended and requested that he examine the mouth as there was a "whitish substance" on his lips. The doctor told the police following his examination that this was dried foam.

138. The Duty Governor contacted the man's son by telephone at 9.42am and informed him that his father had died. The son said they would make the funeral arrangements. Another governor acted as family liaison officer to support the family and kept them informed of all the follow-up arrangements.

ISSUES

Clinical care

139. A clinical reviewer conducted a clinical review of the man's clinical care and concluded that he received "an appropriate level of healthcare, and had the opportunity to see a health professional on a regular basis".

140. She found that:

> "The man suffered from a number of long term health conditions, such as diabetes, cardiac problems, neuropathy, and depressive illness. He had suffered a myocardial infarction (heart attack) on three separate occasions.
>
> "Regrettably, he did not comply very well with his medication regime and the advice he was given to improve his health.
>
> "He received healthcare in Wymott and Preston and his health was assessed on arrival at each establishment. He had follow-up appointments with health professionals regarding each area of his health. He had a number of physical health problems, which were all treated by the appropriate specialist."

141. She adds:

> "The man had access to emergency care from professionals throughout the 24 hour period and also had access to a paramedic service in the same way as any other resident of Central Lancashire. He was also treated in hospital."
>
> "He received considerable medical care and treatment in hospital and his clinical record shows that all scheduled appointments went ahead. Healthcare staff back at Wymott continued to liaise with the hospital and monitored his progress. It seems he had mixed reactions to the care he received and this could change on a daily basis. There are no noted complaints from him.
>
> "He had a history of depression but he managed to cope with this and the prison healthcare team and he did not think it necessary to make a referral to the mental health team.
>
> "He was treated at two hospitals. Staff from healthcare maintained effective communication with staff at these hospitals to monitor his progress and make preparations for his return.

142. The clinical reviewer makes eight recommendations with the objective of improving healthcare practice and standards at Wymott. I have written to the PCT outlining these recommendations.

143. The clinical reviewer also identifies a number of areas of good practice which include:

> "The introduction of social carers at Wymott was an innovative and effective means to provide support to the man. The social carers were employed by the Governor and feedback from the man and both prison and healthcare staff illustrates how successful this initiative has been and is an example of collaborative working to provide care for this vulnerable group of prisoners.

144. She reports that the level of service provision the man experienced at Wymott:

> " … arguably exceeded the provision offered in the general community as the man was able to access health professionals as he needed to within minutes".

Concerns expressed by the man's son and Wymott's responses

145. A meeting on 13 May 2010 was attended by the man's son, my investigator and my family liaison officer. The son expressed a number of concerns, specifically:

- He was upset that some of his father's property was mislaid and he was also unhappy that his father's cell was cleaned and emptied before he had a chance to view it.

  Wymott's written response to this matter was as follows:

  The Governor who acted as Family Liaison Officer confirmed that a yellow metal watch was sent to the man's son by recorded delivery on 31 January 2009. He offered to deliver the watch in person or for the son to collect it from the prison as he had with the rest of the property. The son said he was content for the watch to be posted out to him. A cheque in settlement of the man's PIN phone credit account was also included.

  The man's two sons visited Wymott on 5 January 2009 and met with both the prison Family Liaison Officer and the currently Acting Deputy Governor. The Acting Deputy Governor was duty governor on the day that the man died and wanted to meet the family. The cell was cleaned and emptied out of respect for the family because he had been in poor health and it was felt that it would have been distressing for the family to visit the cell without it having been cleaned a number of days after his death.

- The man's son did not think that his father made deliberate attempts to throw himself to the floor whilst in prison; he thought that he probably fell because of his poor mobility.

Wymott responded:

The Acting Deputy Governor made enquiries with Wymott's Head of Healthcare about the man's physical condition. The man had told staff his falls were due to a number of reasons, including dizziness, effects of medication and the fact that he had chosen to wear socks and no shoes.

- The man's son felt that the staff at Wymott used his father as a 'guinea pig' or 'test case' in terms of developing their care programme for elderly and disabled prisoners.

  Wymott responded:

  The man had a care plan which was considered normal practice for someone with complex needs.

- The man's son did not feel that the prison supported him very well after his father died and expressed concerns that staff did not return his calls.

  Wymott responded:

  The Acting Deputy Governor was surprised and disappointed that he did not feel supported by Wymott after his father's death. She said she spoke to him on a number of occasions. The meeting with the two sons on 5 January was very informal and staff at Wymott made every effort to ensure that the family's wishes were respected throughout.

- The man's son was confused by the fact that his father was discharged from hospital on the day before he died but wondered if he was really too ill to go back to prison, because he deteriorated and died within hours of returning to Wymott.

  Wymott responded:

  The man was seen by a consultant at the hospital prior to his discharge back to Wymott. The hospital did not diagnose any ongoing health problems that required continuing in-patient care though they requested that a special mattress should be ordered and plans be put in place to provide him with social care support. When Wymott confirmed these arrangements were in place the consultant discharged him from hospital.

