

**Investigation into the circumstances surrounding the  
death of a man in September 2010,  
at hospital, whilst in the custody of HMP Wymott**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**February 2011**

This is a report into the death of a man at hospital in September 2010, whilst he was in the custody of HMP Wymott. He was 70 years old when he died. A post mortem showed that he died from cancer

I offer my sincere condolences to the man's family and friends for their loss. One of my Family Liaison Team contacted his sister to tell her about the investigation and give her the opportunity to raise any issues about the care her brother received in custody.

The investigation was carried out by my colleague. Both he and I would like to thank the Governor and his staff for their co-operation during the course of our enquiries.

I also thank the local Primary Care Trust for appointing a clinical reviewer to review the man's clinical care.

As he died from natural causes, the findings of the clinical review play an essential part in my report. The review shows that he received good care which was equitable to that which he could have expected in the community. I make no recommendations and I commend the quality of work by healthcare staff and their engagement with him. His sister has asked me to thank prison staff for the help that the family were given both before and after her brother's death. I am pleased to take this opportunity to do so.

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

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**Acting Prisons and Probation Ombudsman**

**February 2011**

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## SUMMARY

1. The man was convicted of sex offences and sentenced to life imprisonment on 6 March 1974. He had a history of angina and was a smoker. He was moved between various prisons until eventually he transferred to HMP Wymott on 13 December 2005.
2. Whilst at Wymott, he had regular contact with healthcare staff. However he often refused treatment, failed to attend appointments with healthcare staff and refused to be referred to outside hospital, despite encouragement and advice.
3. On 10 May 2010, he saw a prison doctor as he complained of swelling in his neck and loss of weight. The doctor referred him to hospital for urgent specialist assessment of suspected cancer. He saw the hospital consultant two days later who confirmed that he had cancer. A treatment plan was put in place which included advice from palliative care nursing specialists.
4. Over the next three months, healthcare staff monitored him every day to make sure that he was not in any pain. He was re-admitted to hospital on five separate occasions for treatment. There were two occasions during this time where he refused to go to hospital despite the advice of healthcare staff.
5. His condition deteriorated on 2 September and he was admitted to hospital. Initially he was accompanied by two escort officers and restrained with an escort chain to make sure that he did not escape. The next day, due to the seriousness of his condition and following a risk assessment, all the restraints were removed. He contacted his sister and she visited him that afternoon. Three days later the escort arrangement was reviewed and reduced to a single officer.
6. On 8 September, his condition deteriorated rapidly. He had been visited by his sister in the afternoon. At 5.30pm hospital staff became concerned that he was very near the end of his life and so they attempted to contact her, but unfortunately without success. He died at 6.00pm.
7. Wymott followed the requirements of Prison Service Order (PSO) 2710 'Follow up to death in custody' and offered financial assistance towards the cost of the funeral.
8. I am satisfied that the care and attention he received was equitable to that he could have expected to receive in the community. I make no recommendations and comment on the good quality of engagement between prison healthcare staff and him.

## **THE INVESTIGATION PROCESS**

9. The investigation was opened on 10 September 2010 when my investigator issued notices announcing the investigation to staff and prisoners and inviting anyone with any information relevant to the investigation to contact him. No one came forward as a result.
10. The investigator visited HMP Wymott on 14 September. During his visit he was given copies of all the documentation relating to the man.
11. The local Primary Care Trust appointed a clinical reviewer to review the man's clinical care. The investigator and the clinical reviewer discussed aspects of his treatment with healthcare staff at Wymott. I am grateful to the clinical reviewer for his report.
12. The investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and request a copy of the post mortem report. Upon completion, the investigation report will be sent to the Coroner to assist his enquiries into the man's death.
13. A member of the Family Liaison Team contacted the man's sister to tell her about the investigation and invite her to ask any questions or raise any concerns about the care her brother received in prison. She said that she believed that he was well looked after at the prison. In particular she said that prison staff always told her when he was taken to hospital and offered to arrange transport for her and their sister to visit him there. She described the officers who were with him at the hospital as helpful. She was grateful for the support she has received since her brother's death, including the help with the funeral arrangements. She was very complimentary about the way the prison had handled matters relating to her brother and she wanted this to be reflected in my report.

