PRISONS AND PROBATION
OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man, on 4 January 2015, at HMP Wymott

Our Vision

*To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision.*

This is the investigation report into the death of a man who died of hypertensive heart disease and bronchopneumonia, exacerbated by chronic obstructive pulmonary disease, on 4 January 2015, at HMP Wymott. He was 81 years old. I offer my condolences to his family and friends.

An investigator carried out the investigation. A clinical reviewer reviewed the clinical care the man received at Wymott. The prison cooperated fully with the investigation.

The man had been in prison since September 2010. He had severe lung disease, and often required treatment with antibiotics and steroids, or admission to hospital for monitoring and further treatment. On 13 December 2014, a prison GP prescribed antibiotics for a chest infection, but did not review him after that. On 1 January 2015, the man felt unwell and a nurse, who happened to be on his wing at the time, assessed him. She was unable to carry out a full examination as she did not have her medical bag with her at time, but was satisfied that he had no significant worrying symptoms at the time. On 4 January, the man collapsed in his cell and died.

The man was an elderly prisoner who remained independent and self-caring. The clinical reviewer noted that he received appropriate clinical treatment at the prison. While she identified some areas for improvement in aspects of health services at the prison, she considered that the man's overall care was equivalent to that he could have expected to receive in the community. I am satisfied that the man received an appropriate standard of care at Wymott. While I do not consider these issues would have affected the outcome for the man, the investigation identified a need to improve the management of chronic conditions and emergency response arrangements at Wymott.

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 **July 2015**

CONTENTS

Summary

The investigation process

HMP Wymott

Key Events

Issues

Recommendations

Action Plan

SUMMARY

1. On 24 September 2010, the man was sentenced to 13 years in prison. He was sent to HMP Manchester and transferred to Wymott on 2 December 2011.

2. At an initial reception health screen at Wymott, a nurse noted that the man had chronic obstructive pulmonary disease (COPD), type 2 diabetes, and high blood pressure and high cholesterol levels. The man was a smoker, was short of breath and had limited mobility due to his COPD. After a disability assessment, he moved to a wing for older prisoners with additional care needs. (In 2013, he moved to a standard residential wing.) On 20 December, a nurse referred him for help to stop smoking. He stopped smoking for some time but started again in 2013.

3. The man had a number of chest infections over the next year or so, which healthcare staff treated appropriately with steroids and antibiotics. On 14 July 2013, the man had an acute episode of COPD and a doctor arranged his admission to hospital to stabilise his condition. Nurses found he had not been taking his medication correctly for some months and, after the hospital discharged him, his medication was given daily.

4. On 13 December 2014, a doctor prescribed the man antibiotics for a chest infection and asked to see him again in a week, but this did not happen. On 1 January, officers asked a nurse, who happened to be on the wing at the time, to take a look at the man as a friend of his had said that he was not well. The nurse did not know that the doctor had recently diagnosed a chest infection, but assessed him and did not consider he had any worrying symptoms. She was unable to examine him fully as she did not have her medical bag with her at the time.

5. Just before 10.00am on 4 January 2015, a friend of the man visited him in his cell and thought he appeared unwell. He returned a little later to check on him and found the man collapsed on the floor. The prisoner alerted an officer, who checked the man and noted he was not breathing. Another officer called a medical emergency code for urgent help at 11.10am. This should have prompted the control room to call an ambulance immediately but it was 11.18am before this was done.

6. Two nurses, a senior officer and a prison doctor went to the wing and attempted to resuscitate the man. Paramedics arrived at 11.45am and took over emergency treatment. At 12.11pm, the doctor declared the man dead. 12.11pm.

7. Overall, we are satisfied that the man received a reasonable standard of care at the prison. While it does not appear that these issues would have affected the outcome for the man, the investigation identified a need for improvements in some aspects of clinical care, including the management of chronic conditions and emergency response procedures. We make three recommendations.

