

**Investigation into the circumstances surrounding the  
death of a man at HMP Wymott  
in November 2007**

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

**June 2008**

This is my report into the death of a man at HMP Wymott. The man died in November 2007 at a local hospital. The cause of death was bronchopneumonia with secondary causes of diabetes mellitus and ischaemic heart disease. The man was aged 58.

My colleagues and I would like to extend our condolences to the man's family and friends for their loss.

This investigation was carried out on my behalf by one of my investigators. In addition, a review of the man's clinical care was conducted by the Deputy Director of Public Health, on behalf of Central Lancashire Primary Care Trust (PCT). The clinical reviewer was asked to ensure that the medical care the man received in prison was comparable to that he which he might have had in the community. I am most grateful for her assistance.

As this report shows, the man had a complex medical history and was receiving regular treatment for diabetes-related health problems. Although she found some evidence of poor medical appointment attendance, the clinical reviewer assesses that the man received regular and appropriate care from the healthcare staff in the prison and at the local hospital.

The clinical reviewer has made two recommendations which I endorse. I have made one further recommendation and highlight two areas of good practice.

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**Prisons and Probation Ombudsman**

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## SUMMARY

The man at the centre of this investigation was released from prison in September 2006, and went to live in an Approved Premises (probation hostel). In October that year, however, he was found to have breached his licence conditions and was recalled to prison. He was initially held at HMP Forest Bank where his reception health assessment identified a history of angina, hypertension, diabetes and two previous myocardial infarctions (heart attacks).

In January 2007, the man was transferred to HMP Wymott. His complex medical history was noted at reception, but his recent prescription list was not available. The man had been receiving treatment for foot ulcerations as a result of his diabetes. Prison healthcare staff made appropriate referrals with the local hospital for specialist treatment and consultations. Whilst at Wymott, the man was also seen regularly by a podiatrist and prison nursing staff at the dressing clinic. He had an insulin pen that he kept in his possession, and he was encouraged to keep a log of his blood glucose levels that could be monitored by healthcare.

During 2007, the man had problems with angina and hypertension, and was admitted to hospital in February after experiencing acute chest pain. He was diagnosed with acute coronary syndrome (an umbrella term for a group of clinical symptoms compatible with poor heart function). In August, the man had a bleed in his left eye. An ophthalmology clinic appointment was arranged but, due to a series of events, he was not seen until September at which point he was scheduled to have laser treatment on his eye.

On 19 November 2007, prison officers contacted the healthcare centre because the man complained of feeling weak and unwell. He was seen in his cell by healthcare staff three times during the day, including an examination by the doctor. A diagnosis of suspected gastrointestinal infection was made. The man was advised to drink fluids hourly and to be regularly reviewed. The following day, when a nurse went to see him, he complained of dizziness and aching limbs. Again he was advised to take fluids and have bed rest. The man did not complain of chest pain and the nurse was not unduly concerned.

Early the following morning (21 November), healthcare staff were called to see the man. He had been vomiting through the night and had shortness of breath. It was also reported that he had not been eating or drinking over the previous three days. The man was given oxygen and his condition appeared to improve. Two hours later, however, his health had deteriorated. An ambulance was called and he was admitted to hospital.

During the early hours of the next morning, his condition deteriorated rapidly and prison staff were asked to contact his next of kin. Unfortunately, there was no record of any next of kin in the man's prison file. An hour later, at 3.30am on 22 November, he passed away.

The medical care that the man received in prison was reviewed by the clinical reviewer on behalf Lancashire PCT. She has found that the man's overall care was entirely appropriate.

## **INVESTIGATION PROCESS**

1. My investigator requested all the relevant documentation including the man's medical and core prison records. My investigator visited HMP Wymott with another of my investigators.
2. Notices to staff and prisoners were displayed by the prison. These invited anybody with information to talk to my investigator. In this instance, two prisoners asked to speak about their contact with the man.
3. Central Lancashire Primary Care Trust (PCT) was asked to carry out a clinical review and the Deputy Director of Public Health, undertook this on their behalf.
4. HM Coroner for Preston and West Lancashire was informed of my investigation and provided my investigator with the man's official cause of death. The Coroner will receive a copy of this report.
5. The man's sister was traced through the Probation Service. One of my Family Liaison Officers, contacted the man's sister to offer her the opportunity to raise any concerns for my investigator to consider. She has not raised any concerns but has asked to see a copy of my report.

