Prisons & Probation Ombudsman
Independent Investigations

Investigation into the death of a man, a prisoner at HMP Wymott, in December 2014

A report by the Prisons and Probation Ombudsman
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Our Vision

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

Our Values

We are:

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

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

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

The man died of heart failure in hospital, while a prisoner at HMP Wymott, in December 2014. He was 85 years old. I offer my condolences to his family and friends.

The man had a number of chronic and serious conditions, including heart failure. Healthcare staff saw him frequently, but his care was reactive and there were no structured care plans to ensure his health was reviewed regularly. In the few days before he was taken to hospital on 20 December, he had signs of worsening heart failure and respiratory distress, but no one fully assessed him at the time. I am also concerned that when he was first taken to hospital in December, restraints were used without a fully considered risk assessment, which took into account how his heath affected his risk of escape.

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 **October 2015**

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Summary

Events

1. In November 2012, the man was sentenced to five years in prison and had been at Wymott since December 2012. He had a number of medical conditions including kidney disease, chronic obstructive pulmonary disease and diabetes, for which he took medication. He had a history of transient ischaemic attacks (mini-strokes) and had a cardiac pacemaker fitted.

2. Healthcare staff saw the man frequently to treat his health conditions. In May 2014, he was diagnosed with heart failure for which he received medication. In September, a cardiologist noted he was receiving the optimum treatment for his condition and nothing more could be done.

3. The man's condition steadily deteriorated. On 17 December, a nurse noted he was pale and breathless and asked a GP to review him. The GP asked the nurse to make a routine appointment. The next day, he fell and was short of breath. A nurse was concerned about his poor respiratory rate and irregular heartbeat and a GP examined him two hours later. The GP recorded normal blood pressure and pulse rate but did not carry out any other assessments.

4. On the evening of 20 December, a nurse was concerned about the man's shortness of breath and arranged for a GP to see him the next morning. Later that night, he fell again. A nurse noted he was short of breath, his respiration rate was high and his blood oxygen level was low. The nurse called an ambulance on the advice of the on-call doctor and he was taken to hospital. He remained in hospital until he died. His family were with him at the time.

Findings

5. The clinical reviewer considered that, although healthcare staff saw the man frequently, his care was unplanned. In days before he went to hospital, he showed clear signs of deteriorating heart failure and respiratory distress, yet no one fully assessed him or arranged for earlier admission to hospital. For these reasons, the clinical reviewer considered that his care was not equivalent to that he could have expected in the community.

6. Despite the man's frail condition, he was restrained by an escort chain for his first two days in hospital. We are not satisfied that the use of restraints was justified by a fully considered risk assessment, a matter we have raised with the prison a number of times before.

Recommendations

- The Head of Healthcare should ensure that prisoners with COPD, heart failure and other chronic conditions have detailed care plans and are managed and reviewed in line with NICE guidelines.
- The Head of Healthcare should ensure that healthcare staff are trained to use the Modified Early Warning Score (MEWS) system to assess the severity of acute illness and escalate care when indicated.

- The Head of Healthcare should ensure that all clinical equipment, including that in emergency bags, is correctly maintained and checked and that consumables are replaced when necessary.
- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, that assessments fully take into account the health of a prisoner, and are based on the actual risk the prisoner presents at the time.

The Investigation Process

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

8. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.

9. The investigator obtained copies of relevant extracts from the man's prison and medical records. The investigator and clinical reviewer interviewed four members of staff at Wymott on 19 February 2015.

10. We informed HM Coroner for Preston and West Lancashire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report. Our investigation was suspended for nearly three months until the post-mortem report was received and we regret the consequent delay in issuing this report.

11. One of the Ombudsman's family liaison officers contacted the man's son to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He had no issues for the investigation, and praised the support and care both he and his father received from staff at Wymott.

12. The initial report was shared with the Prison Service. There were no factual inaccuracies and the action plan has been added to the end of the report.

