Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Wylie a prisoner at HMP Durham on 23 February 2017

A report by the Prisons and Probation Ombudsman

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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*

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 David Wylie died on 23 February 2017 of a heart attack, which led to multi organ failure, while a prisoner at HMP Durham. He was 54 years old. We offer our condolences to Mr Wylie's family and friends.

Mr Wylie had significant heart disease, which could have brought about a sudden and unexpected cardiac death at any time. He collapsed in his cell and was taken to hospital, where he died.

I am satisfied that Mr Wylie's care was equivalent to that which he could have expected to receive in the community.

I am, however, concerned that there was a delay before an emergency code was called when he complained of chest pains, and I have made a recommendation about this.

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 **March 2018**

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Summary

Events

1. On 3 October 2016, Mr David Wylie was remanded into custody for driving offences. He was sent to HMP Durham.

2. Mr Wylie arrived into prison with an extensive medical history. He had chronic obstructive pulmonary disorder (COPD) and ischaemic heart disease (including previous heart attacks) for which he had had stents inserted into the arteries of the heart to improve the blood flow. He also had epilepsy and depression. A prison GP prescribed medication for his various conditions.

3. In addition to his complex medical history, Mr Wylie had a history of substance misuse. He admitted to taking drugs in the 24 hours before arriving at Durham. He was referred to the substance misuse team.

4. Mr Wylie also disclosed that he had outstanding hospital appointments for suspected bowel cancer. Fresh appointments were arranged by healthcare staff.

5. On 27 October, he was seen by a nurse after he complained of non-specific chest pains. His observations were satisfactory and he had no 'cardiac flags' (warning signs indicating a need for urgent treatment). He was referred to a prison GP who found nothing abnormal.

6. On 31 January, Mr Wylie reported coughing up blood. He was seen by a prison GP on 2 February. The prison GP diagnosed an exacerbation of his COPD, and prescribed antibiotics and steroids and referred him for a chest x-ray.

7. During the night of 20 February, Mr Wylie experienced chest pains. His cellmate pressed the cell bell for staff assistance and an officer responded. When she arrived at the cell, she found Mr Wylie sitting on a chair. His cellmate was comforting him. My Wylie told the officer he was having chest pains and she used her radio to summon assistance from a member of healthcare staff. Shortly after a nurse arrived at the cell, Mr Wylie collapsed clutching his chest. The nurse called an emergency code and control room staff telephoned for an emergency ambulance. Paramedics arrived at the prison shortly afterwards.

8. Mr Wylie was taken to hospital where he was placed in intensive care. He was unconscious and a ventilator assisted him to breathe. His condition deteriorated and he died on 23 February.

Findings

9. Contrary to Prison Service policy, the prison officer who responded to the cell bell did not use an emergency code to summon healthcare assistance when Mr Wylie told her he had chest pains, and instead asked a nurse to attend. As a result, an ambulance was not called immediately and the nurse arrived at the cell without any emergency equipment, such as a defibrillator or oxygen masks.

Recommendation

- The Governor and Head of Healthcare should ensure that all staff are aware of PSI 03/2013 and local guidance and understand their responsibilities during medical emergencies, including that staff use the appropriate code to communicate a medical emergency immediately.

The Investigation Process

10. The investigator, issued notices to staff and prisoners at HMP Durham informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

11. The investigator obtained copies of relevant extracts from Mr Wylie's prison and medical records.

12. NHS England commissioned a clinical reviewer to review Mr Wylie's clinical care at the prison.

13. We informed HM Coroner for Durham and Darlington of the investigation who gave us Mr Wylie's cause of death. We have sent the coroner a copy of this report.

14. The investigator wrote to Mr Wylie's next of kin to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked that she be kept updated about the ongoing investigation, but did not raise any specific questions for us to answer.

15. The investigation has assessed the main issues involved in Mr Wylie's care, including his diagnosis and treatment, his location, security arrangements for hospital escorts, and liaison with his family.

16. Mr Wylie's family received a copy of the initial report. They raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

17. 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 Durham

18. HMP Durham is a reception prison serving the courts of Tyneside, Durham, Teeside and Cumbria. It holds approximately 1,000 men. G4S provides primary healthcare. The prison's inpatient unit has six beds with 24-hour healthcare.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Durham was in October 2016. Inspectors reported that joint working between providers and the prison was improving and generally effective. Many health policies needed a review to update them. Prisoners with social care needs were identified and assessments completed. An appropriate range of services were provided, although there were no life-long conditions nurse-led clinics because of staff shortages. Prisoners were instead referred appropriately to other services.

Independent Monitoring Board

20. 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 October 2016, the IMB reported that the delivery of primary care at the prison was of a good standard. Prisoners received a health screen within 72 hours of arriving at the prison and there were screening clinics for chronic conditions, including diabetes and cardio-vascular disease. However, the Board noted concerns with the recruitment and retention of nurses.