## **HMP FOREST BANK**

6. HMP Forest Bank in Salford is a contracted out (privately managed) prison operated by Kaylx, formerly United Kingdom Detention Services (UKDS). The prison opened in 2000 and can hold up to 1,160 unconvicted and convicted adult males and young offenders.
7. The healthcare service is provided by Kalyx employed nurses. There are inpatient facilities and some joint work with the local PCT.

## **HMP WYMOTT**

8. HMP Wymott is a male category C training prison in Leyland near Preston. It has an operational capacity (maximum crowded capacity) of 1,074, and holds sentenced adult men. It has facilities for vulnerable prisoners (predominantly sex offenders) who make up over half the total population.
9. The healthcare centre provides primary care. It does not have inpatient facilities and prisoners with these needs are referred to a nearby prison or local hospital. There is a general practitioner (GP) surgery five days a week. Overnight and weekend services are covered by a local GP on call service.

## **Release on licence**

10. All prisoners sentenced to more than 12 months imprisonment are released on licence, which means they are supervised by the Probation Service until the licence expiry date. There are standard conditions for all licences. These include:
  - keeping in touch with the probation officer in accordance with any instructions that may be given
  - residing at an address approved by the supervising officer
  - being well behaved, not committing any offence and not doing anything that could undermine the purposes of supervision, which are to protect the public, prevent re-offending and help successful resettlement into the community.
11. Further conditions can be added by the Secretary of State if they are deemed necessary to manage a person's risk. A person on licence may be recalled to prison if they are found to be in breach of any of their licence conditions.

## **Assessment, Care in Custody and Teamwork (ACCT)**

12. ACCT has been introduced by the Prison Service to monitor and support prisoners assessed to be at risk of suicide or self harm. ACCT replaced a previous system (known as F2052SH). Once placed on ACCT, a prisoner is observed at intervals according to their perceived level of risk. An action plan for individual care and support is also developed.

## KEY FINDINGS

13. The man transferred to HMP Wymott on 12 January 2007. The reception health assessment identified his history of health issues, including diabetes, angina, hypertension and osteoarthritis. The man carried his own insulin pen for self-administration. He had been treated at HMP Forest Bank for ulcers and calluses on his feet which were caused by his diabetes. However, his prescription list was not initially available to the staff at Wymott.
14. A prison doctor saw the man on 15 January. The doctor recommended his referral to the diabetic clinic, ears, nose and throat (ENT) clinic, and the foot ulcer clinic at the local hospital. In the meantime, the man was seen regularly by healthcare staff for continued treatment for his feet.
15. The recommended referrals were only sent on 26 January, although there is no explanation for this delay. The prison healthcare team chased the hospital for an appointment on 31 January, and the man attended the diabetic clinic on 6 February. The consultant increased the man's insulin prescription because he had a high level of blood sugars. A community podiatry appointment was also arranged.
16. On 23 February, the man complained of a sharp chest pain that did not settle with an angina spray. An ambulance was called and the man was admitted to the local hospital. He was diagnosed with acute coronary syndrome. The man remained in hospital overnight and returned to Wymott the following day.
17. Two days later, the man attended the diabetic clinic at the hospital but the appointment had been cancelled. Later that evening he reported further chest pain, although it was settling.
18. Over the next week and a half, the man was seen by healthcare staff to change his feet dressings and have diabetic reviews. On 7 March, after a consultation with the specialist diabetic nurse, the man's insulin dose was increased. The nurse noted in the medical record that the infection in his feet might have maintained his raised blood glucose levels. The dressings on both his feet were changed by healthcare staff and he was to have another review the next day.
19. At this review the following day, the man complained of a headache. The dressings on his feet were removed and their condition was noted to be worse. The man was prescribed medication and referred to a tissue viability nurse (a specialist for wound and pressure sore care). The nurse saw the man the following day (9 March 2007), and recommended using dry dressings only. She also noted that, if there was any deterioration, the man should go to hospital. The nurse spoke to the man's consultant at the hospital to bring his next appointment forward.
20. The man attended an appointment with his consultant on 13 March. The poor state of his feet was noted and he was to be seen again in a week's time. In the meantime he was to see the podiatrist. However, on 16 March the escort

for the appointment arrived late and the man was not seen. The appointment was rescheduled and took place four days later. At this point, the man's ulcers were noted to be improving.

