Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr William Jolly, a prisoner at HMP Wymott, on 26 March 2024

A report by the Prisons and Probation Ombudsman

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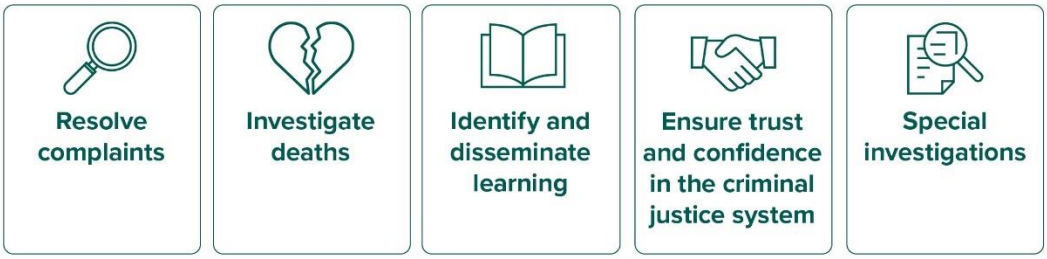
OUR VISION

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 William Jolly died of coronary artery disease on 26 March 2024 at HMP Wymott. He was 64 years old. I offer my condolences to Mr Jolly's family and friends.

My investigation found issues relating to the medical emergency response on 26 March, including a delay in healthcare staff responding to the medical emergency code.

The clinical reviewer concluded that the clinical care Mr Jolly received at Wymott was not equivalent to what he could have expected to receive in the community.

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

Contents

Summary

Events

1. On 21 September 2018, Mr William Jolly was sentenced to 20 years in prison for sexual offences. He was 58 years old. Mr Jolly remained at HMP Manchester, where he had been on remand since 4 December 2017.

2. Mr Jolly had a medical history including high blood pressure and Chronic Obstructive Pulmonary Disease (COPD - a group of lung conditions that cause breathing difficulties).

3. On 5 February 2021, Mr Jolly was transferred to HMP Wymott. In March, he moved to B wing, a unit with a spur for older prisoners with disabilities and their buddies.

4. Healthcare staff completed a first and secondary health screen in line with guidance. Mr Jolly received appropriate medication for his conditions. Healthcare staff created a COPD care plan which was reviewed in 2022, but had not been reviewed again prior to his death.

5. On 5 February 2022, healthcare staff created an older persons care plan for Mr Jolly, which was regularly reviewed.

6. On 6 November, Mr Jolly was moved to the Haven Unit, for older prisoners and those with a disability, social and palliative care needs.

7. On 8 February 2024, a GP at the prison saw Mr Jolly after he reported chest pain. The GP determined that Mr Jolly had a chest infection and prescribed him with antibiotics and steroids.

8. At 5.00am on 26 March, an officer began conducting the routine check of all prisoners on the Haven Unit. When he could not see Mr Jolly in his cell, he opened the cell door and found Mr Jolly lying on the floor, unresponsive. The officer raised the alarm and other officers arrived and began cardiopulmonary resuscitation (CPR). It took the emergency response nurse six minutes to reach Mr Jolly's cell.

9. At 5.05am, the control room staff called an ambulance.

10. At 5.21am, paramedics arrived at the prison and took over Mr Jolly's care. At 5.30am, the paramedics confirmed that Mr Jolly had died.

Findings

11. The clinical reviewer concluded that the care Mr Jolly received at Wymott was not of a satisfactory standard and was not equivalent to what he could have expected to receive in the community. He was concerned that Mr Jolly's COPD care plan was not reviewed, and there were inaccuracies in data recording. There was a significant delay in healthcare staff responding to the medical emergency code.

The Investigation Process

12. HMPPS notified us of Mr Jolly's death on 26 March 2024.

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

14. The investigator obtained copies of relevant extracts from Mr Jolly's prison and medical records, and recordings of radio transmissions.

15. NHS England commissioned a clinical reviewer to review Mr Jolly's clinical care at the prison. The clinical reviewer and investigator conducted joint interviews with three members of staff at Wymott on 3, 4 and 7 June 2024.

