

**Investigation into the Death in Custody of
a man at
HMP Wymott in March 2005**

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

September 2005

This is the report of an investigation into the circumstances of the death of a man at HM Prison Wymott in March 2005. He died as a result of a thrombosis in a coronary artery bypass graft and a narrowing of the coronary arteries.

The man had suffered from heart disease and poor health for a number of years, suffering heart attacks in 1983 and again in May of 2004. He also suffered two strokes in 1986 and 1987. In 1985, the man underwent surgery for a coronary artery bypass graft and in 2001 for the placement of a stent. He was on medication for his heart problems until his death.

The investigation was led by one of my Assistant Ombudsmen and a colleague. An independent review of the man's medical care in prison was commissioned from the Clinical Governance Lead for Chorley & South Ribble Primary Care Trust. The review was prepared by the Director of Public Health for Chorley & South Ribble Primary Care Trust. I am most grateful to her.

I would also like to thank the management and staff at HMP Wymott for their assistance and co-operation during the course of this investigation.

I extend my condolences to the man's partner and to members of his family and all those touched by his death.

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

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Prisons and Probation Ombudsman

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Contents

Summary

The investigation process

Wymott Prison

Events leading up to 1 March 2005

The day of the man's death – 1 March 2005

The prison response following the death of the man

Issues considered during the investigation

 The defibrillator machine

 Staff statements and Action Sheets

Conclusions & Recommendations

Summary

The man was a 61 year old man who was serving a sentence of two years and six months sentence at HMP Wymott. He died on 1 March 2005 from a thrombosis in a coronary artery bypass graft and a narrowing of the coronary arteries. His death was not connected to his imprisonment or to the level of care he received whilst in prison.

He was born in 1943 in Widnes. He was a skilled manual worker but had not worked for several years prior to imprisonment due to ill health. Before sentence he lived in Widnes with his long time partner. The man was located on I wing at HMP Wymott. I wing is a community of elderly, disabled and vulnerable prisoners. He lived there from his reception into Wymott on 16 June 2004 until the time of his death.

The man had suffered from ill health for many years, suffering heart attacks in 1983. In 1985, he had surgery for a coronary artery bypass graft. He suffered a further heart attack in 2004. He also suffered strokes in 1986 and 1987. The man had angina and arthritis. He was being treated with a range of medicines, including Warfarin, and in 2001 he had further surgery for the placement of a stent. In the three weeks leading up to his death, he had been diagnosed as having cellulitis in his leg which was being treated with an antibiotic cream.

The post mortem report was prepared by a consultant pathologist, for the Preston and West Lancashire Coroner. The report indicates that the man died as a result of a thrombosis in one of the three coronary artery bypass grafts. He had almost complete blocking of those coronary arteries that had not been grafted. He also had an enlarged left ventricle in his heart which was an underlying and contributory factor to his death. No mention is made in the report of the swelling in his leg. The pathologist concludes that the man died from natural causes.

The clinical review was carried out by the Director of Public Health for the Chorley & South Ribble Primary Care Trust. No major concerns were raised by the clinical review regarding the medical care that the man received during his time in prison. Three prisoners told my investigators that the man had been dissatisfied with the treatment of the cellulitis during the three weeks prior to his death. One prisoner believed the cellulitis was mis-diagnosed and that in fact there was a blood clot present in his leg. The clinical review does not endorse this view.

The Director of Public Health recommends that, because of problems encountered during the resuscitation process, health care staff should undergo annual re-training in these techniques. She felt that the failure of the prison defibrillator was unlikely to have contributed or otherwise to the man's death.

The investigation identified the prison's family liaison work as an area of best practice. I make six recommendations.

Investigation Process

My practice in investigations into a death from apparently natural causes is to conduct an initial review to determine the extent of investigation required.