THE INVESTIGATION PROCESS

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

9. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. She interviewed seven members of staff and one prisoner at Wymott in February 2015.

10. NHS England commissioned a nurse to review the man's clinical care at the prison.

11. We informed HM Coroner for Preston and West Lancashire District of the investigation, who provided the post-mortem report. We have sent the coroner a copy of this investigation report.

12. One of the Ombudsman's family liaison officers contacted the man's family to explain the investigation process. They did not have any issues for the investigator to consider.

13. The draft report was issued for consultation with the Prison Service. There were no factual inaccuracies and the action plan has been added to the end of this report.

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.

HM Inspectorate of Prisons

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

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In its most recently published report for the year to May 2014, the IMB noted that waiting times for GP appointments was an issue. However, the IMB noted that the nurse practitioner triage system ensured that urgent cases were seen promptly. The IMB noted that there were two full time carers on I wing and several cells had been modified to accommodate prisoners with specific care needs.

Previous deaths at Wymott

17. The man's death was the seventh from natural causes at Wymott since January 2014 and the second to die from a heart condition. We have made previous recommendations about the use of emergency codes and the need for care plans for prisoners with chronic conditions.

KEY EVENTS

18. On 24 September 2010, the man was sentenced to 13 years in prison for sexual offences. He was sent to HMP Manchester and transferred to Wymott on 2 December 2011.

19. At an initial health screen, a nurse noted that the man had chronic obstructive pulmonary disease (COPD), type 2 diabetes, high blood pressure and cholesterol. The man was a smoker, was short of breath and had limited mobility due to his COPD. The nurse referred the man to the prison's asthma and diabetic clinics. The man used a nebuliser (a device used to administer medication in the form of a mist inhaled into the lungs), ventolin inhalers and a seretide accuhaler to manage his COPD. He also took diltiazem for high blood pressure, simvastatin for his cholesterol and frusemide for his heart condition.

20. On 3 December, the man had a disability assessment and moved from the prison's induction wing to I Wing, a specialist facility for older and disabled prisoners with enhanced care needs.

21. On 20 December, a nurse reviewed the man and noted that his COPD was severe and he was breathless. He said he would like help to stop smoking and the nurse agreed to refer him to the smoking cessation nurse. She noted that the man had completed a stop smoking course in July 2011, at Manchester, but had started smoking again.

22. National guidelines for people who have previously been unsuccessful in giving up smoking using nicotine replacement therapy indicate that there should not be a repeat prescription within six months. In line with the guidance, a nurse saw the man on 26 March 2012, for stop smoking advice and gave him nicotine replacement patches. It appears this attempt to stop smoking was successful for a while as he was listed as an ex-smoker during a further COPD review on 21 June. (He relapsed in 2013.) At this review, the nurse agreed that he appeared to be managing his own COPD well and that further reviews should be every six months.

23. Apart from treatment for a number of chest infections, for which doctors appropriately prescribed steroids and antibiotics, there was no further significant change noted in the man's physical health over the next year. On 10 June 2013, a senior nurse reviewed the man's long-term conditions. The man said he had swollen ankles towards the end of each day, but this had been the case for some years. He did not report any episodes of recent chest pain, but said the he had recently started to smoke again after giving up for 12 months. He asked to be referred back to the stop smoking clinic. On 10 July, the man attended the stop smoking clinic and a nurse gave him nicotine replacement patches.

24. On 14 July, a doctor reviewed the man in his cell as he was short of breath and had a cough producing green sputum. His oxygen saturations were low at 79% and his chest was crackly. The man had an acute episode of COPD with respiratory failure and was admitted to hospital for ten days until his COPD stabilised.

25. When a nurse went to the man's cell to collect his medication to take to hospital, she found a mixture of partially used and unopened boxes of medication, indicating that he had not been taking his medication as prescribed. After the hospital discharged him, nurses gave him his medication each day.

26. On 16 November, the man moved from I Wing to B Wing after a social care assessment on 7 November had noted that the man was independent and able to manage on his own. He was mobile for short distances and no longer needed as much monitoring by healthcare or the support available on I Wing.

