

**Prisons &
Probation**

Ombudsman
Independent Investigations

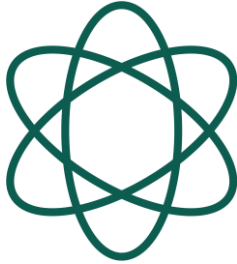
Independent investigation into the death of Mr Mel Orme, a prisoner at HMP Wymott, on 12 December 2022

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

OGL

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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 Mel Orme died of coronary artery atheromatous disease (which causes restricted blood flow to the heart) on 12 December 2022 at HMP Wymott. He was 57 years old. I offer my condolences to Mr Orme's family and friends.

The clinical reviewer concluded that the care Mr Orme received at Wymott was equivalent to that which he could have expected to receive in the community. However, she found that some aspects of Mr Orme's diabetes care fell short of what was expected (although she also noted that Mr Orme managed his diabetes poorly and was frequently non-compliant with his diabetes medication).

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Kimberley Bingham
Acting Prisons and Probation Ombudsman

June 2023

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Summary

Events

1. On 21 October 2019, Mr Mel Orme, who had received a life sentence in 1997, was recalled to prison for committing a further offence. On 31 January 2020, he was sentenced to two years and eight months for sexual offences.
2. On 17 November 2020, Mr Orme was moved to HMP Wymott.
3. Mr Orme had type 2 diabetes, hypertension (high blood pressure) and high cholesterol. He was poor at managing his diabetes and was frequently did not take his diabetes medication as he should.
4. On 7 July 2022, a nurse saw Mr Orme, as he had been vomiting, and found that he had low blood sugar. The nurse advised him to eat something and take his insulin. Later that day, a nurse recorded that Mr Orme was feeling better but still had some dizziness.
5. On 8 July, a nurse conducted an electrocardiogram (ECG - a test to check the heart's rhythm) on Mr Orme, which showed he had an irregular heartbeat.
6. On 9 July, healthcare staff tested Mr Orme's thyroid function and found that he had hyperthyroidism (when the thyroid gland makes too much thyroid hormone), which can cause an irregular heartbeat.
7. On 29 July, the prison GP saw Mr Orme to discuss the results of the ECG. The GP referred Mr Orme to the hospital cardiology department, asking that they monitor Mr Orme's heart for 24 hours.
8. On 2 September, the hospital cancelled Mr Orme's cardiology appointment, as Mr Orme was attending another appointment the same afternoon. The hospital said they could not offer another cardiology appointment until January 2023.
9. At around 8.00am on 12 December, during a welfare check, an officer found Mr Orme unconscious and unresponsive in his bed and called a medical emergency code blue. Healthcare staff attended and assessed that Mr Orme had been dead for some time as he had rigor mortis (stiffening of the body that occurs two to six hours after death). Paramedics confirmed Mr Orme's death at 8.15am.

Findings

10. The clinical reviewer concluded that the care Mr Orme received at Wymott was equivalent to that which he could have expected to receive in the community. However, she had some concerns with aspects of his diabetes care.
11. The clinical reviewer found that when Mr Orme arrived at Wymott, the reception nurse failed to record baseline observations for his blood sugar level, which was important for a person with diabetes. There was no evidence that Mr Orme had a secondary health screen as he should have done. She also found that a

subsequent request by healthcare staff for a special diabetic diet for Mr Orme was never received by the prison kitchen.

Recommendations

- The Head of Healthcare should ensure that second stage health assessments are undertaken in line with NG57 guidance.
- The Head of Healthcare should ensure that blood sugars are taken as baseline at reception/second health screening for those patients with type 1 or type 2 diabetes.
- The Governor and Head of Healthcare should ensure that there is a robust process in place for receipt of information into the kitchens for prisoners' medical diets (for example diabetic diets).

The Investigation Process

12. 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.
13. The investigator obtained copies of relevant extracts from Mr Orme's prison and medical records.
14. NHS England commissioned a clinical reviewer to review Mr Orme's clinical care at the prison.
15. We informed HM Coroner for Lancashire of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
16. The Ombudsman's family liaison officer contacted Mr Orme's sister to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.
17. We shared our initial report with HM Prison and Probation Service (HMPPS). They pointed out some factual inaccuracies which have been amended in this report.

Background Information

HMP Wymott

18. HMP Wymott is a category C prison holding over 1,100 adult men. Healthcare services are provided by Greater Manchester Mental Health NHS Foundation Trust.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Wymott was in August 2020. Inspectors reported that primary care staff were providing wing-based triage and treatment, and appointments in the healthcare department were well managed, with social distance markings on the floor and patients being offered a face covering and hand sanitation.

Independent Monitoring Board

20. 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 31 May 2022, the IMB reported that communication in relation to the appointment system was an ongoing issue. Prisoners complained that they did not receive their appointment slips, they did not know why they were waiting or, having attended the previous day, they were called again needlessly.

Previous deaths at HMP Wymott

21. Mr Orme was the fourteenth prisoner to die at Wymott since December 2020. Of the previous deaths, one was self-inflicted, and the rest were from natural causes. We have previously made recommendations to Wymott about recording clinical observations at the reception health screen and carrying out a secondary screen.