## HMP WYMOTT

14. HMP Wymott is a large category C prison which holds sentenced prisoners. Some, like the man, are classed as vulnerable prisoners (prisoners deemed at risk, often due to the nature of their offence) and others are held on ordinary location. The ordinary prisoners and vulnerable prisoners are held in separate accommodation and so Wymott is effectively two separate prisons with their own range of workshops, education and training facilities. The prison opened in 1979 and new accommodation was added in 1996. Vulnerable prisoners mainly live in the original house blocks. Wymott can hold a maximum of 1,176 prisoners.
15. Healthcare services at Wymott are commissioned and provided by the local Primary Care Trust. Services do not include inpatient beds and so prisoners often go to HMP Preston, which has an inpatients unit.
16. Wymott was last inspected by HM Chief Inspector of Prisons (HMCIP) in October 2008. The former Chief Inspector commented that:

“Wymott is a large category C training prison, holding over a thousand men. It has expanded 25% since its last inspection in 2003. Unlike many training prisons which have undergone similar expansion, Wymott has managed to sustain its performance and the quality and quantity of activity available to its prisoners.

“Health services were commissioned and provided by the local Primary Care Trust (PCT), which also commissioned health services for HMPs Garth and Preston. A health needs assessment and health delivery plan had been completed. A partnership board, which met bimonthly, was held jointly for the three prisons.

“The healthcare centre was centrally located. The department was on the first floor, with access by stairs or lift.

“GP services were provided by a private company, and clinics were run every weekday morning and two afternoons each week. Out-of-hours medical cover was provided by the same provider. Although there was no inpatient facility at the prison, there was nursing cover 24 hours a day.

“Some appropriately trained primary care nurses took responsibility for specific life-long conditions. One of the band six nurses had just taken the lead for the care of older people. There were plans to offer all older prisoners health assessments but these had not been implemented. The nurse practitioner ran four clinics a week.”

17. In their annual report for the period ending May 2009, the Independent Monitoring Board (a body of local volunteers who independently monitor and report on the prison) made the following comments:

“The Board considers that the Prison is providing a safe environment in which prisoners are treated with decency and respect and have access to an extensive programme of education and skills. The Senior Management of the Prison have set out to address those areas where prisoners are not treated decently within the limitations of what the Prison can do given its national resource allocation.

“Generally Healthcare in the Prison has improved since its takeover by the PCT and the appointment of a new Healthcare Manager in 2008. However the Board considers that the Unit still has some way to go before it achieves the NHS aim of treating prisoners to the same standard as patients in the community. Given the high concentrations of poor physical and mental health, drug addiction, general low self-esteem and lack of access to private medicine and retail pharmacies, the Board considers the PCT should be offering a service that exceeds what it provides for the general population.

“A lead nurse for elderly prisoners has been designated. Care plans for elderly prisoners are now being developed and the prison has produced an Elderly Prisoner Action Plan as a response to the HMCIP Thematic Review. However due to staffing shortages and pressure of work, the lead nurse has been delayed in producing an individual healthcare plan for each elderly prisoner. A revised induction document has been designed to more fully assess elderly prisoners' medical and social needs and is implemented.”

18. There have been four other deaths at Wymott this year, all of which were due to natural causes. There are no similarities between the man's death and the other deaths at Wymott.