13. The man's family received a copy of the draft report. They did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Wymott

14. HMP Wymott is a medium secure prison holding over 1,100 adult 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.

15. I wing accommodates older, infirm and disabled men. There are two professional carers employed on the wing. It also has a prisoner 'buddy' scheme to help with day to day living for those who need additional support.

HM Inspectorate of Prisons

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

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its most recently published report for the year to May 2014, the IMB noted the introduction of two full time carers on I wing, and the modification of some cells to accommodate prisoners with specific care needs. The IMB was concerned that meeting the needs of the aging population on I wing reduced healthcare resources for the rest of the prison.

Previous deaths at HMP Wymott

18. The man was the sixth prisoner to die of natural causes at HMP Wymott since the beginning of 2013. We have raised the issue of the unjustified use of restraints before and the need for care plans for prisoners with chronic health conditions.

Key Events

19. On 23 November 2012, the man was sentenced to five years in prison for sexual offences and went to HMP Manchester. He had a number of chronic conditions including kidney disease, chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema) and diabetes. He had had a cardiac pacemaker fitted. He also had a history of transient ischaemic attacks (TIA – commonly known as a 'mini-stroke' caused by a temporary disruption in the blood supply to the brain). He received medication for his conditions.

20. On 21 December 2012, the man transferred to HMP Wymott. A nurse noted his medical conditions and a doctor prescribed his medications. He lived on I wing, a special wing for elderly and infirm prisoners. Over the next 20 months, healthcare staff saw him frequently to treat his conditions. He attended regular diabetic clinics at the prison and hospital clinics to monitor his pacemaker and his risk of TIAs.

21. The man was taken to hospital as an emergency seven times with chest pain and breathing difficulties. On 9 May 2014, after an emergency admission to hospital, doctors diagnosed him with heart failure and prescribed medication. His heart failure continued to worsen and, on 17 September, a cardiologist considered he was receiving the optimum treatment (through medication) and nothing further could be done. He therefore discharged him from the cardiology clinic.

22. Over the next three months, the man's health gradually declined and he became frailer. Records show he had several falls from August onwards and his legs were swollen.

23. On 15 December, a nurse saw the man after a fall. She reviewed him again the next day and wanted to perform an electrocardiogram test (ECG - which checks the electrical activity of the heart) because he had an irregular pulse. As the ECG machine had run out of paper with no replacement stock, she was unable to complete the test.

24. On the morning of 17 December, a nurse noted the man was weary, pale and breathless. She asked a GP to review him but the GP declined and asked her to book a routine GP appointment one week later. The records do not show which GP this was.

25. At 10.32am on 18 December, a nurse saw the man again and noted he had fallen during the night and was short of breath. She was concerned about his breathing and irregular heartbeat. His respiratory rate was 28 per minute (a respiratory rate faster than 20 is considered abnormal and indicates the need for urgent assessment) and his pulse was 88 beats per minute (bpm). She arranged for a prison GP to see him that day. A prison GP examined him about two hours later and recorded a normal blood pressure level and pulse rate. He also noted the man had an abrasion on his back and crackles in his chest, but did not assess him further.

26. In the early evening of 20 December, a nurse was concerned that the man was short of breath. His pulse rate, oxygen saturation level, blood pressure and

temperature were all normal; however, his respiratory rate was slightly elevated. She noted he should see a GP the next morning.

27. At 10.11pm, a nurse reviewed the man after he had fallen. He was short of breath, his respiration rate was high (28 breaths per minute), his pulse was irregular (fluctuating between 138 – 78 bpm) and his blood oxygen level was falling. His blood oxygen level dropped to 79% and she tried to administer oxygen from the bottle in her emergency bag but found it was empty. She quickly obtained a replacement but there was no suitable oxygen mask to deliver a high flow of oxygen. She used a nebuliser mask instead and had difficulty administering an appropriate level of oxygen because the connecting tube kept dislodging. At 10.18pm, she called an ambulance on the advice of the on-call doctor.

