

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Wellings, a prisoner at HMP Rye Hill, on 25 April 2020

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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Summary

1. 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.
2. 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 David Wellings, who was 74 years old, died of ischaemic heart disease, bronchopneumonia (pneumonia that causes swelling in the air sacs of the lungs), lung fibrosis (the result of damage and scarring of the lungs) and systemic hypertension (high blood pressure in the cardiovascular arteries) on 25 April 2020, while a prisoner at HMP Rye Hill. We offer our condolences to Mr Wellings' family and friends.
3. The clinical reviewer concluded the care Mr Wellings received at HMP Rye Hill was equivalent to that which he could have expected to receive in the community.
4. We did not find any non-clinical issues of concern.

Investigation Process

5. NHS England commissioned an independent clinical reviewer to review Mr Wellings' clinical care at HMP Rye Hill.
6. The PPO investigator has investigated non-clinical issues, including Mr Wellings' location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
7. One of the PPO's family liaison officers wrote to Mr Wellings' next of kin, his brother, to explain the investigation. He did not raise any issues or concerns with the care Mr Wellings received while at Rye Hill.
8. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at Rye Hill

9. Mr Wellings was the 13th prisoner to die at Rye Hill since April 2018. All the previous deaths were from natural causes. There are no similarities between our findings in the investigation of Mr Wellings' death and the previous deaths.

Key Events

10. On 27 June 2014, Mr David Wellings was sentenced to 13 years and six months imprisonment for sexual offences. He was sent to HMP Birmingham.
11. During his initial health screen, a nurse noted that Mr Wellings had been previously diagnosed with asthma and type 2 diabetes. Careplans were created to manage his conditions and he was regularly reviewed by healthcare staff.
12. On 24 July 2014, he transferred to HMP Rye Hill. Following an initial healthscreen, Mr Wellings' prescribed medications and careplans were reviewed and updated.
13. Aside from regular reviews by healthcare staff for the symptoms of his conditions, and a hospital admission in October 2017 for injuries he sustained in a fall in his cell, Mr Wellings had little significant contact with either healthcare, or secondary care staff over the years that followed.
14. On 13 December 2019, Mr Wellings was reviewed by a prison GP after he had reported suffering from intermittent vomiting for the previous six months. She referred him for blood tests, the results of which revealed he had a cortisol level of 101.8 nmol/L (a normal cortisol reading is between 119-618 nanomoles per litre, low levels of cortisol can cause weakness, fatigue and low blood pressure). He was referred to secondary care for a lower gastrointestinal review.
15. On 13 January 2020, Mr Wellings was reviewed by a nurse after he again reported feeling nauseous. He noted Mr Wellings was difficult to rouse, suffering from incontinence and that his skin felt cold and clammy to the touch. He took his observations and noted he was suffering from tachycardia (a raised heartrate).
16. A nurse decided to send Mr Wellings to Coventry Hospital by emergency ambulance for review. Hospital staff took the decision to admit him as an inpatient to enable them to carry out tests to determine the cause of his symptoms. However, despite those tests, they could find nothing of note. Mr Wellings was discharged back to Rye Hill on 17 January. Following his discharge from hospital, he was regularly reviewed by healthcare staff.
17. On 18 February, a prison GP reviewed Mr Wellings after he had reported becoming doubly incontinent. He was concerned that Mr Wellings had developed an acute kidney injury and carried out a kidney function test. The results of the test again revealed nothing of note. He prescribed Mr Wellings finasteride (used to treat an enlarged prostate, often a cause of incontinence.)
18. Mr Wellings' earlier referral for a lower gastrointestinal review was carried out on 21 March. Following their review, hospital staff diagnosed him as suffering from diverticular disease (a condition in which small pouches form in the lining of the bowel eventually pushing out through the wall of the bowel.)
19. On 27 March, Mr Wellings was reviewed by a mental health nurse at the prison. However, she was unable complete her assessment as Mr Wellings was not able to fully engage with the process. She planned to review him again to carry out a mini mental state examination (MMSE, a 30-point questionnaire designed to assess levels of cognitive impairment.)

20. On 9 April, a prison GP reviewed Mr Wellings. He noted he was frail, drowsy, unable to enter into conversation, significantly dehydrated and was still doubly incontinent. Following his review, the GP considered that Mr Wellings did not have the capacity to make informed decisions about his care.
21. Later the same day, an MDT meeting (multidisciplinary meeting attended by representatives of areas of the prison involved in his care) was held to discuss Mr Wellings' increasing care needs. Following the meeting, a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order was put in place by a prison GP and he was subject to 30-minute reviews by both healthcare, and social care, staff. Mr Wellings' condition continued to deteriorate.
22. At 7.11am on 25 April, a nurse discovered Mr Wellings had stopped breathing. A prison paramedic immediately confirmed his death.
23. The coroner gave Mr Wellings' cause of death as:
 - 1a) ischaemic heart disease
 - 1b) bronchopneumonia
 - 2) lung fibrosis, systemic hypertension

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