Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Doherty a prisoner at HMP Wymott on 29 January 2016

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: 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*

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 Robert Doherty died on 29 January 2016 of lung disease at HMP Wymott. He was 70 years old. I offer my condolences to Mr Doherty's family and friends.

Mr Doherty had a number of long-term health conditions, including chronic obstructive pulmonary disease. He was often an uncooperative patient, but healthcare staff managed his chronic illnesses as well as they could and reviewed him frequently. When Mr Doherty was found unresponsive in his cell on 29 January, staff responded quickly, but it was evident that he had died. Prison staff could not have prevented his death and I am satisfied that Mr Doherty received a good standard of healthcare at Wymott, equivalent to that he could have expected to receive in the community.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **July 2016**

Contents

Summary

Events

1. In November 1980, Mr Robert Doherty was sentenced to life imprisonment for murder. He had been at HMP Wymott since February 2015.

2. In his later years, Mr Doherty suffered from prolonged weight loss, diabetes and chronic obstructive pulmonary disease (COPD - the name for a collection of long-term progressive lung diseases, including chronic bronchitis and emphysema). Healthcare staff monitored these conditions frequently, prescribed relevant medication, and arranged investigations when necessary. Mr Doherty did not always cooperate with his treatment and often did not attend appointments.

3. Shortly before midday on 29 January 2016, another prisoner found Mr Doherty unresponsive in his cell and alerted staff. An officer responded, called an emergency code and he and another officer tried to resuscitate Mr Doherty. A nurse arrived minutes later, and assessed Mr Doherty. As it was evident that Mr Doherty had died, she asked the officers to stop resuscitation. At 12.05pm, a prison GP recorded that Mr Doherty had died.

Findings

4. Mr Doherty frequently refused treatment for his conditions and often did not attend scheduled healthcare appointments. This made it difficult to manage his health conditions effectively. Despite his lack of cooperation, the clinical reviewer concluded that healthcare staff implemented clear care plans to review and manage his conditions and medication.

5. Officers and healthcare staff responded promptly to the emergency, but, sadly, it was evident that Mr Doherty had died.

6. We are satisfied that the care Mr Doherty received at Wymott was at least equivalent to that he could have expected to receive in the community and staff could not have done anything to prevent his death.

The Investigation Process

7. 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.

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

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

10. We informed HM Coroner for Preston and West Lancashire District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

11. One of the Ombudsman's family liaison officers contacted Mr Doherty's sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. His sister wanted to know why Mr Doherty had lost so much weight. She had a number of questions not directly related to the circumstances of Mr Doherty's death, which we have not covered in this report and have answered in separate correspondence.

12. Mr Doherty's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

13. The initial report was shared with the Prison Service. The prison Service did not find any factual inaccuracies.

Background Information

HMP Wymott

14. HMP Wymott is a medium security 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

15. The most recent inspection of Wymott was in July 2014. Inspectors reported that the quality of health care was reasonably good, but undermined by long delays and poor access to GPs. The range of clinics provided reflected the needs of the prison population and included clinics for chronic diseases. Pharmacy services needed improvement to ensure that prisoners received their medication on time. There were good palliative care and end of life procedures.

Independent Monitoring Board

16. 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 2015, the IMB reported ongoing problems with the supply of medication and a severe shortage of nurses. The IMB was also concerned about difficulties in prisoners getting GP appointments, unclear waiting times and that the process for notifying prisoners of their appointments was ineffective.

Previous deaths at HMP Wymott

17. Mr Doherty was the eighth man to die of natural causes at HMP Wymott since January 2014. There have been two other deaths since Mr Doherty died. There were no significant similarities with the circumstances of the other deaths.

Key Events

18. On 27 November 1980, Mr Doherty was sentenced to life imprisonment for murder. He spent time at a number of prisons and transferred to HMP Ryehill on 8 March 2010. He had a number of long-term conditions including diabetes and asthma.

19. In August 2011, at GP at Ryehill was concerned about Mr Doherty's weight loss. He had difficulty swallowing and abnormal lung sounds, so the GP referred Mr Doherty for X-rays. Mr Doherty was then diagnosed with chronic obstructive pulmonary disease (COPD – the name for a collection of long-term progressive lung diseases including chronic bronchitis and emphysema). Mr Doherty smoked cigarettes but refused advice about giving up.

20. Over the next four and a half years, hospital and healthcare staff saw Mr Doherty frequently to monitor and treat his conditions, including COPD. Records show that Mr Doherty often did not attend appointments and was uncooperative about his treatment. Clinicians considered he had the mental capacity to make decisions about his care.

21. On 10 February 2015, Mr Doherty was moved to HMP Wymott. On 12 February, a prison GP reviewed and prescribed his medications. Healthcare staff created care plans for COPD, diabetes and asthma. They continued to monitor Mr Doherty's conditions when he allowed, but he was often rude to staff and refused to engage.

22. On 27 May, a prison GP reviewed Mr Doherty and noted that he had had a number of investigations for weight loss over the previous three to four years, with no clear explanation or diagnosis to account for it. He ordered a chest X-ray and blood tests, but Mr Doherty refused to attend appointments for these tests. On 15 June, he signed a disclaimer refusing the investigations. Clinicians considered Mr Doherty had the mental capacity to make decisions about his treatment. Healthcare staff gave him nutritional drinks to help his weight loss and continued to review him frequently, despite his non-cooperation.

23. On 6 October, a nurse examined Mr Doherty on his wing after staff radioed a medical emergency. She noted that he looked grey and was struggling to breathe. His oxygen saturation level was 80% well below the normal level of 98-100%. While waiting for an emergency ambulance, a prison GP reviewed Mr Doherty and diagnosed exacerbation of COPD (a sudden worsening of symptoms that typically lasts for several days). The GP gave him medication and an ambulance took Mr Doherty to hospital.

24. Shortly after he arrived at the hospital, Mr Doherty was confused and delirious and tried to discharge himself. Hospital staff stopped him discharging himself, as a mental capacity assessment indicated that his decision-making was impaired by hypoxia (lack of oxygen) and sepsis (a potentially life-threatening condition triggered by infection). Another assessment the next day concluded that he had mental capacity but was too unwell to be discharged to Wymott because the prison did not have an inpatient facility. The healthcare manager arranged for him to go to the regional inpatient unit at HMP Preston that day.

25. On 8 October, a prison GP reviewed Mr Doherty at Preston after nurses reported he was having difficulty breathing. He suspected neoplasm (abnormal tissue growth or tumour) in the abdomen and lung and arranged for him to be admitted to hospital for further investigations.

26. Prison healthcare staff kept in contact with the hospital about Mr Doherty's condition. On 22 October, a prison nurse met the ward sister who informed her that doctors were treating Mr Doherty for acute exacerbation of COPD. Investigations had ruled out any underlying malignancy (cancer) and doctors attributed his weight loss to COPD.

27. Mr Doherty returned to Preston on 30 October. On 3 November, he moved back to Wymott as staff assessed that he no longer needed inpatient care. Staff also noted that he had been abusive to staff at Preston while he was there and he had been found in possession of a new psychoactive substance (synthetic cannabis).

28. Over the next three days, healthcare staff at Wymott reviewed Mr Doherty many times and referred him to Preston again. Preston declined to take him for security reasons and because they considered he did not have an active medical problem that needed inpatient treatment. Healthcare staff at Wymott continued to monitor him, but he did not always cooperate.

29. On 13 January 2016, a nurse reviewed Mr Doherty and noted that he was struggling to breathe. Later that day, a prison GP examined him and prescribed an antibiotic to treat a suspected chest infection. On 21 January, the GP reviewed him and requested an urgent chest X-ray.