27. On 21 January 2014, an offender supervisor was concerned about the man's location on B Wing and his mobility. The Head of Safer Custody arranged for someone to speak to the man to assess his needs and his suitability for returning to the supported wing. However, the man said that he was happy on B Wing and did not want to move.

28. At 9.15am on Saturday 13 December 2014, the man told an officer that he felt unwell and had been experiencing left sided chest pain for an hour. The officer radioed an emergency medical code blue and two nurses attended. They noted that the man had pain on inhaling and a mild cough. His oxygen saturations were normal at 93%. They spoke to the on-call doctor, at 9.30am, who prescribed antibiotics, ibuprofen and paracetamol. The control room did not call an ambulance as is supposed to happen when a code blue is called.

29. The next day, Sunday 14 December, a doctor and a nurse reviewed the man in his cell. The doctor diagnosed a chest infection, made worse by his COPD and the fact that he was smoking again. He advised the man to cut down on smoking and said he would review him again in seven days, after he had completed the course of antibiotics. There is no record that this review took place.

30. At around 9.00am on 1 January 2015, a nurse reviewed the man in his cell after a prisoner had told officers that the man was unwell. The nurse happened to be on the wing at the time so had been unable to review the man's medical record before she saw him, so was unaware that the doctor had diagnosed a chest infection on 14 December. The man was in bed and complained of a rattling chest. He was cool to the touch but complained of no other symptoms. The nurse did not have her medical bag with her so could not examine him fully. She asked the man to use his nebuliser and another prisoner said that he would sit with him to make sure he was okay. Later that afternoon, the nurse telephoned the wing and an officer told her that the man had made no further complaints about his feeling unwell that day.

Sunday 4 January 2015

31. At about 10.00am on Sunday 4 January, another prisoner visited the man in his cell. He thought he looked unwell at the time and came back to check him a short time later. The man's breathing was heavy so the other prisoner told him to use his nebuliser, go back to bed and he would check him again after a while. The other prisoner returned about 20 minutes later and found the man collapsed on the floor of his cell.

32. The other prisoner ran to the wing office to alert an officer. The officer found the man on the floor with his head resting on a chair. He could not get the man to respond and noticed that he was not breathing. The officer lay the man flat on the floor and tipped his head back to try to open his airway. He did not have a radio so shouted to another officer, who was on the landing outside the cell, to call a code blue. The second officer immediately radioed a code blue emergency at 11.10am, before going into the cell to assess the situation. The second officer then telephoned the control room to give them details about what was happening. He told an operational support grade working in the control room that the man was unresponsive and it looked like he had died. The operational support grade called an ambulance at 11.18am.

33. Two nurses arrived at the cell at around 11.15am, and began cardiopulmonary resuscitation by giving chest compressions. A senior officer arrived five minutes later and took over the chest compressions while the nurses prepared oxygen and other emergency equipment. They attached a defibrillator, which found no shockable heart rhythm and continued to attempt resuscitation. At 11.40am, a doctor, who had just arrived at the prison for an afternoon clinic, came to the cell. The doctor gave the man adrenaline to help restart his heart, but without success and the staff continued with chest compressions. Paramedics arrived at 11.45am and gave another dose of adrenaline. They continued to attempt to resuscitate the man but, at 12.11pm, the doctor declared the man dead.

Liaison with the man's family

34. Because of victim sensitivities, the police, at their request, informed the man's next of kin of his death. A prison manager and an officer visited his next of kin that evening and offered condolences and support. The man had a pre-paid funeral plan so a contribution to funeral costs was not needed.

Support for staff and prisoners

35. A Governor's notice informed staff and prisoners of the man's death. A senior manager debriefed prison staff and offered them the support of the prison's care team.