- The man's son thought, based on what the main carer told my investigator, that there were signs on the night he died that his father's health was deteriorating. Rather than being locked in his cell for the night, he thought that staff should have organised for his father to be taken to hospital that evening so that he would not be

left alone in his cell overnight. He thought that staff should have been more worried when his father's condition appeared to deteriorate, given that he had only just returned from the hospital.

Wymott responded as follows:

The nurse on night duty works to a protocol where if she had had any concerns that the man's health was deteriorating then she would have made an immediate assessment and, if indicated, made arrangements for his return to hospital.

- The man's son believed that his father had suffered a stroke at some stage because his speech was slurred. He was concerned that healthcare staff did not seem to notice this.

  Wymott responded:

  The clinical record shows that, following one of the man's falls, a CT scan was carried out but no evidence of a bleed was found.

- The man's son asked the prison's family liaison officer for recordings of his father's final telephone conversations but, despite repeated requests and assurances, he told my investigator that they had not been supplied.

  Wymott responded:

  The man's son requested that the telephone calls of his father's final conversations were released to him. The Family Liaison Officer said he would make some enquiries with the prison's security department whether that would be possible. However, he was later told that due to data protection measures the recordings of the telephone conversations could not be disclosed.

- The man's son was concerned about the reference in the investigation to his father having smoked because he said that his father did not actually smoke.

  Wymott responded as follows:

  The Head of Healthcare identified an assessment form dated October 2008 in which the man provided medical information to healthcare staff. That assessment indicated there was no evidence that he was a smoker.
  .

CONCLUSIONS

146. The man suffered from extremely poor health. He had a number of long term conditions and was clinically obese with very poor mobility. His poor physical health impacted negatively on his quality of life. Regrettably, he seemed either unable, or unwilling, to change his unhealthy behaviours and lifestyle. I believe that his poor cooperation to his care was in contrast to the considerable efforts from all staff working in the prison to help him improve his health.

147. Staff were frequently concerned about the food the man ordered from the prison shop. He would buy syrup and sweets, though both his carers and prison staff encouraged him to eat healthily. As the main carer said: "He liked his chips and pies so the carers had little success to get him to eat better".

148. The man was described as "being hard work and argumentative at times". Staff said: "He always knew best. He had put on a lot of weight, especially after going downhill and seemed to take to his chair". Although they reiterated that he was reluctant to help himself, the investigator found that his motivation significantly improved following the introduction of the carers.

149. Nevertheless the man did not cooperate properly with his care plan at any point during his time in custody. Healthcare staff told the investigator that he was mostly uncooperative when they tried to encourage him to change his unhealthy lifestyle by improving his diet or trying to do more exercise or when he needed to attend hospital appointments. They tried to discourage him from overeating, especially sugary and fatty foods, but with little success.

150. The investigator found healthcare staff consistently responded in a timely manner to all the man's requests for medical assistance. He found staff from the elderly and disabled community and the carers demonstrated a consistently caring and sympathetic approach to the man's frequent, and sometimes unreasonable, requests for assistance.

151. The investigator found that prison staff working in the elderly and disabled community care for prisoners with a variety of chronic health problems, such as diabetes. He considered that the staff would benefit from additional training as they are often the first people approached by prisoners to help with their health needs and problems. The IMB has previously identified staff training as a gap that needs to be addressed.

152. The carers adjusted quickly to the prison environment and soon got to know the man very well. They developed productive working relationships with healthcare and prison staff.

153. The carers' contribution to the man's care and management was considerable from the outset. For the first time during his time in custody there was a noticeable improvement in his motivation to take more responsibility for his health and lifestyle. This change was directly attributable to the carers' involvement. I commend the individual carers who made a difference to his life.

154. The man had a number of long term health conditions which were all treated by professionals who specialised in that particular area. He had access to a specialist diabetic nurse who saw him on a regular basis and ensured that all care was offered in accordance with NICE guidelines and PCT policy. He was also seen by a community occupational therapist who undertook two comprehensive functional assessments of his capabilities.

RECOMMENDATIONS

To the Governor

1. The Governor should consider providing prison staff working within the elderly and disabled community with training to raise awareness of how staff should respond to the health problems experienced by prisoners in that community.

   The prison's response to this recommendation was:

   Locally training for prison staff working with elderly and disabled prisoners to raise awareness of how they should respond to health problems will be scheduled between February and June 2010. Target date for completion is June 2010.

GOOD PRACTICE

1. The social carers' contribution to the man's care and management was considerable from the outset. For the first time during his time in custody there was a noticeable improvement in his motivation to take more responsibility for his health and lifestyle. This change was directly attributable to the carers' involvement. I commend the individual carers who made a difference to his life.