

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Arthur Carroll a prisoner at HMP Wymott on 28 July 2017

**A report by the Prisons and Probation Ombudsman**

PO Box 70769  
London, SE1P 4XY

Email: [mail@ppo.gsi.gov.uk](mailto:mail@ppo.gsi.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T | 020 7633 4100  
F | 020 7633 4141

## 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*



© Crown copyright 2017

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](http://nationalarchives.gov.uk/doc/open-government-licence/version/3) or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: [psi@nationalarchives.gsi.gov.uk](mailto:psi@nationalarchives.gsi.gov.uk).

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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.

On 28 July 2017, Mr Arthur Carroll died of kidney cancer, which had spread to his brain, while a prisoner at HMP Wymott. He was 70 years old. We offer our condolences to his family and friends.

The clinical care Mr Carroll received at Wymott was of a good standard and equivalent to that which he could have expected to receive in the community. We are, though, concerned that healthcare staff did not book a follow-up appointment for Mr Carroll after his blood test results were abnormal in March 2017, and that they did not appropriately review subsequent abnormal blood tests in June.

It was inappropriate that officers restrained Mr Carroll when he went to hospital on 1 July 2017, where he remained restrained until 3 July, even though he was very unwell, wheelchair-bound and had only one leg.

We note that this is not the first time that we have made recommendations to Wymott about following up blood tests and the inappropriate use of restraints.

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

**Elizabeth Moody**  
**Acting Prisons and Probation Ombudsman**

**January 2018**

## Contents

Summary .....	1
The Investigation Process .....	4
Background Information .....	5
Key Events .....	6
Findings.....	10

# Summary

## Events

1. On 21 February 2011, Mr Arthur Carroll was sentenced to 14 years in prison for sex offences. He had been at HMP Wymott since 15 May 2013. He had a complex medical history, including a leg amputation.
2. On 27 March 2017, a prison GP saw Mr Carroll because he said he had been passing urine frequently for the last six months. The GP prescribed micabegron for incontinence and asked for blood tests. This showed that Mr Carroll had a low haemoglobin level (the protein molecule in red blood cells that carries oxygen from the lungs to the body's tissues and returns carbon dioxide from the tissues back to the lungs). The GP noted that Mr Carroll had an appointment with a GP to review the results on 24 April. There is no evidence in his medical records that Mr Carroll had an appointment to see a prison GP that day or that any appointment took place.
3. However, on 24 April, a nurse saw Mr Carroll because a healthcare support worker had said she was concerned about Mr Carroll's health. She asked for a GP review because of the blood test results of 27 March.
4. On 9 May, a prison GP saw Mr Carroll and told him he was anaemic (a lack of iron in the blood) and gave him iron tablets. He had more blood tests, which again showed a low haemoglobin level. The GP asked for more blood tests to be taken in three weeks. On 4 June, another GP asked for bodily fluid samples, including blood tests, to be taken but there is no evidence of these test results.
5. On 12 June, a staff nurse saw Mr Carroll because officers said that he looked unwell, grey and pale. She asked for blood tests, which were taken the next day. A prison GP reviewed the results, which again showed a low haemoglobin level but he did nothing further.
6. On 18 June, a staff nurse saw Mr Carroll in his cell because he was unwell. A prison GP saw Mr Carroll and asked for an ambulance because he had low blood pressure, a fast pulse rate, a high temperature, was short of breath and had recently had a low level of haemoglobin. He was taken to hospital, where he remained for five days. He had a CT scan, which showed a mass on the right side of his kidney. A kidney specialist saw him. On 23 June, Mr Carroll was returned to Wymott.
7. On 1 July, a healthcare support worker saw Mr Carroll when he got his evening meal. He started to shake heavily so a staff nurse saw him. She said his blood oxygen saturation was very low and he was cold. She noted a National Early Warning (NEW) score of 13 (which indicated a high clinical risk). She asked for an ambulance and Mr Carroll was taken to hospital.
8. A nurse completed Mr Carroll's medical information in his escort risk assessment. She noted there were no medical objections to the use of restraints but noted that his condition restricted his ability to escape unaided. A custodial manager authorised the use of an escort chain (a long chain, with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). Hospital

staff said Mr Carroll had a chest infection. They gave him intravenous antibiotics and intravenous hydration because he was dehydrated.

9. On 3 July, officers completed a new restraints risk assessment. A deputy governor authorised the removal of his restraints because he was elderly, with very poor mobility. Officers removed the restraints that afternoon.
10. On 10 July, Mr Carroll was returned to Wymott. Hospital staff wrote to the prison healthcare team to tell them that Mr Carroll had kidney cancer. They planned to remove his kidney tumour but they said that the surgery was very high risk and they had to assess him further before making a decision.
11. On 18 July, a healthcare support worker saw Mr Carroll who was unwell. He broke his stoma bag, and was confused. (A stoma is an opening on the surface of the abdomen, which has been surgically created to divert the flow of faeces into an attached stoma bag.) Two nurses saw him. He then had three small seizures. They called an ambulance and paramedics took him to hospital.
12. Hospital staff told Mr Carroll that he would need palliative care. Mr Carroll died in hospital on 28 July. A hospital doctor recorded the cause of his death as kidney cancer, which had spread to the brain (renal cancer with brain metastases).