36. Staff offered prisoners on the man's wing appropriate support and access to the Listeners (prisoners trained by the Samaritans to provide emotional support to other prisoners). The prisoner who found the man declined any specific support. Prisoners considered at risk of self-harm or suicide were checked in case they had been affected by the man's death.

Post-mortem

37. A post-mortem examination found that the man had died from hypertensive heart disease and bronchopneumonia exacerbated by COPD.

ISSUES

Clinical Care

38. The man was diagnosed with a number of long-term health conditions before his prison sentence. A nurse identified his chronic conditions when he arrived at Wymott and referred him appropriately to asthma and diabetic clinics. The clinical reviewer was satisfied that his initial health screen effectively established the man's physical history and provided the basis for appropriate action. Overall, the clinical reviewer was satisfied that the man received an appropriate standard of care at Wymott, equivalent to that he could have expected to receive in the community. In her clinical review, she identified some areas for improvement, not all of which are included in this report, which the Head of Healthcare will need to address.

Follow –up appointments

39. On 13 December 2014, the man was diagnosed with a chest infection, after it was noted that he had pain on inhaling with a mild cough. A doctor prescribed antibiotics and asked the nurse who attended with him to arrange a review in a week, but this did not happen. The clinical reviewer explained that this was an omission in his care, and the post-mortem examination found he had early signs of a chest infection. We make the following recommendation:

    The Head of Healthcare should ensure there are appropriate procedures so that follow up appointments are not missed.

Management of chronic conditions

40. The next time a member of healthcare staff reviewed the man was on 1 January 2015, when a nurse saw him in his cell. This was an ad hoc visit and the nurse could not examine him fully as she did not have her medical bag with her. The nurse did not know that the man had recently been treated for a chest infection, but he had no significant symptoms and she did not take any further action. She did not review him in person later that day, but telephoned the wing and asked if the man has reported any further symptoms. A senior nurse, the primary care manager, considered that as the nurse had not been able to examine the man earlier that day she should have done so later.

41. However, the man's primary cause of death was hypertensive heart disease, which is a complication of high blood pressure. The man had high blood pressure and healthcare staff had advised him to lose weight and stop smoking. The clinical reviewer noted that, up until May 2014, the man's blood pressure was taken routinely and was not unusually high. After this date, there is no record of further regular monitoring. The primary care manager said that at that time, they were extremely short staffed and the management of long term conditions was reactive to any change, rather than by proactive regular monitoring. No one had identified that the man had heart disease, but he had a number of symptoms, which were also symptoms of COPD. The signs and symptoms of hypertensive heart disease depend on a number of

factors such as the presence of heart failure. In the absence of heart failure, it is usually symptomless.

42. The clinical reviewer considered that the man received mostly appropriate treatment for his long-term conditions, including blood pressure, diabetes and COPD. However, in 2014 staff shortages limited the availability chronic disease clinics to monitor and manage his conditions. There were also no nursing care plans for the man's chronic conditions, which might have helped improve the continuity of care. We have previously made a recommendation to Wymott about the need for care plans for prisoners with chronic conditions. In response to that recommendation, Wymott told us that they had started to implement a care pathway. They aimed to ensure that all prisoners over 60 had an initial health and social care assessment to identify those with social care needs, chronic or life limiting conditions. This was due to be completed by October 2014, but it does not appear that the man was assessed. We repeat that recommendation:

The Head of Healthcare should ensure that care plans are implemented for all prisoners with chronic and/or life limiting conditions.

Emergency Code Procedures

43. Prison Service Instruction (PSI) 03/2013 requires a code blue (or equivalent) emergency code to be used in a medical emergency, in circumstances such as when a prisoner has chest pain, has difficulty breathing or is unconscious. It directs that when a medical emergency code is called the control room must call an ambulance immediately and should not wait for a decision from healthcare staff or a duty manager.

44. We are concerned that when a code blue was called on 13 December 2014, no one called an ambulance. On the day that the man died, the control room did not call an ambulance until eight minutes after the code blue was broadcast, after receiving a telephone call from an officer at the scene.

