

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Andrew Martindale a prisoner at HMP Wymott on 20 October 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 Andrew Martindale died of biliary sepsis (a severe infection of the biliary tract) caused by gallstone disease on 20 October 2018 while a prisoner at HMP Wymott. He was 58 years old. I offer my condolences to his family and friends.

The clinical reviewer concluded that the clinical care that Mr Martindale received at Wymott was good and equivalent to that which he could have expected to receive in the community. However, Mr Martindale had had surgery to remove gallstones, was awaiting further surgery to remove his gallbladder and had been advised by a prison GP to seek urgent medical advice if he had stomach pain. In this context, I am concerned that when he presented with stomach pain and blood in his urine in the early hours of 18 October, healthcare staff did not review him in the morning but expected him to present again if he continued to have pain.

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 2 June 2014, Mr Andrew Martindale was sentenced to three years in prison for sex offences. On 25 January 2016, he was sentenced to a further six years for sex offences. On 5 July 2017, he was transferred to HMP Wymott.
2. On 22 April 2018, Mr Martindale went to hospital because he had pain and tenderness below the right ribs in his upper stomach area. Hospital staff completed blood tests, a chest x-ray and an ultrasound scan (an image of the inside of the body) and found that he had gallstones (small stones made of cholesterol that form in the gallbladder). They prescribed a painkiller and sent him back to Wymott.
3. On 29 June, a prison GP saw Mr Martindale who was jaundiced and had a pain in his abdomen. The prison GP said that he had acute cholecystitis (an inflammation of the gallbladder) which put him at risk of sepsis, and sent him to hospital. Hospital staff removed the gallstones. On 4 July, he went back to Wymott. The prison GP noted that Mr Martindale was also scheduled for an operation to remove the gallbladder.
4. At 10.55pm on 17 October, a nurse saw Mr Martindale in his cell after he complained of stomach pain. She told him to take painkillers and to see a nurse the next morning if he continued to feel unwell. She checked on him again at 3.22am on 18 October. He told her that he still had stomach pain and had blood in his urine. The nurse took his NEWS score and temperature which were normal. She told him to take more painkillers and to see a nurse at the medication hatch in the morning. Mr Martindale did not do so and there are no records to indicate whether he continued to feel unwell that day.
5. On 19 October, Mr Martindale was unwell in his cell. A nurse noted that he was breathing but not communicating, had been incontinent of faeces, had a low pulse rate (30 beats per minute), low blood oxygen saturation (70%) and a high temperature (38.9 degrees). The nurse gave him oxygen. An officer telephoned the control room and said that there was a medical emergency code blue (which indicates that a prisoner is unconscious or not breathing). An ambulance arrived promptly and paramedics took Mr Martindale to hospital.
6. Later that day, a nurse telephoned the hospital and noted that Mr Martindale was in the intensive care unit and that hospital staff were intubating (inserting a tube into the mouth) and ventilating him. Hospital doctors said that he may have sepsis caused by a gallbladder or bile duct infection. Mr Martindale's condition deteriorated and at 4.15am on 20 October, he died of biliary sepsis. His partner and family were with him when he died.

Findings

7. The clinical reviewer found that the care that Mr Martindale received at Wymott was equivalent to that which he could have expected to receive in the community. His existing health conditions were assessed and reviewed in a timely manner.

8. Mr Martindale developed gallstones which were treated in hospital. He was listed for an operation to remove the gallbladder but he developed sepsis before this took place.
9. We acknowledge that the nurse who saw Mr Martindale after he reported having stomach pain on the night of 17 October appropriately told him to take painkillers, returned to see him in the early hours of the morning, took his NEWS score and temperature (which were normal). However, although the clinical reviewer concluded that it was appropriate for the nurse to ask Mr Martindale to present himself to the medication hatch on the morning of 18 October, we consider that she should instead have arranged for healthcare staff to review him the next day. Mr Martindale not only had continued stomach pain but also reported having blood in his urine, was awaiting surgery to remove his gallbladder and had been advised by a GP a few months earlier to seek urgent medical advice if he had stomach pain.

