

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Wiltshire a prisoner at HMP Hollesley Bay on 10 December 2018

A report by the Prisons and Probation Ombudsman

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 Paul Wiltshire died on 10 December 2018 of heart disease at HMP Hollesley Bay. He was 50 years old. I offer my condolences to Mr Wiltshire's family and friends.

I am satisfied that the standard of care Mr Wiltshire received at Hollesley Bay was equivalent to that he could have expected to receive in the community.

I am, however, concerned that there was a short delay in calling an ambulance when Mr Wiltshire collapsed on 10 December. I am also concerned that Mr Wiltshire's father was told of his son's death over the telephone and not in person as he should have been.

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

Sue McAllister CB
Prisons and Probation Ombudsman

June 2019

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Summary

Events

1. On 17 July 2015, Mr Paul Wiltshire was sentenced to ten years' imprisonment for robbery and possessing an imitation firearm. He was moved to HMP Hollesley Bay on 19 September 2018.
2. Mr Wiltshire had a heart attack in August 2017 and he also had COPD (chronic obstructive pulmonary disease - an umbrella term for a variety of respiratory conditions).
3. Mr Wiltshire reported increasing shortness of breath in November 2018 and was referred to hospital, but investigations showed nothing of concern.
4. On 10 December, Mr Wiltshire went to the healthcare unit and reported pains in his chest and left arm (he was also sweating profusely). He collapsed and the nurse called a medical emergency code. Healthcare and prison staff attended and attempted to resuscitate him. Paramedics arrived and continued resuscitation attempts, but they were unsuccessful and declared Mr Wiltshire's death at 10.33am.
5. A post-mortem examination found that Mr Wiltshire died from ischaemic heart disease and coronary artery atheroma (build-up of fatty deposits on the walls of the arteries around the heart).

Findings

6. We are satisfied that the care Mr Wiltshire received at Hollesley Bay was equivalent to that he could have expected to receive in the community.
7. An ambulance should have been called immediately when the medical emergency code was called but there was a two-minute delay in this case. There was then a delay in providing information to the ambulance service operator while control staff tried to put the operator through to a telephone in the healthcare unit, which went unanswered. Radios were eventually used to obtain the required information.
8. The prison telephoned Mr Wiltshire's next of kin, his father, to break the news of Mr Wiltshire's death, when they should have told him in person.

Recommendations

- The Governor should ensure that control room staff call an ambulance immediately when a medical emergency code is called and that information about the prisoner's condition is obtained and passed promptly to the ambulance service.
- The Governor should ensure that, wherever possible, a family liaison officer, or another representative from the prison, breaks the news of a prisoner's death to their next of kin in person.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Hollesley Bay informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
10. The investigator obtained copies of relevant extracts from Mr Wiltshire's prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr Wiltshire's clinical care at the prison.
12. We informed HM Coroner for Suffolk of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
13. The investigator contacted Mr Wiltshire's father to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not raise any issues.
14. Mr Wiltshire's father received a copy of the initial report. He did not raise any further issues, or comment on the factual accuracy of the report.
15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Hollesley Bay

16. HMP Hollesley Bay is an open prison located in Suffolk. There are nine residential units holding up to 485 adult and young adult men. Prisoners who move to Hollesley Bay are trusted to live in open conditions. Many of the prisoners are temporarily released on licence to work in the local community in preparation for their eventual release from custody.
17. Care UK provide healthcare services. Nurses are available from 7.00am-5.00pm weekdays and until 2.30pm at the weekend. GPs provide five sessions a week.

HM Inspectorate of Prisons

18. The most recent inspection of Hollesley Bay was in October to November 2018. Inspectors found that Hollesley Bay was a successful and effective open prison. Care UK's partnership working with the prison was deemed effective and appropriate governance meetings were in place. Staffing levels were good and interactions with prisoners were caring and professional.

Independent Monitoring Board

19. 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 2017 (published August 2018), the IMB reported that waiting times for access to healthcare services were good and better than services in the community. The Board was satisfied that the healthcare needs of prisoners were being met.