## Findings

### Clinical care

13. The care Mr Carroll received at Wymott for his many medical conditions was of a good standard and equivalent to that which he could have expected to receive in the community. Prison GPs saw Mr Carroll a number of times before he went to hospital in June 2017, and they investigated appropriately, including arranging blood tests and facilitating Mr Carroll's treatment for anaemia.
14. We do have two concerns however, (although neither affected the outcome for Mr Carroll).
15. There is no evidence that the scheduled GP follow-up appointment took place on 24 April 2017. It is important that such appointments take place and are recorded.
16. The blood test results on 12 June, showed low haemoglobin levels, and should have been appropriately reviewed by a prison GP.

### Restraints

17. It was not appropriate for prison staff to restrain Mr Carroll with an escort chain when he went to hospital on 1 July, and to continue restraining him while he remained at hospital, escorted by officers, until 3 July.

## Recommendations

- The Head of Healthcare should ensure that all abnormal blood tests are identified, recorded on System One and appropriately reviewed by a clinician to allow effective continuity of care.

- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and 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

18. 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.
19. The investigator obtained copies of relevant extracts from Mr Carroll's prison and medical records.
20. NHS England commissioned a clinical reviewer to review Mr Carroll's clinical care at the prison.
21. We informed HM Coroner for Lancashire of the investigation who informed us of the cause of death. We have sent the coroner a copy of this report.
22. The investigator wrote to Mr Carroll's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.
23. The investigation assessed the main issues involved in Mr Carroll'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.
24. We shared the initial report with the Prison Service. There was one factual inaccuracy.

# Background Information

## HMP Wymott

25. HMP Wymott is a medium secure prison which holds over 1,100 adult men. Bridgewater Community NHS Trust and Greater Manchester Mental Health Trust provide healthcare services and Indigo Locum Agency provides GP services and out of hours care, including 24-hour nursing cover. There are no inpatient beds.

## HM Inspectorate of Prisons

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

## Independent Monitoring Board

27. 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 2017, the IMB reported that the standard of healthcare provision fell below that expected in the community. Although the IMB reported some improvements in the second half of the previous reporting period, these were not sustained and they concluded that there had been a regression in many areas. They noted that there was insufficient GP provision, leading to excessive delays for appointments. They considered that there were insufficient nursing staff, often leading to managers distributing medication or medication being delivered at night.

## Previous deaths at HMP Wymott

28. Mr Carroll was the ninth prisoner to die of natural causes at HMP Wymott since July 2016. We have previously made recommendations about the use of restraints and the need to follow up abnormal blood test results.

# Key Events

## Background

29. On 21 February 2011, Mr Arthur Carroll was sentenced to 14 years in prison for sex offences. He had a complex medical history, which included coronary artery disease; the amputation of his leg and part of his pelvis because of a rare infection; and colon cancer as a result of which he had had a colostomy and used a stoma bag. (A colostomy is an operation to divert part of the bowel through an opening – a stoma – in the stomach.) He also received care for heart disease, poor appetite, pressure sores, a urinary infection, acid reflux and chronic obstructive pulmonary disease (COPD - inflamed airways and damaged air sacs in the lungs).
30. On 15 May 2013, Mr Carroll was transferred to HMP Wymott. A nurse saw him for his initial health screen. She noted that he was not mobile because of his amputation. She created a plan so that he had access to a wheelchair. On 20 May, the nurse manager saw him for a secondary assessment and noted that he had a stoma. She completed a disability assessment for him.

## 2017

31. On 27 March 2017, a prison GP saw Mr Carroll because he said that he had been passing urine frequently for the last six months. He prescribed micabegron for incontinence and asked for blood tests to be taken. These showed that Mr Carroll had a low haemoglobin level of 10.3g/dl. (The normal range is 13-18g/dl.) He noted that Mr Carroll had an appointment with a GP for 24 April, but there is no record of any appointment or that this took place.
32. On 24 April, a nurse saw Mr Carroll because a healthcare support worker said that she was concerned about Mr Carroll's health. The nurse asked for a GP review because of the blood test results of 27 March.
33. On 9 May, Mr Carroll saw a prison GP. He told him that his appetite and bowel habits had not changed but that he felt tired. He had not lost any weight but the GP noted that he was pale. He said Mr Carroll was anaemic and gave him iron tablets. He took more blood tests, which again showed a low haemoglobin level of 9.5g/dl. He asked for more blood tests to be taken in three weeks.
34. On 10 May, a nurse saw Mr Carroll and created an older person's care plan. On 18 May, a prison GP saw Mr Carroll and noted that he was free of pain, alert, but pale. He again diagnosed anaemia and asked him to continue taking the iron tablets.
35. On 4 June, a prison GP asked for bodily fluid samples, including blood tests, to be taken. While these were taken, there is no evidence in the records of the results.
36. On 11 June, a healthcare support worker saw Mr Carroll who said he did not feel well. His temperature and blood pressure were normal but his blood oxygen saturation was low (at 80%). She told a nurse who noted that he was very pale and cold. The nurse took his vital signs, which remained the same, but he now