21. Over the next four months, the man continued to have regular contact with prison healthcare staff as well as with his consultant diabetologist and podiatrists (both in house and at a clinic). His medication had been altered by his consultant, but at an appointment in May 2007 it was noted that the changes had not yet been made. The clinical reviewer has noted that, although regrettable, this would not have had a long term adverse effect on the man's health. Additionally, the clinical reviewer has said that there were four cancelled hospital appointments during this period, predominantly due to prison staffing and security reasons.
22. An appointment on 31 July was also missed because the man refused to wear handcuffs on the escort. When an officer was taking him back to the wing, the man made a comment about taking "a load of tablets". Staff immediately opened an ACCT document. During an assessment for this, the man said that he had calmed down and had no intention of self harming and had no history of doing so. Nonetheless, staff kept him on the ACCT for three days until they were sure he was not a threat to himself. (It appears that the handcuffs hurt because the man suffered from Reynaud's disease (circulatory problems) and his arms would occasionally swell. Confirmation of this was received from prison healthcare staff.)
23. In August 2007, the man was experiencing difficulty participating in an offending behaviour programme because of visual and auditory impairment. The nurse who saw him on 1 August arranged for him to see the doctor the following day for consideration of a referral to the optician and audiology clinic. The man was seen by a doctor again on 27 August, after experiencing a bad headache and pain behind the left eye the night before. An examination showed a bleed in the eye and the doctor decided to monitor it until the man attended an ophthalmology appointment the next day.
24. Due to a prison operational error, the man did not attend the ophthalmology appointment on 28 August. The rescheduled appointment for the following day was also cancelled due to a national strike by prison officers. A new appointment was arranged for 31 August, but the man arrived too late to be seen. He was eventually seen at the clinic on 7 September.
25. On 1 October, the man attended the ENT clinic and was prescribed a hearing aid. He had complained again that the handcuffs he wore during the escort were too tight. Also that day, the man had a medical review at the prison. It was noted that he was under regular review at the hospital by a doctor, chiropodist and podiatrist. The ulcers on his feet had healed and he was due to have a review with the consultant at the hospital four weeks later. It was also recorded that, as a result of the ophthalmology appointment in September, the man was listed to have laser treatment on his eyes on 3 October. The medical records do not give further information about this and it appears that the treatment did not take place.

26. The man continued to be cared for by healthcare staff and his specialists, although there were two more cancelled hospital appointments in October and November. His medication continued to be reviewed and altered as necessary.
27. During the morning of 19 November 2007, prison staff contacted healthcare because the man was feeling unwell. A nurse saw him on the wing and recorded that he had been dizzy, sick and retching since the previous day. The man complained of tingling down his left arm and felt too weak to get out of bed. The nurse discussed this with a doctor at 12.45pm and was advised to check the man's blood sugar level again in two hours. The doctor saw the man at 3.40pm. After an examination the doctor suspected a gastrointestinal infection and prescribed fluids and paracetamol.
28. The following day, a nurse saw the man on the wing. He was reportedly still dizzy and had aching limbs. His blood sugar level was high (which the clinical reviewer has commented is not unusual for an acutely ill diabetic patient). He was advised to take fluids, eat normally and have bed rest. The man did not complain of chest pains and the nurse was not unduly concerned. The nurse advised the man to contact healthcare if he had any further problems.
29. At 7.13am on 21 November, prison staff called healthcare to the wing again. The man had been vomiting during the night. He told the nurse that he had been short of breath. The nurse gave oxygen which appeared to improve his condition, although he still felt nauseous. The nurse was then told by another prisoner that, for the previous three days, the man had not been eating or drinking. Prison officers were asked to monitor him.
30. Two hours later, a nurse returned to the wing at the request of the officers. The man's temperature had risen, he had "rigors and chills" and fluctuated between being confused and lucid. The nurse was unable to take his medical observations because the man was shaking. As it was therefore difficult to ascertain a diagnosis, an ambulance was called and the man was transferred to hospital.
31. At 2.16am on 22 November, officers on escort with the man informed the prison communication room that his handcuffs had been removed due to a deterioration in his health. A hospital doctor and nurses said that he had suffered a cardiac arrest. They were giving him treatment and oxygen because he was having difficulties breathing on his own.
32. Due to the continued deterioration in his health, the hospital asked the prison officers to notify the man's next of kin. The bedwatch staff contacted the prison at 2.29am to pass on this information. An hour later, at 3.30am, hospital staff were unable to do any more to treat the man and he was pronounced dead.