Previous deaths at HMP Hollesley Bay

20. Mr Wiltshire's death is the first death at Hollesley Bay since 2011.

Key Events

21. On 10 October 2014, Mr Paul Wiltshire was remanded in custody, charged with robbery and possessing an imitation firearm, and sent to HMP Wandsworth. On 17 July 2015, he was sentenced to ten years' imprisonment.
22. On 22 June 2016, Mr Wiltshire was moved to HMP Wayland. On 3 August 2017, he had a heart attack. He was admitted to hospital, but a procedure to unblock an artery and insert a stent failed. He self-discharged and staff at Wayland monitored him daily, ensured he rested and signed him off work for six weeks until he was considered to have stabilised. Mr Wiltshire was under the care of a cardiologist at a hospital until February 2018, when he was discharged from the service.
23. On 19 September 2018, Mr Wiltshire was moved to HMP Hollesley Bay. A nurse conducted Mr Wiltshire's reception screen. She recorded that he had had a heart attack in 2017 and had maintained a low-fat diet since. He also had COPD and sciatica. He was prescribed his medication in possession including: atorvastatin (a preventative against cardiovascular disease), aspirin, omeprazole (for gastric issues) and perindopril erbumine (for high blood pressure).
24. On 20 September, a nurse conducted Mr Wiltshire's secondary health screen. She offered screening for blood borne viruses and recorded that Mr Wiltshire's BMI was 30.6, putting him in the obese category.
25. On 21 September, Mr Wiltshire completed a PAR-Q (Physical Activity Readiness Questionnaire – used to assess a prisoner's suitability to use the gym). He answered 'yes' to three questions on the form, showing that he had a heart condition, a back problem and that there were other reasons why physical activity may not be suitable for him.
26. A physical education officer, asked healthcare staff to complete a 'Physical Education Clearance Form', giving more details about his condition. On 22 September, a nurse noted that the clearance form had been completed, detailing that Mr Wiltshire had a back problem and a cardiovascular condition and that he should work to his own limitations.
27. The physical education officer noted that Mr Wiltshire's routine was to attend the gym every weekday, from 1.30pm to 3.00pm. He would typically weight train for one hour and then play badminton for half an hour.
28. On 23 October, a nurse reviewed Mr Wiltshire's gym attendance. His blood pressure and heart rate readings were satisfactory.
29. On 8 November, Mr Wiltshire told a nurse that he had felt short of breath over the last three days and had chest pains. Mr Wiltshire was taken to hospital, assessed in the Accident and Emergency Department and prescribed enoxaparin – an anti-thrombus injection (which reduces the formation of blood clots) to be given over five days. Healthcare staff administered this and when Mr Wiltshire went for a scan at the hospital on 13 November to rule out an embolism, no trace of one was found.

30. On 16 November, a nurse conducted another review of Mr Wiltshire's gym attendance. His blood pressure and heart rate were satisfactory and he had lost some weight.
31. On the evening of 9 December, one of Mr Wiltshire's roommates, played pool with him until approximately 8.15pm. He told police that Mr Wiltshire had not seemed too well and that during the night he had visited the lavatory several times.
32. On the morning of 10 December 2018, Mr Wiltshire woke up and chatted with his roommates as usual. He answered the morning roll check which was taken by an officer who said there was nothing unusual about his presentation. Neither cellmate reported anything unusual about him either, and they went to work leaving Mr Wiltshire in his room.
33. One of his roommates bumped into Mr Wiltshire again at approximately 9.30am outside the education block. Mr Wiltshire told him he was not feeling too well before they parted company.
34. At approximately 9.37am, Mr Wiltshire went to the healthcare unit and approached a nurse. He did not have an appointment and the nurse described him as physically struggling. He was sweating profusely and reported central chest pain and pain down the left arm.
35. The nurse was with another prisoner at the time but he asked that person to leave and to fetch another nurse for assistance. Mr Wiltshire said he was in a lot of pain. The nurse was aware of Mr Wiltshire's cardiac history and was concerned he was having another heart attack. Mr Wiltshire's pulse was erratic and weak and he collapsed.
36. The Deputy Head of Healthcare attended. The nurse called a medical emergency code blue (used to indicate a prisoner is unconscious or having breathing difficulties) at 9.44am. The Deputy Head of Healthcare and the nurse took turns to collect emergency equipment (including oxygen) and they placed Mr Wiltshire on the floor. They applied a defibrillator which recommended cardiopulmonary resuscitation (CPR) even though Mr Wiltshire was lashing out and very confused. Two officers attended and helped by trying to hold Mr Wiltshire's arms and legs still. Another nurse also attended and helped.
37. Staff in the control room did not call an ambulance until 9.46am, and then they spent around a minute and a half trying to put the ambulance service operator through to someone in the healthcare unit so the operator could get the information they needed to despatch an ambulance. No one answered the call and radios were eventually used to get information for the ambulance service.
38. Paramedics arrived at 10.09am but were unable to resuscitate Mr Wiltshire. They pronounced his death at 10.33am.