28. The ambulance arrived at 10.45pm and took the man to hospital. Two escort officers accompanied him and used an escort chain to restrain him. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.) The hospital admitted him and moved him to the Coronary Care Unit. His condition continued to deteriorate and he died several days later.

Contact with the man's family

29. The prison informed the man's son when he was taken to hospital and an officer acted as the prison's family liaison officer. During the final week of his life, the officer and other prison staff supported the man's family, including meeting them at the hospital.

30. The man's family were with him when he died and the officer met his son at the hospital that day to offer condolences. His son asked the prison to arrange the funeral. The prison contributed towards the costs, in line with national policy.

Support for prisoners and staff

31. The prison posted notices to prisoners and staff informing them of the man's death. Prisoners on I wing were offered support principally from the chaplaincy and staff were offered support from the prison's care team.

Post-mortem report

32. A post-mortem examination found that the man died of cardiac failure caused by ischaemic heart disease. Chronic kidney disease and diabetes also contributed to his death. The pathologist considered that his death was due to a natural disease process.

Findings

Clinical Care

33. From the man's reception into Wymott input from healthcare staff was substantial and ongoing. There was good communication between primary and secondary care and he did not miss any scheduled appointments.

34. However, the clinical reviewer noted that the man was frail and elderly with multiple chronic conditions many of which were life limiting, yet there was a lack of cohesive care plans and no evidence that clinicians at Wymott had considered palliative care planning. In July 2014, it was noted that he had a possible lung or kidney swelling but there is no record that this was followed up. He had a number of falls, but there was no falls risk assessment or plan to minimise his risk of falls.

35. The clinical reviewer noted that in the community the man would have had a clear care plan, with structured reviews of his conditions. Wymott did not have a clear structure for regular reviews of prisoners' medical conditions. In his case, they appeared to be ad hoc and reactive and did not follow National Institute for Health and Care Excellence (NICE) guidance or allow for patient centred planning. We make the following recommendation:

    The Head of Healthcare should ensure that prisoners with COPD, heart failure and other chronic conditions have detailed care plans and are managed and reviewed in line with NICE guidelines.

Assessment of the man's deteriorating condition

36. On the morning of 17 December, a nurse asked a GP to review the man as he was pale and breathless. The GP declined and advised her to book a routine appointment. There is no record of the GP or the reasons. The next day, the nurse was concerned about his breathing and irregular heartbeat. The clinical reviewer considered that poor breathing and irregular heartbeat together with his recorded unsteadiness and swollen legs were clear signs that his heart failure had worsened. A GP saw him about two hours later and recorded that he had an abrasion on his back and crackles in his chest. The clinical reviewer noted that the crackles were another obvious sign of worsening heart failure.

37. Although the GP examined the man, it is evident that he did not read the relevant records from the referring nurse and he said that he was not aware of a deterioration in his breathing. He did not think that the man needed a full assessment and he did not have the appropriate equipment with him. The clinical reviewer concluded that his symptoms should have prompted a full assessment or admission to hospital.

38. We agree with the clinical reviewer, that there should have been an earlier urgent full review of the man's health, especially as his respiration was deteriorating and he had heart failure. The clinical reviewer noted that the Modified Early Warning Score (MEWS) is a standard tool to detect and manage signs, which if used for him, would have clearly indicated the need for earlier hospital admission or full assessment. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff are trained to use the Modified Early Warning Score (MEWS) system to assess the severity of acute illness and escalate care when indicated.

Maintenance of equipment

39. A nurse saw the man on 16 December and was concerned about his irregular heartbeat. She was unable to carry out an ECG, because the machine had run out of paper and there was no replacement stock in the prison.

40. On 20 December, the night the man went to hospital, a nurse was concerned about his shortness of breath. She found the oxygen cylinder in her bag was empty and there was no appropriate oxygen mask.

