Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Baxter, a prisoner at HMP Wealstun, on 26 May 2024

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

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 David Baxter died of acute pyelonephritis (inflammation of the kidney) and cystitis (bladder infection) on 26 May 2024 at HMP Wealstun. He was 64 years old. I offer my condolences to Mr Baxter's family and friends.

The clinical reviewer concluded that the care Mr Baxter received at Wealstun was not of the required standard and was not equivalent to what he could have expected to receive in the community. She made recommendations relating to clinical assessments and clear plans for future care.

My investigation found that the officers who found Mr Baxter unresponsive on 26 May, did not commence cardiopulmonary resuscitation immediately.

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 **January 2025**

Contents

Summary

Events

1. On 31 May 2023, Mr David Baxter was sentenced to 21 months imprisonment for making threats to kill. On 6 February 2024, he was released from HMP Wealstun on licence.

2. On 24 February, Mr Baxter was recalled to prison for breaching his licence. He was also charged with a new offence. He was sent to HMP Nottingham.

3. On 18 March, Mr Baxter was sentenced to 12 months imprisonment for offences against a person. On 27 March, Mr Baxter was transferred to Wealstun.

4. Mr Baxter had type 2 diabetes and had a stroke in 2020. Healthcare staff gave him his prescribed medication which he was allowed to keep in his cell.

5. On 16 April, healthcare staff saw Mr Baxter after he reported issues with bladder control. On 26 April, a GP at the prison saw Mr Baxter, conducted some tests and referred him to hospital for further review.

6. On 15 May, a nurse saw Mr Baxter after he reported struggling to pass urine. On 17 May, the GP saw Mr Baxter and sent him to hospital for further care and treatment. Mr Baxter started using a catheter (a thin, flexible tube that carries fluids into or out of the body). He remained in hospital until 20 May. Mr Baxter discharged himself against hospital advice.

7. On 25 May, Mr Baxter told an officer that he had fallen in his cell overnight. A nurse attended Mr Baxter's cell later that day to check on him. Mr Baxter told the nurse that he had lost consciousness but did not know for how long. The nurse arranged for him to see the GP on 27 May.

8. At 8.47am on 26 May, an officer went to unlock Mr Baxter's cell. He found Mr Baxter unresponsive on the toilet in his cell. He checked for signs of life but there were none. At 8.48am, an officer radioed a medical emergency code. Two officers responded immediately and the three officers waited for healthcare staff to arrive.

9. After seeking clarification from the officers, control room staff called an ambulance at 8.50am.

10. Two Supervising Officers (SO) attended Mr Baxter's cell. They immediately moved Mr Baxter onto the floor and commenced cardiopulmonary resuscitation (CPR). Staff attached a defibrillator to Mr Baxter's chest.

11. At 8.51am, nursing staff attended and provided additional healthcare support.

12. At 9.10am, paramedics arrived at the prison and took over Mr Baxter's care. At 9.29am, the paramedics confirmed that Mr Baxter had died.

Findings

13. The clinical reviewer concluded that the care Mr Baxter received at Wealstun was not of the required standard and not equivalent to what he could have expected to receive in the community. She was concerned that there were missed opportunities to recognise Mr Baxter's deteriorating health, a lack of professional curiosity and detailed record keeping.

14. We found that there was a delay in staff commencing CPR when Mr Baxter was found unresponsive in his cell. We do not consider that the outcome would have been different in this instance, however it could be critical in future emergencies.

Recommendations

- The Head of Healthcare must ensure that all healthcare staff are trained and competent in the use of the NEWS2 assessment.

- The Head of Healthcare should ensure that a clear plan is documented within the patients SystmOne records following self–discharge from the hospital to ensure that all outstanding care/treatment is re-initiated as soon as possible.

- The Head of Healthcare should ensure that care plans are created to support in the management of incontinence as per NICE 'When should I suspect a urinary tract infection in a man' (2024).

- The Governor should conduct regular emergency response drills to allow staff to practice response requirements, including when to commence CPR.

- The Governor should ensure that staff in the control room request an ambulance immediately when a medical emergency code is called.

The Investigation Process

15. HMPPS notified us of Mr Baxter's death on 29 May 2024.

16. The investigator issued notices to staff and prisoners at HMP Wealstun informing them of the investigation and asking anyone with relevant information to contact her. One officer contacted the investigator by email.