Contact with Mr Wiltshire's family

39. On 10 December, a Custodial Manager (CM) was appointed as the prison's family liaison officer (FLO). At 10.45am, he attempted to call Mr Wiltshire's nominated next of kin, his father, but received no answer despite several

attempts. At 1.50pm, Mr Wiltshire's father answered. The FLO broke the news, explained what would happen next and offered support.

40. Mr Wiltshire's funeral was held on 4 January 2019. No one from the prison attended, at the family's request. The prison contributed to the cost of the funeral in line with national policy.

Support for prisoners and staff

41. After Mr Wiltshire's death, the duty governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
42. The prison posted notices informing other prisoners of Mr Wiltshire'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 Wiltshire's death.

Post-mortem report

43. The post-mortem examination concluded that the cause of Mr Wiltshire's death was ischaemic heart disease and coronary artery atheroma (build-up of fatty deposits on the walls of the arteries around the heart).

Findings

Clinical care

44. The clinical reviewer found that the care Mr Wiltshire received at HMP Hollesley Bay was equivalent to that he could have expected to receive in the community. His medication was prescribed, staff were fully aware of his cardiac history and monitored him appropriately.
45. On 8 November, when Mr Wiltshire presented with shortness of breath, a nurse considered Mr Wiltshire's cardiac history and appropriately assessed him before referring him to hospital for further (inconclusive) investigations.
46. Mr Wiltshire's remedial gym referral was appropriate, he was reviewed (in October and November) and there were no concerns.
47. When Mr Wiltshire complained of chest pain on 10 December, healthcare staff responded promptly and appropriately: they called a code blue, collected the necessary equipment and rotated CPR between them until the ambulance crew arrived.

Emergency Response

48. Prison Service Instruction (PSI) 03/2013 requires prisons to have a medical emergency response code protocol which should ensure that an ambulance is called immediately when a medical emergency is called. Hollesley Bay's local policy is in line with this instruction.
49. However, on 10 December, control room staff did not call an ambulance immediately after the code blue was called – there was a two-minute delay. The investigator listened to a recording of the call between the control room and the ambulance service operator, and it revealed a further delay (of approximately a minute and a half) while control room staff tried to put the operator through to a telephone on the healthcare unit without success. We make the following recommendation:

The Governor should ensure that control room staff call an ambulance immediately when a medical emergency code is called and that information about the prisoner's condition is obtained and passed promptly to the ambulance service.

Family Contact

50. Prison Service Instruction (PSI) 64/2011 requires the prison's family liaison officer to break the news of a prisoner's death to the next of kin in person. Where a significant distance would need to be travelled, it is acceptable to request assistance from a more local prison.
51. The FLO phoned Mr Wiltshire's next of kin, his father, on multiple occasions on 10 December before ultimately getting through to him at 1.50pm. However, the news should have been broken in person. We make the following recommendation:

The Governor should ensure that, wherever possible, the family liaison officer, or another representative from the prison, breaks the news of a prisoner's death to their next of kin in person.

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