My colleagues first visited Wymott on 21 March 2005 and met with a governor. They were given a full briefing about the circumstances surrounding the man's death and the current situation regarding family contacts and actions instigated by the establishment to deal with his death. Offers to meet with a Prison Officers' Association representative and IMB were made but were not taken up. A notice to staff and a notice to prisoners were published in the prison, inviting anyone who might have information relating to his death to make themselves known to the inquiry team. Three prisoners who knew the man very well came forward and spoke to the investigation team.

My colleagues took away with them all of the files and records relating to the man. They commissioned a clinical review from the Clinical Governance Lead, for Chorley and South Ribble Primary Care Trust. A post mortem report from the Preston and West Lancashire Coroner was also requested.

One of my family liaison officers contacted the man's partner. She stated that she did not have any concerns to raise about her partner's care whilst in prison. She explained that his health had been bad for a few years before he went to prison and she was concerned when he was sentenced to imprisonment that his health would suffer further. She was in fact surprised that he lived as long as he did in prison, due to his ill health. Since visiting Wymott following his death, she now has a diary that he kept during his time in prison and this contains several entries complaining about the pain in his leg.

The man's partner was first told that he had passed away by way of a personal visit from the Governor, the Family Liaison Officer and a member of Chaplaincy who visited her home on the day he died. She said the Family Liaison Officer had been extremely helpful. He had kept in regular contact with her offering help. He also attended the funeral to represent Wymott. I wing had a collection raising £117, which the man's partner is donating to a charity (the Stroke Foundation). She says that the Family Liaison Officer handled the sensitive issue of dealing with her partner's family extremely well. The Governor followed his own visit with a letter of condolence.

The way in which the prison established and maintained a good, professional but sensitive rapport with the man's partner is to be commended. I regard it as a model of good practice.

HMP Wymott

HMP Wymott is a category C training prison for adult male prisoners. A high proportion of the population are vulnerable prisoners, many of them being sex offenders.

Wymott has an ageing population. At the time of my investigation, 158 prisoners were aged between 50 and 83 years old. An older population means that Wymott have higher prescription drug costs and greater escort commitments. I wing is the Elderly and Disabled Community and accommodates up to 62 prisoners in a mixture of single and double cells. It opened about two years ago. The regime is relaxed and informal and association is available every weekday evening. There is a workroom that offers sedentary jobs for prisoners. Many prisoners on the wing are aged and some have special needs due to sight impairment or wheelchair use. Healthcare arrange multi-disciplinary reviews to assess those prisoners who have social care needs such as difficulty bathing or incontinence and outside carers are employed when required. My investigators saw evidence of good staff and prisoner relationships but perhaps an occasional over-reliance on prisoners helping each other.

Healthcare in Wymott transferred to the local Primary Care Trust in April 2005. At the time of the investigation, changes were taking place in preparation for this handover of commissioning responsibility. All staff who work in Wymott healthcare are clinically qualified. There are no in-patient beds. A full time doctor is available each weekday. Medical cover is provided during the weekends and evenings by two GP's from a local practice. Appointments to see a doctor are triggered by wing application. The waiting time to see a doctor varies from a few days to a few weeks dependent on the urgency of the request.

There is a code system (blue / red) used to notify medical staff of the level of seriousness of a particular incident. An emergency bag, nebuliser and defibrillator machine are taken to all serious incidents. All nurses are trained in the use of the defibrillator.

Events leading up to 1 March 2005

The man came into prison custody on 23 April 2004 at Altcourse. His first reception health screen form indicates he told staff that he had heart problems and arthritis. Medical staff noted that he did not appear to be unduly breathless at that time and had no chest pains.