Key Events

22. On 21 October 2019, Mr Mel Orme, who had previously received a life sentence in 1997, was recalled to prison for committing a further offence. On 31 January 2020, he was sentenced to two years and eight months in prison for sexual offences.
23. On 17 November 2020, Mr Orme was moved to HMP Wymott.
24. Mr Orme had type 2 diabetes, hypertension (high blood pressure) and high cholesterol. Records show that Mr Orme often did not check his blood sugar levels or take his diabetes medication as he should.
25. On 7 June 2021, Mr Orme had his annual diabetic review. Healthcare staff decided that Mr Orme needed a special diet and sent a medical diet sheet to the kitchens. However, the kitchen staff did not receive it.
26. On 7 July 2022, a nurse saw Mr Orme because he had been vomiting and had low blood sugar. The nurse took Mr Orme's clinical observations and found that they were normal. The nurse advised Mr Orme to eat something and take his insulin. Later that day, a nurse visited Mr Orme to check on him. The nurse noted that while Mr Orme was feeling better, he was still feeling some dizziness.
27. On 8 July, a nurse conducted an electrocardiogram (ECG – to check the heart's rhythm) on Mr Orme. The ECG showed that Mr Orme had an irregular and slightly slow heartbeat. The nurse recorded that a GP would review the results.
28. On 9 July, healthcare staff tested Mr Orme's thyroid function. They found that Mr Orme had hyperthyroidism (when the thyroid gland makes too much thyroid hormone) which can cause an irregular heartbeat.
29. On 14 July, Mr Orme said he felt unwell, dizzy, sweaty and had been vomiting. A nurse checked on him and found him to be cold and clammy. The nurse took his clinical observations and decided he needed to go to hospital. Hospital doctors diagnosed Mr Orme with COVID-19 and prescribed antibiotics. Mr Orme returned to Wymott the next day.
30. On 28 July, Mr Orme said he felt dizzy and had been vomiting. A nurse saw him and found that he had low blood sugar. The nurse gave him a glucose tablet (sugary tablet) and advised him to eat when taking his insulin. They also conducted an ECG to rule out an irregular heartbeat, which it did.
31. On 29 July, a prison GP saw Mr Orme to discuss the results of the ECG done on 8 July. The GP noted that Mr Orme's chest was clear and recorded that his blood pressure and heart rate were within the normal range. The GP then sent a referral to the hospital cardiology department asking that they monitor Mr Orme's heart for 24 hours.
32. On 2 September, the hospital cancelled Mr Orme's cardiology appointment as Mr Orme was attending another appointment the same afternoon for a different issue. The hospital said that a new appointment could not be offered until January 2023.

33. At around 8.00am on 12 December, during a welfare check, an officer found Mr Orme unconscious and unresponsive in his bed and called a medical emergency code blue. Healthcare staff attended and assessed that he had been dead for some time as he had rigor mortis (stiffening of the body that occurs two to six hours after death) and lividity (bluish-purple discoloration of skin after death). Paramedics arrived at approximately 8.15am and confirmed that Mr Orme was dead.

Contact with Mr Orme's family

34. At around 8.20am on 12 December, the prison appointed a family liaison officer (FLO). The FLO and the Deputy Governor visited Mr Orme's sister to inform her of Mr Orme's death and offer their condolences. The prison offered to contribute to the funeral costs in line with policy.

Support for prisoners and staff

35. After Mr Orme's death, a Custodial Manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
36. The prison posted notices informing other prisoners of Mr Orme'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 Orme's death.

Post-mortem report

37. The post-mortem report concluded that Mr Orme died of coronary artery atheromatous disease (a build-up of fatty material inside the arteries that supply the heart). It also listed aortic valve disease (aortic valves keep blood flowing in the right direction so when these become diseased or damaged it affects blood flow to the rest of the heart and body) and left ventricular hypertrophy (disease of the heart muscle that affects the ability of the heart to pump blood around the body as contributory factors).

Findings

38. The clinical reviewer concluded that the care Mr Orme received at HMP Wymott was equivalent to that which he could have expected to receive in the community. She found that prison healthcare staff put in place care plans for Mr Orme's diabetes and high blood pressure, and they monitored him appropriately.
39. However, the clinical reviewer had some concerns with aspects of his diabetes care. She found that the nurse who carried out Mr Orme's reception health screen when he arrived at Wymott did not take a baseline measurement of his blood sugar level, despite knowing Mr Orme had diabetes. There is no evidence that Mr Orme received a secondary health screen, so a baseline measurement was not taken then either. We recommend:

The Head of Healthcare should ensure that second stage health assessments are undertaken in line with NG57 guidance.

The Head of Healthcare should ensure that blood sugars are taken as baseline at reception/second health screening for those patients with type 1 or type 2 diabetes.

40. The clinical reviewer found that following Mr Orme's annual diabetic review in June 2021, healthcare staff decided that Mr Orme needed a special diabetic diet and sent a medical diet sheet to the kitchens. However, kitchen staff did not receive the diet sheet. We recommend:

The Governor and Head of Healthcare should ensure that there is a robust process in place for receipt of information into the kitchens for prisoners' medical diets (for example diabetic diets).

Inquest

41. The inquest, heard on 19 June 2023, concluded that Mr Orme died from natural causes.

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