45. We interviewed the operational support grade in September 2014, as part of an investigation into an earlier death at the prison in June 2014. She said that it was not her practice to call an ambulance immediately when she received an emergency medical code, unless a manager explicitly requested one. As a result, of this investigation (and another death around the same time) the prison issued a notice to staff (issue number 234/2014) in November and again in the December reminding prison staff of their responsibilities upon hearing a medical emergency code.

46. The man died on 4 January, one month after the second notice was issued. The operational support grade was also the person on duty in the control room that day. She told the investigator that she did not call an ambulance immediately because it was still her understanding that she should not do so until someone explicitly gave her an instruction to request one.

47. During the investigation, a number of staff said that ambulances were not called automatically in response to an emergency code and it was apparent that codes were being misused to get healthcare staff to attend urgently,

rather than in a life-threatening situation. An officer commented that it was common practice that when someone was unwell, staff would call a code blue to ensure that healthcare staff attended quickly. The Head of Safer Prisons at Wymott told the investigator that he was unaware of this practice and could not understand why staff did not follow the recently issued clear guidance.

48. While there is no evidence that the delay in calling the ambulance affected the outcome for the man, in other medical emergencies this could be crucial. The misuse of emergency codes for routine situations is dangerous practice. We have previously made recommendations to the Governor about the need to ensure that all prison staff are aware of and understand PSI 03/2013 and their responsibilities during medical emergencies. It is worrying that the managers responsible seemed to be unaware that established practice had not changed. It is apparent that managers need to do more than issue a notice to staff to change deep-rooted practice. We make the following recommendation.

The Governor should take robust steps to ensure that all staff are clear about their responsibilities under PSI 03/2013. In particular, all staff at Wymott must understand the need to use emergency medical codes in line with the national instruction and that control room staff call an ambulance immediately when an emergency medical code is used, without waiting for further confirmation.

RECOMMENDATIONS

1. The Head of Healthcare should ensure there are appropriate procedures so that follow up appointments are not missed.

2. The Head of Healthcare should ensure that care plans are implemented for all prisoners with chronic and/or life limiting conditions.

3. The Governor should take robust steps to ensure that all staff are clear about their responsibilities under PSI 03/2013. In particular, all staff at Wymott must understand the need to use emergency medical codes in line with the national instruction and that control room staff call an ambulance immediately when an emergency medical code is used, without waiting for further confirmation.

ACTION PLAN: The man - HMP Wymott

No	Recommendation	Accepted/ Not accepted	Response	Target date for completion and function responsible
1	The Head of Healthcare should ensure there are appropriate procedures so that follow up appointments are not missed.	Accepted	Follow up appointments can now be made on the record system at the time by the doctor, or they can ask the nurse who is accompanying them in the clinic or receptionist to book an appointment. Staff have been reminded of this process at the team governance meeting. If the prisoner fails to attend the first appointment a second appointment is offered at the next earliest available time. If the prisoner fails to attend the second appointment then no further appointments are made. The prisoner is advised that they will need to re-submit an application if they want the appointment to be re-booked.	Head of Healthcare Completed
2	The Head of Healthcare should ensure that care plans are implemented for all prisoners with chronic and/or life limiting conditions.	Accepted	Patients with chronic and/or long standing health needs will be registered with a chronic disease lead nurse who will ensure consistency and continuity of care as per care-plan. Care plans will be reviewed/updated by either the nurse or doctor.	Head of Healthcare Completed
3	The Governor should take robust steps to ensure that all staff are clear about their responsibilities under PSI 03/2013. In particular, all staff at Wymott must understand the need to use emergency medical codes in line with the national instruction and that control room staff call an ambulance immediately when an emergency medical code is used, without waiting for further confirmation.	Accepted	A notice to staff has been issued advising all staff members of the protocol for summoning medical assistance and calling an ambulance immediately when an emergency medical code is used. All communications room staff have now signed to say that they understand and will comply with the instruction.	Safer Custody Completed