### **Events after the man's death.**

33. Unfortunately, there was no identified next of kin in the man's prison records. The prison were eventually able to obtain this information from the Probation Service later on the morning of 22 November.
34. Two prisoners who knew the man asked to speak to my investigator. Neither knew him particularly well, but both said that he had told them about missed hospital appointments and not receiving the correct medication. One of the prisoners also mentioned that there could be long waits for medication to be dispensed.
35. My investigator spoke to two members of the healthcare team who said that there had been problems dispensing medication at dedicated times. For example, morning medication might not be dispensed until lunchtime. This was apparently due to staffing levels, which my investigator was told are being addressed.

## ISSUES

36. The clinical review looks at the care and treatment a prisoner receives in prison, ensuring that it is appropriate and comparable to that which is available in the community. The clinical reviewer has found that the man had appropriate and regular medical care whilst in prison.

### **Prescribed medication**

37. When the man transferred to Wymott, healthcare staff did not have his recent prescription list. Arrangements were made to obtain this, which is good practice. Prison Service Orders (PSOs) 3050, continuity of healthcare for prisoners, and 6200, transfer of prisoners, set out the guidelines for transferring prisoners. These guidelines include instructions for sending the prisoner's medical record with the escort paperwork. This is especially important when transferring prisoners with complex medical histories and receiving regular prescriptions or treatment.

**The Director of HMP Forest Bank should remind staff to adhere to the guidance in PSOs 3050 and 6200.**

### **Hospital appointments**

38. The man had many external hospital and clinic appointments. These were primarily related to his feet ulcerations but also included visual and auditory specialist appointments. In the main, he attended these appointments, but as my report shows, there were several occasions when appointments were cancelled by the hospital and the prison. There were also occasions when he arrived at the hospital too late to attend the clinics.
39. Whilst some of these cancellations were unavoidable, prisons should have sufficient notice to get a prisoner to an appointment on time. Potential clinical implications aside, all patients (whether prisoners or not) become frustrated and anxious when they believe they are not receiving appropriate treatment. One of the prisoners who spoke with my investigator mentioned the man's frustrations in this regard.
40. The clinical reviewer has noted that, in this instance, the missed appointments did not have any adverse effect on the man's health. This may not always be the case for other prisoners.

**The Head of Healthcare should ensure tighter monitoring and follow up of delays and missed appointments, particularly those of chronically ill patients.**

### **Fluid intake monitoring**

41. When the man became unwell with a suspected gastrointestinal infection, he was advised to drink plenty of fluids. This was the advice given on two consecutive days. However, when his condition was reviewed on the third

day, healthcare staff were informed that he had not eaten or drunk anything for three days.

42. There was no system in place to monitor this, nor was a food refusal log opened so there is no evidence of the man's food or liquid consumption. When an unwell prisoner is advised to take fluids regularly there should be an appropriate multi-disciplinary system to ensure that this happens.

**The Governor and Health of Healthcare should develop a means of using a multi-disciplinary monitoring system to record a prisoner's fluid intake as medically advised.**

## **RECOMMENDATIONS**

### **HMP Forest Bank**

1. The Director of HMP Forest Bank should remind staff to adhere to the guidance in PSOs 3050 and 6200.

Forest Bank have accepted this recommendation. Notices to staff will be issued by the end of June 2008.

### **HMP Wymott**

2. The Head of Healthcare should ensure tighter monitoring and follow up of delays and missed appointments, particularly those of chronically ill patients.

Wymott have accepted this recommendation. An electronic healthcare system will be introduced which will enable this process to be audited and report back to the strategic board. The target completion date for this is September 2008.

3. The Governor and Health of Healthcare should develop a means of using a multi-disciplinary monitoring system to record a prisoner's fluid intake as medically advised.

Wymott have accepted this recommendation. A local tool/proforma will be developed to monitor diet and fluid intake. The target completion date for this is September 2008.

### **Good Practice**

1. Healthcare staff at Wymott recognised the man's medical need in terms of his diabetes. They quickly and appropriately made referrals for his continued treatment by consultants and specialists at the local hospital.
2. Staff at Wymott opened an ACCT form to monitor the man more closely after he threatened to take a large dose of tablets. Even after the man had calmed down, staff kept the form open for several days.