He first saw a doctor at Altcourse about his cardiac problems on 2 May 2004. He was taking a number of prescribed medicines at that time including Warfarin, Simvastatin and Ramipril for his heart problems, Naproxen for his arthritis and Carbamazepine and GTN spray for his angina. During his time at Altcourse, he was regularly monitored by medical staff. The man suffered a heart attack on 26 May 2004 whilst in his cell. Paramedics used a defibrillator for two cycles to regularise his heart rhythm. He was taken to a hospital and admitted as an in-patient, before being discharged back into custody at Altcourse on 2 June 2004. The man was then monitored regularly by medical staff, having several blood tests, until he was transferred to Wymott on 16 June 2004. During this latter period he complained of breathlessness. He also complained of a swelling of the ankles and an infected eye.

The man was seen by medical staff on reception into Wymott. A Healthcare Reception Screening form was completed, identifying his heart and other medical conditions. He remained on his prescribed medication.

On 6 July 2004, he was admitted to a hospital because of a rash on his body. The rash was attributed to the prescribed medication he was receiving and an external cream and bath additive were prescribed. He was discharged on 7 July 2004 and returned to Wymott. On 29 July 2004, he attended a clinic at hospital when he was prescribed further external creams and was returned on the same day to Wymott. On 6 August 2004, the man was taken to the Cardiology Department at a hospital for a pre-booked appointment and a further appointment was made for 24 August 2004 which he attended. The clinic was reasonably happy with his progress and did not alter his medication and advised a low intensity cardiac rehabilitation programme. On 12 October 2004 he was seen at hospital by a Consultant Dermatologist, who was satisfied with his progress and advised on the management of his skin condition.

In September 2004, the man was assessed for the Smoking Cessation Clinic at Wymott and on 22 October had agreed to cease smoking from 5 November. He was supported by nicotine replacement patches which were prescribed by the prison doctor. The course lasted for six weeks but, although he reduced his smoking, he did not cease completely.

The man remained on the daily dosage of his prescribed medication throughout January and February 2005. On 11 February, a review of his medication took place with the prison doctor. He was also seen on seven separate occasions during January and on three occasions in February as a 'special sick' patient. On 18 February, cellulitis was diagnosed in his left leg and appropriate medication given. He continued to undergo regular blood tests as he had in the previous months of his imprisonment. The man's final blood test was a full blood count test performed on 21 February 2005.

The day of the man's death - 1 March 2005

On the morning of 1 March 2005, the man was working normally in the workroom on the wing, attaching cord handles to shopping bags. He worked alongside another prisoner that day. The prisoner told the investigation team that the man had appeared normal and had not complained about feeling unwell in any way. At about 1.55pm, the man told the prisoner that he was going to go to the toilet. He then decided to wait for five minutes until the scheduled break time.

At the 2pm break, the man left the workroom to use the lavatory and five minutes later was sitting in his cell, I-3-3, talking and joking with his friend.

The man's friend says that during the conversation the man put his hands to his head and slowly collapsed sideways to his right, his glasses fell from his face and his head came to rest on the small table beside him. The man's friend shouted for help and another prisoner ran from his cell next door and pressed the cell call bell. This is an unusual occurrence on this wing and the effect of the call bell is to instigate instant action from staff on the wing. Coincidentally, a meeting of staff involved in a previous fatal incident was taking place on the wing and, because of that, many experienced staff were immediately on the scene to assist the man. An officer arrived to find the I wing governor and another governor already in attendance. At 2.06pm a "code blue" radio message was sent by a second officer on the instruction of a principal officer. He also requested that an ambulance be called to I wing urgently. "Code blue" is an internal radio call message to medical staff and others and is transmitted when a prisoner requires emergency intervention because he is not breathing, or is having difficulty breathing, or is unconscious, hanging, or is attempting to hang himself, or has chest pains.

The I wing governor said to an officer that the man appeared to be having a fit. Both officers both went into cell I-3-3 and found the man in a sitting position. Both noted that he had urinated and his head was described by them as being "floppy". He was unconscious but he appeared to be breathing. They immediately put pillows under his head to protect it and covered his lower body with a bed sheet to preserve the man's dignity. Both officers continued to talk to the man during which time his lips and complexion began to turn purple. It became apparent to them that something more serious was happening to him.

