

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Rutter a prisoner at HMP Wymott on 22 April 2018

A report by the Prisons and Probation Ombudsman



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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 Rutter died on 22 April 2018 due to heart failure while a prisoner at HMP Wymott. He was 68 years old. I offer my condolences to Mr Rutter's family and friends.

The clinical care was of a good standard and equivalent to that which he could have expected to receive in the community. Mr Rutter had a number of long-term health conditions, including chronic obstructive pulmonary disease. Healthcare staff managed his chronic illnesses well and reviewed him frequently.

However, I am concerned that the regime on the wing where Mr Rutter lived meant that staff did not identify that Mr Rutter had died for some time. It is not the first time that we have raised this issue with Wymott and the Prison Group Director will wish to assure himself that it is properly addressed.

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

September 2018

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Summary

Events

1. On 21 April 1998, Mr Rutter was sentenced to life imprisonment for sexual offences. He was transferred to HMP Wymott on 19 November 2013.
2. Mr Rutter had a history of raised cholesterol diagnosed in 2005, chronic obstructive pulmonary disorder (COPD) diagnosed in 2007, and peripheral vascular disease (PVD) diagnosed in 2012. His conditions were managed well by the healthcare staff at Wymott.
3. On 22 April 2018 at approximately 11:30am, staff found Mr Rutter unresponsive in his cell. Officers called an emergency, but it was clear that Mr Rutter had been dead for some time and staff did not attempt resuscitation. A paramedic pronounced Mr Rutter dead at 11:43am.

Findings

Clinical care

4. The care Mr Rutter received at HMP Wymott was equivalent to that which he could have expected to receive in the community. Management of his chronic medical conditions was of a good standard and in accordance with national guidelines. Staff made appropriate attempts to offer Mr Rutter annual follow up assessments for his chronic health conditions and arranged further appointments when he failed to attend.

Wymott Regime

5. The investigation found that it is not standard practice at Wymott for staff to carry out individual welfare checks on prisoners during roll checks or at unlock. Although such a check may not have resulted in a different outcome for Mr Rutter, it may do for prisoners in the future.

Recommendation

The Governor should ensure that, at key points of the day, staff satisfy themselves of the safety and welfare of all prisoners and that there are no immediate issues that need attention.

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 Rutter's prison and medical records.
8. The investigator interviewed five members of staff and prisoners by telephone on 4 July, 24 July, and 23 August 2018.
9. NHS England commissioned a clinical reviewer to review Mr Rutter's clinical care at the prison.
10. We informed HM Coroner for Lancashire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
11. The investigator contacted Mr Rutter's next of kin 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.
12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Wymott

13. 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

14. The most recent inspection of 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

15. 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

16. Mr Rutter's is the twenty-second death from natural causes at Wymott in the last four years. We have made recommendations about staff checking on the welfare of prisoners at unlock on two previous occasions, although this is not surprising given the type and size of the prison population at Wymott.

B Wing

17. Mr Rutter lived on B wing. The cells there do not have bathrooms, and prisoners are given keys to their cells so they can access the shared facilities that are on each landing. Each landing has a landing bell that prisoners can use to call staff for assistance, cells do not have individual cell bells.
18. A roll check is carried out between 5am and 5.30am. This is a head count only and if prisoners appear to be sleeping they are not disturbed. The landing gates are unlocked at about 8.45am at weekends (unlock is earlier on weekdays as prisoners may have work, education or healthcare appointments to attend).
19. At weekends, landing gates are locked again after the evening meal at about 5.15pm. At around 9.30pm night staff carry out a roll check. Again, this is a head count only; if prisoners appear to be sleeping they are not disturbed.

Key Events

20. On 21 April 1998, Mr Rutter was sentenced to life imprisonment for sexual offences. He was transferred to Wymott on 19 November 2013.
21. Mr Rutter had a history of raised cholesterol diagnosed in 2005, chronic obstructive pulmonary disorder (COPD) diagnosed in 2007, and peripheral vascular disease (PVD) diagnosed July 2012.
22. On his arrival at Wymott, a nurse completed Mr Rutter's reception screening. He noted that Mr Rutter had COPD, osteoarthritis in his back and hips, peripheral vascular disease and smoked cigarettes. He also noted that Mr Rutter had a history of depression and referred him to the mental health team. Mr Rutter was located on B wing.
23. Mr Rutter completed a smoking cessation course and successfully stopped smoking on 28 September 2017.
24. On 14 March 2018, Mr Rutter saw a nurse and complained of heartburn. She prescribed Gaviscon (an antacid). She completed a thorough examination of Mr Rutter where he denied any chest pain, shortness of breath, nausea, vomiting, diarrhoea, sweating or palpitations. She also observed a rash on Mr Rutter's abdomen, chest, back and groin and prescribed antibiotic therapy.
25. Mr Rutter's medical records showed that his chronic health care needs were managed in accordance with national guidelines. Healthcare staff made appropriate attempts to offer Mr Rutter annual follow up assessments for his chronic health conditions. Mr Rutter did not always attend these appointments. Specifically, Mr Rutter did not attend two appointments for a spirometry tests on 30 January 2018 and 10 April 2018. Staff made reasonable attempts to encourage Mr Rutter to attend all his medical appointments and rebooked them where necessary.
26. Medical records indicate no concerns about Mr Rutter's level of mobility. He could get to and from the toilet facilities and collect his meals and medication, aided by a walking stick.