30. Mr Doherty was due to attend hospital for the chest X-ray on 28 January, but he refused to go. He signed a disclaimer and said that he was too unwell. A nurse assessed Mr Doherty later, after officers reported he was slumped and not eating or drinking. She noted that he was fully alert and aware, but he would not give her any information about how he felt or allow her to take any clinical observations.

31. At approximately 11.50am on 29 January, an officer finished giving prisoners their lunches and noticed that Mr Doherty had not collected his. He asked another prisoner to take it to him. The prisoner took Mr Doherty's lunch to his cell but came back very shortly afterwards and told the officer that it looked like Mr Doherty had died. The officer immediately went to his cell and noted that Mr Doherty was cold and not breathing. At 11.54am, he radioed a code blue medical emergency (indicating circumstances such as when a prisoner is unconscious or not breathing) and the control room immediately called an ambulance. The officer began cardiopulmonary resuscitation and a colleague arrived and assisted him.

32. A few minutes later, a nurse assessed Mr Doherty. She noted he was not breathing, his pupils were fixed and his arms were rigid. She considered he had died and asked the officers to stop the resuscitation attempt. At 12.05pm, a prison GP confirmed Mr Doherty's death. Paramedics arrived at the prison but did not examine Mr Doherty, as the doctor had already confirmed his death.

Contact with Mr Doherty's family

33. Later that afternoon, the prison appointed the managing chaplain and an officer, as the prison's family liaison officers. At about 1.25pm the officer and a prison manager went to Mr Doherty's daughter's home to break the news, but she was not in. At 3.35pm, they went to Mr Doherty's sister's home and informed her that Mr Doherty had died. They offered condolences and support. The officer remained in contact with Mr Doherty's family.

34. The prison contributed to the costs of Mr Doherty's funeral, in line with national policy.

Support for prisoners and staff

35. A prison manager 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.

36. The prison posted notices informing staff and prisoners of Mr Doherty's death, and offering support. The prison offered additional support to the prisoner who had found Mr Doherty unresponsive in his cell. Staff reviewed all prisoners assessed as at risk of suicide or self-harm, in case they had been adversely affected by Mr Doherty's death.

Post-mortem report

37. A post-mortem examination found that Mr Doherty had died of bronchopneumonia and chronic obstructive pulmonary disease (COPD).

Findings

Clinical care

38. Mr Doherty suffered from several complex chronic health conditions. Healthcare reviewed him frequently, usually for shortness of breath and chest infections related to his chronic lung disease, but he often refused to accept treatment. He was a heavy smoker, which made his symptoms worse. Despite frequent encouragement from prison GPs and nurses, he refused to stop smoking.

39. The clinical reviewer considered that prison healthcare staff monitored Mr Doherty's COPD in line with National Institute of Clinical Excellence (NICE) guidelines. Despite his limited engagement and non-cooperation, he noted that treatment included regular reviews, tests and medication therapies to open his airway and to reduce the level of mucus in his lungs.

40. Mr Doherty lost weight over a number of years and there was no clear understanding of the cause. Healthcare staff referred him for numerous tests, as they were concerned he was suffering from undiagnosed cancer, but there was no evidence of any cancer. After further tests for cancer at hospital in October 2015, doctors concluded that the weight loss was caused by COPD. The clinical reviewer noted that all the referrals were made in accordance with NICE guidelines. Mr Doherty was given appropriate nutritional supplements to try to counter the weight loss.

41. The clinical reviewer concluded that Mr Doherty's overall care in prison was of a high standard. We are satisfied that the care Mr Doherty received for his chronic conditions was at least equivalent to that he could have expected to have received in the community.

Emergency response

42. An officer responded quickly when a prisoner reported that Mr Doherty had collapsed and used an appropriate emergency medical code. The control room called an ambulance immediately, in line with Prison Service instructions. Other officers and healthcare staff responded promptly. Sadly, it was evident that Mr Doherty had died and officers stopped attempting to resuscitate him. The clinical reviewer was satisfied that the resuscitation attempt and the subsequent decision to stop, was correct.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141