16. We informed HM Coroner for Lancashire of the investigation. The Coroner gave us the results of the postmortem examination and the toxicology report. We have sent the Coroner a copy of this report.

17. The Ombudsman's office contacted Mr Jolly's family to explain the investigation and to ask if they had any matters they wanted us to consider. They had no questions but asked for a copy of our report.

18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

19. Mr Jolly's family received a copy of the draft report. They did not make any comments.

Background Information

HMP Wymott

20. 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

21. The most recent inspection of HMP Wymott was in December 2023. Inspectors reported that all teams across healthcare were stretched as staff shortages continued, and the team were struggling to meet the needs of an aging and complex population even with regular agency and bank staff. Inspectors reported that resuscitation equipment was in good order and was placed strategically throughout the prison, but only 67% of healthcare staff were trained in the use of immediate life support skills.

Independent Monitoring Board

22. 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 June 2022 to May 2023, the IMB reported that healthcare were still relying, to a worrying extent (up to 60%), on agency staff which led to problems in staffing on several nights and certain weekends during the reporting period.

Previous deaths at HMP Wymott

23. Mr Jolly was the 30th prisoner to die at Wymott since March 2021. Of the previous deaths, 26 were from natural causes and three were self-inflicted.

24. In a previous death at Wymott, we made a recommendation about care plans being initiated and reviewed on a regular basis. The Head of Healthcare agreed to review care plan audits regularly which aimed to highlight any areas of concern, and agreed to remind all staff of the initiation and review of care plans.

25. In another previous death, we made a recommendation to the Governor about ensuring that an ambulance is requested immediately when a medical emergency code is called. The Governor agreed that the Safety Custodial Manager would carry out awareness sessions with all control room staff, and once completed staff would be required to sign a compact to confirm they had undertaken the session and understood what actions were required.

Key Events

26. On 4 December 2017, Mr William Jolly was remanded to HMP Manchester, charged with sexual offences. On 21 September 2018, he was sentenced to 20 years in prison. He was 58 years old.

27. Mr Jolly had a number of medical conditions including high blood pressure and Chronic Obstructive Pulmonary Disease (COPD - a group of lung conditions that cause breathing difficulties). In 2017, Mr Jolly had a stroke.

28. On 5 February 2021, Mr Jolly was transferred to HMP Wymott. His first and second reception health screens were completed appropriately.

29. On 31 March, Mr Jolly was moved to B Wing, a unit with a spur for older people with disabilities and their buddies.

30. On 29 September, healthcare staff created a Chronic Obstructive Pulmonary Disease (COPD) care plan for Mr Jolly. In August 2022, healthcare staff reviewed the plan. He was due to have his next annual COPD care plan review in August 2023, but this did not take place and it had not been reviewed again before his death.

31. On 5 February 2022, healthcare staff created an older persons care plan and conducted regular reviews. However, the last review on 20 March 2024 was conducted without Mr Jolly being present.

32. On 6 November, Mr Jolly was moved to the Haven Unit, a unit for older prisoners and those with a disability, social and palliative care needs. Healthcare staff continued to monitor his conditions and no concerns were raised over the months that followed.

33. On 25 October 2023, prison staff called a medical emergency code blue (indicating a prisoner is unconscious or is having breathing difficulties) as Mr Jolly reported shortness of breath. Healthcare staff attended and conducted observations. They gave Mr Jolly oxygen and saw an improvement in his observations and presentation. They determined that an ambulance was not required and provided Mr Jolly with new inhalers.

34. On 28 October, Mr Jolly reported to healthcare staff that he had a bad chest due to his COPD. The nurse prescribed him with antibiotics, steroids, and nebulisers.

35. On 8 February 2024, the GP at the prison saw Mr Jolly after he reported chest pain. The GP determined that Mr Jolly had a chest infection and prescribed him with antibiotics and steroids.

Events of 26 March

36. At 5.00am on 26 March, an officer began conducting the routine check of all prisoners on the Haven Unit.

37. When the officer looked through Mr Jolly's observation panel, he could not see him. The officer opened Mr Jolly's cell door and found Mr Jolly lying on the floor, with his head and torso under the bed, unresponsive. At 5.02am, the officer radioed a code blue.