Recommendations

- The Head of Healthcare should ensure that when a prisoner with a more complex medical history reports health concerns overnight, healthcare staff should review him the next day rather than waiting for him to present to them again.

The Investigation Process

10. 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. Two prisoners contacted the investigator as a result.
11. The investigator obtained copies of relevant extracts from Mr Martindale's prison and medical records.
12. NHS England commissioned a clinical reviewer to review Mr Martindale's clinical care at the prison.
13. We informed HM Coroner for Preston and West Lancashire of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
14. The investigator wrote to Mr Martindale's partner to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She was concerned that Mr Martindale went back to Wymott too soon after his gallstone operation because he was in severe pain. She was also concerned that he went back to a standard wing and not the medical wing. We have addressed these points in this report.
15. Mr Martindale's partner received a copy of the initial report. She did not make any comments.
16. We shared the initial report with the Prison Service. There was one factual inaccuracy and this report has been amended accordingly and their action plan has been appended to this report.

Background Information

HMP Wymott

17. 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 Geometric Results International Agency provides locum GP services and GPD Healthcare professionals provide the out of hours care, including 24-hour nursing cover. There are no inpatient beds.

HM Inspectorate of Prisons

18. 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 found that the clinical care of prisoners with chronic conditions was not good enough.

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 to May 2018, the IMB reported that the standard of healthcare provision regularly fell below that which could be expected in the community. They found that an under resourcing of staff at all levels had led to excessive delays in seeing a GP, cancelled clinics, prisoners being left without prescribed medication for several days and inconsistency in the provision of care for older prisoners.

Previous deaths at HMP Wymott

20. Mr Martindale was the twentieth prisoner to die at Wymott since October 2015. Eighteen of those deaths were from natural causes.

Key Events

21. On 2 June 2014, Mr Andrew Martindale was sentenced to three years in prison for sex offences. On 25 January 2016, he was sentenced to a further six years for sex offences. He served time in a number of prisons before he was transferred to HMP Wymott on 5 July 2017.
22. On 22 April 2018, Mr Martindale went to the wing office because he was not feeling well. Nurse A saw him, and he told her that he had diarrhoea, no appetite and a pain in his upper stomach below the right ribs. She noted that the area was tender and said that he should go to hospital. Officers took him by taxi to the Chorley walk-in centre (a facility that offers urgent medical attention)
23. A doctor at the walk-in centre advised that he should go to hospital so the officers took him to the Royal Preston Hospital, where he had blood tests, a chest x-ray and an ultrasound scan. Hospital staff said that he had gallstones and made an appointment for him at a urology clinic. Hospital staff prescribed dihydrocodeine, a painkiller, and Mr Martindale was sent back to Wymott.
24. On 14 June, Nurse B saw Mr Martindale as a medical emergency. She noted that Mr Martindale was leaning against a gate, that he did not look in pain, had good colour, was not sweating or breathless. Mr Martindale told her that he had gallstones and that no one was helping him. He wanted to rest in his cell but Nurse B advised him to go back to work. She noted that Mr Martindale had missed several medical appointments. On 15 June, Mr Martindale did not attend an appointment with a nurse.
25. On 28 June, Nurse B saw Mr Martindale because he wanted to know the results of a recent urine test. She noted that he looked jaundiced but had no other symptoms and booked an appointment for him to see a prison GP. On 29 June, Dr A, a prison GP, saw Mr Martindale who was still jaundiced and had a pain in his abdomen beneath the liver. Dr A diagnosed him with acute cholecystitis which put him at risk of sepsis. He asked for Mr Martindale to be sent to hospital.
26. On 29 June, before Mr Martindale went to hospital, prison staff completed an escort risk assessment. Mr A, the Deputy Governor, noted that two officers should escort him and use a single cuff during the transfer and an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer) for treatment. He was then taken to hospital, where he had the gallstones removed from the bile duct. Dr A noted that Mr Martindale was scheduled for an operation to remove the gallbladder and asked for liver function blood tests to be repeated in two weeks.
27. On 3 July, Mr Martindale's behaviour in hospital was poor. He was rude to the hospital nursing staff, he tried to tangle the escort chain around his body, he lunged at an officer who restrained him on the bed and called hospital security. Ms B, a custodial manager, reviewed his risk and increased the number of officers at the hospital to three. A hospital doctor said that the operation and his medication had caused Mr Martindale's behaviour so Ms B reduced the number of officers at the hospital to two. On 4 July, Mr Martindale went back to Wymott.