41. While neither of these incidents directly contributed to the man's death, it is important that such equipment is effectively maintained for use when needed. We make the following recommendation:

The Head of Healthcare should ensure that all clinical equipment, including that in emergency bags, is correctly maintained and checked and that consumables are replaced when necessary.

Restraints, security and escorts

42. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process.

43. The man went to hospital a number of times in the year before he died. All risk assessments considered he was a high risk to children, but a low risk to the public, hospital staff and escape. However, there was no healthcare input into how his condition at the time affected his risk of escape (which was considered low). Each time he attended hospital, officers restrained him with either single handcuffs or an escort chain.

44. When the man went to hospital on 20 December, he was again assessed as a high risk to children but a low risk to the public, hospital staff and of escape. A prison manager authorised two officers to escort and restrain him with an escort chain. There was no healthcare input to say whether and how his condition at the time affected his risk of escape. After he had been in hospital two days, at 5.15pm on 22 December, a prison manager reviewed the risk assessment and authorised the removal of restraints. Restraints were not used again.

45. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances, which must be fully considered, taken into

account and balanced against the security risks. The man was elderly and frail, suffered from breathing difficulties and had a serious heart condition. He was clearly very unwell and deteriorating. It is evident that no one considered his health condition for any of the risk assessments, as the 2007 High Court judgment. It is important that there is meaningful healthcare input into assessments, which clearly shows whether the prisoner's health at the time impacted on their risk of escape. We are not satisfied that the use of restraints was justified by a fully considered risk assessment.

46. Ultimately, it is the Governor's responsibility to ensure that the risk assessment process is managed properly. However, healthcare staff also need to have an appropriate and considered input into the risk assessment process. We have raised this issue with Wymott before who undertook to make changes. We make the following recommendation:

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

Action plan

Action Plan					
No	Recommendation	Accepted / Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that prisoners with COPD, heart failure and other chronic conditions have detailed care plans and are managed & reviewed in line with NICE guidelines.	Accepted	All prisoners with a recognised chronic heart condition will be managed in line with NICE guidelines. The Healthcare Manager will ensure that all prisoners with chronic heart conditions will be reviewed regularly by the nursing team, and have a detailed care plan which is reviewed by the Head of Healthcare.	Head of Healthcare 31 January 2016	
2	The Head of Healthcare should ensure that healthcare staff are trained to use the Modified Early Warning Score (MEWS) system to assess the severity of acute illness and escalate care when indicated	Accepted	The Modified Early Warning Score (MEWS) system will be implemented in October 2015 and used with all patients presenting with an acute illness. Staff will receive training in October 2015 around the use of MEWS which will be supported by the Resuscitation Manager within Lancashire Care NHS Foundation Trust.	Head of Healthcare 31 October 2015	
3	The Head of Healthcare should ensure that all clinical equipment, including that in emergency bags, are correctly maintained and checked and that consumables are replaced when necessary.	Accepted	All emergency bags and equipment will be checked on a daily basis by nursing staff ensuring that all equipment is maintained and consumables are replaced when necessary. A monthly audit will begin in October 2015 to make sure this occurs, and the audit results will be communicated to relevant staff by the Head of Healthcare.	Head of Healthcare 31 October 2015	
4	The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to	Accepted	A Governors Order (05/2014) was issued in September 2014 to instruct staff that the new escort risk assessment forms are used with immediate effect when completing	Governor and Head of Healthcare	

	hospital understand the legal position, that assessments fully take into account the health of a prisoner, and are based on the actual risk the prisoner presents at the time.		all escort risk assessments. The local risk assessment document at HMP Wymott will take into account the requirements contained in the standard risk assessment form within the National Security Framework The hospital escort risk assessment states: “A new risk assessment is required for every escort / appointment”. The Healthcare section within the assessment records the current condition and risks posed of a prisoner. All future risk assessments will consider and evidence the actual risk posed at the time of escort and all risk assessments carried out will be monitored via external and internal audits processes.	Completed	