17. The investigator obtained copies of relevant extracts from Mr Baxter's prison and medical records, CCTV, body worn video camera (BWVC) footage, and recordings of radio communications.

18. The investigator interviewed nine members of staff, including the officer who emailed the investigator, at Wealstun between 18 July and 22 August.

19. NHS England commissioned a clinical reviewer to review Mr Baxter's clinical care at the prison. The clinical reviewer conducted joint interviews with the investigator.

20. We informed HM Coroner for Wakefield of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

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

22. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

23. Mr Baxter's family received copies of the draft report. They pointed out some factual inaccuracies and/or omissions. This report has been amended accordingly. Mr Baxter's family also raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

24. At the inquest held on 3 September 2024, the Coroner concluded that Mr Baxter died of acute pyelonephritis (inflammation of the kidney) and cystitis (bladder infection). Ischaemic heart disease, enlarged prostate gland and diabetes mellitus contributed to, but did not cause, his death.

Background Information

HMP Wealstun

25. Wealstun is a category C adult training and resettlement prison for men. Practice Plus Group provides physical and mental health care services.

HM Inspectorate of Prisons

26. The most recent inspection of Wealstun was in October 2022. Inspectors reported that healthcare staff were well trained and had access to appropriate, regularly checked equipment, and arrangements to respond to medical emergencies were robust when the health care team was on duty.

Independent Monitoring Board

27. 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 appeared to be a number of instances where communications between healthcare staff and prison staff had potential gaps, and where wing staff were not aware of treatment plans (including GP advice) suggested for prisoners by the healthcare team.

Previous deaths at HMP Wealstun

28. Mr Baxter was the third prisoner to die at Wealstun since May 2021. Of the previous deaths, one was from natural causes and one was self-inflicted. Since Mr Baxter's death, there have been no further deaths at Wealstun.

Key Events

29. On 31 May 2023, Mr David Baxter was sentenced to 21 months imprisonment for making threats to kill.

30. On 6 February 2024, Mr Baxter was released from Wealstun on licence.

31. On 24 February, Mr Baxter was recalled to prison for breaching his licence and was charged with breach of a restraining order. He was transferred to Nottingham.

32. At his first reception health screen, nurses noted that Mr Baxter had type 2 diabetes. Healthcare staff created an older persons care plan.

33. On 14 March, Mr Baxter was transferred to Leeds, as he had a court hearing. On 18 March, Mr Baxter was sentenced to 12 months imprisonment for offences against a person.

34. On 27 March, Mr Baxter was transferred to Wealstun.

35. During his first reception health screen, nurses noted that Mr Baxter had type 2 diabetes and that he had a stroke in 2020. Nurses gave Mr Baxter his prescribed medication which he was allowed to keep in his cell.

36. On 2 April, Mr Baxter was moved from the induction wing to a standard residential wing.

37. On 16 April, healthcare staff saw Mr Baxter as he reported issues with bladder control. He said that he was getting up every hour in the night to urinate, and sometimes he was incontinent when he could not wake up. Nurses gave Mr Baxter incontinence pads and booked an appointment for him to see the GP.

38. On 26 April, the GP at the prison saw Mr Baxter to conduct some tests and a further examination. He referred Mr Baxter to hospital for an ultrasound.

39. On 1 May, healthcare staff conducted a diabetic review with Mr Baxter. As Mr Baxter's urine test came back abnormal, a new appointment was booked for him to see the GP.

40. On 3 May, the GP saw Mr Baxter to follow up on his blood test results, which were taken on 30 April. The results showed a slightly raised prostate-specific antigen, which indicated possible prostate cancer. The GP requested repeat blood tests.

41. On 9 May, the GP saw Mr Baxter to discuss the results of his recent tests. Mr Baxter reported that he felt well but was slightly constipated. The GP prescribed Mr Baxter laxatives and healthcare staff completed a fast track hospital referral to the urology department for suspected cancer the next day.

42. On 15 May, a nurse saw Mr Baxter after he reported he was struggling to pass urine. The nurse noted that he may need to attend A&E for catheterisation. She noted that Mr Baxter had an arranged appointment with the GP and considered this could be discussed then. On 17 May, the GP saw Mr Baxter and sent him to hospital. He remained in hospital until 20 May during which time he was

catheterised (meaning he passed urine through a thin tube inserted into his bladder and into a bag).

