Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Patrick Williams, a prisoner at HMP Leyhill, on 6 July 2022

A report by the Prisons and Probation Ombudsman

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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

Resolve complaints

Investigate deaths

Identify and disseminate learning

Ensure trust and confidence in the criminal justice system

Special investigations

WHAT WE VALUE

Ambitious thinking

Professional curiosity

Diversity & inclusion

Transparency

Teamwork

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 Patrick Williams died on 6 July 2022, at HMP Leyhill. His cause of death was cardiac failure (the heart is unable to pump blood round the body), caused by coronary artery thrombosis (blockage of a vessel to the heart muscle) due to coronary atheroma (build-up of fatty material within the arteries) and cardiomegaly (an enlarged heart). Mr Williams was 57 years old. I offer my condolences to his family and friends.

The clinical reviewer concluded that the clinical care that Mr Williams received at HMP Leyhill was equivalent to that which he could expect to receive in the community.

Prison staff did not make an immediate medical emergency response call when Mr Williams died. Although this would not have made a difference on this occasion, in other circumstances a timely call for emergency assistance could be crucial to the outcome.

I am also concerned that prison staff did not contact Mr Williams' family until a week after he had died.

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 **March 2023**

Contents

Summary 1

The Investigation Process.....2

Background Information.....3

Key Events.....4

Findings 7

Summary

Events

1. On 11 October 2006, Mr Patrick Williams was sent to prison for sex offences and false imprisonment. He was later sentenced to Imprisonment for Public Protection (IPP) with a minimum time to serve of 15 years. He was transferred to HMP Leyhill on 6 October 2021.

2. At approximately 5.35am on 6 July 2022, an officer found Mr Williams sat at the desk in his cell, slumped forward. The officer went into the cell and was unable to find a pulse. Another officer attended to check for signs of life and concluded that Mr Williams had died, and that cardiopulmonary resuscitation was not appropriate. At 5.42am, the officer called a medical emergency code blue and explained to the ambulance service that Mr Williams had been dead for some time. The on-call doctor attended and verified the death.

3. On 6 July, the prison nominated a custodial manager to be the family liaison officer.

4. Due to the distance Mr Williams' family lived from the prison, and uncertainty about their address, Leyhill asked local police to inform them of his death. On 7 July, the police confirmed that they had informed the family. No one from Leyhill contacted Mr Williams' family until 13 July, when his cousin contacted the family liaison officer.

Findings

5. Prison staff did not immediately radio a medical emergency code blue when Mr Williams died. Although this had no bearing on the outcome for Mr Williams, in other circumstances an immediate call for medical assistance could be crucial and it is important that prison staff are aware of their responsibilities in a medical emergency.

6. We are concerned that the family liaison officer did not contact Mr Williams' next of kin once they had been notified of his death by the police.

Recommendations

- The Governor should ensure that all prison staff understand their responsibilities during a medical emergency, including that they communicate the emergency without delay using the appropriate medical emergency response code.

- The Governor should ensure that prison staff liaise with families following a death in custody in line with national instructions, including that the family liaison officer initiates and maintains contact with the bereaved family and provides appropriate information and support.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Leyhill informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

8. The investigator visited Leyhill on 19 August 2022. She obtained copies of relevant extracts from Mr Williams' prison and medical records.

9. The investigator interviewed two members of staff on Microsoft Teams on 29 and 30 September.

10. NHS England commissioned a clinical reviewer to review Mr Williams' clinical care at the prison.

11. We informed HM Coroner for Bristol 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. The Ombudsman's family liaison officer contacted Mr Williams' next of kin, his cousin, to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Williams' cousin had some questions not directly relating to this investigation which we have addressed in separate correspondence. She told us that the family were not aware of Mr Williams having any illnesses and asked the following questions which we have addressed in this report:

    - What time was the first and last check on Mr Williams and by whom?
    - What was the time of death?
    - Why did prison staff not notify his family of Mr Williams' death?
    - Why did prison staff not contact the family after they were informed of Mr Williams' death?

13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

14. Mr Williams' family received a copy of the draft report. They did not make any comments.

Background Information

HMP Leyhill

15. HMP Leyhill is an open prison in South Gloucestershire, holding up to 515 prisoners who require minimum security. Some are life sentence prisoners preparing for release.

16. Healthcare services are provided by Inspire Better Health. Nurses are on duty between 7.30am and 4.30pm Monday to Friday and 7.30am and 11.30am on Saturdays and Sundays.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Leyhill was in March 2021. Inspectors reported that Leyhill was, overall, a safe and decent establishment. They found that access to health provision was good and that many prisoners spoke positively about it.