28. On 17 July, Dr A noted that Mr Martindale's liver function blood test results were abnormal. He booked an appointment for him to see a doctor. On 1 August, Dr A reviewed Mr Martindale who said that he felt better, had no nausea or vomiting and was eating and drinking normally. Dr A advised Mr Martindale to seek medical advice as soon as possible if he developed abdominal pain, nausea, vomiting or fever in future. Dr A noted that his jaundice was reduced and asked for the blood tests to be repeated. Mr Martindale did not attend an appointment on 15 August, but he saw Dr A on 29 August, who told him that his blood test results were normal
29. At 10.55pm on 17 October, Nurse C saw Mr Martindale because he had stomach pain and did not feel able to work the next day. She noted that when she arrived, he was able to get out of bed and walk to the wing gate to speak to her. He told her that he thought that the pain was caused by his gallstones as it felt the same. He had passed urine without problem and had no issues eating or drinking. Nurse C told him to take his painkillers (which he had not taken) to see if that eased the pain and to see a nurse the following morning if he still felt ill and was unable to go to work.
30. At 3.22am the following morning, 18 October, Nurse C went back to review Mr Martindale. When she arrived, he was asleep. He awoke and told her that the pain had not eased and that he had seen some blood in his urine. His temperature was normal and he had a NEWS score of 0. (The National Early Warning – NEWS - score is a tool used by medical services to quickly determine the degree of illness of a patient. A score above 0 indicates a deterioration in clinical condition. A score of 7 or more indicates a high clinical risk.) She gave him a urine pot and asked him to provide a sample when he could for testing. She advised him to take more paracetamol and to see a nurse at the medication hatch in the morning.
31. There is no record that Mr Martindale saw a nurse on 18 October and no records in his prison or medical records that he reported feeling unwell.
32. At about 12.10pm on 19 October, Officer A was in the wing office when she heard the wing alarm bell. (Mr C, the Head of Safer Prisons, said that there are 11 rooms on a spur, and officers were not allowed to go onto the spur alone.) Officer A asked Officer B to telephone the healthcare team who, she said, were already aware that Mr Martindale was not feeling well. (Mr Martindale had told Officer A earlier in the week that he had stomach pain and she was aware that he had seen a nurse at the medication hatch.) She then went to the spur with Officer B. Two prisoners told her that Mr Martindale was unwell in his cell. Officer A pushed open Mr Martindale's cell door, saw faeces on the floor and Mr Martindale slumped in the chair, with his eyes closed. She tried to wake him and after two attempts, he opened his eyes and closed them again.
33. Nurse B, Ms F, a healthcare assistant, and Mr G, the Head of Healthcare, went to Mr Martindale's cell. Nurse B noted that Mr Martindale was sitting upright in his chair, was unable to talk and was incontinent of faeces. He was breathing, had a low pulse rate (30 beats per minute), low blood oxygen saturation levels (70%) and a high temperature (38.9 degrees). Nurse B was unable to record his blood pressure. She asked for an ambulance to be called and gave him oxygen.

