

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Tom Lee a prisoner at HMP Wymott on 1 April 2017

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## 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*



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

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

Mr Tom Lee, a prisoner at HMP Wymott, died in hospital on 1 April of congestive cardiac failure and chronic kidney disease. He was 79 years old. I offer my condolences to those who knew him.

Mr Lee's long term health conditions were appropriately managed by healthcare staff at Wymott. However, the investigation found that there was a delay in following up Mr Lee's abnormal blood test results, which indicated that he was suffering from chronic kidney failure. While the delay did not affect the outcome for Mr Lee, it is important that prison GPs follow up abnormal test results promptly.

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

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

**October 2017**

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# Summary

## Events

1. Mr Tom Lee was sent to prison in January 2014, aged 76. He had a number of long-term medical conditions which were managed by appropriate care plans. He arrived at HMP Wymott in April 2015.
2. On 28 February 2017, blood test results indicated that Mr Lee had chronic kidney failure. These were not followed up until 11 March, when a prison GP requested a further set of blood tests. The results were reviewed the same day and remained abnormal. As a result, Mr Lee was sent to hospital, where doctors diagnosed a raised potassium level. Mr Lee was returned to Wymott on 17 March.
3. On 26 March, a further blood test result showed that Mr Lee's potassium level remained high and he was readmitted to hospital. Doctors diagnosed chronic kidney disease and decided he was not suitable for active treatment. Mr Lee continued to deteriorate and he died at 10.35am on 1 April.

## Findings

4. Healthcare staff managed Mr Lee's long term complex medical conditions appropriately. However, when Mr Lee's blood test results were found to be abnormal, prison GPs did not take any action for 11 days. We agree with the clinical reviewer that the delay in assessing these results may have contributed to Mr Lee's hospital admission on 11 March 2017.
5. With the above exception, we are satisfied that the standard of care provided to Mr Lee was equivalent to that which he could have expected to receive in the community.

## Recommendations

- The Head of Healthcare should ensure that prison GPs follow up abnormal blood test results promptly.

## The Investigation Process

6. The investigator issued notices to staff and prisoners at HMP Wymott informing them of the investigation and asking anyone with relevant information to contact her. No one responded
7. The investigator obtained copies of relevant extracts from Mr Lee's prison and medical records.
8. NHS England commissioned a clinical reviewer to review Mr Lee's clinical care at the prison.
9. We informed HM Coroner for Preston and West Lancashire District of the investigation who gave us the results of the cause of death. We have sent the coroner a copy of this report.
10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

# Background Information

## HMP Wymott

11. HMP Wymott is a medium secure prison holding over 1,100 adult men. Lancashire Care NHS Foundation Trust provides the healthcare services and Indigo Locum Agency, 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

12. The most recent inspection of HMP Wymott was in October 2016. Inspectors reported that Wymott remained a reasonably safe prison and staff-prisoner relationships were generally respectful, but healthcare provision was weak and in some areas potentially unsafe. They felt that the care of prisoners with chronic conditions was not good enough.

## Independent Monitoring Board

13. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to May 2016, the IMB reported that although there had been some improvement in health services since 2015, there were still serious problems with providing medication. This was exacerbated by staff shortages, although the report noted that staffing levels had recently improved.

## Previous deaths at HMP Wymott

14. Mr Lee was the ninth prisoner to die of natural causes at HMP Wymott since January 2016. There have been three deaths since. There were no similarities with the circumstances of Mr Lee's death