## KEY EVENTS

19. The man was born in July 1940 and, before coming into prison, he lived in Wales. He was convicted of sex offences and sentenced to life imprisonment on 6 March 1974. He had a history of angina and was a smoker.
20. Since being imprisoned, he moved between various prisons until he was transferred to HMP Wymott on 13 December 2005. On arrival he saw Nurse A who completed a healthscreen assessment. (The purpose of the healthscreen is to identify any immediate mental or physical health problems requiring referral to the doctor or other specialist service.) The nurse recorded his weight as 81kg and his blood pressure was 140/85. (The normal range for blood pressure is 100/70 to 140/90, although the pressure does vary throughout the day depending on the individual's activities. A blood pressure reading of greater than 140/90 is classed as high and a reading of 90/60 or below is classed as low.)
21. The nurse also recorded that he had a history of angina and was allergic to penicillin. His prescribed medication was listed as lansoprazole (treatment for gastric ulcers), isosorbide mononitrate (for angina), bisoprolol (for angina and high blood pressure), warfarin (prevents blood clots), perindopril (for high blood pressure), simvastatin (for high cholesterol) and nicorandil (for angina).
22. From 14 December to 15 March 2010, he had regular contact with prison doctors and healthcare staff. His medication was regularly reviewed and he had ongoing blood tests to monitor that he was being given the correct level of warfarin (International Normalised Rates (INR) - the blood is tested to see how long it takes to clot and the warfarin dose is adjusted accordingly). However there were many instances when he would refuse to take his medication, accept treatment or attend hospital appointments, despite the proactive encouragement by healthcare staff. When he refused treatment, he signed a disclaimer to state that his refusal was against the advice of the healthcare staff.
23. On 16 March, Nurse B responded to an emergency call at 7.00pm for medical assistance which was made by staff on the wing. He was choking whilst eating his tea. He told the nurse that he swallowed something that had appeared to have scratched the inside of his throat and had coughed up blood into a tissue. The nurse assessed that the choking episode had resolved itself naturally and reassured him, advising him to contact healthcare immediately if he felt that there was something stuck in his throat.
24. Eight days later, he had another INR blood test to check the correct prescribed level of warfarin and no changes were required. A review was set in place for one month's time. The next review took place on the 14 April, after which the dose was reduced.
25. On 21 April, he saw Prison Doctor A, who recorded that the man said he had stopped smoking the previous week. He had a cough that produced phlegm, pain on the right side of his chest and shoulder and his neck was stiff. The

doctor prescribed cocodamol (pain relief) and antibiotics for a chest infection. At the same time he had a further INR test and the doctor advised him to stop taking his warfarin for the next two days.

26. Two days later he had a further INR test and was prescribed warfarin again with a further review set for one week's time.
27. Another emergency call was made to healthcare on 27 April, as he complained of chest pains. Nurse C responded and saw him in his cell. The nurse recorded that his blood pressure was 140/78, and confirmed that he was currently taking antibiotics and pain relief for shoulder and back pain. The nurse assessed that there were no signs of cardiac problems, and she advised him to contact healthcare immediately if he was in any further pain. The nurse referred him to the doctor the following day.
28. The next day he had a further INR test and he was advised to continue taking his warfarin medication. Prison Doctor A saw him later that morning and referred him to the hospital for further assessment.
29. A risk assessment was completed and two officers escorted him using an escort chain which was to be removed for treatment purposes. (On each occasion when a prisoner is escorted outside the prison to hospital, a risk assessment is completed which considers the risk to the public, the potential for escape and likelihood of outside assistance. The assessment informs the decision about the number of escorting officers and the type of restraint to be used. The restraint can be a handcuffs or a two metre long escort chain with a cuff at either end. The assessment also determines the circumstances and the authority required for the restraints to be removed. The risk assessment is reviewed each day that a prisoner is in hospital and amended where necessary.)
30. He returned to the prison the same day having had x-rays and blood tests whilst he was at the hospital. A hospital doctor confirmed that he had a chest infection and that all other results were negative.
31. On 9 May, he saw Nurse D as he had complained of a painful lump in his neck. The nurse examined him and noted a swelling at the base of his neck on the right-hand side which was painful to the touch. The nurse recorded his blood pressure as 110/71, which is within the normal range, and referred him to see the prison doctor the following morning.
32. Prison Doctor A saw him the next morning. He said that the swelling had appeared in the past few days and he had been losing weight. The doctor assessed that the swelling needed urgent specialist assessment and immediately referred him to the Ear, Nose and Throat (ENT) consultant surgeon at hospital.
33. Two days later he attended hospital for an assessment of his neck. A risk assessment was completed that authorised the same level of restraints, that is two officers to escort him using an escort chain which was to be removed for

treatment purposes. He saw an ENT Consultant Surgeon who diagnosed that he had cancer and decided that he should have more tests before treatment, including a biopsy operation on his neck. The consultant wrote to healthcare at Wymott confirming that he had told the man of the diagnosis and the proposed treatment plan.

