Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Hart, a prisoner at HMP Wymott, on 1 September 2019

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.

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 Peter Hart died in hospital on 1 September 2019 of pneumonia caused by a stroke, while a prisoner at HMP Wymott. He was 74 years old. I offer my condolences to those who knew him.

I am not satisfied that the healthcare that Mr Hart received at Wymott was equivalent to that which he could have expected to receive in the community. There is no evidence that staff completed a thorough reception health screen or that they conducted a secondary health screen for him as they should have done. I am also concerned that when Mr Hart's blood pressure was elevated, staff made no plans to monitor his blood pressure levels.

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 **March 2020**

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Summary

Events

1. On 4 September 2015, Mr Peter Hart was sentenced to life in prison for sexual offences. He was transferred to HMP Wymott on 9 February 2018.

2. His reception health screen at Wymott was incomplete. There were no observations taken and no follow-up screens arranged.

3. The first record of a blood pressure check for Mr Hart was on 13 June 2018. As the reading indicated that his blood pressure was elevated, a prison GP arranged for a nurse to review his pressure. Two days later, a nurse completed another blood pressure check and his reading was still elevated. However, she took no further action.

4. In June 2019, Mr Hart complained that he felt short of breath. A prison GP diagnosed a chest infection and prescribed antibiotics and paracetamol. No one took his observations.

5. On 13 July, Mr Hart slipped in his cell. A prison nurse noted that he was breathing but was confused and had been incontinent of urine. She suspected that he had had a stroke and arranged for an emergency ambulance to take him to hospital. Two officers escorted Mr Hart, to the hospital, restrained with a single cuff. His restraints were reviewed at hospital and his restraints changed to an escort chain.

6. Hospital staff treated Mr Hart with intravenous antibiotics and noted that his blood pressure was still elevated. He had suffered an intercranial bleed (bleeding inside the brain). Escort staff removed his restraints on 15 July and they were not used again. His condition deteriorated and he died of aspiration pneumonia caused by a stroke on 1 September.

Findings

7. The clinical reviewer found that Mr Hart’s clinical care at Wymott was not equivalent to that which he could have expected in the community. She was concerned that Mr Hart’s initial health screen was incomplete, that healthcare staff did not arrange a secondary health screen, and did not monitor his blood pressure readings or take appropriate action when his blood pressure was found to be elevated.

8. On 4 June 2019, when Mr Hart was unwell, healthcare staff did not use the National Early Warning Score (a tool to assess unwell patients) as they should have done.

Recommendations

- The Head of Healthcare should ensure that all newly arrived prisoners have a comprehensive initial health screen, including that their medical history is reviewed and any health concerns identified, and that a secondary health screen is appropriately documented.

- The Head of Healthcare should ensure that healthcare staff use the National Early Warning Score (NEWS) tool to assess prisoners effectively and ensure that any clinical deterioration is appropriately addressed.
- The Head of Healthcare should ensure that clinical staff assess and manage prisoners effectively to enable good standards of care, including that:
    - all treatment and care is fully documented in prisoners' medical records to allow effective continuity of care; and
    - clinical staff are aware of the triggers for escalation and when to organise further investigations.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Wymott informing them of the investigation and asking anyone with relevant information to contact her. Two people responded and said that they had seen Mr Hart's decline. They said that prison staff and healthcare staff had treated Mr Hart poorly due to his difficult behaviour.

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

11. NHS England commissioned an independent reviewer to review Mr Hart's clinical care at Wymott.

12. We informed HM Coroner for Lancashire and Blackburn with Darwen of the investigation. He shared the cause of Mr Hart's death with us. We have sent him a copy of this report.

13. Mr Hart had no contact with his family while he was in prison and had not identified a next of kin. We have therefore not been able to contact his family about our investigation.

14. 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

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

HM Inspectorate of Prisons

16. 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 inadequate.

Independent Monitoring Board

17. 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

18. Mr Hart was the eleventh prisoner to die at Wymott since September 2017. Five of these previous deaths were due to natural causes and three deaths were drug-related. In 2019, Wymott agreed three times to implement by November 2019 our recommendations that prisoners should be offered a secondary health screen within seven days of arrival. The Head of Healthcare confirmed that the new reception process now includes arrangements for a secondary screen. Two prisoners have died of natural causes since Mr Hart's death, and their deaths are under investigation.

Key Events

19. On 4 September 2015, Mr Peter Hart was sentenced to life in prison for sexual offences and sent to HMP Liverpool. He was transferred to HMP Wymott on 9 February 2018.

20. A nurse conducted an initial health screen in Reception when Mr Hart arrived at Wymott. She noted that healthcare staff at Liverpool had very recently diagnosed Mr Hart with depression for which they had prescribed mirtazapine, an antidepressant. She prescribed his medication and offered him advice about stopping smoking (which he declined). There is no record that she conducted any health or general wellness checks, took any observations or referred him for any secondary health screens.