- had low blood pressure (82/52). He said he was very weak, had no energy and kept falling asleep. She called an ambulance because of his underlying health issues but the ambulance staff did not take him to hospital as he was stable and comfortable.
37. On 12 June, a nurse saw Mr Carroll because officers said that he looked unwell. She said that he looked grey and pale. She asked for blood tests, which were taken the next day. A prison GP reviewed the results, which again showed a low haemoglobin level (8g/dl). He took no action. Later that day, Mr Carroll told a healthcare support worker that he felt better.
  38. On 17 June, a nurse saw Mr Carroll because a healthcare support worker said that his symptoms were worse. She recorded his vital signs and said that he had a National Early Warning (NEW) score of four. A nurse saw Mr Carroll later that day. She asked for officers to monitor him and for a GP to review him the next day. Later that evening, a nurse saw him. She noted his NEW score as three. She said his temperature was high (38.5°) so she gave him paracetamol. She asked for a GP to review him urgently in the morning.
  39. On 18 June, a nurse saw Mr Carroll in his cell as he was unwell. She asked the duty GP to see him. The GP visited him and asked for an ambulance to be called because Mr Carroll had low blood pressure (82/50), a fast pulse rate (98 beats per minute), a high temperature (38.8°), was short of breath and had recently had a low haemoglobin level (8.0g/dl). Mr Carroll was taken to hospital. Two officers escorted him without restraints.
  40. Mr Carroll was in hospital for five days. Hospital staff gave him intravenous antibiotics and steroids for an infection, a blood transfusion for anaemia and took blood tests. He had a CT scan, which showed a mass on the right side of his kidney. The scan covered Mr Carroll's chest, abdomen and pelvis and did not show the spread of cancer to other parts of his body. A kidney specialist saw him.
  41. On 23 June, Mr Carroll was returned to Wymott. Officers did not restrain him in hospital or during his return to Wymott.
  42. On 1 July, a healthcare support worker saw Mr Carroll when he got his evening meal. Mr Carroll started to shake heavily so a nurse saw him. She said his blood oxygen saturation was low (81% with air, dropping to 56%) and he was cold to the touch. She noted a NEW score of 13 (which indicated a high clinical risk). She asked for an ambulance.
  43. Mr Carroll was taken to hospital. An officer and a custodial manager escorted him and restrained him with an escort chain (a long chain, with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). A nurse had completed Mr Carroll's medical information in his escort risk assessment. She noted that there were no medical objections to the use of restraints but that his medical conditions restricted his ability to escape unaided. She did not note what these conditions were.
  44. A custodial manager, authorised the use of an escort chain. She said that she would have checked the risk assessment on the day he was escorted and

because the healthcare section contained nothing which objected to restraints being used, she said that officers should use an escort chain due to Mr Carroll being in a wheelchair and travelling in an ambulance.

45. A custodial manager said that the duty governor made a final decision about whether and which type of restraints were used. She said that she made her recommendation based on very limited medical information in the risk assessment as medical information was confidential. She said that she telephoned the duty governor from the hospital the next day (where she was monitoring Mr Carroll's condition) and asked if Mr Carroll's escort chain could be removed due to his poor health. She said that the duty governor rejected this.
46. Hospital staff said that Mr Carroll had a chest infection. They gave him intravenous antibiotics and intravenous hydration because he was dehydrated.
47. On 3 July, a custodial manager reviewed Mr Carroll's risk assessment and told the deputy governor that restraints were no longer necessary. The deputy governor agreed and noted on the risk assessment that Mr Carroll was an elderly patient, with very low mobility, and restraints were not necessary while he was being monitored by officers in hospital. At 2.40pm, officers removed the restraints.
48. On 10 July, Mr Carroll was returned to Wymott. Hospital staff wrote to the prison healthcare team to let them know that Mr Carroll had kidney cancer. They planned to remove the tumour but they said the surgery was very high risk because Mr Carroll had other medical conditions, and they had to assess him further before making a decision. Officers did not restrain him during his return to Wymott.
49. On 18 July, a healthcare support worker saw Mr Carroll who was unwell. He broke his stoma bag and was confused. Two nurses saw him. A nurse noted his NEW score as eight and his blood oxygen saturation as low (91%) so she gave him oxygen. He then had three small seizures. They called an ambulance and paramedics took him to the hospital. Officers did not restrain him.
50. Hospital staff said Mr Carroll's cancer had spread to his brain and told Mr Carroll that he needed palliative care. Mr Carroll told a hospital doctor that he did not want to be resuscitated if his heart or breathing stopped and signed an order to that effect.
51. On 26 July, a custodial manager started the application process for compassionate release because a healthcare manager said that Mr Carroll was at the 'end of life' stage. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they have a terminal illness and a life expectancy of less than three months. He did not complete the application before Mr Carroll died.
52. A healthcare manager spoke to staff at a hospice to see if Mr Carroll could go there, and to a prison manager to organise this. Mr Carroll died in hospital on 28 July.

