Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Ridehalgh, a prisoner at HMP Wymott, on 1 October 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*

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 Mark Ridehalgh died in hospital of a heart attack on 1 October 2019, while a prisoner at HMP Wymott. He was 51 years old. I offer my condolences to his family and friends.

The clinical reviewer was satisfied that the healthcare Mr Ridehalgh received at HMP Wymott was equivalent to that which he could have expected to receive in the community. However, she was concerned that he did not have a repeat blood test when he should have done.

I am concerned that staff did not call a medical emergency code when Mr Ridehalgh reported chest pains, and that he was inappropriately restrained when he was transferred to hospital while having a heart attack.

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 **January 2021**

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Summary

Events

1. On 1 September 2015, Mr Mark Ridehalgh was sentenced to 14 years in prison. He was transferred to HMP Wymott on 21 April 2017.

2. Mr Ridehalgh had no known health concerns, other than deafness in his left ear, and was not prescribed any regular medication. He lived on the Vulnerable Prisoners' Unit (VPU).

3. On 8 October 2018, Mr Ridehalgh was referred to a nurse following a routine blood test because he had high triglyceride levels. (Triglycerides are a type of fat, and high levels raise the risk of heart disease.) On 16 October, a nurse reviewed Mr Ridehalgh and noted that he would arrange for him in to have a further blood test in January 2019. There is no evidence that this happened.

4. At 7.30pm on 1 October 2019, a prisoner pressed the landing bell on the VPU as Mr Ridehalgh had chest pains and a sore arm. An officer responded but was not able to enter the unit as she was on duty alone. She contacted the healthcare department by telephone and asked a nurse to attend immediately.

5. A prisoner pressed the landing bell again as Mr Ridehalgh's condition was getting worse. The officer responded but still could not enter as she was alone.

6. On her way back to the wing office to ask for more staff to attend, the officer came across another officer. They returned to the landing together and entered the VPU. Mr Ridehalgh was lying on the floor, with pillows under his body and head, still conscious and talking to other prisoners. He reported chest pains and tingling in his arm. The officers left the wing to contact healthcare staff when they were satisfied that Mr Ridehalgh was breathing and conscious.

7. Shortly afterwards, two nurses arrived at the VPU and went to Mr Ridehalgh's cell. They staff took Mr Ridehalgh's observations and conducted an electrocardiograph (ECG) which suggested that Mr Ridehalgh had had a heart attack.

8. An ambulance was requested at 7.58pm and arrived at 8.35pm. The paramedics conducted another ECG which indicated that Mr Ridehalgh was having a heart attack.

9. At 9.09pm, Mr Ridehalgh was transferred to hospital, escorted by two officers and restrained with an escort chain.

10. Mr Ridehalgh died shortly after surgery in hospital at 10.53pm.

Findings

11. The clinical reviewer found that the healthcare Mr Ridehalgh received at HMP Wymott was of a reasonable standard and was at least equivalent to that which he could have expected to receive in the community.

12. She was, however, concerned that there is no evidence that nursing staff booked a repeat blood test for January 2019 for Mr Ridehalgh after he was found to have raised triglyceride levels in October 2018, and that there is no evidence that he had such a test. High triglyceride levels can indicate a raised risk of heart disease. We cannot say whether Mr Ridehalgh's underlying heart disease may have been identified if his triglyceride levels had been monitored.

13. We are concerned that staff failed to radio a medical emergency code immediately on 1 October 2019 when Mr Ridehalgh reported chest pains. This led to a delay of 28 minutes before an ambulance was called. We cannot say whether the outcome might have been different if an ambulance had been called earlier.

14. We are also concerned that Mr Ridehalgh was inappropriately restrained when he was transferred to hospital on the day he died.

Recommendations

- The Head of Healthcare should put a system in place to ensure that repeat blood tests are appropriately scheduled and take place.
- The Governor should ensure that all staff understand PSI 03/2013 and radio a medical emergency code appropriately.
- The Governor should ensure that this report is shared with Officer B and with Officer A (if she is still employed by HMPPS) and that a senior manager discusses the Ombudsman's findings with them.
- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.
- The Governor should ensure that a copy of this report is shared with a prison manager and that a senior manager discusses the Ombudsman's findings with her.

