Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Kevin Heron, a prisoner at HMP Wymott, on 1 September 2020

**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*

# 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.

3. Mr Kevin Heron, who was 60 years old, died of an intraventricular haemorrhage and Moyamoya disease on 1 September 2020, while a prisoner at HMP Wymott. We offer our condolences to Mr Heron's family and friends.

4. The clinical reviewer concluded that the care Mr Heron received at HMP Wymott was equivalent to that which he could have expected to receive in the community. However, she has made three recommendations.

5. We did not find any non-clinical issues of concern.

## Recommendations

- The Head of Healthcare should ensure that care plans are initiated and developed in a timely manner.
- The Head of Healthcare should review the processes already in place, and the training currently given to healthcare staff, for the completion of risk assessments.
- The Head of Healthcare should ensure that any meetings held in respect of a prisoner's care are documented in his or her medical records in a prompt and timely manner.

## Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Heron's clinical care at HMP Wymott.

7. The PPO investigator has investigated non-clinical issues, including Mr Heron's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

8. One of the PPO's family liaison officers wrote to Mr Heron's next of kin, his brother, to explain the investigation. He did not respond to our letter.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found one factual inaccuracy which we have addressed in the report.

## Previous deaths at Wymott

10. Mr Heron was the 13th prisoner to die at Wymott since September 2018. Of the previous deaths, ten were from natural causes, one was a drug-related death and one is awaiting classification. There are no similarities between our findings in the investigation of Mr Heron's death and the previous deaths.

## Key Events

11. On 11 April 2002, Mr Kevin Heron was remanded into custody charged with murder and assault. He was sent to HMP Durham. On 20 December 2002, he was sentenced to life imprisonment.

12. On 20 August 2003, he transferred to HMP Liverpool. On 20 February 2007, he transferred again, to HMP Garth. Aside from routine reviews, he had little significant contact with healthcare staff.

13. However, on 19 June 2010, Mr Heron was admitted to Royal Preston Hospital, after suffering a stroke. He suffered two further strokes in September of the same year. Care plans were created, and he was subject to regular reviews by both healthcare, and secondary care staff.

14. On 10 June 2011, Mr Heron transferred to HMP Wymott. At an initial health assessment, a prison nurse noted he had been previously diagnosed with epilepsy. She also noted he had previously suffered a number of strokes which had caused him left sided weakness and mobility issues. His prescribed medications were reviewed, and care plans were updated. Referrals were made to secondary care providers to ensure continuity of his care and he was referred to specialist clinics at the prison who managed his conditions. Mr Heron was noted to be a heavy smoker and was offered smoking cessation advice, which he eventually accepted.

15. While at Wymott, Mr Heron was the subject of several medical emergencies, primarily as a result of chest pains and breathing difficulties.

16. On 26 June 2020, he was again the subject of a code blue medical emergency, after falling in his cell and striking his head. He was taken to hospital by emergency ambulance and admitted as an inpatient. A computerised tomography scan (CT) revealed he had three areas of bleeding on his brain, which were treated using prescribed medication. He was discharged back to Wymott on 29 June. His prescribed medications and care plans were reviewed and updated, and he was regularly reviewed by healthcare staff.

17. On 21 August, while Mr Heron was being helped from his bed to his chair, he became vague and unresponsive. Healthcare staff considered he may have suffered another stroke. He was taken to Royal Preston Hospital by prison minibus accompanied by two prison officers. Following a review by hospital staff, he was diagnosed with a subarachnoid haemorrhage (an uncommon type of stroke caused by bleeding on the surface on the brain). In an attempt to stabilise his condition, Mr Heron was placed into an induced coma.

18. The following day, he underwent a surgical procedure to insert an external ventricular drain at the base of his skull (used to relieve the pressure caused by the swelling between the brain and the skull). Following the procedure, he was moved to the hospital's intensive therapy unit (ITU). Mr Heron's condition continued to deteriorate.

19. On 29 August, hospital staff told the staff accompanying Mr Heron, that palliative care was the only treatment option left for Mr Heron. He was moved from ITU to a normal ward at the hospital.

20. At 1.20am on 1 September, Mr Heron died. His death was confirmed by a hospital doctor at 1.25am.

21. The Coroner concluded that Mr Heron died of died of intraventricular haemorrhage (a bleed on the brain) and Moyamoya disease (a narrowing of the blood vessels to the brain).

**Lisa Burrell** **May 2021**
**Assistant Ombudsman**