

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jack Denison a prisoner at HMP Wymott on 31 May 2016

**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.

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

Mr Jack Denison died of sepsis and pneumonia at hospital on 31 May 2016, while a prisoner at HMP Wymott. He was 86 years old. I offer my condolences to Mr Denison's family and friends.

Mr Denison was a frail man with several health conditions which healthcare staff managed well. I am satisfied that his care in prison was equivalent to that he could have expected to receive in the community and healthcare staff could not have prevented his death.

Although it did not affect the cause of death, I am concerned that poor communication between HMP Garth and Wymott resulted in Mr Denison missing vital hospital appointments. There was no medical input to the security risk assessment when Mr Denison was taken to hospital and managers gave insufficient consideration to the impact of his health on his level of risk. It is also a concern that Mr Denison's next of kin details were not updated when he arrived at Wymott.

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

Richard Pickering
Deputy Prisons and Probation Ombudsman

December 2016

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Summary

Events

1. On 18 February 2011, Mr Jack Denison was sentenced to 13 years in prison. He was moved from HMP Garth to HMP Wymott on 8 April 2015.
2. Mr Denison was 84 years old when he arrived at Wymott. He had several longstanding health conditions including stage four kidney disease, hypertension (high blood pressure), cataracts, chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema), and a urostomy bag (a bag that collects urine through an opening in the abdomen), fitted during surgery for bladder cancer in 2011. At his initial health screen, a nurse noted that he had no outstanding hospital appointments. In fact, he did, but the information had not been passed on by Garth.
3. Prison healthcare staff prescribed eight medications to manage Mr Denison's conditions and allocated him to a cell in the elderly and disabled unit. Over the following twelve months, Mr Denison had access to 24-hour care and healthcare staff closely monitored him.
4. From 18 May 2016, Mr Denison had severe constipation and rarely left his cell. Healthcare staff gave him senna tablets (a laxative) and healthcare support workers helped with him eating and drinking. On 24 May, a prison GP examined Mr Denison. Due to his confused state, dehydration and general deterioration, the doctor referred sent him to hospital for further assessment. He was escorted by two officers using restraints. The restraints were removed the next morning.
5. In hospital, Mr Denison was treated for dehydration and renal failure. His condition deteriorated and he died on 31 May 2016.

Findings

6. Mr Denison was a frail and elderly man when he arrived at Wymott where he was appropriately located and closely monitored. We are satisfied that Mr Denison received a standard of health care at Wymott, equivalent to that he could have expected to receive in the community. Mr Denison's death was sudden and there was nothing healthcare staff could have done to prevent it.
7. However, we are concerned that vital medical appointments were not followed up due to poor communication between healthcare departments at Garth and Wymott. We are also concerned that when Mr Denison was taken to hospital the prison did not appropriately consider Mr Denison's risk as healthcare staff did not complete the medical section of the risk assessment. Mr Denison's next of kin details were not updated during his reception at Wymott.

Recommendations

- The Governor and Head of Healthcare at HMP Garth should ensure that when prisoners are transferred all patient medical records and subsequent correspondence is promptly sent to the receiving prison to ensure continuity of care.

- The Governor and Head of Healthcare should ensure that staff complete all relevant sections of risk assessments for prisoners taken to hospital and that they understand the legal position and take full account of the prisoner's health and the impact this has on his risk.
- The Governor should ensure that next of kin details are recorded on reception, reviewed regularly and kept up to date, so that they can be informed of a prisoner's serious illness or death as soon as possible.

The Investigation Process

8. 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.
9. The investigator obtained copies of relevant extracts from Mr Denison's prison and medical records.
10. NHS England commissioned a clinical reviewer to review Denison's clinical care at the prison.
11. 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.
12. One of the Ombudsman's family liaison officers contacted Mr Denison's stepdaughter, to explain the investigation and to ask if she had any matters they wanted the investigation to consider. She raised several questions about Mr Denison's medication and missed hospital appointments. These questions have been addressed. She also asked us to consider why the next of kin details on Mr Denison's record were three years out of date, despite asking for this to be updated.
13. The investigation has assessed the main issues involved in Mr Denison's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.
14. Mr Denison's stepdaughter received a copy of the initial report. She raised a couple of issues that do not impact on the factual accuracy of this report.
15. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Wymott

16. 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

17. The most recent inspection of HMP Wymott was in July 2014. Inspectors reported that the wing for older prisoners and those with disabilities provided excellent care. The healthcare department gave good care, although medication issues undermined this. The relationship with local hospitals was good.

Independent Monitoring Board

18. 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 also improved.

