

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

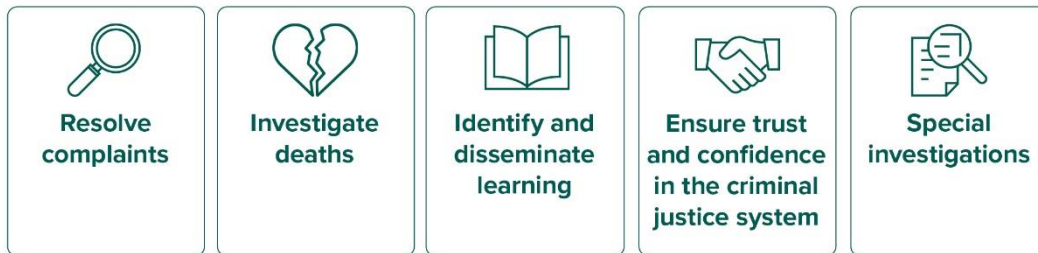
# **Independent investigation into the death of Mr Michael Landymore, a prisoner at HMP Winchester, on 25 April 2022**

**A report by the Prisons and Probation Ombudsman**

## OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

## WHAT WE DO



## WHAT WE VALUE



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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 Michael Landymore died of an upper gastrointestinal bleed on 25 April 2022 at HMP Winchester. He was 75 years old. I offer my condolences to Mr Landymore's family and friends.

I am concerned that when Mr Landymore was found unresponsive in his cell, officers did not tell the control room about the circumstances for two minutes. This did not impact on the outcome for Mr Landymore, but it might make a crucial difference in future emergencies. It is important that staff at Winchester are aware of their responsibility to share all initial information on an emergency quickly, so that it can be relayed to emergency services.

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**

**February 2023**

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# Summary

## Events

1. On 22 April 2022, Mr Michael Landymore was remanded to HMP Winchester.
2. The next day, he reported abdominal pain and was assessed by a prison nurse who provided pain relief.
3. At approximately 8.39am on 25 April, an officer went to Mr Landymore's cell and found him unresponsive. She could not get a response from Mr Landymore so called for assistance from another officer. Another officer arrived quickly and called a code blue (indicating an emergency and requesting an ambulance) at 8.40am.
4. Shortly after the code blue, healthcare staff arrived and found blood around Mr Landymore's mouth and on the floor. Mr Landymore was showing no signs of life. At 8.42am, the prison GP confirmed that Mr Landymore had died. Paramedics arrived at 8.50am.

## Findings

5. The clinical reviewer found that the healthcare Mr Landymore received was equivalent to that which he could have expected to receive in the community.
6. The control room log noted that the prison call operator had to ask officers three times for the initial information to pass on to the ambulance service. It took officers two minutes to clarify the circumstances of the emergency. This did not impact on the outcome for Mr Landymore, who was showing no signs of life and was pronounced dead shortly after he was found. However, in other circumstances, a delay in notifying the control room of the nature of an emergency could be crucial. They require initial information when liaising with emergency services, who prioritise calls or provision of advice over the phone according to the information that they are given.

## Recommendations

- The Governor should remind staff of their responsibility to communicate all of the relevant initial information on an emergency to the control room as quickly as possible, as set out in Winchester's Emergency Call Out Protocol 2018.

## The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Winchester informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
8. The investigator obtained copies of relevant extracts from Mr Landymore's prison and medical records.
9. NHS England commissioned an independent clinical reviewer to review Mr Landymore's clinical care at the prison.
10. We informed HM Coroner for Portsmouth and South East Hampshire of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
11. The Ombudsman's family liaison officer contacted Mr Landymore's next of kin, to explain the investigation and to ask if they had any matters they wanted us to consider. They asked for a copy of the report and had no questions.
12. Mr Landymore's family received a copy of the draft report. They raised an issue that did not impact on the factual accuracy of this report and have been addressed through separate correspondence.
13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

## **Background Information**

### **HMP Winchester**

14. HMP Winchester holds up to 564 men. It has a local category B unit for young and adult men and a separate category C unit for adult men. Practice Plus Group provide the healthcare and substance misuse services.

### **HM Inspectorate of Prisons**

15. The most recent inspection of HMP Winchester was in February 2022. Inspectors found that healthcare staff performed health screenings for prisoners entering into Winchester in a timely manner and they made appropriate referrals for physical healthcare when required. When discussing Winchester's emergency responses, Inspectors noted that ambulances were called automatically when an emergency code was radioed.

### **Independent Monitoring Board**

16. 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 2020 - 2021, the IMB reported that Winchester has continued to progress and has now been removed from the prison performance support programme.