## Key Events

15. On 9 January 2014, Mr Tom Lee was remanded in custody for sexual offences and sent to HMP Leicester. On 14 March, he was sentenced to 14 years in prison. Mr Lee spent time in HMP Rye Hill and HMP Manchester before moving to HMP Wymott on 1 April 2015.
16. At an initial health screen at Wymott, a nurse noted that in October 2003 hospital doctors had fitted Mr Lee with a pacemaker (a small device placed in the chest or abdomen to help control abnormal heart rhythms). Mr Lee had a history of ischaemic heart disease, type 2 diabetes, chronic obstructive pulmonary disease (COPD- the name for a collection of lung diseases such as chronic bronchitis and emphysema) and chronic kidney disease with proteinuria (excess proteins in the urine). Prison GPs prescribed appropriate medication and nurses created care plans to manage his long-term health conditions. There is nothing of significance in his medical record until January 2017.
17. At 4.11am on 5 January 2017, a nurse saw Mr Lee in his cell because he had problems passing urine. She recorded his blood pressure as 150/88 (which is slightly above the normal range) and noted his pulse was regular. Mr Lee's national early warning score (NEWS- a guide used by medical services to quickly determine the degree of illness of a patient) was 1, which is low. Mr Lee provided a urine sample and, the same day, a prison GP diagnosed a urinary tract infection. He prescribed antibiotics.
18. On 27 February, a prison GP arranged a full set of blood tests. A nurse received the results on 28 February and these showed that Mr Lee's serum potassium level (known as hyperkalemia and indicates chronic kidney failure), serum urea level and creatine serum level (a raised level indicates chronic kidney failure) were all high. She contacted the out of hours GP, who advised that Mr Lee could be dehydrated and nurses should encourage him to increase his fluid intake.
19. Nurses saw Mr Lee daily in accordance with his care plans and he did not express any concerns.
20. On 11 March, a prison GP arranged another full set of blood tests. Another prison GP reviewed the results the same day and noted that Mr Lee's serum potassium level, serum urea level and creatine serum level were still high. He arranged for Mr Lee's transfer to hospital. Two officers accompanied Mr Lee and did not use restraints.
21. Hospital doctors diagnosed Mr Lee with hyperkalemia (raised potassium level) and a urinary tract infection. Doctors stopped Mr Lee's water retention medication to reduce the potassium level in his blood and amended his prescribed medication. Mr Lee was returned to Wymott on 17 March.
22. On 24 March, a prison GP arranged a routine blood test to check the potassium level in Mr Lee's blood. He reviewed the blood test results on 25 March and noted that Mr Lee's potassium level was high. He sought advice from an out of hours hospital doctor at the hospital, who advised a repeat blood test.

23. On 26 March, the results of a repeat blood test showed that Mr Lee's potassium level remained high. A prison GP arranged for Mr Lee's transfer to hospital. Two officers accompanied Mr Lee and did not use restraints.
24. Hospital doctors treated Mr Lee with intravenous fluids and arranged a further set of blood tests. Hospital doctors diagnosed hyperkalemia and chronic kidney disease and decided that Mr Lee was not suitable for active treatment. Mr Lee continued to deteriorate and he died at 10.35am on 1 April.

### **Contact with Mr Lee's family**

25. On 29 March 2017, the prison appointed a prison chaplain as the family liaison officer. She was unable to identify a next of kin for Mr Lee. Mr Lee had previously told prison staff that he had no contact with anyone in the community. The prison paid for and arranged Mr Lee's funeral which took place on 19 April.

### **Support for prisoners and staff**

26. The prison posted notices informing other prisoners of Mr Lee's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Lee's death.
27. The prison did not consider it necessary to debrief staff because Mr Lee's death was not unexpected. The prison offered support to the escort officers who were with Mr Lee when he died.

### **Post-mortem report**

28. The coroner concluded that the cause of death was congestive cardiac failure. The coroner noted that Mr Lee also suffered from chronic kidney disease.

# Findings

## Clinical care

29. Mr Lee entered prison aged 76, in poor health with a number of pre-existing long-term medical conditions. The clinical reviewer considered that healthcare staff appropriately assessed and managed Mr Lee's complex health needs. In most respects, the standard of care provided to Mr Lee was equivalent to that which he could have expected to receive in the community.
30. However, on 28 February, prison healthcare staff received Mr Lee's abnormal blood test results, which indicated that he was suffering from chronic kidney failure. Disappointingly, there was no evidence that a prison GP reviewed the results or took any action until 11 March, when a prison GP arranged a further set of blood tests.
31. The clinical reviewer considered that the delay in assessing Mr Lee's abnormal blood test results may have contributed to his admission to hospital on 11 March. While the delay did not affect the ultimate outcome for Mr Lee, it is important that GPs follow up abnormal blood test results promptly. We make the following recommendation:

**The Head of Healthcare should ensure that prison GPs follow up abnormal blood test results promptly.**

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