38. The officer checked for a pulse and noted that Mr Jolly's mouth and eyes were wide open. Another officer responded to the code blue and helped him to move Mr Jolly into a more accessible position. They then began CPR.

39. At 5.03am, control room staff radioed for the emergency healthcare response (the only healthcare staff member on duty that night) to attend Mr Jolly's cell, as he had not responded to the code blue call. At 5.05am, the officer radioed the emergency healthcare response again, asking him to attend immediately. At 5.06am, the officer radioed the control room, asking for the whereabouts of the emergency healthcare response.

40. At 5.05am, control room staff called an ambulance.

41. At 5.08am, the emergency healthcare response confirmed that he had now arrived at Mr Jolly's cell. He checked for signs of breathing and a pulse. He noted that rigor mortis was present. He attached a defibrillator as officers continued with CPR. The defibrillator did not advise a shock throughout.

42. At 5.21am, the ambulance arrived at the establishment. When the paramedics arrived at Mr Jolly's cell, the emergency healthcare response briefed them, explaining there were no signs of life and rigor mortis (stiffening of the body after death) was present.

43. At 5.30am paramedics pronounced Mr Jolly deceased.

Contact with Mr Jolly's family

44. Shortly after Mr Jolly's death, the prison allocated an officer as the family liaison officer (FLO). The FLO and a Governor attended the address of Mr Jolly's next of kin, his wife, to notify her of Mr Jolly's death and offered continued support.

45. The prison contributed towards the cost of Mr Jolly's funeral in line with national guidance.

Support for prisoners and staff

46. After Mr Jolly's death, a Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support.

47. The prison posted notices informing other prisoners of Mr Jolly's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Jolly's death.

Post-mortem report

48. The coroner gave Mr Jolly's cause of death as coronary artery disease.

Findings

Clinical care

49. The clinical reviewer concluded that the care Mr Jolly received at Wymott was not of a satisfactory standard and was not equivalent to what he could have expected to receive in the community.

50. He was concerned that Mr Jolly's COPD care plan was not reviewed annually as it should have been, however he noted that Mr Jolly's condition was adequately monitored. He also identified that there were inaccuracies in data recording.

51. The clinical reviewer has made recommendations not directly linked to Mr Jolly's death which the Head of Healthcare will wish to address.

Emergency response

52. The local Medical Emergency Response Code Protocol at HMP Wymott says that the first officer on the scene must initiate basic life support if trained to do so and continue with basic life support until healthcare staff arrive. It says that nursing staff will prioritise their work to attend each individual call.

53. The officer called a code blue at 5.02am. The emergency healthcare response arrived at Mr Jolly's cell at 5.08am, after repeated radio calls asking for his whereabouts. We asked the emergency healthcare response why it took him six minutes to respond to the code blue. He said that although he was already on the wing, he went to collect the emergency equipment from the wing treatment room. He said the distance between Mr Jolly's cell and the treatment room was not far and that the delay may have been because he was checking that all the emergency equipment was in the bag.

54. We spoke to the primary care manager, who told us that all emergency bags were checked weekly, and the tags on the bags were checked daily. She said she would not expect a nurse to check the bag during a medical emergency. She spoke to the emergency healthcare response following the interview to address the issue. We make no recommendation.

Governor to note

55. Giving staff the opportunity to collectively discuss an incident and reflect on all aspects of how it was managed is fundamental to providing the prison with feedback on any issues that need to be addressed. It also provides those directly involved with an opportunity to process events and receive support.

56. Although the prison said a debrief was held after Mr Jolly's death (and that the officer who found Mr Jolly attended), the officer told us that he was not aware of any debrief being held. He said he was not signposted to or offered support following Mr Jolly's death and that he sought support from his line manager and the TRiM team himself. The Governor will wish to consider this.

Inquest

57. At the inquest held on 30 April 2025 the coroner concluded Mr Jolly died of natural causes.

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