34. At 12.20pm, Officer B telephoned the control room and said that this was a medical emergency code blue (which indicates that a prisoner is unconscious or not breathing) and asked for an ambulance. Two ambulances went to Wymott because there were two medical emergencies at the prison. The first ambulance arrived at 12.35pm, and the second at 12.56pm.
35. A paramedic noted that Mr Martindale's stomach appeared large and caused him discomfort. His respiratory rate was high and he had a National Early Warning Score of 15, indicating a high clinical risk.) Paramedics took Mr Martindale to hospital, unrestrained but with two escort officers.
36. At 10.35pm that day, Nurse C telephoned the hospital. She noted that Mr Martindale was in the intensive care unit and that hospital staff were intubating and ventilating him. She noted that hospital doctors said that he may have sepsis caused by a gallbladder or bile duct infection.
37. Mr Martindale's condition deteriorated and at 4.15am on 20 October, he died of a severe infection.

Contact with Mr Martindale's family

38. At 4.17pm on 19 October, Mr H, a custodial manager, told Mr Martindale's partner that he had been taken to the Royal Preston Hospital.
39. At 1.25am on 20 October, Officer C gave a hospital nurse Mr Martindale's partner's telephone number. A hospital doctor told her that he was very ill. When Mr Martindale died, his partner and his family were with him.
40. On 20 October, Ms D, the Head of Safety, appointed Officer D as the family liaison officer and Mr E, a prison chaplain, as the deputy family liaison officer. At 9.45am, Officer D spoke to Mr Martindale's partner and offered her condolences and support.
41. Mr Martindale's funeral took place on 20 November, and Wymott contributed to its cost in line with national instructions.

Support for prisoners and staff

42. The staff care team offered support to the officers who were on duty when Mr Martindale became ill and who were at the hospital when Mr Martindale died.
43. The prison posted notices informing other prisoners of Mr Martindale'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 Martindale's death.

Post-mortem report

44. A post-mortem examination found that the cause of Mr Martindale's death was biliary sepsis (a severe infection of the biliary tract) caused by gallstone disease.

Findings

Clinical care

45. The clinical reviewer found that the care that Mr Martindale received at Wymott was equivalent to that which he could have expected to receive in the community. His existing health conditions were assessed and reviewed in a timely manner. Mr Martindale had regular reviews for his pre-existing conditions and healthcare staff frequently took his clinical observations.
46. Mr Martindale developed gallstones which were treated in hospital. He was listed for an operation to remove the gallbladder but he developed sepsis before this took place.

Reviewing Mr Martindale

47. After Mr Martindale reported feeling unwell at 10.55pm on 17 October, the nurse who saw him told him to take his painkillers and went back to see him at 3.22am the following morning. She noted that he was sleeping and when he woke up, he told her that he still had stomach pain and some blood in his urine. The nurse appropriately noted a NEWS score of 0, which is within normal limits, and that his temperature was normal. She advised Mr Martindale to go to the medication hatch in the morning if he still felt ill and was unable to go to work. He did not do so and there is no record to confirm whether he went to work.
48. The clinical reviewer concluded that the nurse acted appropriately in advising Mr Martindale to report to the medication hatch on 18 October as his NEWS score did not indicate anything of concern, and she found that there was nothing further that the nurse could have done.
49. However, Mr Martindale had had surgery to remove his gallstones, was awaiting further surgery to have his gallbladder removed and had been told by a prison GP on 17 July that he should seek medical help “as soon as possible” if he had abdominal pain. While we appreciate that the nurse reviewed Mr Martindale in the early hours of the morning, and checked his NEWS score and temperature, we are concerned that in the context of his medical history, the nurse did not arrange for healthcare staff to review him the next morning, particularly as he also reportedly had blood in his urine. There are no medical records for 18 October and we would have expected healthcare staff to have checked on him rather than expecting him to report to them again when he had already complained of continued stomach pain. We therefore make the following recommendation:

The Head of Healthcare should ensure that when a prisoner with a more complex medical history reports health concerns overnight, healthcare staff should review him the next day rather than waiting for him to present to them again.

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