34. On 17 May, he saw Prison Doctor B and complained of itchy spots on his back and chest which had appeared in the past few days. The doctor discussed the diagnosis of cancer at length with him. He was prescribed cetirizine (for skin conditions) and naproxen (pain relief).
35. Nurse D saw him on the morning of 23 May, when he came to collect his medication. The nurse noticed that he seemed to be short of breath. He told the nurse that he had pain in the top of his back and the right side of his chest. The nurse recorded his blood pressure as a 110/69 and told him that he would be reviewed later. The nurse and Nurse E went to see him in his cell later in the day and recorded his blood pressure as very low at 82/56. They assessed that he needed further hospital treatment. An emergency ambulance was called to take him to hospital and the same level of restraints was used. After an initial assessment at hospital, he was admitted for treatment.
36. On 1 June, healthcare staff were informed by the hospital that his planned biopsy operation for 4 June had to be cancelled due to another very urgent case. His operation was re-scheduled to 9 June at 11.00am. The hospital advised that he should stop taking warfarin five days prior to his operation. He returned to the prison on 2 June.
37. A week later, he was re-admitted to hospital for his operation. Another risk assessment confirmed that the same level of restraints were to be used. He was discharged from hospital on 10 June, following a pharyngo laryngo esophagoscopy (biopsy of lump in neck). He was seen by Nurse F when he arrived back at the prison. He was to rest his vocal chords for two weeks, and have a soft diet but his medication was unchanged.
38. The next day at 4.47pm, Nurse G saw him as he complained of more chest pains. The nurse recorded his blood pressure as 82/64 and conducted an echocardiogram (ECG), which showed some abnormal results. The nurse discussed his symptoms and ECG results with Prison Doctor C who advised that, if the pain recurred and was constant, he should be taken back to the emergency department at the local hospital.
39. Later at 7.00pm, Nurse A and Nurse H reviewed him in his cell. He told the nurses that the pain in his chest had gone and he felt much better. His blood pressure was recorded as 87/59 and he was advised to rest and call healthcare immediately if he had any more pain. An appointment was made for him to be seen by the doctor the next morning.
40. The following day, 12 June, Prison Doctor A saw him as arranged. The doctor recorded that he was free from chest pain and his blood pressure was 80/62. He assessed the ECG results and explained to him that they indicated the

possibility of a mild heart attack, which had resulted in his low blood pressure. The doctor advised that he needed to go back to hospital but he refused to go. The doctor explained the possible life threatening consequences of his decision, but he still refused. He did agree that, if his condition worsened, he would give his consent to be admitted to hospital.

41. The following morning Nurse H reviewed him and recorded his blood pressure as 102/65. He told the nurse he was anxious about being diagnosed with cancer and worried about his life expectancy. The nurse encouraged him to continue with his daily living activities, reassured him about the support which healthcare staff would give him and told him that he would be seen again the next day.
42. Nurse G saw him on the next morning as arranged. His blood pressure was recorded as 95/61 and he did not complain of any more chest pain. A further ECG was conducted which indicated an improvement from the previous test. The nurse discussed the findings with Prison Doctor A who said that he would review him after his hospital appointment which was due the next day.
43. He attended hospital on 15 June. The same level of restraints were used. He saw consultant otolaryngologist (ENT specialist), who informed him that he had advanced terminal cancer.
44. The following day, Prison Doctor A, accompanied by Nurse A, talked to him about the various treatment options and the involvement of Macmillan palliative care nurses. (Macmillan nurses have at least five years' experience, including two or more years in the field of cancer or palliative care. They provide advice on managing pain and other symptoms, and give psychological support to those diagnosed with cancer.) The doctor recorded that he was to have buprenorphine patches (opiate based pain relief) and his other medication was to be changed to a liquid form wherever possible as it would be easier for him to swallow.
45. Five days later, the doctor saw the man who said he had been sick the previous day. The doctor recorded that he looked weak and tired and he had problems swallowing. The doctor prescribed diazepam (for anxiety), zopiclone (to help him sleep), morphine sulphate (for severe pain) along with metoclopramide (anti-sickness). The doctor also noted that he was due to go to the hospital the next day for a review.
46. Nurse A accompanied him to his hospital appointment on 22 June. The usual levels of restraints were used. He was told by the consultant otolaryngologist that, due to his advanced and widespread cancer, he was being considered for chemotherapy treatment but the doctor could not guarantee that it would be effective. The consultant advised that all of his current analgesic medication (pain relief) was to be discontinued. Instead, oromorph (an opiate based pain relief) was to be given as required every four hours and no more than six times a day. As this a controlled medication it was given to him as required by two nurses in line with the consultant's instructions. The consultant said the morphine sulphate could still be prescribed, but this should be reviewed every

two to three days. His medication was subsequently amended and reviewed over the next few days.

47. On 29 June, Nurse I responded to a call from staff on the wing who were concerned about the man's health. The nurse recorded that his blood pressure was 81/48, which is particularly low, and he complained of pain in his right shoulder. The nurse noted that he had not taken his oromorph since 8.00am that morning. The nurse ensured that he took his medication and told him to contact healthcare staff when he was in pain.
48. The next morning, Nurse A saw him in his cell. He appeared quite weary, complained of pain in his shoulder and found it difficult to lift his right arm. The nurse gave him his prescribed dose of oromorph. The nurse discussed the pain relief with Prison Doctor A and the doctor increased the morphine sulphate to 30mg twice a day with the oromorph still prescribed in accordance with the consultant's instructions.
49. From 1 July, he was seen every day by healthcare staff who reviewed his prescribed medication and pain control. On 5 July, Nurse A recorded that his blood pressure was 101/68 and he appeared very weak. He told the nurse that he felt sick, had vomited every time he ate or drank and had significant chest pain. The nurse called for an emergency ambulance to take him to hospital for further assessment. The previous levels of restraints, that is two officers as escort and an escort chain, were used.
50. He remained in hospital until he was discharged back to prison on 22 July. During this time the escort risk assessment was regularly reviewed and no changes were made. Healthcare staff kept in contact with the hospital by telephone and by visiting him, to remain up to date about his condition.
51. The hospital provided a discharge letter which outlined the medication prescribed for him. Nurse J recorded the detail as:
  - ranitidine elixir (for skin conditions)
  - metoclopramide (for anti-sickness conditions)
  - paracetamol elixir (pain relief)
  - becotide inhaler (for asthma)
  - Fortisip (food supplement drinks)
  - glyceryl trinitrate (GTN) (for angina)
  - salbutamol (for asthma)
  - levomepromazine (strong pain relief)
  - dexamethasone (steroid anti-inflammatory)
  - pregabalin (strong pain relief)
  - diazepam
  - nystatin (for oral infections)
  - OxyNorm liquid (opiate based pain relief)
  - Durogesic Dtrans patch (strong pain relief).

Over the next 12 days, he was seen every day by healthcare staff. He was also visited by the Community Specialist Palliative Care Nurse from the hospice.

52. On 4 August, Nurse K was called to see him in his cell as the wing staff were concerned that he had collapsed. He was lying on his bed and was unresponsive. His blood pressure was recorded as 117/63 and his extremities were cold to the touch. The nurse called for an ambulance to take him back to hospital.
53. The same level of restraints was used. Later that same afternoon, Nurse F contacted the hospital to check on his progress and she was informed that he was being transferred to the Medical Assessment Unit (MAU). He remained in hospital until he was discharged back to prison on 12 August.
54. When he got back to the prison, Nurse H went to see him in his cell. He told the nurse that he experienced difficulty turning his head, but otherwise he was able to move around. He said that he was happy to be back at Wymott. He became tearful when he asked about his life expectancy and the nurse advised him that it was not possible to give him any time scale.
55. Over the following seven days, he saw healthcare staff each day to review and adjust his medication and pain relief.
56. On 20 August, the Parole Board considered an application for his compassionate release from custody. The panel believed that the risk he posed to others was too high to allow his release. However they expected that every effort would be made to ensure that, due to his illness, he would be made as comfortable as possible and receive the best care available.
57. The next day, Nurse H was called by staff on the wing to assess him as he complained of weakness in his right arm. His blood pressure was 94/60. The nurse thought that he had a "definite weakness" to his right side and a slight droop to the right side of his face. The nurse called for an ambulance and he was admitted to hospital under the usual level of restraints (two officers to escort him using an escort chain which was to be removed when treatment was given).
58. He remained in hospital until 31 August, when he was discharged back to prison. Again, healthcare staff maintained contact with the hospital to monitor his progress. He was also seen whilst he was in hospital by a Macmillan nurse at the hospital, who enquired about a hospice.
59. On 2 September, his condition deteriorated again and Prison Doctor C assessed that he needed to be admitted to hospital and requested an ambulance. He initially refused to go to hospital however, after encouragement from the paramedics, he eventually agreed. A further risk assessment was completed that authorised the same arrangements as before.
60. The next day, due to the seriousness of his condition, the risk assessment for the escort arrangements was reviewed and the governor authorised the

removal of the restraints although the bedwatch officers remained. He said that he wished to contact his sister, and he was allowed to telephone her. She visited him at 3.15pm that afternoon.