Independent Monitoring Board

18. 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 January 2022, the IMB reported that the prison was safe and fair, that the humane treatment of prisoners is evident, and prisoners' health and wellbeing needs were being met.

Previous deaths at HMP Leyhill

19. Mr Williams was the seventh prisoner to die at Leyhill since July 2020. Since his death there has been one subsequent death. All deaths since July 2020 have been as a result of natural causes.

Key Events

20. On 11 October 2006, Mr Patrick Williams was sent to prison for sex offences and false imprisonment. He was sentenced to Imprisonment for Public Protection (IPP), with a minimum time to serve of 15 years. IPP sentences set a minimum term that should be spent in custody and the prisoner's release must be agreed by the Parole Board.

21. On 6 October 2021, Mr Williams was transferred to HMP Leyhill.

22. Mr Williams had a medical history of sciatica (nerve pain emanating from the back down the leg), diabetes (a condition that causes too much sugar in the blood), hypertension (high blood pressure) and high cholesterol (too much cholesterol in the blood). He also had a history of substance and alcohol misuse.

23. At 11.02pm on 5 July 2022, an Operational Support Grade (OSG) completed the evening roll check on the wing. She reported that when she looked into Mr Williams' cell, he was sat in front of his desk praying and that he appeared happy and well.

Events of 6 July 2022

24. At approximately 5.35am, the OSG and Officer A completed the morning roll check. The OSG found Mr Williams sat at his desk, slumped forward. She entered the room and placed her hand on Mr Williams' neck to check for a pulse and noted that he was cold to touch. She told the officer that Mr Williams was not responding to her. The officer checked Mr Williams and reported that he had no pulse and was cold and rigid. The officers radioed for Officer B, the assistant night manager, to attend. They did not attempt to resuscitate Mr Williams as they both concluded that he had been dead for some time.

25. At approximately 5.37am, Officer B arrived. He identified rigor mortis and agreed that cardiopulmonary resuscitation was not appropriate.

26. At 5.42am, Officer B radioed a medical emergency code blue. (A code blue triggers the control room to call an emergency ambulance.) A Custodial Manager (CM) spoke to Officer B and requested that he called the ambulance himself.

27. At 5.44am Officer B called the emergency services, explained the situation and requested an ambulance attend the prison. The emergency services said that an ambulance could take up to seven hours to arrive.

28. At 9.30am, a prison GP confirmed that Mr Williams had died.

Contact with Mr Williams' family

29. Following Mr Williams' death, the Head of Public Protection nominated a family liaison officer (FLO) and a deputy FLO.

30. On 6 July, the Head of Public Protection identified that Mr Williams' next of kin, his cousin, lived in the London area. Due to the distance that the family lived from the

prison, and uncertainty that the address was correct, he requested that the police attend the address to notify Mr Williams' cousin of his death. He asked the police to provide the family with the contact details for the FLO and to tell them to contact him. The FLO reported that the Head of Public Protection informed him there would be nothing else for him to do at that time.

31. On 7 July, the police informed the FLO that they had notified Mr Williams' cousin of his death.

32. On 13 July, Mr Williams' cousin contacted the FLO. The FLO answered the family's questions regarding property and explained the processes following a death in custody. He agreed to send some more information in the post and to send Mr Williams' property to the family.

33. On 24 July, a prison chaplain contacted the family to discuss Mr Williams' funeral arrangements. She explained that the prison would be holding a memorial service for him.

34. On 25 July, the deputy FLO contacted the family to inform them the coroner was ready to release Mr Williams' body.

35. On 28 July Mr Williams' cousin contacted the deputy FLO to discuss the death certificate and Mr Williams' property. She provided the deputy FLO with the address to send the property to.

36. On 28 July another FLO was appointed. She telephoned Mr Williams' cousin to introduce herself, offer support and discuss the funeral arrangements. She remained in contact with the family until after the funeral.

37. Mr Williams' funeral took place on 30 August 2022. Leyhill contributed to the cost, in line with national instructions.

Support for prisoners and staff

38. Leyhill informed the investigator that after Mr Williams' death, the Head of Residence and Services had debriefed the staff involved in the emergency response. The debrief was to ensure they had the opportunity to discuss any issues arising, and to offer support.

39. The prison posted notices informing other prisoners of Mr Williams' 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 Williams' death.