### Contact with Mr Carroll's family

53. On 18 July, Wymott appointed a chaplain as the family liaison officer. Mr Carroll's next of kin was his mother, who lived in a care home. He spoke to the care home manager, who agreed to tell his mother about his poor health. The chaplain told Mr Carroll's partner and half brother about his poor health.
54. On 19 July, the chaplain met Mr Carroll's partner at the hospital. She said she wanted him to contact her by telephone when he died. On 20 July, Mr Carroll's mother and partner visited him in hospital.
55. At 11.30am on 26 July, the chaplain asked the care home manager to tell Mr Carroll's mother that he was very ill. Mr Carroll's mother did not want to visit him in hospital.
56. At 12.15am on 29 July, the chaplain told Mr Carroll's partner that he had died. At 9.15am, he visited the care home, told Mr Carroll's mother that he had died and telephoned his half brother and broke the news to him. He offered his condolences to all of them. The prison held a memorial service for Mr Carroll on 16 August, and his funeral took place on 17 August. Wymott contributed to the cost in line with national instructions.

### Support for prisoners and staff

57. After Mr Carroll's death, a formal debrief did not take place but a custodial manager, asked the officers present when Mr Carroll died if they had any issues, and he offered them support. The prison posted notices informing other prisoners of Mr Carroll'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 Carroll's death.

### Cause of death

58. There was no post-mortem examination. A doctor at the hospital gave the cause of death as kidney cancer, which had spread to the brain (renal cancer with brain metastases).

# Findings

## Clinical care

59. We agree with the clinical reviewer that the care Mr Carroll received at Wymott was of a good standard and equivalent to that which he could have expected to receive in the community. Mr Carroll had a number of chronic underlying health issues, including coronary heart disease, historic colon cancer and limited mobility, as he had had a leg amputated. The healthcare team at Wymott had suitable care plans for these conditions, which they regularly and appropriately reviewed. Prison GPs saw Mr Carroll a number of times before he went to hospital in June 2017, and appropriate investigations, including blood tests, were taken and he appropriately started treatment for anaemia.
60. Despite this, the clinical reviewer made a number of recommendations about Mr Carroll's underlying health issues, which the Head of Healthcare will need to address.
61. While it would not have changed the outcome for Mr Carroll, we are concerned that Mr Carroll's scheduled GP appointment to review his abnormal blood test results did not take place on 24 April 2017 (although we acknowledge that a nurse saw him that day after a healthcare support worker said he was unwell). It is important that follow-up appointments are carried out as scheduled. When the blood test results on 12 June again showed low haemoglobin levels, a prison GP should have reviewed them. We make the following recommendation:

**The Head of Healthcare should ensure that all abnormal blood tests are identified, recorded on SystmOne and appropriately reviewed by a clinician to allow effective continuity of care.**

## Restraints

62. 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.
63. 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 they have 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. The judgement found that using handcuffs or other restraints on terminally ill or seriously ill prisoners was inhumane, unless justified by security considerations.
64. We are concerned that Mr Carroll was inappropriately restrained when he went to hospital on 1 July, and that the duty governor missed a further opportunity to authorise the custodial manager to remove the restraints at hospital on 2 July.

65. The prison's approach to the use of restraints was inconsistent and, at times, misdirected. Mr Carroll's risk should have been assessed using the tests required by the High Court judgement. This did not happen. The custodial manager authorised the use of an escort chain because a member of the healthcare team had not objected to the use of restraints for medical reasons even though they had, appropriately, indicated that his medical conditions impacted on his ability to escape. The confidentiality of medical information is not material to this consideration. Mr Carroll was being escorted and supervised by two prison officers. He had one leg and a number of chronic illnesses. He was a wheelchair user, and the manager was aware of this. Mr Carroll was entering the final few weeks of his life and it was not appropriate for prison staff to restrain him with an escort chain from the time he went to hospital on 1 July until 2.40pm on 3 July. 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 on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations