Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Michael Fitzgerald a prisoner at HMP Wymott on 2 July 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*

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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.

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 Michael Fitzgerald died on 2 July 2017, of a heart attack while a prisoner at HMP Wymott. He was 75 years old. We offer our condolences to Mr Fitzgerald's family and friends.

Mr Fitzgerald's care was not equivalent to that which he could have expected to receive in the community. In June 2017, Mr Fitzgerald had a heart attack and was treated in hospital. Care plans were not put in place to manage his rehabilitation following his return to the prison.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **February 2018**

Contents

Summary

Events

1. On 10 January 2014, Mr Michael Fitzgerald was sentenced to eight years imprisonment for sexual offences. After a short period at HMP Preston, he was transferred to HMP Stafford on 2 June 2014. He had no significant medical history and had little contact with healthcare staff in either prison.

2. During a routine annual health check at Stafford in March 2016, healthcare staff noted Mr Fitzgerald had a raised cholesterol level. Staff prescribed him medication to help reduce his cholesterol, but he refused to take it. A year later, healthcare staff repeated the cholesterol test. Mr Fitzgerald's cholesterol level remained raised but was stable.

3. On 18 September 2016, a prison GP carried out a test using a screening tool designed to detect any raised risk of heart problems. Mr Fitzgerald scored above that considered to be a normal level. The GP recommended regular routine ECG tests to monitor Mr Fitzgerald.

4. In April 2017, Mr Fitzgerald was transferred to HMP Wymott. A nurse reviewed him when he arrived at the prison. She noted that apart from the need for regular ECGs, he appeared fit and well. Although ECG tests continued, the results were not recorded in Mr Fitzgerald's medical records.

5. On 5 June, Mr Fitzgerald told healthcare staff he had vomited, felt short of breath and had experienced dizziness. Although Mr Fitzgerald had not reported any palpitations or chest pains, healthcare staff carried out an ECG, but did not record the results in his medical records. Mr Fitzgerald was taken to Chorley District Hospital by emergency ambulance.

6. Hospital staff diagnosed Mr Fitzgerald as having had a heart attack and discovered he had developed fibrotic lung disease. They referred Mr Fitzgerald to the hospital's cardiology department and to a chest physician. He remained in hospital as an inpatient until he returned to Wymott on 12 June.

7. On 2 July, Mr Fitzgerald was short of breath and staff were unable to take his blood pressure or oxygen saturation level due to his symptoms. They radioed an emergency code and Mr Fitzgerald was taken to hospital by emergency ambulance.

8. Following his arrival at hospital, Mr Fitzgerald had a heart attack. Hospital staff were unable to resuscitate him, and he died shortly afterwards.

Findings

9. The prison healthcare team reviewed Mr Fitzgerald when he presented with symptoms. On occasion, those reviews were not documented fully, on occasion, not at all. Similarly, there was evidence that ECGs were carried out, but the results not recorded.

10. When Mr Fitzgerald was released from hospital following a heart attack in June, healthcare staff at Wymott were advised to create a cardiac care plan to manage

his rehabilitation and care. There is no evidence in his medical records that a care plan was created.

11. We note that an ambulance was not called immediately following a code blue emergency radio call. This is not in line with Prison Service policy.

Recommendations

- The Head of Healthcare should ensure that all healthcare staff fully comply with professional requirements for accurate record keeping.
- The Head of Healthcare should ensure that all prisoners with serious or long-term health conditions have detailed care plans in place in accordance with National Institute for Clinical Excellence guidance.
- The Governor should ensure that the control room call an ambulance immediately when a medical emergency code is received.

The Investigation Process

12. 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.

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

14. NHS England commissioned an independent clinical reviewer to review Mr Fitzgerald's clinical care at the prison.

15. We informed HM Coroner for Preston and West Lancashire District of the investigation who gave us Mr Fitzgerald's cause of death. No post-mortem examination was carried out on Mr Fitzgerald. We have sent the coroner a copy of this report.

16. The investigator wrote to Mr Fitzgerald's next of kin to explain the investigation and to ask if she had any matters he wanted the investigation to consider. She did not reply.

17. The investigation has assessed the main issues involved in Mr Fitzgerald's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, and liaison with his family.

18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Wymott

19. HMP Wymott, which is near Preston in Lancashire, is a medium secure prison holding over 1,100 adult men. Bridgewater Community Trust and Greater Manchester Mental Health Trust took over the provision of healthcare services in March 2017 from the previous provider, Lancashire Care NHS Foundation Trust. There are no inpatient beds but there is 24-hour nursing cover.

HM Inspectorate of Prisons

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

Independent Monitoring Board

21. 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 they had serious concerns about the standard of healthcare provision delivered by the previous healthcare providers. They considered it fell below the standard of healthcare provision in the wider community and raised those concerns with ministers.

22. The IMB also repeated their concerns of the previous year about the growing number of older prisoners, and those suffering from terminal illness or in need of palliative care, and the strain that placed on resources when having to provide staff for escorts. While the board accepted that at the time of review the new healthcare providers had only been in place for two months, they were still concerned at the lack of progress shown and the deterioration in some of areas of healthcare provision.

Previous deaths at HMP Wymott

23. Mr Fitzgerald was the fourth prisoner to die at Wymott from natural causes since the beginning of 2017. There are no similarities with those cases.

Key Events

24. On 10 January 2014, Mr Michael Fitzgerald was sentenced to eight years imprisonment for sexual offences. He was sent to HMP Preston.

25. A prison nurse reviewed Mr Fitzgerald when he arrived at Preston. He noted Mr Fitzgerald had no significant past medical history and recorded him as being fit and well. He noted Mr Fitzgerald was a smoker and offered him smoking cessation advice, which Mr Fitzgerald refused. Mr Fitzgerald had no further significant contact with healthcare while at Preston.

26. On 2 June, Mr Fitzgerald was transferred to HMP Stafford. A prison nurse carried out a reception health screen and noted that Mr Fitzgerald was fit and well. She offered him smoking cessation advice, which he again refused.

27. On 18 September, Mr Fitzgerald had a routine Abdominal Aortic Aneurysm Screening scan (a screening programme for men over 65 where an ultrasound scan is performed to detect any swelling of the aorta or other issues with the heart). The results were normal. Mr Fitzgerald declined any subsequent screenings.

28. While at Stafford, Mr Fitzgerald received annual health checks, which included a series of blood tests. On 16 March 2016, a blood test result indicated a raised cholesterol level (naturally occurring fats in the blood) and a possible risk of a heart attack. A prison GP reviewed Mr Fitzgerald and discussed the results with him. Mr Fitzgerald said he had no family history of heart disease. The GP suggested that he take a statin, a medication used to reduce the level of cholesterol in the blood. However, Mr Fitzgerald refused. The GP again offered Mr Fitzgerald smoking cessation advice; he again refused the offer of help. The GP noted that they should repeat the blood tests in 12 months time.

29. Mr Fitzgerald had little further significant contact with healthcare in the year that followed.

30. On 16 March 2017, a healthcare assistant carried out the planned blood tests. While the results still indicated a raised cholesterol level, the levels appeared to be stable and comparable with the previous year's results.

31. The following day, a prison GP carried out a QRisk2 test (a predictive screening tool used to calculate the risk of heart problems). Mr Fitzgerald scored 34.43% (a score above 10% indicates an increased risk of possible heart issues which would require ongoing monitoring). The GP advised that regular electrocardiograms should be carried out (ECGs used to check the electrical and rhythmic output of the heart).

32. On 21 April, Mr Fitzgerald was transferred to HMP Wymott. A nurse reviewed Mr Fitzgerald and noted that although he was not prescribed any medication, he required ECG monitoring, but otherwise appeared fit and well. Mr Fitzgerald's observations were recorded (temperature, respiratory rate, pulse, blood pressure and, where appropriate, blood oxygen saturation) along with his height and weight. She offered him smoking cessation advice, but as previously, he refused.

Healthcare staff encouraged Mr Fitzgerald to stop smoking on a number of occasions, but he consistently refused.

33. On 17 and 18 May, Mr Fitzgerald's medical records noted that ECG tests were carried out. However, staff did not record the results of those tests.

34. On 5 June, Mr Fitzgerald told healthcare staff he had vomited, felt short of breath and experienced dizziness. Although Mr Fitzgerald had not reported any palpitations or chest pains, healthcare staff carried out an ECG, the results of which, again, were not recorded.

35. Following the ECG, Mr Fitzgerald was taken to Chorley District Hospital by emergency ambulance to be reviewed by hospital staff. Two prison officers accompanied him, and he was restrained using an escort chain (an escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). His restraints were removed when he arrived at hospital and were not reapplied.

36. Hospital staff carried out a number of tests. They diagnosed Mr Fitzgerald as having suffered a myocardial infarction (heart attack) and having developed fibrotic lung disease (scar tissue on the lungs impacting the efficiency and making breathing difficult). They informed him he had left ventricular systolic dysfunction (reduced function in the left ventricle of the heart) which had caused the heart attack, and that his heart was functioning at a level equivalent to only 25% of that of a healthy heart. They referred Mr Fitzgerald to the hospital's cardiology department and chest physician. He remained in hospital as an inpatient.

37. While in hospital, Mr Fitzgerald was prescribed furosemide to reduce the fluid build up in his lungs, lansoprazole to reduce acid reflux in the stomach, bisoprolol to control high blood pressure, apixaban, an anticoagulant, atorvastatin, used to reduce cholesterol, and aspirin, also used as an anticoagulant for patients who have suffered a heart attack. Hospital staff recommended that healthcare staff at Wymott should formulate a care plan to include regular blood testing, to support his cardiac rehabilitation in readiness for his discharge from hospital.

38. Following his return from hospital on 12 June, there is no evidence in Mr Fitzgerald's medical records to indicate healthcare staff had implemented a care plan for his cardiac rehabilitation. Aside from receiving medication, Mr Fitzgerald had little documented contact with healthcare staff.

39. On 22 June, Mr Fitzgerald told a nurse that he was experiencing shortness of breath when lying down. The nurse took his observations. She noted his oxygen saturation level was 91% (oxygen saturation level is a measure of the amount of oxygen in the blood stream and is used as an indicator of a patient's condition, 98-100% is considered normal). She also noted Mr Fitzgerald's blood pressure was low. She referred him to a nurse practitioner for further review.

40. The nurse practitioner reviewed Mr Fitzgerald later the same day. She recorded his oxygen saturation level as 98%. She acknowledged his recent history of heart problems and advised him to contact healthcare if he experienced any further symptoms.

41. On 27 June, a prison GP reviewed Mr Fitzgerald following a full blood test. The test included thyroid function, liver function, bone profile, urea and electrolytes. All of the results were within normal limits.

42. The following day, a nurse went to see Mr Fitzgerald to carry out a routine ECG. Mr Fitzgerald refused and said that he felt fine, had no chest pain and in his opinion he did not need an ECG.

43. On 29 June, a nurse practitioner again attempted to carry out an ECG. Mr Fitzgerald told her he felt fine and, as he had a routine review booked with a cardiac nurse at Chorley District Hospital at the end of July, he had no need for an ECG. The nurse told Mr Fitzgerald to speak to healthcare staff if he had any concerns in the meantime.

Events of 2 July

44. At 3.30am on 2 July, a nurse reviewed Mr Fitzgerald because he had told prison officers he was having a panic attack and was feeling short of breath. The nurse noted Mr Fitzgerald scored 2 on the National Early Warning Score, indicating a low clinical risk (a tool used to assist medical staff in assessing deteriorating patients). The nurse told Mr Fitzgerald she would get healthcare staff to review him again later that morning.

45. At 10.54am before the review had taken place, an officer radioed an emergency code blue (indicating that a prisoner is unconscious, not breathing or is having breathing difficulties). A nurse responded to the call arriving at the cell at 10:57am. She noted Mr Fitzgerald was breathing and able to talk in sentences. She took his observations, recording his heart rate at 62bpm and his temperature as being low at 34.8 degrees celsius (37 degrees celsius is considered normal body temperature). She recorded that she was unable to obtain his oxygen saturation level, or gain a reading of his blood pressure, because he was suffering from white finger (known also as Raynauds Phenomenon, which causes a reduction of the blood supply to the fingers and toes, usually in emotionally stressful situations). However, she did record a systolic blood pressure reading of 80 (a low reading, a reading of 120 being considered normal). She also noted his skin demonstrated turgor (a measure of skin elasticity used to indicate dehydration).

46. At 11.00am, the nurse informed the prison control room that she did not require an ambulance. Instead, at 11.19am, she took Mr Fitzgerald to healthcare to be reviewed by a prison GP. At 11.57am, the GP decided to send Mr Fitzgerald to hospital by emergency ambulance. The ambulance arrived at 12.15pm.

47. Paramedics reviewed Mr Fitzgerald and they left for the hospital at 1.00pm, accompanied by two prison officers. Mr Fitzgerald was not restrained. They arrived at the Accident and Emergency department at 1.30pm.

48. Hospital staff noted that although Mr Fitzgerald was conscious, he was short of breath. They gave him oxygen therapy, intravenous fluids to treat his dehydration and a chest X-ray. The X-ray indicated a pulmonary oedema (an excess build up of fluid in the lungs). They moved him to the resuscitation area

of the hospital and noted that his observations were improving. They continued to monitor his condition.

49. At 4.30pm, Mr Fitzgerald had a cardiac arrest. Hospital staff were unable to resuscitate him. A hospital doctor confirmed Mr Fitzgerald's death at 4.57pm.