The Investigation Process

15. 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. No one responded.

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

17. NHS England commissioned a clinical reviewer to review Mr Ridehalgh's clinical care at the prison. The clinical reviewer interviewed two members of healthcare staff.

18. We informed HM Coroner for Lancashire and Blackburn with Darwen of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

19. One of the Ombudsman's family liaison officers contacted Mr Ridehalgh's mother and partner to explain the investigation and to ask if they had any matters they wanted to be considered in the investigation. They had no specific questions but wanted a copy of this report.

20. 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.

21. Mr Ridehalgh's mother and partner received a copy of the initial report. They did not make any comments.

Background Information

HMP Wymott

22. HMP Wymott is a medium security prison which holds over 1,100 adult men. 40% of the population are Category C prisoners and 60% have been convicted of a sexual offence.

23. Bridgewater Community NHS Trust and Greater Manchester Mental Health Trust provide healthcare services, including GP surgeries, dentistry, specialist clinics and mental health services.

HM Inspectorate of Prisons

24. 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

25. 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 2019, the IMB reported that although there had been significant improvements in healthcare provision, they remained concerned that in some areas, it continued to fall below the statutory duty to provide a service of equivalent standard to that in the community.

Previous deaths at HMP Wymott

24. Mr Ridehalgh's death was the tenth death at Wymott since October 2017. Of the previous deaths, six were from natural causes, one was drug-related and in two cases the cause of death has not yet been determined. Since Mr Ridehalgh died, there have been three more deaths at Wymott, all from natural causes.

25. We previously made a recommendation about the inappropriate use of restraints in a report dated April 2019 which Wymott agreed to implement.

Key Events

26. On 1 September 2015, Mr Mark Ridehalgh was sentenced to 14 years in prison for sexual offences.

27. On 21 April 2017, he was transferred to HMP Wymott. A nurse who is now the Head of Healthcare, completed Mr Ridehalgh's initial and second reception screening. She noted that he was deaf in his left ear but otherwise, had no physical health issues.

28. Mr Ridehalgh lived in the Vulnerable Prisoners' Unit (VPU), a dormitory-style landing, accessed through a gate at one end. Prisoners are free to leave their cells at night and visit other cells. Each prisoner has a key to their own cell which they are able to lock from the inside and outside. Staff keys override the locks.

29. On 17 and 18 May 2017, a member of staff noted in Mr Ridehalgh's medical record that he had had an ECG. However, there is no evidence that Mr Ridehalgh had had an ECG and the Head of Healthcare was unable to explain this entry.

30. On 8 October 2018, Mr Ridehalgh had a healthcare check. A blood test showed that his triglyceride levels were elevated (indicating a raised risk of heart disease) and an appointment was made for him to see a nurse.

31. On 16 October, a nurse reviewed Mr Ridehalgh and noted that he was overweight. The nurse discussed the importance of having a healthy diet and noted that he would arrange for him in to have a further blood test in January 2019. There is no evidence that this happened.

32. On 1 October 2019, at 7.30pm, a prisoner pressed the landing bell in the VPU to get the attention of prison staff. Officer A was in the wing office upstairs and immediately went to the VPU. She was not able to enter the unit as she was on duty alone, and spoke to an unnamed prisoner through the gate. The prisoner told her that Mr Ridehalgh had chest pains and a sore arm. Officer A asked if Mr Ridehalgh was breathing and talking and the prisoner said that he was. She told him that she would ask healthcare staff to review him.

33. Officer A returned to the wing office and at 7.40pm, she phoned the control room to ask them which member of the healthcare team she should contact. Staff in the control room told Officer A to contact a nurse in the healthcare department, who was the immediate response duty member of the healthcare team that day. Officer A telephoned the nurse and explained that a prisoner had told her that Mr Ridehalgh had chest pains and a sore arm, and asked her to attend. Officer A noted that the nurse said that Mr Ridehalgh had no medical history and that she would attend. Officer A returned to the VPU and told the prisoners that healthcare staff were on their way.