43. On 20 May, Mr Baxter discharged himself from hospital against clinical advice. Two officers escorted Mr Baxter back to the prison. At interview, they said that hospital staff did not want to discharge Mr Baxter but he was insistent on returning to the prison as he had a visit with his sister the following day, and he agreed he would return to the hospital following his visit. Both officers said that Mr Baxter had been given another appointment to attend the hospital later that week. There is no record that the appointment had been arranged.

44. A nurse saw Mr Baxter upon his return from hospital to conduct a post-hospital review. She explained to Mr Baxter how to use his catheter, and how to fit the night bags. Mr Baxter declined any further support from healthcare. Following advice from the hospital, she booked a blood test for Mr Baxter.

45. On 23 May, Mr Baxter was due to attend the healthcare clinic for his blood test, but failed to attend. An officer on Mr Baxter's wing called the healthcare unit and asked them if Mr Baxter could be seen on the wing instead due to issues with his leg. Healthcare staff re-booked Mr Baxter's blood test.

46. On 24 May, a nurse saw Mr Baxter on the wing to discuss some problems he was having with his catheter. Mr Baxter said that his catheter bag had burst overnight and he needed the nurse to show him how to change it. She showed Mr Baxter how to use and change the catheter bag. Mr Baxter told her that he was feeling unwell and was not sleeping. She conducted some clinical observations but did not complete a National Early Warning Score (NEWS2 - a tool to facilitate the early detection of clinical deterioration). She arranged for Mr Baxter to see the GP the following day.

47. On 25 May, Mr Baxter told an officer that he had fallen in his cell overnight. The officer called healthcare, and a nurse attended Mr Baxter's cell later that day to check on him. Mr Baxter told her that he had lost consciousness but did not know for how long. She observed a small cut to Mr Baxter's eyebrow. She took his clinical observations, including his blood pressure, pulse rate, oxygen saturation, Glasgow Coma Score (GCS) and temperature. She provided Mr Baxter with solution and a gauze to clean his wound. She did not check Mr Baxter's blood glucose levels, his NEWS2 score or complete a falls risk assessment. She arranged for him to see the GP on Monday 27 May.

Events of 26 May 2024

48. At 8.47am, Officer A went to Mr Baxter's cell to unlock him for a religious service. He found Mr Baxter unresponsive on the toilet in his cell. As he was trying to get a response from Mr Baxter, Officer B entered the cell. Officer A checked for signs of life and noted that Mr Baxter did not have a pulse and was not breathing.

49. At 8.48am, Officer B radioed a code blue (indicating a prisoner is unconscious or is having breathing difficulties). Officer C responded immediately as she was already on the wing. The officers discussed whether they should commence CPR, but they decided to wait until healthcare staff arrived.

50. At 8.50am, control room staff asked if an ambulance was needed. Officer C said yes and left the cell to access Mr Baxter's prison record to provide control room staff with more information.

51. Two Supervising Officers (SOs) attended Mr Baxter's cell. They immediately lifted Mr Baxter off the toilet and onto the floor and commenced CPR. Staff got a defibrillator from the office and attached it to Mr Baxter's chest.

52. At 8.52am, a nurse arrived at the cell. She worked on Mr Baxter's airway, while both SOs continued with CPR. At 8.56am, another nurse arrived and gave additional healthcare support.

53. At 9.10am, paramedics arrived at the cell and took over Mr Baxter's care. At 9.15am, more paramedics arrived. The first nurse told them that Mr Baxter had been in hospital recently. The paramedics asked to see Mr Baxter's medical records, which she retrieved for them.

54. At 9.22am, more paramedics arrived. A nurse told them that Mr Baxter had collapsed the night before and he reported unconsciousness and had a small cut to his head.

55. At 9.29am, the paramedics confirmed that Mr Baxter had died.

Contact with Mr Baxter's family

56. Shortly after Mr Baxter's death, a Custodial Manager (CM) contacted Mr Baxter's sister to notify her of Mr Baxter's death by telephone, as the prison did not have her address on record. Mr Baxter's sister and her husband visited the prison. She shared the news of Mr Baxter's death with his ex-partner.

57. On 28 May, the prison allocated a family liaison officer (FLO). The FLO continued to liaise and support Mr Baxter's sister, ex-partner and daughter.

58. The FLO and a prison chaplain attended the funeral on behalf of the prison. They arranged a memorial service in the prison for Mr Baxter, which was attended by his ex-partner, their daughter and 20 prisoners who knew Mr Baxter.