At this stage, the governor and two officers placed the man on the floor in the recovery position. They then re-examined him and found him unresponsive with no sign of recovery. Both officers felt that the application of cardio pulmonary resuscitation (CPR) was necessary to try to resuscitate the man. To this end they placed him on his back prior to commencement of CPR. At 2.07pm, a healthcare centre nurse and a staff nurse arrived with the "code blue" equipment. CPR was immediately started by two nurses. A second staff nurse arrived after CPR had started and he assisted one of the nurses in the attachment of the ambubag to an oxygen cylinder and then connected it to an airway. The second staff nurse then took over from the first staff nurse, continuing resuscitation at a rate of 15 cardiac compressions to two breaths.

At 2.20pm, they were joined by a doctor and a second staff nurse. The doctor took charge of the CPR process and administered intravenously one litre of normal saline solution. The man's carotid pulse was absent and only occasional respiratory effort was being made by him. Adrenaline was administered and three rotations of CPR were attempted. At this stage the defibrillator was attached to the man and the machine indicated that it was appropriate to administer a shock and the appropriate button was pressed. The defibrillator failed to administer the shock and failed to do so during several subsequent attempts. CPR was recommenced for three minutes and a further injection of adrenaline was administered. At 2.25pm, a paramedic from the local ambulance service, arrived and assisted with the CPR followed at 2.33pm by two other paramedics. The paramedics decided to move the man to the corridor outside his cell as this would afford more room. They then attached a cardiac monitor to him and established that a cardiac rhythm of ventricular fibrillation was present. The paramedics attached their own defibrillator to the man and administered a shock that was indicated as necessary. This had no effect and CPR was recommenced and adrenaline injected. After the three-minute CPR cycle, Lignocaine and two further defibrillation cycles were delivered. At 2.45pm, the man's pupils were fixed and dilated. There was no pulse and no effort to breathe was being made. All medical staff present were in agreement that further attempts to resuscitate the man were futile and death was certified at 2.45pm by the doctor.

At 3pm, prayers were said on the wing by a member of the prison chaplaincy, and at 3.55pm a Roman Catholic member of chaplaincy performed another act of prayer on I wing.

The prison response following the death of the ma

At 2.50pm on 1 March 2005, the prison contingency plans for a death in custody were implemented. All necessary people were informed of the death. The Coroner's officer and police attended at 4.20pm and examined the scene and interviewed the man's friend who was with him when he collapsed. Cell I-3-3 was sealed until the funeral directors removed the man's body at 5.40pm.

Staff debriefings took place and the Care Team were actively involved in supporting those staff who had been involved.

The Governor, the Prison Family Liaison representative and a member of the chaplaincy went to visit the man's partner in order to break the news of his death. The governor sent a follow up letter of condolence the next day. The Family Liaison Officer had recently attended the first Prison Service-run Family Liaison Officer Course. After this initial visit he took the lead as the central contact point for the man's partner. He ensured that she had all of the relevant telephone numbers for people to contact at the prison. The Family Liaison Officer also offered assistance with the funeral arrangements which the prison have paid for. He organised the return of the man's property and a visit to the prison. During this visit, the man's partner went to see his cell, walked around I wing and spoke to staff and prisoners who knew him. The Family Liaison Officer kept a very detailed log of the dates, time and content of telephone conversations with the man's partner, the Coroner's officer and others. On 5 March 2005, the Family Liaison Officer also had telephone conversations with two of the man's children.

The family liaison work undertaken is an example of best practice that should be mirrored by other prison establishments. I commend this work. It also reflects very well on the course that he had attended.

The governor issued a notice to prisoners informing them of the man's death and a memorial service was held for him in the prison chapel. Prisoners to whom the investigation team spoke told them that they had supported each other and that some staff had also shown concern for their wellbeing.

