Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr George Rose, a prisoner at HMP Wymott, on 18 January 2024

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

WHAT WE VALUE

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr George Rose died of a ruptured abdominal aortic aneurysm (AAA) on 18 January 2024, at HMP Wymott. He was 77 years old. I offer my condolences to Mr Rose's family and friends.

The clinical reviewer concluded that the clinical care Mr Rose received at HMP Wymott was variable. The healthcare team at Wymott did not adhere to guidance in relation to the secondary health screens, as a result a referral for AAA screening was not considered.

Mr Rose only missed one appointment due to lack of escort staff. He was taken to his appointment on 25 August; however, the hospital had cancelled the clinic due to doctors strikes and they failed to inform the prison.

These aspects of Mr Rose's care were not equivalent to what he could have expected to receive in the community.

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

Adrian Usher
Prisons and Probation Ombudsman **September 2024**

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Summary

Events

1. On 20 May 2021, Mr George Rose was sentenced to 15 years in prison for sexual offences. He was 75 years old. He was sent to HMP Wymott.

2. Mr Rose had several medical conditions, which included diabetes, transient ischaemic attack (known as a mini stroke) and chronic obstructive pulmonary disease (COPD). Healthcare staff monitored his diabetes and prescribed medication for these conditions.

3. On 9 May 2023, a GP at the prison saw Mr Rose after he reported a lump in his abdomen. The GP referred him for an urgent ultrasound, which was completed on 24 May. The results showed that Mr Rose had an 8.3cm abdominal aortic aneurysm (AAA – this is a swelling in the aorta, the artery that carries blood from the heart to the abdomen). The GP referred him to the vascular team at Royal Preston Hospital.

4. On 7 June, an appointment with the vascular team was booked for Mr Rose but the prison was unable to take him to the appointment due to staffing issues. Another appointment was arranged for 25 August, escort staff took Mr Rose to his appointment, however the hospital had cancelled the clinic due to doctors strikes. The hospital had failed to inform healthcare that his appointment was cancelled. A consultant vascular surgeon saw Mr Rose on 29 November and explained the AAA diagnosis and prognosis to him.

5. On 18 December, Mr Rose discussed a Do Not Attempt Resuscitation (DNACPR) order (meaning in the event of a heart attack or if his breathing stopped, he would not be resuscitated) with a GP which was agreed and signed.

6. On 18 January 2024, an officer found Mr Rose unresponsive in his cell. She radioed a medical emergency code and healthcare staff attended. As Mr Rose had a DNACPR in place, cardiopulmonary resuscitation (CPR) was not initiated. Paramedics arrived and confirmed that Mr Rose had died.

Findings

7. The clinical reviewer concluded that the care Mr Rose received at Wymott was variable. Although there were elements of care which were equivalent to what he could have expected to receive in the community, there were some aspects of his care that were not.

8. Mr Rose was not adequately assessed and screened during his first and secondary health screens. As a result, he was not referred for AAA screening as he should have been. Mr Rose had missed one hospital appointment due to the lack of communication and partnership working between healthcare staff and prison staff which had the potential to negatively impact on his health. These aspects of Mr Rose’s care were not equivalent.

The Investigation Process

9. HMPPS notified us of Mr Rose's death on 18 January 2024.

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

11. The investigator obtained copies of relevant extracts from Mr Rose's prison and medical records.

12. NHS England commissioned a clinical reviewer to review Mr Rose's clinical care at the prison. She and the PPO investigator conducted joint interviews with healthcare staff.

13. We informed HM Coroner for Lancashire of the investigation. The coroner gave us the cause of death. We have sent the coroner a copy of this report.

14. The Ombudsman's office contacted Mr Rose's family to explain the investigation and to ask if they had any matters, they wanted us to consider. The family raised concerns about Mr Rose's missed hospital appointments. These concerns have been addressed in this report and the clinical review report.

Background Information

15. HMP Wymott is a category C prison holding male prisoners. It is managed by HMPPS. Greater Manchester Mental Health NHS Foundation Trust provides healthcare services.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Wymott was in December 2023. Inspectors noted that levels of staff sickness were far too high leading to the cancellation or curtailment of activities, including health care appointments. Specialised officers, most of them with additional psychological training or prison offender managers, were frequently redeployed to do operational tasks.

Independent Monitoring Board

17. 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 May 2023, the IMB reported that there was a shortage of staff and increase in inexperienced staff that had put a strain on the prison's ability to maintain a safe and secure environment for all.

Previous deaths at HMP Wymott

18. Mr Rose was the 29th prisoner to die at Wymott since 1 January 2021. Of the previous deaths, 25 were from natural causes. There were no similarities between our findings in this investigation into Mr Rose's death and the investigation findings for the other deaths.

Key Events

19. On 20 May 2021, Mr Rose was convicted of sexual offences and sentenced to 15 years imprisonment. He was sent to HMP Wymott.

20. Mr Rose had several pre-existing health conditions, including pre-diabetes, transient ischaemic attack, and chronic obstructive pulmonary disease (COPD). Healthcare staff monitored and prescribed medication to help control his conditions.

21. On 18 June, a nurse carried out the first and second health screens. There is no record that he asked Mr Rose if he had been involved in NHS checks and screening programmes relevant to his age as he should have done. As a result, the nurse did not check whether Mr Rose had engaged in the NHS abdominal aortic aneurysm (AAA) screening programme, so no referral was made.

22. On 9 May 2023, a GP at the prison saw Mr Rose after he had found a lump in his abdomen. He referred Mr Rose for an ultrasound of his abdomen and pelvis.