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

Support for prisoners and staff

60. After Mr Baxter's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

61. The prison posted notices informing other prisoners of Mr Baxter'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 Baxter's death.

Post-mortem report

62. The post-mortem gave Mr Baxter's cause of death as acute pyelonephritis (inflammation of the kidney) and cystitis (bladder infection). Ischaemic heart disease, an enlarged prostate gland and diabetes mellitus also contributed to his death.

Findings

Clinical care

63. The clinical reviewer concluded that the care Mr Baxter received at Wealstun was not of the required standard and was not equivalent to what he could have expected to receive in the community.

64. The clinical reviewer was concerned that healthcare staff missed opportunities to recognise Mr Baxter's deteriorating health. There was also a lack of professional curiosity and detailed record keeping. She was concerned that when Mr Baxter returned to the prison from hospital on 20 May, there was insufficient information recorded about the plan for follow-up care. There were also missed opportunities to recognise Mr Baxter's deteriorating health between 20 May and 26 May.

65. The clinical reviewer found that a nurse did not complete a falls risk assessment for Mr Baxter following his fall on the night of 24 to 25 May, and a falls care plan was not created for him as it should have been. She was also concerned that there was no hypertension or urinary incontinence care plan in place.

66. Despite healthcare staff being notified that Mr Baxter self-discharged from hospital on 20 May, no arrangements to return him to hospital were made and there was no evidence that healthcare staff who interacted with Mr Baxter after his return to the prison discussed his self-discharge with him. We recommend:

    The Head of Healthcare must ensure that all healthcare staff are trained and competent in the use of the NEWS2 assessment.

    The Head of Healthcare should ensure that a clear plan is documented within the patients SystmOne records following self–discharge from the hospital acute Trust to ensure that all outstanding care/treatment is re-initiated as soon as possible.

    The Head of Healthcare should ensure that care plans are created to support in the management of incontinence as per NICE 'When should I suspect a urinary tract infection in a man' (2024).

Emergency response

67. The local guidance, Wealstun Safety Awareness Guide, says that if someone is discovered unresponsive and not breathing, CPR should be commenced immediately.

68. When Officer A found Mr Baxter unresponsive on 26 May, he called a medical emergency code. Officers B and C responded immediately. There was some discussion among the officers as to whether they should commence CPR, but they decided to wait until healthcare arrived.

69. Officer A told us that he was surprised when he found Mr Baxter unresponsive on the toilet. He was worried about preserving his decency considering he was with two female officers. He said that this was his first experience of a medical

emergency of this nature and he felt like it would have been disrespectful to move Mr Baxter from the toilet on the floor and begin chest compressions. Officer A received first aid training in October 2022.

70. Officer B told the investigator that she did not commence CPR immediately because she panicked. She said she had never dealt with something like this before, and she felt commencing chest compressions would have been indecent as it was clear to her that resuscitation attempts would have been futile. She also said that she was with Officer A, a more experienced officer, from whom she was taking lead. Officer B received first aid training in July 2023.

71. Officer C told us she did suggest to Officers A and B that they should commence CPR, but she could not pinpoint why exactly CPR was not started. She said it may have been the shock of finding a prisoner unresponsive in this way, and said it felt undignified given that Mr Baxter was on the toilet, in a state of undress. Officer C received first aid training in September 2023.

72. At interview, all three responding officers recognised that they should have started CPR immediately, and that in hindsight, they would have commenced CPR sooner.

73. While we recognise that it is difficult for staff to make instant decisions in shocking situations, it is critical that staff act quickly when there is a potentially life-threatening situation. We do not consider that the outcome would have been different in Mr Baxter's case had CPR commenced earlier, but it could be critical in future emergencies. We make the following recommendation:

    The Governor should conduct regular emergency response drills to allow staff to practice response requirements, including when to commence CPR.

74. Prison Service Instruction (PSI) 03/2013, Medical Emergency Response Codes set out the actions staff should take in a medical emergency. It states that if an emergency code is called over the radio network, an ambulance must be called immediately.

75. Radio communications evidence shows that the medical emergency code was called at 8.48am. The control room staff asked if an ambulance was required at 8.50am. Officer C confirmed that an ambulance was needed, then the control room called for an ambulance. There was a delay of two minutes in requesting an ambulance. Whilst this did not affect the outcome for Mr Baxter, it could be critical in future emergencies. We recommend:

    The Governor should ensure that staff in the control room request an ambulance immediately when a medical emergency code is called.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100