Saturday 21 - Sunday 22 April 2018

27. On 21 April 2018 at 4pm, an officer saw Mr Rutter collect his evening meal. She saw Mr Rutter again at approximately 4.45pm eating his meal in his cell when she left the landing. She said that Mr Rutter looked well and that he collected his meal unaided.
28. At approximately 9.30pm, an officer carried out a roll check. This was a head count only. He recorded that all prisoners were in their cells and he reported no concerns. He does not specifically recall seeing Mr Rutter.
29. Between 10pm and 5.30am on 22 April 2018, staff carried out four night patrols on each landing on B wing to check that everything was settled on each landing and that prisoners were in their cells. During these checks officers check the communal areas, but do not look through the observation panels or check

individual cells unless there is a specific reason to do so. No concerns were recorded.

30. At approximately 5.10am, an officer carried out the roll check on Mr Rutter's landing. The officer said that he has no recollection of any particular cell or specially seeing Mr Rutter, and does not recall anything unusual. The roll check was a head count only, looking at prisoners using the observation panel, which is in line with the regime on this particular wing.
31. At approximately 8.45am, the landings on B wing were unlocked (prisoners have keys to their own cells, so unlock their doors themselves). Shortly before 11:30am, a prisoner noticed that Mr Rutter had not come out of his cell to collect his lunch. He said that he knocked on Mr Rutter's cell door four times then opened the observation panel. He saw Mr Rutter lying in bed facing the wall. He alerted another prisoner, who also banged on Mr Rutter's cell door, but Mr Rutter did not respond.
32. The prisoner asked another prisoner nearby to press the landing bell and tell staff that he thought that Mr Rutter was dead. This prisoner pressed the bell, walked towards the attending staff and explained that fellow prisoners had knocked on Mr Rutter's door but there was no response.
33. Two officers went to Mr Rutter's cell. An officer opened the observation panel and saw Mr Rutter in his bed on his side. He opened the cell door and called out to Mr Rutter but he did not respond. He entered the cell and shook Mr Rutter's leg and shoulder and found that Mr Rutter was cold and stiff to touch. He checked for signs of breathing and found none. He radioed a code blue emergency (indicating that a prisoner is unconscious, or having breathing difficulties). The control room log recorded that the code blue was called at 11.29am. There was an external paramedic still in the prison from a previous medical emergency. The paramedic was directed to attend Mr Rutter's cell by the control room, as was a nurse from the prison's healthcare team.
34. Officers concluded that Mr Rutter had been dead for some time and decided not to attempt resuscitation. An officer updated the control room at 11:32am, advising that Mr Rutter was cold and blue.
35. A nurse arrived shortly followed by the paramedic. The paramedic confirmed that attempting resuscitation would be futile and pronounced Mr Rutter dead at 11:43am.

Contact with Mr Rutter's family

36. The prison appointed the managing chaplain as the family liaison officer. Prison records identified Mr Rutter's son and sister as the next of kin. The chaplain and the Deputy Governor went to visit Mr Rutter's son, but found that the address no longer existed. They went directly to Mr Rutter's sister home and informed her of Mr Rutter's death. The chaplain maintained contact with the Mr Rutter's family and provided support.
37. Mr Rutter's funeral was held on 31 May 2018. The chaplain conducted the funeral and a governor also attended. The prison contributed to the funeral costs in line with national policy.

Support for prisoners and staff

38. On 22 April, a Custodial Operations Manager held a hot debrief after Mr Rutter's death to ensure the staff involved in the emergency response had the opportunity to discuss any issues arising and to offer support. The staff care team also offered support.
39. The prison posted notices informing other prisoners of Mr Rutter'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 Rutter's death.

Post-mortem report

40. The coroner provided a copy of the post-mortem report which said the cause of death was 1a) cardiac tamponade (caused by the build of blood, fluid, pus, clots or gas in the space around the heart) and 1b) hemopericardium (blood in the sac around the heart) and ruptured left ventricular wall and occlusion of the circumflex artery (blockage in an artery of the heart).

Findings

Clinical care

41. The clinical reviewer is satisfied that the care Mr Rutter received at Wymott was equivalent to that which he could have expected to receive in the community. The care Mr Rutter received at Wymott for his chronic medical conditions was of a good standard and managed in accordance with national guidelines. Staff made appropriate attempts to offer Mr Rutter annual follow up assessments for his chronic health conditions, but he did not attend some of these appointments.
42. The clinical reviewer found that there was nothing of concern in Mr Rutter's healthcare records and concluded that there was no clinical indication that could have identified that Mr Rutter had an impending cardiac condition.
43. The clinical reviewer was satisfied that the emergency response was timely and that the paramedic on the scene ensured that the decision not to start CPR was appropriate in the circumstances.

Unlock procedures

44. Prison Service Instruction (PSI) 74/2011, paragraph 2.3 clarifies the responsibility of the unlocking officer:

"Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process."

The investigation found that it is not standard practice at HMP Wymott for staff to seek a response from prisoners who remain in their cells when the landing gate is unlocked. We appreciate that the regime on B wing means that roll checks do not take place at the same time as unlock, but consider that a welfare check in the spirit of the PSI would be appropriate. Although we do not know if such a check would have resulted in a different outcome in the case of Mr Rutter, it may make a difference for other prisoners in the future.

45. We note that our investigations into two deaths in 2014, one from natural causes and the other a self-inflicted death, made recommendations about the need for welfare checks. We repeat those recommendations:

The Governor should ensure that, at key points of the day, staff satisfy themselves of the safety and welfare of all prisoners and that there are no immediate issues that need attention.

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