Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stanislav Slisko, a prisoner at HMP Wymott, on 7 July 2020

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

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 Stansilav Slisko died from heart disease on 7 July 2020 at HMP Wymott. He was 46 years old. I offer my condolences to Mr Slisko's family and friends.

The investigation found that the care Mr Slisko received at Wymott was of a reasonable standard and was mostly equivalent to that which he could have expected to receive in the community.

However, I am concerned that when officers found Mr Slisko unresponsive on his cell floor on the morning of 7 July, they did not start cardiopulmonary resuscitation (CPR). There was a short delay before another officer arrived and started CPR. We cannot say if the delay affected the outcome for Mr Slisko, but we know that in a medical emergency a delay of a few minutes may be critical.

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 2021**

Contents

Summary

Events

1. On 20 December 2016, Mr Stanislav Slisko was remanded in custody for rape, sexual assault and threats to kill. He was subsequently sentenced to 12 years and three months in prison. On 16 January 2020, he was moved to HMP Wymott.

2. Mr Slisko had several long-term health conditions including chronic lymphoid leukaemia, suspected epilepsy, heart disease and high blood pressure. He was prescribed appropriate medication and seen regularly by healthcare staff.

3. On 7 July, at around 10.44am, a prisoner told staff that Mr Slisko was lying on the floor of his cell. Two officers went to Mr Slisko's cell and found him lying unresponsive on the floor. One of the officers called a medical emergency code and left the cell to get a more experienced officer.

4. When the third officer arrived a minute or so later, he saw that Mr Slisko looked blue and immediately started cardiopulmonary resuscitation (CPR). Healthcare staff responded to the code and continued CPR until the paramedics arrived.

5. At 11.07am, paramedics arrived at the cell. They examined Mr Slisko and at 11.10am, pronounced him dead. The post-mortem examination found that Mr Slisko died from heart disease.

Findings

6. The clinical reviewer found that overall, Mr Slisko's care was of a reasonable standard and was mostly equivalent to that he could have expected to receive in the community. She noted that when Mr Slisko was moved from HMP Garth to Wymott, staff at Garth had not given a full handover. She also noted that staff at Wymott did not update his care plans. However, as neither issue impacted on Mr Slisko's death, we have not included her recommendations in this report.

7. We are concerned that there was a delay in the emergency response. When the officers found Mr Slisko lying unresponsive on his cell floor, neither started CPR. There was a delay of a minute or so before a third officer arrived, and immediately started CPR. We cannot say whether the delay affected the outcome for Mr Slisko, but we know that in a medical emergency a delay of a few minutes may be critical.

Recommendations

- The Governor should ensure that all prison staff understand that they should administer basic life support as needed until healthcare staff arrive.

- The Governor should share this report with Officer A and Officer B and arrange for a senior manager to discuss the Ombudsman's findings with them.

The Investigation Process

8. 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

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

10. NHS England commissioned a clinical reviewer to review Mr Slisko's clinical care at the prison. The clinical reviewer conducted joint interviews with the investigator. Due to coronavirus restrictions, the interviews were conducted by telephone.

11. We informed HM Coroner for Lancashire and Blackburn of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted Mr Slisko's son to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. He did not respond.

13. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Wymott

16. HMP Wymott, which is near Preston in Lancashire, is a medium secure prison holding over 1,100 adult men. Greater Manchester Mental Health Trust provide healthcare services at the prison. There are no inpatient beds but there is 24-hour nursing cover.

HM Inspectorate of Prisons

17. The most recent full inspection of HMP Wymott was in October 2016. Inspectors reported that Wymott remained a reasonably safe prison and staff-prisoner relationships were generally respectful. Healthcare provision was weak, and in some areas potentially unsafe. The inspectors considered that the care of prisoners with chronic conditions was not good enough.

18. In August 2020, HMIP conducted a short scrutiny visit at Wymott. Inspectors reported that, the lack of senior healthcare leadership, staffing vacancies, weak governance arrangements and the poor pharmacy working environment resulted in delays in delivering medications to prisoners, and created unnecessary risks. However, it was also reported that, primary care staff were providing wing-based triage and treatment, and appointments in the health care department were well managed,

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 2020, the IMB noted that there had been improvements in the provision of primary healthcare, most notably the introduction of an in-house pharmacy which had led to better and more regular distribution of medication.

20. However, several long-standing problems, which had been raised in previous reports, persisted. The healthcare centre remained too small, with insufficient treatment rooms and waiting rooms which were frequently overcrowded. Healthcare staffing remained an issue with undue reliance on agency staff in all areas, although a number of these staff were long-term. This had led on occasion to staffing shortfalls which in turn led to the cancellation of clinics and late distribution of medication.

Previous deaths at HMP Wymott

21. Mr Slisko was the 12th prisoner to die at Wymott since July 2018. Of the previous deaths, ten were from natural causes and one was drug-related. There were no similarities between the circumstances of Mr Slisko's death and previous deaths at the prison.

Key Events

22. On 20 December 2016, Mr Stanislav Slisko was remanded in custody for rape, sexual assault and threats to kill. He was later sentenced to 12 years and three months in prison. He spent time at HMP Doncaster and HMP Leeds before being sent to HMP Garth in April 2018.

23. On 16 January 2020, Mr Slisko was moved to HMP Wymott. He had several long-term health issues, including chronic lymphoid leukaemia (a type of cancer of the blood and bone marrow), suspected epilepsy, heart disease and high blood pressure. He had also previously suffered bleeds in the brain and a stroke. He was prescribed medication for epilepsy, dizziness/vertigo, heart disease and high blood pressure and was under the care of the hospital's haematology department for his leukaemia and the neurology department for his suspected epilepsy.