61. He remained in hospital and, on 6 September a governor reviewed the risk assessment and reduced the number of escorting officers to a single uniformed officer. He continued to receive visits from his sister.
62. By 8 September, his condition had deteriorated rapidly. His sister visited from 1.15pm until 3.40pm that afternoon. At 5.30pm hospital staff assessed that he was near to the end of his life and they attempted to contact his sister but without success. At 6.00pm, the hospital doctor confirmed that he had died.
63. In the days that followed, the prison family liaison officer maintained regular contact with the man's sister to offer support and assist with organising the funeral arrangements, which was held in Wales. Financial assistance was offered towards funeral expenses.

## ISSUES

### Clinical care

64. Both the clinical reviewer and I are satisfied that the care the man received was equivalent to what he could have expected in the community. The clinical review makes the following comments:

“He received appropriate care for his ongoing ischaemic heart disease with suitable assessments of his blood pressure and relevant blood tests. His INR record shows quite considerable variation reflecting his difficulties in complying with the set Warfarin regime. There was a question as to whether he was diabetic going back to the early 2000s. His subsequent blood testing and the blood tests involved in his final illness do not support that diagnosis.”

65. Specifically relating to his diagnosis and treatment of cancer the clinical review makes the following comments:

“The adeno-carcinoma (cancer) which presented in late April/early May unfortunately presented at a stage where it was already not curative.

“He was referred under the (National Health Service) 14 day referral process for suspected cancer which was entirely appropriate and he was seen within two days by the hospital and his diagnosis made very quickly though further investigation was necessary to delineate the origin of his cancer and its spread.

“The prison medical staff received appropriate advice and assistance from the palliative care team, both doctors and the specialist palliative care nurse. ....it would seem appropriate that he was transferred to hospital again for his final days.

“The adeno-carcinoma which he suffered from was not specifically related to any previous healthcare issues and the care received was as good as it could have been in the circumstances.

“The medical nursing staff put a lot of time and effort into caring for him and that in general his wishes were complied with as much as they could be which is commendable. His diagnosis was made in a timely manner and both primary and secondary care was given as appropriate to his needs.”

The clinical reviewer also commented that, considering he was a serving prisoner, he had as much autonomy as possible over where he lived and his “social environment”.

## **Use of restraints**

66. Unfortunately there have been some reports where the Ombudsman has criticised the level of restraints used when prisoners are under escort at outside hospital. It is pleasing therefore to recognise that Wymott ensured that the man was treated with dignity and respect during the emergency response and treatment in hospital, and that the restraints were removed in the final five days of his life. He was frail and did not have long to live. Removing the escort chain gave him some dignity in his last days and, I am sure, was a comfort to his sister.

## CONCLUSION

67. During his time at Wymott, the man had regular contact with the doctors and other healthcare staff which was well documented. He was also well supported by wing staff who often alerted healthcare that his condition had deteriorated. Despite many older prisoners, Wymott does not have any inpatient medical facilities and so the responsibility of supervising terminally ill prisoners rests with wing staff. The nature of the prison's population means that, sadly, they have some considerable experience of looking after men who, like him, do not have long to live. I am pleased to see that he was so well looked after and I am satisfied that the care that he received at Wymott was equitable to that expected in the community. He had a responsibility for his own health and could have accepted medical attention but occasionally exercised his right to refuse treatment.
68. I believe that he was treated with dignity and respect whilst he was in custody both at the prison and when he was admitted to hospital. He was not restrained for the last five days of his life and only one bedwatch officer remained with him. I am pleased to follow his sister's request and pass on her appreciation to the Governor. I hope that her sentiments will be passed on to the staff concerned. Following his death Wymott appropriately followed the guidance given in PSO 2710, "Follow up to death in custody" and again there was good contact with his next of kin.