Previous deaths at HMP Wymott

19. Mr Denison was the twelfth prisoner to die of natural causes at HMP Wymott since January 2014. There has been one subsequent death. We have previously made recommendations about security risk assessments.

Key Events

20. On 18 February 2011, Mr Jack Denison was sentenced to 13 years in prison for sexual offences. After spending time in HMP Leeds and HMP Garth, he moved to HMP Wymott on 8 April 2015.
21. When Mr Denison arrived at Wymott he was 84 years old. He had several chronic medical conditions, including stage four advanced kidney disease, hypertension (high blood pressure), cataracts, chronic obstructive pulmonary disease (COPD), and hypothyroidism (underactive thyroid). He also had a urostomy bag (to collect urine as his bladder had been removed as a result of bladder cancer in 2011). Mr Denison was not receiving treatment for cancer when he transferred to Wymott. In 2014 Mr Denison had suffered an epileptic fit and a stroke.
22. A nurse assessed Mr Denison on his arrival at Wymott and noted he had no outstanding hospital appointments. In fact, he did have outstanding hospital appointments relating to renal medicine for 19 June 2015, diabetes and endocrinology for 25 June and urology for 14 July. However, Mr Denison did not attend these appointments because healthcare staff at Garth had not passed this information to healthcare staff at Wymott. (At the time the hospital planned to investigate whether his cancer had spread.)
23. A prison GP prescribed eight medications to Mr Denison, including amiloride for hypertension, clopidogrel to prevent blood clots and levothyroxine for his underactive thyroid.
24. Mr Denison lived in a ground floor cell on an elderly and disabled unit with 24-hour access to carers. Over the following twelve months, healthcare staff closely monitored him.
25. On 18 May 2016, a nurse examined Mr Denison and he told her he was constipated. She noted that he was already taking senna (a laxative). She also saw that Mr Denison's urine was cloudy and took a sample to be tested. The test result indicated that the sample was contaminated and another was requested. There was no record that a second sample was taken.
26. A prisoner and friend of Mr Denison recorded in his diary that on 18 May, Mr Denison had used the last of his medication pack, which contained his prescribed tablets and pain killers. The prisoner recorded in his diary daily that he raised this issue with healthcare staff. (On 22 May he recorded that Mr Denison had received his medication.) There is no information in Mr Denison's medical record about his medication on those days and we consider that this is evidence that Mr Denison didn't receive this medication.
27. Over the next few days, Mr Denison remained in bed and had his meals brought to his cell. Two healthcare support workers monitored his food and fluid intake and general wellbeing.
28. On 21 May, a nurse visited Mr Denison in his cell. He said he felt full on a small amount of food but had since felt much better, although he felt weak when he stood up. She noted that he was speaking slowly and checked for signs of a

stroke. She referred him to the night nurse for observation and for the GP to see him in the morning.

29. On 22 May, a prison locum GP examined Mr Denison. He noted that Mr Denison was engaging, had good coherent conversation, was not in pain or distress and had a clear chest. He prescribed a laxative and planned a review if his condition did not improve, but not specify a timescale for this review.
30. On 24 May at 10.27am, a healthcare support carer asked a nurse to visit Mr Denison in his cell because he had not eaten for two days and was only drinking when prompted. The nurse took his clinical observations and discussed him with a prison GP.
31. Around midday, the prison GP physically examined Mr Denison. Although his clinical observations were normal, his general condition had deteriorated, he was confused and appeared to be dehydrated. Mr Denison told him that there was something wrong with his bowels. In light of his appearance, the GP referred Mr Denison to hospital as a non-emergency. The control room requested an ambulance and Mr Denison was taken to hospital at 3.29pm, escorted by two officers. A senior manager authorised the use of an escort chain for the journey and single cuffs in hospital.
32. Healthcare staff contacted the hospital for updates. On 25 May at 5.57am, a nurse noted Mr Denison was dehydrated and receiving intravenous fluids. Due to Mr Denison's deterioration, a senior manager authorised the removal of cuffs at 8.01am and these were not reapplied. On 27 May Mr Denison moved to the intensive care unit.
33. On 31 May, a hospital nurse told a prison nurse that Mr Denison was not responding to treatment for renal failure. He was not communicating with anyone and taking oxygen to make him more comfortable. At 11.35am, a prison GP submitted an application for early release on compassionate grounds, but Mr Denison died at 8.10pm.

Contact with Mr Denison's family

34. On 27 May, a senior manager was told that Mr Denison's condition had deteriorated and hospital staff had asked for his next of kin to be notified. His next of kin details were out of date so the local police traced his stepdaughter and went to her home to inform her of his condition. She contacted Mr Denison's stepdaughter who asked to be informed if his condition worsened.
35. On 28 May, the senior manager appointed an officer as the family liaison officer. On the same day, the officer introduced herself to Mr Denison's stepdaughter and explained her role. She met Mr Denison's stepdaughter at the hospital that afternoon. She kept in touch with Mr Denison's stepdaughter and when he died offered her condolences and ongoing support.
36. Mr Denison's funeral was held on 21 June. At the request of his family, the prison did not contribute to the costs of the funeral.