Previous deaths at HMP Durham

21. Mr Wylie was the fourth prisoner to die of natural causes at Durham since January 2016. There have been three further deaths from natural causes since Mr Wylie's death. We have made a similar recommendation in the past about emergency response training for prison staff.

Key Events

22. On 3 October 2016, Mr David Wylie was remanded into custody for driving offences. He was sent to HMP Durham.

23. At his initial health screen, a nurse noted that Mr Wylie had a number of pre-existing medical conditions including chronic obstructive pulmonary disorder (COPD) and ischaemic heart disease (for which he had had stents inserted into the arteries of the heart to improve the blood flow). He also had epilepsy and depression.

24. A nurse noted that Mr Wylie had a history of substance misuse. He told her that he had taken drugs in the 24 hours before arriving into custody and admitted to previously using heroin and cocaine. He was referred to substance misuse services. Mr Wylie was noted as being a heavy smoker. Despite healthcare staff offering him smoking cessation advice on a number of occasions, Mr Wylie consistently refused to stop smoking.

25. A prison GP reviewed Mr Wylie the same day. He prescribed medication for Mr Wylie's various conditions, including methadone (for opioid dependence), aspirin (to reduce the risk of blood clots) and atorvastatin (to reduce cholesterol).

26. Mr Wylie told the prison GP that his community GP had referred him to hospital for tests for suspected bowel cancer shortly before being sent to prison.

27. Healthcare staff obtained Mr Wylie's medical records from his community GP. These showed a history of myocardial infarctions (heart attacks), possibly as many as twelve. The notes also confirmed that a two-week wait referral had been made for Mr Wylie for suspected bowel cancer (a patient with suspected cancer is guaranteed to be reviewed by hospital staff within two weeks) before he was sent to prison. Healthcare staff rearranged this appointment.

28. On 27 October, Mr Wylie told that he had experienced non-specific chest pain during the previous few days. He examined Mr Wylie and checked his vital observations (body temperature, blood pressure, pulse and respiratory rate used to give an indication of a patient's condition). All were noted as being within the normal range. He checked for cardiac flags (a checklist used to diagnose the possible causes of chest pain) but found nothing of concern. He arranged for a prison GP to review Mr Wylie. The following day, a prison GP reviewed Mr Wylie but found nothing of note.

29. On 3 November, Mr Wylie was due to attend hospital for the two-week wait referral. However, he failed to follow the instructions for the required procedures so the hospital had to cancel the appointment and reschedule.

30. On 14 December, Mr Wylie attended hospital for the rearranged endoscopy. This showed a hiatus hernia, minor ulcers and erosion of the stomach lining. Mr Wylie was prescribed medication reduce the amount of acid being produced in his stomach.

31. On 31 January 2017, Mr Wylie was due to attend hospital for his rearranged colonoscopy. He refused to attend because he said that he had been coughing

up blood. A nurse reviewed Mr Wylie and found nothing of concern. She made a referral to the prison GP for a further review.

32. On 2 February, the prison GP reviewed Mr Wylie. He diagnosed an exacerbation of Mr Wylie's COPD. He prescribed antibiotics and a steroid nasal spray. He also referred Mr Wylie for a chest X-ray. He planned to review Mr Wylie again in 4 weeks.

33. Healthcare staff informed the hospital that Mr Wylie had refused to attend his colonoscopy appointment. As he had refused to attend a previous appointment, hospital staff discharged him from their care.

Events of 20 February

34. At 11.35pm on 20 February, a prisoner who shared a cell with Mr Wylie, pressed the cell bell for staff assistance. An officer responded. Mr Wylie told her he had pains in his chest. She contacted a nurse by radio and asked her to attend the cell. She continued to speak to Mr Wylie while she waited for the nurse to arrive.

35. The nurse arrived at Mr Wylie's cell at 11.42pm (without any emergency equipment). She noted that he was sitting on a chair being comforted by his cellmate. As she entered the cell to speak to him, Mr Wylie fell forward onto the floor clutching his chest. She examined him and noted his breathing was very shallow and laboured. She immediately called an emergency code blue over the radio (indicating a prisoner is unconscious, not breathing or is having breathing difficulties). On receiving the code blue call, staff in the prison control room telephoned for an emergency ambulance.

36. The nurse noted Mr Wylie was becoming cyanosed (a blue discolouration of the skin indicating low oxygen levels). She attempted to check his blood pressure, but was unable to get an accurate reading. Mr Wylie then stopped breathing. The nurse assisted by a prison officer, began cardiopulmonary resuscitation (CPR).