Contact with Mr Fitzgerald's family

50. The prison appointed a member of the chaplaincy team at Wymott as the family liaison officer (FLO). Mr Fitzgerald had named his sister as his next of kin.

51. At 5.00pm, the FLO and the Head of Safer Prisons and Equalities visited the home of Mr Fitzgerald's sister to break the news of his death, but she was not at home. The FLO left a message for her to contact the prison.

52. The FLO and the Head of Safer Prisons and Equalities decided to visit the home of Mr Fitzgerald's daughter. En route they received a telephone call informing them that his sister had returned home and had asked that they visit her. They returned to Mr Fitzgerald's sister's house and broke the news of his death. They offered their condolences and support. The FLO remained in contact with Mr Fitzgerald's family.

53. Mr Fitzgerald's funeral was on 14 July. The prison contributed to the costs in line with national guidance.

Support for prisoners and staff

54. After Mr Fitzgerald's death, the staff involved in the emergency response, and the staff who escorted Mr Fitzgerald to hospital, were debriefed by a Custodial Manager to give them the opportunity to discuss any issues arising, and to offer the support of the staff care team.

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

Post-mortem report

56. A post-mortem was not completed for Mr Fitzgerald. A consultant from Chorley Hospital Accident and Emergency department, confirmed in a statement to the coroner that Mr Fitzgerald's death was caused by congestive cardiac failure (heart attack) caused by heart disease.

Findings

Clinical care

57. The clinical reviewer noted that there are significant gaps in Mr Fitzgerald's medical records. In addition, some of the entries in his records were not completed to an acceptable standard. The clinical reviewer was particularly concerned that there was minimal reference to Mr Fitzgerald's hospital admission following his heart attack on 5 June 2017. We make the following recommendation:

    The Head of Healthcare should ensure that all healthcare staff fully comply with professional requirements for accurate record keeping.

58. Following Mr Fitzgerald's admission to hospital, contrary to advice from hospital staff, there is no evidence in Mr Fitzgerald's medical records of a care plan being put in place to manage his cardiac rehabilitation following his discharge back to Wymott. The National Institute for Clinical Excellence guidance CG94 is clear that cardiac rehabilitation should be offered to patients following a heart attack. There is no evidence in his medical records to show that this was offered to Mr Fitzgerald at Wymott. We make the following recommendation:

    The Head of Healthcare should ensure that all prisoners with serious or long-term health conditions have detailed care plans in place in accordance with National Institute for Clinical Excellence guidance.

59. There is evidence in the medical records that Mr Fitzgerald received adequate care when he required the assistance of healthcare staff. However, there is little evidence to suggest that his care was managed proactively. The clinical reviewer has made a number of recommendations, some of which we do not repeat in this report but which the Head of Healthcare will wish to address.

60. We agree with the clinical reviewer that the care Mr Fitzgerald received at Wymott was of a mixed standard and not equivalent to that which he could have expected to receive in the community.

Emergency Response

61. Prison Service Instruction (PSI) 03/2013 directs that Governors/Directors of all prisons must ensure that a Medical Emergency Response Code protocol exists 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. It is essential that an ambulance is called in all cases where there are serious concerns about the health of a prisoner and that access to both the prison and the individual prisoner is not delayed.

62. In addition, section 5.4 of PSI 03/2013 notes that a representative NHS Ambulance guide for use in the community states that an ambulance should be called when there are signs of chest pain, difficulty in breathing, unconsciousness, severe loss of blood, severe burns or scalds, choking, fitting or concussion, severe allergic reactions or a suspected stroke. This must also be

the case for prisoners and therefore, in these situations when the medical emergency is called over the radio network, an ambulance must be called immediately. This is reflected in the prison's notice to staff (NTS) 128-16, which states that when the medical emergency is called over the radio network, if the subject of the Code Blue is displaying any of the listed symptoms, an ambulance must be called immediately.

63. Although we note that the nurse did not feel that an emergency ambulance was necessary, we also note that this was not the view of the prison GP. While it is not clear that this failure to telephone for an ambulance had an impact on the outcome for Mr Fitzgerald, it is clear that it was not in line with policy and it could have serious implications in future cases. We make the following recommendation:

The Governor should ensure that the control room call an ambulance immediately when a medical emergency code is received.

Restraints, security and escorts

64. 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.

65. When Mr Fitzgerald had his final admission to hospital on 2 July 2017, he was escorted by two prison officers and was not restrained. Risk assessments took account of his health, length of sentence and risk to the public.

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