### **Previous deaths at HMP Winchester**

17. Mr Landymore was the 14<sup>th</sup> prisoner to die at Winchester since March 2020. Of the previous deaths, nine were from natural causes, three were self-inflicted and one is yet to be determined. Since Mr Landymore's death, there have been two further deaths at Winchester, due to natural causes. There are no similarities between the findings in these investigations and those identified in the case of Mr Landymore.

## Key Events

18. On 22 April 2022, Mr Michael Landymore was remanded to HMP Winchester. At his initial health screening, healthcare staff noted that he had reduced mobility and was on medication for high blood pressure, high cholesterol (a fatty substance in the blood), heart disease and heartburn.
19. On 23 April, a nurse assessed Mr Landymore after he reported abdominal pain. She did not find any concerns but provided pain relief.
20. At 7.15am on 25 April, a supervising officer (SO) completed the morning unlock and roll check on Mr Landymore's wing. The SO wrote in his statement that he looked into Mr Landymore's cell and saw him lying down on his left-hand side. He could not see Mr Landymore's head because of the position of the observation hatch in the cell door, but he did not have any concerns.
21. At approximately 8.39am, an officer went to Mr Landymore's cell to ask if he wanted a shower. The officer called out to Mr Landymore through his observation hatch but got no response. She opened the cell door and found him half on the mattress with his legs hanging off the bed and blood on the floor. She could not get a response from Mr Landymore or find a pulse so called for assistance. An officer responded and could not find Mr Landymore's pulse, so called a code blue (an emergency radio code which communicates that a prisoner is not breathing).
22. At 8.40am, the prison control room recorded that a code blue had been called. Control room staff asked officers if Mr Landymore was breathing and conscious but did not receive a response through the radio.
23. Shortly after the code blue, healthcare staff arrived and recorded blood around Mr Landymore's mouth and on the floor. Mr Landymore was showing no signs of life.
24. At 8.41am, an officer told the control room that Mr Landymore was 'non-conscious'. They asked him to clarify what that meant, and he said that an ambulance was needed but not urgently. Control room staff recorded that there was no clear information about the emergency but called the ambulance service anyway.
25. At 8.42am, the prison GP confirmed Mr Landymore's death. An officer relayed the information to the control room.
26. At 8.50am, an ambulance arrived.

## Contact with Mr Landymore's family

27. Winchester appointed a family liaison officer, who attended the address of Mr Landymore's next of kin to inform them of his death.
28. Winchester offered to contribute to Mr Landymore's funeral expenses, in line with national policy.

## **Support for prisoners and staff**

29. After Mr Landymore's death, the duty governor 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.
30. The prison posted notices informing other prisoners of Mr Landymore's death and offering support.

## **Post-mortem report**

31. The post-mortem report concluded that Mr Landymore died of an upper gastrointestinal bleed (a bleed in the upper intestines) caused by biliary sepsis (sepsis of the bile ducts and gallbladder), gastric erosions (inflammation of the stomach caused by damage) and gallstones (small stones that form in the gallbladder). The coroner also listed heart disease, cardiomegaly (enlarged heart) and chronic obstructive pulmonary disease (a lung condition which causes breathing difficulties) as contributory factors.

# Findings

## Clinical Findings

32. The clinical reviewer found that the healthcare Mr Landymore received was equivalent to that which he could have expected to receive in the community.

## Non-clinical findings

### Emergency response

33. Prison Service Instruction (PSI) 03/2013 requires prisons to have a local protocol in place for clear communication of medical emergencies between prison staff and the prison control room, to ensure that the control room can quickly contact the emergency services when required. PSI 03/2013 was reissued in September 2021 with additional instructions that staff using medical emergency codes must also provide relevant information about the condition of the prisoner to control room staff, so that they can pass it onto the ambulance service.
34. According to Winchester's local emergency call out protocol, published in 2018, control room staff should have a patient's gender, breathing status, presentation description and age (if available) to pass onto the ambulance service.
35. When officers found Mr Landymore unresponsive in his cell, they quickly called a code blue. However, when the control room answered the call, officers did not provide any further information on the emergency. Control room staff requested clarification on three occasions, but it took officers two minutes to respond. Mr Landymore was showing no signs of life and the delay did not impact on the outcome. However, it is important that staff keep the control room updated with all initial information in the event of an emergency so that the appropriate action can be taken by emergency services, who prioritise calls or provision of advice over the phone according to the information that they are given. We make the following recommendation:

**The Governor should remind staff of their responsibility to communicate all of the relevant initial information on an emergency to the control room as quickly as possible, as set out in Winchester's Emergency Call Out Protocol 2018.**

## Inquest

36. The inquest, held on 5 June 2023, concluded that Mr Landymore died from natural causes.

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