Post-mortem report

40. A post-mortem examination established that Mr Williams died of cardiac failure (when the heart is unable to pump blood round the body), caused by coronary artery thrombosis (blockage of a vessel to the heart muscle) as well as coronary atheroma (build-up of fatty material within the arteries) and cardiomegaly (an enlarged heart).

Inquest into Mr Williams' death

41. The inquest into Mr Williams' death was held on 15 January 2024 and a verdict of natural causes was recorded. The coroner concluded that Mr Williams' death was due to cardiac failure caused by coronary artery thrombosis and coronary atheroma and cardiomegaly. Hypertensive heart disease was noted as a contributory factor.

Findings

Clinical care

42. The clinical reviewer found that Mr Williams' medical record was of good quality with clearly documented entries relating to care provided. He found that the rationale behind clinical decisions was clearly stated and that care plans were based on logical decision making.

43. The clinical reviewer identified that Mr Williams had some risk factors for coronary atheroma, the most significant of which was that he smoked. He found that healthcare staff appropriately offered smoking cessation advice, which Mr Williams declined.

Emergency response

44. Prison Service Instruction (PSI) 03/2013 on medical emergency response codes sets out the actions that staff should take in a medical emergency. It contains mandatory instructions for Governors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It stipulates that if an emergency code is called over the radio, an ambulance must be called immediately. Leyhill uses the emergency codes 'red' and 'blue' to comply with PSI 03/2013. Examples of the circumstances in which staff should use code blue are when a prisoner has difficulty breathing or is unconscious.

45. There was a delay of around seven minutes from when the night patrol officers identified the emergency until Officer B radioed a medical emergency code blue. We appreciate that this delay made no difference to the outcome, as the officers were clear that Mr Williams had been dead for some time. However, in other circumstances such a delay might make a crucial difference and it is important that staff recognise their responsibilities in a medical emergency. We make the following recommendation:

    The Governor should ensure that all prison staff are made aware of and understand their responsibilities during a medical emergency, including that they communicate the emergency without delay using the appropriate medical emergency response code.

Liaison with Mr Williams' next of kin

46. PSI 64/2011 requires that the death of a prisoner is reported promptly and accurately to the next of kin. The policy states that wherever possible, the family liaison officer and another member of staff must visit, in person, the next of kin or nominated person in order to break the news of the death. Where the prisoner is held a long distance from their next of kin, the policy allows the prison to ask for a family liaison officer from the nearest prison to break the news of the death instead. Where another prison's family liaison officer or the police have visited the family, then a follow up visit by the prison, must be arranged as soon as possible.

47. In interview the Head of Public Protection said that he asked the police to attend the family home as he was not sure if the next of kin contact details were accurate and up to date as no one had visited Mr Williams whilst in prison. The closest next of kin address was in London, so he asked the prison's Police Intelligence Officer to ask local police to check the details and inform the family. While PSI 64/2011 instructs that prisons should consider asking staff from a nearby prison to inform the next of kin when distance is a factor, we are satisfied that uncertainty about Mr Williams' cousin's address meant that it was reasonable that Leyhill asked local police to visit and break the news.

48. The FLO wrote in the family liaison log that the police would inform the family of Mr Williams' death and that the Head of Public Protection told him there was nothing else for him to do. In interview, the Head of Public Protection said that he gave the police the FLO's direct contact details and expected that the family would be in touch as soon as they had been informed. He said he did not recall the conversation with the FLO regarding what actions he should take next, however he expected that the family would be in contact straight away. He said the police did not report back to him to tell him whether or not the family had been informed and he did not check.

49. The FLO said in interview that he had been told that the police would give the family his details and if the family wanted him to contact them then the police would tell him this. He also said he was concerned that he did not have the correct number for the person that the police had informed, so he did not want to make contact himself.

50. We accept that it was reasonable that Leyhill asked the police to help notify the family on this occasion. However, PSI 64/2011 requires the prison to arrange a follow up visit as soon as possible after the family have been notified. There is no evidence that prison staff attempted to confirm that the police had made contact with the family on 6 July. We are disappointed that they made no attempt to contact Mr Williams' family following confirmation from the police that they had been notified. This meant that the family did not receive any support from the family liaison officer until a week after Mr Williams' death and only after they had initiated contact themselves. We make the following recommendation:

The Governor should ensure that prison staff liaise with families following a death in custody in line with national instructions, including that the family liaison officer initiates and maintains contact with the bereaved family and provides appropriate information and support.

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