34. Two nurses went to the VPU with the emergency bag and ECG machine (which was located in the healthcare department).

35. Before the nurses arrived, Officer A responded to a second landing bell on the VPU. A prisoner told Officer A that Mr Ridehalgh's condition was getting worse and that his face had become "washed out".

36. At 7.45pm, Officer A went to the wing office to ask another officer to attend so that they could enter the VPU together. On her way, she met Officer B by chance and explained the situation. They went back to the landing and entered the VPU. Prisoners told them that they had put Mr Ridehalgh in the recovery position on the floor.

37. When Officer A and Officer B arrived at Mr Ridehalgh's cell, he was lying on the floor, with pillows under his body and head, still conscious and talking to other prisoners. Officer A asked Mr Ridehalgh how he was feeling. He said that he was not good as he had chest pains and pins and needles in his right arm. He said that he had not been feeling right since tea time, but that he had had his tea and felt better afterwards.

38. Officer A said that she and Officer B were satisfied that Mr Ridehalgh was breathing and conscious, so they left the wing to contact healthcare staff and report his condition.

39. Shortly afterwards, the two nurses arrived at the VPU and went to Mr Ridehalgh's cell with Officer A and Officer B. A nurse told us that there were a number of prisoners in Mr Ridehalgh's cell and that Mr Ridehalgh was lying on the floor, with his head on a pillow. Mr Ridehalgh said that he had central chest pain, with tingling down his right arm. The nurse asked him to get onto his bed for an assessment (as it was not usual practice to treat chest pain on the floor).

40. The nurses took Mr Ridehalgh's observations, calculated his national early warning score (NEWS2) which indicates clinical deterioration, and attached the leads for the ECG machine. Mr Ridehalgh's temperature was slightly low and his respirations and oxygen saturation levels were within the normal range. His NEWS2 score was 1, indicating a low clinical risk.

41. A nurse took the results of the ECG to an office nearby and telephoned Broomwell (a remote ECG interpretation service that can analyse ECG readings and report the findings quickly to the healthcare team). Broomwell said that the ECG suggested that Mr Ridehalgh had had a heart attack

42. At 7.58pm, the nurse telephoned the communication room and requested an ambulance. The ambulance service did not give an estimated time of arrival. Mr Ridehalgh was given aspirin and glyceryl trinitrate spray (used to relieve chest pain).

43. At 8.20pm, the nurse contacted the communication room again and asked them to call the ambulance service again as Mr Ridehalgh's symptoms were getting worse. The ambulance service estimated that an ambulance would arrive in eight minutes.

44. At 8.35pm, the ambulance crew arrived and were given a full handover. Paramedics attached their own ECG machine and confirmed that Mr Ridehalgh was having a heart attack. He was transferred to the ambulance in a wheelchair.

45. At 9.09pm, Mr Ridehalgh was transferred to hospital. He was escorted by two officers and restrained with an escort chain. At 10.30pm, an officer telephoned the prison to say that Mr Ridehalgh would be admitted to hospital and that his restraints had been removed for surgery.

46. Shortly after surgery, Mr Ridehalgh went into cardiac arrest and died at 10.53pm.

Contact with Mr Ridehalgh's family

47. At 11.05pm, the Reverend was appointed as the family liaison officer (FLO). Mr Ridehalgh's partner was listed as his next of kin. At 1.30am on 2 October 2019, the FLO visited her and broke the news of Mr Ridehalgh's death. He offered his condolences and support. Later that day, the FLO learned that Mr Ridehalgh's mother was his legal next of kin, and he liaised with her from that point onwards.

48. Mr Ridehalgh's funeral took place on 31 October. The prison contributed to the cost, in line with national instructions.

Support for prisoners and staff

49. After Mr Ridehalgh's death, a prison manager debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

50. The prison posted notices informing other prisoners of Mr Ridehalgh'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 Ridehalgh's death.

Post-mortem report

51. The post-mortem concluded that Mr Ridehalgh died of acute myocardial infarction (a heart attack) caused by coronary heart disease (the reduction of blood flow to the heart muscle due to the build-up of plaque in the arteries of the heart) for which he had surgery immediately before his death.

Findings

Clinical care

52. The clinical reviewer concluded that the care that Mr Ridehalgh received at HMP Wymott was of a reasonable standard and was at least equivalent to that which he could have expected to receive in the community. She found that Mr Ridehalgh had no known underlying medical conditions and did not attend the healthcare department regularly.