23. On 24 May, Mr Rose was taken to hospital by prison escort for the urgent ultrasound. The results showed that Mr Rose had an 8.3cm abdominal aortic aneurysm (AAA) in his abdomen. A prison GP referred Mr Rose to the vascular team at Royal Preston Hospital.

24. On 31 May, Mr Rose had an appointment with the vascular team, however the hospital cancelled the appointment and rescheduled it for 7 June.

25. The prison was not able to escort Mr Rose to his appointment on 7 June due to staffing issues, but the prison did not inform healthcare staff of this, so they did not tell the hospital that Mr Rose was not able to attend.

26. On 19 June, healthcare staff received a letter from the vascular team saying Mr Rose had failed to attend his appointment on 7 June and another appointment was arranged for 25 August.

27. On 25 August, Mr Rose was taken to his appointment, however when he arrived the hospital had cancelled the clinic due to doctors strikes. The hospital had failed to inform healthcare staff that Mr Rose's appointment had been cancelled.

28. On 29 November, a consultant vascular surgeon saw Mr Rose and explained the AAA diagnosis and the prognosis if it ruptured.

29. On 30 November, a nurse saw Mr Rose. He told her he had an aneurysm that could burst at any time, and he did not want staff to start CPR if that happened. Mr Rose requested to have a DNACPR (Do not attempt cardiopulmonary resuscitation) order put in place. She made an appointment for Mr Rose to discuss this with the GP.

30. On 18 December, a GP in the prison saw Mr Rose. Mr Rose was made aware of the implications of a DNACPR, and he confirmed that he understood. A DNACPR was put in place and the decision was recorded in Mr Rose's medical records. A copy of the DNACPR paperwork was taken to his wing and wing staff were made aware of this.

Events of 18 January 2024

31. At approximately 4.45pm on 18 January, wing staff realised that Mr Rose had not collected his evening meal. An officer went to Mr Rose's cell, opened the observation panel of Mr Rose's door, and found that he was unresponsive on the floor. She opened the door and tried to get a verbal response from Mr Rose, but he did not respond. She was unable to find a pulse and radioed a code blue (indicating a prisoner is unconscious or is having breathing difficulties).

32. At approximately 4.50pm, healthcare staff attended but no CPR was started because Mr Rose had an active DNACPR in place.

33. At approximately 5.10pm, the ambulance paramedics arrived at the prison and confirmed that Mr Rose had died.

Contact with Mr Rose's family

34. Following Mr Rose's death, the prison appointed a family liaison officer (FLO). Mr Rose told staff that he had no next of kin. The FLO contacted Mr Rose's solicitor and the coroner to see if they had any record of Mr Rose's next of kin. The coroner provided the contact details for members of Mr Rose's family. The FLO contacted the family, but they did not wish to be involved.

35. On 1 February, the FLO established contact with one of Mr Rose's sons. She offered her condolences and on-going support.

36. The prison contributed towards Mr Rose's funeral in line with prison policy.

Support for prisoners and staff

37. After Mr Rose's death, a prison manager debriefed the staff who were involved to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

38. The prison posted notices informing other staff and prisoners of Mr Rose's death and offering support.

Cause of death

39. The coroner accepted the cause of death provided by the lead GP at HMP Wymott and no post-mortem examination was carried out. The GP gave Mr Rose's cause of death as ruptured abdominal aortic aneurysm.

Findings

Clinical care

40. The clinical reviewer concluded that the clinical care Mr Rose received at Wymott was variable, and there were elements which were not equivalent to what he could have expected to receive in the community.

41. They found that the healthcare team at Wymott did not adhere to NICE guidance in relation to the secondary health screen. Mr Rose was not asked whether he had been engaged with the NHS for health checks and screening programmes. Therefore, a referral for an AAA screening was not considered.

42. A healthcare administration manager at Wymott confirmed that there is now a process in place which ensures that prisoners at Wymott are offered AAA screening when they turn 65 years old, in line with the national guidance. A list of all eligible prisoners is provided quarterly to the NHS AAA screening team who arrange clinics at the prison.

43. Prison Service Order (PSO) 3050, states prisons must ensure continuity of healthcare for prisoners during their time in prison. However, the prison was unable to provide staff to escort Mr Rose for one of his hospital appointments on 7 June. The clinical reviewer said that if Mr Rose had been assessed by the vascular team in June 2023, it may have resulted in him being properly diagnosed with quicker intervention. She found that there was a lack of communication and partnership working between healthcare staff and custodial staff and information was not shared in a timely manner.

44. Since Mr Rose's death the prison has begun work to explore the issues around providing escorts for external hospital appointments which includes:

    - an operational procedure for healthcare, administration and prison staff about the escort process,
    - ensuring that all healthcare, administration and prison staff are aware of their roles and responsibilities in relation to the escort process and the escalation process,
    - an urgent review of the escort profile (the number of staff allocated to escort duties at any given time); this will determine if the current escort profile is sufficient to meet the needs of the population at HMP Wymott,
    - completion of an audit within three months of the implementation of the local operational procedure to ensure that the escort process has measurably improved.

45. In light of the prison's efforts to improve partnership working between healthcare and prison staff and to make improvements to the prison escorts provision for hospital appointments, we make no recommendation.

46. The clinical reviewer made some recommendations not directly linked to Mr Rose's death which we do not repeat here but which the Head of Healthcare will wish to address.

47. The initial report was shared with HM Prison and Probation Service (HMPPS), Greater Manchester Mental Health NHS Foundation Trust pointed out some factual inaccuracies in the clinical reviewer's report and the initial report, and these have been amended accordingly.

48. Mr Rose's family received a copy of the initial report. They did not make any comments.

49. At the inquest held on 30 April 2025, the coroner concluded that Mr Alexander George Rose died of natural causes.

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