A pathologist carried out the post mortem at hospital on 3 March 2005 and confirmed the cause of death as a thrombosis in the coronary artery bypass graft and a narrowing of the coronary arteries.

Issues considered during the investigation:

Defibrillating Machine

Wymott had one defibrillator, kept in the Healthcare centre. The machine was bought in 2002 with one year's maintenance. As far as can be established by the investigators, the defibrillator has not been used since acquisition. No records of maintenance or checking exist.

On 1 March 2005, the defibrillator did not work. It was unable to produce the shock indicated as being needed after having carried out its automatic diagnostic function on the man. The doctor made several attempts to administer the shocks but the defibrillator consistently failed to work. The opinion of the clinical reviewer is that in the man's case this failure was not significant in his death, but under other circumstances it might have been so.

A replacement defibrillator was ordered and has subsequently been delivered. Additional defibrillators have also been ordered so that there is one available on every wing. Appropriate maintenance will need to be arranged.

Staff Statements and Action Sheets

The Ombudsman's investigation team found the Control Room Action sheet for deaths in custody was well completed but that the duty governor checklist was only partially completed and not signed. Some staff who had been involved made statements and these were found to include an appropriate amount of detail. However, several staff do not appear to have made statements.

Conclusions & Recommendations

The man was a 61 year old man in poor health who had suffered heart problems for over 20 years. He had undergone heart surgery and had continued to live an active life but with some constraints imposed by the heart condition.

Wymott (and previously Altcourse) cared for the man well. That care was comparable to that which he would have received in the mainstream community. The management of his health was sensitive to his needs given his age and medical history and is the reason he was located on I wing.

Whilst at Wymott, and in common with others, the man took on a caring role for friends and other prisoners in need of personal attention. This included helping them apply medication, assisting with bathing and similar tasks. Whilst this kind of assistance is to be applauded, and to be expected of friends, there must be questions as to the extent to which this is appropriate.

Having suffered a serious episode on the afternoon of 1 March 2005, the man was treated in a speedy and professional manner by staff who had the necessary skills to make a determined attempt to resuscitate him. Unfortunately, because of the underlying medical circumstances, that attempt was unsuccessful. The failure of the defibrillator machine to deliver the electric shock when required did not materially affect the outcome of the attempt to save his life. A working defibrillator, belonging to the local ambulance service, delivered the electric shock within a few minutes of their arrival to no positive outcome. CPR was maintained throughout the attempts to resuscitate him. However, had the circumstances been different, the defibrillator malfunction might have had a disastrous effect on an attempt to revive a patient.

Following the man's death, the response by Wymott was speedy, effective and sensitive. The manner in which the man's partner was treated by the Governor, Chaplaincy and the Family Liaison Officer was exemplary. The use of the Family Liaison Officer was very effective and the manner in which he has conducted himself has drawn favourable comment from the man's partner and others, particularly his sensitive handling of the man's two estranged children. Within the establishment, the support of prisoners on I wing and the staff closely involved with the man and those involved with the actual event of his death has been good.

The death of the man was from natural causes and was relatively straightforward. However, some actions have not been documented as fully as would be expected. Had this been a more complex situation, the lack of proper documentation could have led to difficulties.

Recommendations

Establishment: There should be regular testing of defibrillator machines and an up to date record of maintenance kept by HMP Wymott health care staff.

Establishment: The governor should remind senior colleagues that the duty governor in charge of an incident must ensure that all incident logs/action sheets are fully completed and signed.

Establishment: The governor should remind senior colleagues that the duty governor must ensure that all staff present at an incident write and sign a relevant incident report, regardless of the size of the role they took in that incident.

Establishment: There should be regular updating and re-training of resuscitation skills for healthcare staff.

Policy: Training and development in the area of Family Liaison Officers should be extended to all prison establishments as soon as possible.

Health: The use of prisoners in a social care role within the prison domestic situation should be reviewed and proper advice and boundaries formulated.