37. A nurse arrived at 11.55pm in response to the code blue. She brought an emergency grab bag with her (the grab bag contains essential items to treat a patient with breathing difficulties such as oxygen masks and a defibrillator). The nurse attached the defibrillator to Mr Wylie's chest. On four separate occasions, the defibrillator indicated that no shock was needed.

38. Paramedics arrived at the cell at 11.59pm, took over Mr Wyllie's care and continued CPR. A second paramedic crew arrived at 12.10am to assist. Mr Wylie regained consciousness and they stabilised him. At 12.30am, they transferred Mr Wylie to the emergency ambulance. They took Mr Wylie to hospital. Two prison officers accompanied him and he was unrestrained.

39. Hospital staff reviewed Mr Wylie and diagnosed him as having had a heart attack, possibly caused by a blood clot in his lung. They stabilised Mr Wylie's condition and transferred him to the intensive care unit.

40. On 23 February, Mr Wylie's condition suddenly deteriorated and at 4.30pm, he died. At 4.40pm, a hospital doctor confirmed Mr Wylie's death.

Contact with Mr Wylie's family

41. On 21 February, the prison appointed a member of the chaplaincy team and a prison officer as the family liaison officers (FLOs). Mr Wylie's next of kin was recorded as his mother.

42. At 9.35am, the FLO contacted Mr Wylie's mother by telephone to inform her of Mr Wylie's condition. He noted that Mrs Wylie was shocked by the news, but not surprised as she was aware of the seriousness of Mr Wylie's heart condition.

43. Both FLOs met the family at the hospital at 10.30am to offer support. They stayed with the family until 11.45am. Mr Wylie's family took the opportunity to visit him as often as they could while he was in hospital.

44. At 5.20pm on 23 February, the FLO was informed that Mr Wylie had died. She and a colleague visited Mrs Wylie at her home to inform her of Mr Wylie's death. Mrs Wylie told the FLO that hospital staff had already telephoned her to break the news of Mr Wylie's death. The FLO remained in contact with Mr Wylie's family.

Support for prisoners and staff

45. After Mr Wylie's death, the prison posted notices informing staff and prisoners of his death, offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Wylie's death.

Post-mortem report

46. The post-mortem confirmed that Mr Wylie died of multi-organ failure and hypoxic brain damage brought about by a heart attack, caused by heart disease. The pathologist noted that Mr Wylie 'had significant heart disease which was of such a degree that it could have brought about a sudden and unexpected cardiac death at any time'.

47. Toxicology tests detected a number of drugs, most of which Mr Wylie had been prescribed. However, the tests indicated a very small trace of quetiapine (an antipsychotic drug prescribed for the treatment of schizophrenia) was also present.

48. This drug had not been prescribed to Mr Wylie but it was not in sufficient quantity to have had an impact on his health. The pathologist considered Mr Wylie's death was more likely than not due to his significant heart disease.

Findings

Clinical care

49. We agree with the clinical reviewer that the care Mr Wylie received at HMP Durham was of a good standard and equivalent to that which he could have expected to receive in the community. The medical records show that healthcare staff enquired about his well-being on a daily basis, while administering his daily prescription of methadone.

50. The clinical reviewer also found that on the night of 20 February, healthcare staff managed the emergency response well and kept in contact with hospital staff to keep up to date with Mr Wylie's condition following his admission to hospital.

51. Although Mr Wylie's medical records show he received a good standard of care, the clinical reviewer has made recommendations about documentation and methadone prescription, which we do not repeat in this report but which the Head of Healthcare will wish to address.

Emergency response

52. Prison Service Instruction (PSI) 03/2013 states that Governors/Directors of all prisons must have a Medical Emergency Response Code protocol in place that enables staff discovering a prisoner in need of urgent medical attention to clearly and concisely convey the nature of the medical emergency simultaneously to all interested parties and contact the communication or control room. The PSI states that it is essential that an ambulance is called in all cases where there are serious concerns about the health of a prisoner. The PSI specifies that chest pains are one of the symptoms that should trigger the calling of an emergency code.

53. When the officer responded to Mr Wylie's cell bell on the night of 20 February, he told her he was experiencing chest pains. She did not call an emergency code blue as she should have done, and instead radioed for a nurse to attend.

54. If the officer had called a code blue, an ambulance would have been called immediately and healthcare staff would have responded with appropriate equipment. Instead, there was a delay of seven minutes before a code blue was called by the nurse who attended.

55. We therefore make the following recommendation:

    The Governor and Head of Healthcare should ensure that all staff are aware of PSI 03/2013 and local guidance and understand their responsibilities during medical emergencies, including that staff use the appropriate code to communicate a medical emergency immediately.

Restraints, security and escorts

56. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should

be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility.

57. When Mr Wylie was admitted to hospital on 20 February 2017, he was escorted by two prison officers and was not restrained. He remained unrestrained in hospital until his death. We consider the decisions on restraint were appropriate.

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