53. She noted that the blood test result in October 2018 indicated an elevated triglyceride level but that it was not excessive. She also noted that it was unclear whether Mr Ridehalgh had followed the dietary advice which the healthcare team gave him. She found that his weight was not documented in his medical record and, therefore, there was no indication of whether he lost weight after October 2018.

Repeat blood tests

54. After a blood test which showed raised triglyceride levels, a nurse reviewed Mr Ridehalgh on 16 October and noted that he would arrange for him to have a further blood test in January 2019. There is no evidence that this took place. The clinical reviewer concluded that as there is no evidence that Mr Ridehalgh attended an appointment in January, it is possible that the appointment was not made.

55. We are concerned that Mr Ridehalgh did not have another blood test in January 2019, and there is no evidence that a nurse arranged for him to have one, as planned. We cannot know whether this may have led to a diagnosis of heart disease, which may in turn have changed the outcome for Mr Ridehalgh. We make the following recommendation:

    The Head of Healthcare should put a system in place to ensure that repeat blood tests are appropriately scheduled and take place.

Non-clinical care

Calling a medical emergency code

56. Prison Service Instruction (PSI) 03/2013 sets out the framework for radioing a medical emergency code to ensure a timely, appropriate and effective response to medical emergencies and maximise the likelihood of a positive outcome for the prisoner.

57. We consider that Officer A should have used a medical emergency code on 1 October as soon as prisoners told her that Mr Ridehalgh had chest pains. This would have triggered the control room to call an ambulance immediately. Instead, Officer A telephoned the control room 10 minutes later and then telephoned healthcare staff.

58. There was a second missed opportunity to call a medical emergency code when Officers A and B entered the VPU and Mr Ridehalgh told them he had chest pains. Instead, they returned to the wing office to contact healthcare staff.

59. An ambulance was not called until 28 minutes after Officer A was first told that Mr Ridehalgh had chest pain. We cannot say whether the outcome might have been different for Mr Ridehalgh if an ambulance had been called sooner, but doing so may be critical in another emergency. We make the following recommendations:

The Governor should ensure that all staff understand PSI 03/2013 and radio a medical emergency code appropriately.

The Governor should ensure that this report is shared with Officer B and with Officer A (if she is still employed by HMPPS) and that a senior manager discusses the Ombudsman's findings with them.

Restraints, security and escorts

60. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account a prisoner's health and mobility.

61. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when he has a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

62. On 1 October, a prison manager concluded that two officers should escort Mr Ridehalgh to hospital using 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) and that the restraints should only be removed for medical treatment or in an emergency with prior approval. She noted in the escort risk assessment that once Mr Ridehalgh was stable, a single cuff restraint could be applied.

63. Mr Ridehalgh was assessed as posing a low risk to the public, females and hospital staff and of hostage taking, escape and external assistance. He was assessed as posing a high risk to children. There were no medical objections to the use of restraints but the escort risk assessment noted that his limited mobility affected his ability to escape and that his condition was life-threatening. The security assessment in the escort risk assessment recognised that Mr Ridehalgh was having a heart attack.

64. Mr Ridehalgh was assessed as posing a low risk of escape, was having a heart attack and needed a wheelchair to go to hospital. In this context, we do not consider that the decision-making process was in line with the requirements of case law and took into account his poor mobility and health. There is no evidence to explain how restraining Mr Ridehalgh was proportionate to the risk he posed, especially as he was escorted by two officers. We are not satisfied that staff considered his risk at the time or that healthcare staff had stated that his medical condition limited his mobility.

65. We made a recommendation about the inappropriate use of restraints following a previous investigation and Wymott agreed to implement it in April 2019. We are, therefore, concerned that restraints were again used inappropriately when Mr Ridehalgh was taken to hospital in a few months later. More effective action now needs to be taken to ensure that staff understand how to make defensible decisions about the use of restraints on prisoners with serious medical conditions.

66. We make the following recommendations:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Governor should ensure that a copy of this report is shared with a prison manager and that a senior manager discusses the Ombudsman's findings with her.

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