Support for prisoners and staff

37. After Mr Denison's death a senior manager debriefed the staff involved in his care, to ensure they had the opportunity to discuss any issues arising and to offer support. The staff care team also offered support.
38. The prison posted notices informing other prisoners of Mr Denison's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Denison's death.

Post-mortem report

39. The post-mortem report concluded that Mr Denison died of sepsis, caused by a urinary tract infection and bronchopneumonia arising from previous bladder cancer. Chronic stage four kidney disease was also a contributing factor to his death.

Findings

Clinical Care

40. Mr Denison arrived at Wymott with several chronic health conditions. When he began to show signs of deterioration he was appropriately transferred to hospital. We are satisfied that with the exception of some deficiencies discussed below, healthcare staff managed Mr Denison's care appropriately, and we agree with the clinical reviewer that overall, Mr Denison's care in prison was equivalent to that he could have expected to receive in the community.
41. Mr Denison did not show any symptoms of sepsis before he was taken to hospital and it cannot be known whether he had a urinary tract infection. However, the clinical reviewer concluded that if a second urine sample had been sent for analysis on 18 May, as requested by the hospital after the first sample showed contamination, it might have identified a possible urine infection and been treated.
42. Prison Service Order 3050 *Continuity of healthcare for prisoners*, highlights the importance of effective communication and suggests that prisoners with more complex healthcare needs might benefit from more detailed planning such as communication with the receiving prison healthcare team before the transfer. Although not directly relevant to the cause of Mr Denison's death, it is disappointing that healthcare staff at Garth did not inform staff at Wymott of Mr Denison's outstanding hospital appointments, particularly those to investigate whether his cancer had spread. We are concerned that the healthcare department at Garth did not respond to the clinical reviewer's request for further information on this issue. We make the following recommendation:

The Governor and Head of Healthcare at HMP Garth should ensure that all patient medical records and correspondence is promptly sent to the receiving prison to ensure continuity of care.
43. It is also a concern that due to deficiencies in the process for ordering medication, it appears Mr Denison may have been without any medication for four days and that healthcare staff did not take any action to rectify this. We note that the IMB raised the poor dispensing of medication as an issue in their annual report. In June 2016, the prison introduced a new electronic system to order medication monthly and ensure the pharmacy is well stocked, so we make no further comment on this matter.
44. Mr Denison was initially prescribed ill-fitting urostomy bags which had to be cut to size by a healthcare assistant. This caused him irritation. However, from November 2015 subsequent prescriptions were ordered pre-cut as Mr Denison had requested. We are satisfied that this removed any risk that his urostomy bags caused or contributed to the urinary tract infection that caused Mr Denison's death.
45. The clinical reviewer has made a number of recommendations not directly relevant to this investigation, which we do not repeat but which the Head of Healthcare will need to address.

Restraints, security and escorts

46. 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 and kept under review as circumstances change.
47. On 24 May, when Mr Denison was taken to hospital, an escort risk assessment concluded that he was a high risk to the public, but a low risk on all other factors, including risk of escape. Healthcare staff did not complete the medical section of the escort risk assessment. A prison manager authorised the use of an escort chain during transportation and single cuffs in hospital. It is difficult to see how he reached the conclusion that Mr Denison, a very unwell 86 year old man in a weakened state and escorted by two officers was a risk of escape or a risk of re-offending. It seems that this was decision based solely on Mr Denison's high risk to the public, without any medical input and therefore no consideration of how his deteriorating condition had affected his risk of escape, as the 2007 High Court judgment requires. In order for managers to make an informed decision, accurate and up to date medical information about the prisoner's ability to escape is essential. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff complete all relevant sections of risk assessments for prisoners taken to hospital and that they understand the legal position and take full account of the prisoner's health and the impact this has on his risk.

Family Liaison

48. Prisons are required to record the name and contact details of the prisoner's next of kin or nominated contact when they arrive at a new prison. Mr Denison's wife had died two years before he arrived at Wymott in 2015. His stepdaughter said that she asked prison staff to update this information. There is no evidence that the prison acted on this request, which resulted in the unnecessary use of local police resources. We therefore make the following recommendation:

The Governor should ensure that next of kin details are recorded on reception, reviewed regularly and kept up to date, so that they can be informed of a prisoner's serious illness or death as soon as possible.

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