24. On the evening of 27 May, Mr Slisko complained of a headache, dizziness and numbness of the left side of his tongue and lips. A nurse took his clinical observations, which were normal apart from raised blood pressure. Staff agreed to monitor him.

25. On 28 May, a nurse assessed Mr Slisko and found that his blood pressure was very high. He continued to feel dizzy and thought his symptoms were similar to those he had before his stroke in 2017. A prison GP saw Mr Slisko later that morning. Mr Slisko was still complaining of a headache, dizziness and loss of sensation in his tongue. The GP found that Mr Slisko's blood pressure had come down but was still high. He made an urgent referral to the Ear, Nose and Throat (ENT) Department at the hospital.

26. Mr Slisko had a telephone appointment with an ENT consultant on 10 June. The consultant referred Mr Slisko for a balance assessment (to determine the cause of the dizziness) and to the neurology department. Mr Slisko had a telephone appointment with the neurology department on 22 June. They noted that Mr Slisko had been seizure free for over a year so they told him his medication regime would stay the same and they would review him again in 12 months.

27. On 1 July, a prison GP saw Mr Slisko who said he was still experiencing mild dizziness, but he had no body weakness and his headache had improved.

28. On 2 July, Mr Slisko was seen in the haematology department at the hospital. He reported that he felt well. Blood tests suggested a mild progression of his leukaemia, but he did not meet the criteria for treatment and would continue to be managed under the 'watch and wait' approach.

29. At approximately 10.44am on 7 July, a prisoner alerted Officer A that Mr Slisko was lying unresponsive on his cell floor. Officer A and Officer B went to the cell and saw Mr Slisko lying on the floor with a duvet draped over him. Officer A said that Mr Slisko was blue in colour. She used her radio to call a code blue (a medical emergency code used to indicate that a prisoner is unconscious or having breathing difficulties that alerts healthcare staff and tells the control room to call an ambulance).

30. Officer A then left the cell to find a more experienced member of staff and to call the control room. On Officer A's way to the office she saw another officer. She told him that Mr Slisko was on the floor and was unresponsive.

31. The officer went straight to Mr Slisko's cell. He said that he could see Mr Slisko was grey in colour and was not breathing, so he immediately started cardiopulmonary resuscitation (CPR). At 10.47am, a nurse and a prison GP responded to the code blue and took over CPR.

32. At 11.07am, ambulance paramedics arrived. They examined Mr Slisko and at 11.10am, pronounced him dead.

Contact with Mr Slisko's family

33. On 7 July, the prison appointed the prison chaplain, as the family liaison officer (FLO). Mr Slisko's only listed next of kin was his solicitor. When the prison contacted her, she said that she had not spoken to Mr Slisko for over two years. The FLO found Mr Slisko's cousin's number on his PIN phone so contacted him to break the news of Mr Slisko's death.

Support for prisoners and staff

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

35. The prison posted notices informing other prisoners of Mr Slisko'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 Slisko's death.

Post-mortem report

36. The post-mortem report concluded that Mr Slisko died from left ventricular hypertrophy (thickening of the walls of the left ventricle, the heart's main pumping chamber) caused by aortic valve disease (poor functioning of the valve between the left ventricle and the aorta, the main artery in the body).

Findings

Clinical Care

37. The clinical reviewer concluded that the clinical care Mr Slisko received at Wymott was of a reasonable standard and was mostly equivalent to that he could have expected to receive in the community. Staff appropriately assessed and supported Mr Slisko with his physical health needs and responded promptly to his health concerns.

38. The clinical reviewer was concerned that when Mr Slisko was moved from Garth to Wymott, staff at Garth did not do a full handover of his complex medical and neurological health needs. She also noted that staff at Wymott did not update Mr Slisko's care plans to reflect that he had moved prisons. However, as these issues did not impact on Mr Slisko's death, we have not included the clinical reviewer's recommendations in this report.

Emergency response

39. In May 2019, the Governor at Wymott issued a notice to staff that clearly set out the expectations of staff who are first on scene to a life threatening medical emergency. The notice says, '*If you are one of the first on scene and you find an individual in a life threatening medical situation, you must immediately check for signs of life. You must the [sic] initiate basic life support if you are trained to do so, or summon a First Aider via the radio net and continue with basic life support until Healthcare staff arrive.'*

40. When Officer A went to Mr Slisko's cell she saw Mr Slisko lying on the floor looking blue in colour, and she appropriately called a code blue. However, we are concerned that Officer A did not check for signs of life or start CPR. When asked at interview why she had not started CPR, she said that it was because she had never done it before and did not know what to do in that situation, even though she confirmed that she had been trained in first aid. We are also concerned that Officer A left the cell to get another officer, and then went to the office to call the control room. When we interviewed Officer A, she told us that she had never dealt with a situation like that before so wanted to get a more experienced member of staff.

41. Officer B, who had only been a prison officer for five days, said that he stayed in the cell and tried to feel for a pulse, but said that he could not find a pulse and that Mr Slisko was not breathing. We are concerned that Officer B did not start CPR immediately even though he had recently received first aid training that included CPR.

42. A minute or so later, another officer arrived at the cell, he immediately started CPR and continued until the nurse arrived and took over. We cannot say whether there would have been a different outcome for Mr Slisko had CPR been started sooner, but we know that in a medical emergency a delay of a few minutes may be crucial. We therefore make the following recommendations:

The Governor should ensure that all prison staff understand that they should administer basic life support as needed until healthcare staff arrive.

The Governor should share this report with Officer A and Officer B and arrange for a senior manager to discuss the Ombudsman's findings with them.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100
F I 020 7633 4141