21. On 13 June, Mr Hart complained that his legs were itchy. A prison GP examined him and checked his blood pressure which was high (158/92mmHg). A nurse reviewed his blood pressure on 20 June, and it was again high (210/120mmHg). She noted that Mr Hart's blood pressure should be checked again in two days and that if it remained high, he should be referred to a GP. There is no evidence that his blood pressure was reviewed or that he was referred to a GP.

2019

22. On 4 June 2019, Mr Hart told a nurse that he was short of breath. She checked his observations and noted that his blood pressure was high (160/85mmHg), his heart rate was elevated (103bpm), his temperature was in the normal range (36.8˚C) and his oxygen saturation level was a little low (95%). She did not check his National Early Warning Score (NEWS, a tool used to detect clinical deterioration) but arranged for him to see a GP.

23. On 6 June, a prison GP reviewed Mr Hart and diagnosed a chest infection, for which he prescribed antibiotics and paracetamol. He booked a chest x-ray. There is no record that any observations were taken.

24. On 13 July, a nurse examined Mr Hart as he had slipped in his cell. She noted that he was breathing but was confused and had been incontinent of urine. His oxygen saturation level was a little low (95%). She suspected that he had had a stroke and arranged for an emergency ambulance to take him to hospital. Two officers escorted Mr Hart, restrained with a single cuff, to the hospital. When he was admitted to hospital, he was restrained instead with an escort chain.

25. Hospital staff treated Mr Hart with intravenous antibiotics and noted that his blood pressure remained elevated and that he had had an intercranial bleed (bleeding inside the brain). His restraints were removed on 15 July and were not used again. His condition deteriorated and he died on 1 September at 10.05pm.

Contact with Mr Hart's family

26. Mr Hart had not named anyone as his next of kin, he had never received any prison visits and he had no contact with his family. Prison staff were unable to locate Mr Hart's family when he died. Wymott arranged and paid for Mr Hart's funeral.

Support for prisoners and staff

27. After Mr Hart's death, a duty prison manager debriefed the escort staff who were with him in hospital to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

28. The prison posted notices informing other prisoners of Mr Hart'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 Hart's death.

Cause of death

29. The Coroner accepted the cause of Mr Hart's death from the hospital doctor as aspiration pneumonia caused by a right thalamic bleed (a stroke).

Findings

Clinical care

30. The clinical reviewer found that Mr Hart's clinical care at Wymott was not equivalent to that which he could have expected in the community. Her main concerns were that healthcare staff did not arrange a secondary health screen and did not monitor his blood pressure or take appropriate action when his blood pressure was elevated.

Reception and secondary health screens

31. Prison Service Order (PSO) 3050 on the continuity of healthcare emphasises the importance of continuity in the success of clinical interventions and treatment. A reception health screen should ensure that a prisoner is referred to a specialist if he has healthcare issues. When Mr Hart arrived at Wymott, healthcare staff continued his prescription of antidepressants but failed to refer him to the mental health team or take his clinical observations such as blood pressure, pulse rate and oxygen saturation levels.

32. PSO 3050 also gives guidance on the clinical management of prisoners. As well as initial health assessments, the PSO requires prisons to offer newly arrived prisoners a secondary general health assessment a week after their initial health screen in Reception to gather further information about their health and check how they are settling. The Head of Healthcare said that Mr Hart had been offered a secondary health screen but had not attended. However, there is no evidence of this in his SystmOne medical records.

33. Wymott had agreed to implement our previous recommendations about secondary health screens by November 2019. As this was after the date of Mr Hart's arrival in February 2018, we have not repeated our previous recommendation.

34. The Head of Healthcare told the clinical reviewer that the health screen process has changed since Mr Hart's arrival at Wymott to merge the initial and secondary health screens. This is not in line with PSO 3050 and the clinical reviewer has flagged her concerns about this to the NHS England Commissioning Team. We make the following recommendation:

The Head of Healthcare should ensure that all newly arrived prisoners have a comprehensive initial health screen, including that their medical history is reviewed and any health concerns identified, and that a secondary health screen is appropriately documented.

35. When Mr Hart reported being short of breath on 4 June 2019, healthcare staff monitored him but did not complete a NEWS assessment which should be used routinely when a prisoner is unwell. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff use the National Early Warning Score (NEWS) to assess prisoners effectively and ensure that any clinical deterioration is appropriately addressed.

36. We are also concerned that healthcare staff did not appropriately address Mr Hart's elevated blood pressure. The clinical reviewer said that it was difficult to say if the elevated blood pressure readings from 2018 contributed to Mr Hart's stroke. However, healthcare staff should have followed up Mr Hart's elevated blood pressure reading on 4 June 2019. There is no evidence that Mr Hart's blood pressure was subsequently checked or that he had any follow-up blood tests which might have prompted further investigations about how best to manage his high blood pressure. We recommend that:

The Head of Healthcare should ensure that clinical staff assess and manage prisoners effectively to enable good standards of care, including that:

- **all treatment and care is fully documented in prisoners' medical records to allow effective continuity of care; and**
- **clinical staff are aware of the triggers for escalation and when to organise further investigations.**

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