Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Gerald Downey, a prisoner at HMP Wayland, on 15 May 2021

**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 Gerald Downey died of a heart attack on 15 May 2021, while a prisoner at HMP Wayland. He was 62 years old. We offer our condolences to Mr Downey's family and friends.

4. The clinical reviewer concluded that the clinical care that Mr Downey received at Wayland was of the required standard and equivalent to that which he could have expected to receive in the community.

5. The clinical reviewer was however concerned that Mr Downey's National Early Warning Score 2 (NEWS2 – a tool to detect acute illness) was not recorded alongside his observations and considered this would have supported clinical assessments. She was also concerned that healthcare staff did not record the results of Mr Downey's electrocardiogram (ECG) in his records. She made two recommendations, reflected below.

6. We did not identify any non-clinical issues of concern.


### Recommendations

- The Head of Healthcare should ensure that staff use the National Early Warning Score (NEWS) assessment tool and follow the recommended clinical escalation procedures.

- The Head of Healthcare should ensure that staff make full and accurate entries in the prisoner's medical record, including full details of the clinical observations taken.

# The Investigation Process

7. NHS England commissioned to review Mr Downey's clinical care at Wayland.

8. The PPO investigator has investigated the non-clinical issues in Mr Downey's care, including his location, the security arrangements for his hospital escorts and liaison with his family.

9. The investigator interviewed two members of staff from Wayland on 20 August with the clinical reviewer. These interviews were conducted by video conference.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and the clinical review has been amended accordingly. The action plan has been annexed to this report.

11. Mr Downey's family received a copy of the draft report. They asked a question that does not impact on the factual accuracy of this report and has been addressed through separate correspondence.

### Previous deaths at HMP Wayland

12. There were three deaths from natural causes (one of which was related to COVID-19) and one self-inflicted death at Wayland in the two years before Mr Downey's death. There are no significant similarities between our findings in this investigation and those of the other deaths.

# Key Events

13. On 27 February 1996, Mr Gerald Downey was convicted of murder and was sentenced to life in prison. He was initially sent to HMP Manchester and then spent time in several prisons before he transferred to HMP Wayland on 16 May 2019.

14. Mr Downey had a history of arthritis, hypertension (high blood pressure), peripheral arterial disease (narrowed arteries causing reduced blood flow to the limbs), depression and personality disorder. Mr Downey had a painful leg condition called aortoiliac disease (a narrowing of blocked arteries in the legs causing pain, numbness and cramping). He was under the care of a consultant vascular surgeon until December 2020.

### May 2021

15. On 11 May 2021, a nurse reviewed Mr Downey because he had told officers that he had been feeling ill for about a week and was worried that it was COVID-19. The nurse took his observations and was concerned that his pulse was higher than normal and his temperature was low. She arranged an ECG and a blood test, which was sent to Norwich & Norfolk University Hospital (NNUH) for analysis. The nurse did not record Mr Downey's National Early Warning Score (NEWS2) (a tool to standardise the assessment and response to acute illness).

16. The nurse consulted an advanced nurse practitioner who confirmed that the results of Mr Downey's ECG were normal. During the investigation, the clinical reviewer reviewed the record of the ECG, which was signed by the nurse practitioner, although there was no reference to the outcome of the ECG in Mr Downey's healthcare record.

17. At midnight on 12 May, an out of hours doctor from NNUH called the prison and sent an emergency ambulance to collect Mr Downey. The blood test results taken earlier that day indicated that Mr Downey had suffered a heart attack and required urgent medical attention. His troponin levels were dangerously high at 4223.8ng. (The normal range is below 34.3ng - the heart releases troponin into the blood following a heart attack.)

18. Mr Downey was admitted to NNUH immediately. His health deteriorated in hospital and he died on 15 May.

### Cause of death

19. A post-mortem examination was not conducted. The Coroner accepted the cause of death determined by the hospital doctor as myocardial infarction - a heart attack.

# Findings

20. The independent clinical reviewer concluded that the care that Mr Downey received was equivalent to that he could have expected to receive in the community.

21. However, the clinical reviewer was not satisfied that healthcare staff were consistent in their use of NEWS2. She also said that the level of medical recording did not meet national standards. She made two recommendations which we have reflected in this report.

**Sue McAllister CB**
**Prisons and Probation Ombudsman** **December 2021**

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