Investigation into the circumstances surrounding the death of a man in April 2011 at hospital, whilst in the custody of HMP Wakefield

Report by the Prisons and Probation Ombudsman for England and Wales

December 2011

This is the report into the death of a man at HMP Wakefield in 19 April 2011. He died of natural causes and was an older prisoner who was over 70 years old. A post mortem concluded that he died from acute myocardial infarction (a heart attack). I offer my condolences to his friends and family.

The investigation was carried out on my behalf by my colleague. I would like to thank the Governor and her staff for their co-operation. I am also grateful to the local NHS Primary Care Trust (PCT) for appointing a clinical reviewer to review the man's clinical care. As he died from natural causes, the findings in the clinical review are essential to my own conclusions. I am sorry that the report has been slightly delayed.

The clinical review found that the standard of care which the man received was equitable to that which he could have expected in the community.

Like many Wakefield prisoners, the man had lived there for many years; in his case since 2006. He had a number of medical conditions which were well monitored; he received increasing support for his mobility issues and a good level of health care whilst at Wakefield. However, there is always scope for learning from cases such as the man's. In particular I make one recommendation to address apparent procedural flaws to ensure that restraints are not used unnecessarily on the seriously ill.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **December 2011**

CONTENTS

Summary

The investigation process

HMP Wakefield

Key events

Issues

Conclusion

Recommendations

SUMMARY

1. The man appeared at Crown Court on 3 March 2005, when he was sentenced to 15 years imprisonment and was sent to HMP Exeter. On 8 March 2006, he was moved to HMP Wakefield. On arrival, he had a first reception health screen with a nurse and disclosed a number of medical conditions, including angina and Type 2 diabetes.

2. Over the next few years, the man's physical health deteriorated. He had a number of invasive procedures to address coronary artery disease and he managed his diabetes well. Due to his age, he began to experience forgetfulness and showed signs of early dementia, and his physical health problems led to an increased lack of mobility. He developed other problems such as high blood pressure, swelling to his ankles and was accommodated in an adapted room following a disability assessment. He was encouraged to stop smoking, which he successfully did in October 2010.

3. In February 2011, the man experienced faecal incontinence. He was admitted to the healthcare centre and his medication was reviewed.

4. On 19 April at 5.25am, the man was found on the floor of his cell, he had vomited and had suffered a significant bout of faecal incontinence. Staff responded and a nurse assessed that he was fit to be transferred to the healthcare centre, where he was washed and monitored closely. Initially, he was not experiencing pain, although his blood pressure was very low. At 7.07am, his blood pressure had fallen further, he complained of chest pains and an ambulance was called. Paramedics attended and administered emergency resuscitation during his transfer to hospital.

5. The man underwent heart surgery as soon as he arrived at hospital, but his condition deteriorated shortly afterwards and despite further resuscitation attempts was pronounced dead at 11.28am.

6. Devon police were asked by Wakefield to help locate a next of kin, they located one of his daughters and she was informed of his death. A prison family liaison officer spoke with the man's son-in-law, who had been nominated by the family as the point of contact, explained their role and offered financial support towards the funeral costs.

7. We are satisfied that the care the man received at Wakefield was comparable to that which would be expected in the community. We make one recommendation, concerning the use of restraints whilst he was at outside hospital.

THE INVESTIGATION PROCESS

8. The investigation was opened on 3 May, when the investigator contacted the Head of Litigation, who was to act as the liaison officer for the investigation, and arranged to visit Wakefield. In advance of his visit, notices were issued announcing the investigation to staff and prisoners. He was provided with all documentation relating to the man. Five prisoners came forward in response to the notices of the investigation and were subsequently interviewed.

9. The investigator and his colleague visited HMP Wakefield on 16 May and 31 May. During these visits they interviewed seven members of staff and five prisoners. Initial feedback from the investigation was provided, in writing, to the governing Governor on 2 June 2011.

10. The local Primary Care Trust (PCT) asked the clinical reviewer to review the man's clinical care on their behalf. He was provided with all relevant documentation to assist this review and jointly conducted all the interviews with prisoners and staff at Wakefield. The Ombudsman thanks him for undertaking this review and for his report.

11. The investigator contacted Her Majesty's Coroner for West Yorkshire Eastern District to inform him of the nature and scope of the investigation and request a copy of the post mortem report. Upon completion, the investigation report will be sent to the Coroner to assist his enquiries into the man's death.

12. Our family liaison officer contacted the man's son-in-law, as the family's preferred point of contact, in writing on 23 May 2011, to inform him about the investigation and to invite the family to ask questions or raise concerns about the care of him whilst he was at Wakefield. The family raised no issues at the outset of the investigation. They were also offered an opportunity to receive and comment on the draft version of the report however, to date, have chosen not to do so.

13. This report has been slightly delayed, for which we apologise. This is on account of casework pressure.

HMP WAKEFIELD

14. HMP Wakefield is a high security prison of which there are only eight in England and Wales. It holds in excess of 750 category A and B prisoners and those on remand for whom high security conditions are needed. (Category A prisoners are those for whom the highest security is needed. Category B prisoners are those for whom the highest security conditions are not necessary but for whom escape must be made very difficult.) Wakefield has four residential wings, A, B, C, and D, of which B wing houses remand prisoners in a separate unit. Prisoners are also located in the healthcare centre, the segregation unit and closed supervision centre both located on F Wing. A number of outside agencies provide services, including the local PCT which provides healthcare. The prison is attended by prison visitors (independent volunteers recruited by prison establishments on behalf of the Prison Service, who visit prisons in order to offer friendship to prisoners) and the Independent Monitoring Board (IMB), whose role is explained below.

Independent Monitoring Board

15. Each prison has an Independent Monitoring Board (IMB) whose members are appointed by the Secretary of State for Justice from members of the community. Their role is to satisfy themselves that the prisoners are treated humanely and justly and that there are adequate programmes for preparing prisoners for release. The IMB reports directly to the Secretary of State for Justice if they have any concerns. They also submit annual reports about how the prison has met the standards and requirements placed on it. Members of the IMB have access to every prisoner, every part of the prison and every prison record.

    In their annual report for the period 1 May 2009 to April 2010, the IMB made the following comments:

    > ”The ageing population of Wakefield does raise our concerns regarding available accommodation and purposeful activity not just for the ageing but for the prisoners of limited abilities. Simple activities we feel should be more available for the prisoners of limited ability.”

    In respect to the provision of the healthcare centre:

    > ”The Primary Care Centre has now been in operation for a full year and is providing a comprehensive first-contact service throughout the time that cells are unlocked. Medication is dispensed three times each day with up to 100 prescriptions being filled at each morning session. Seasonal immunisations are administered when appropriate. A GP is available from 8 o’clock in the morning until 6 p.m., with an average of 30 prisoners on call-up each day for the treatment of acute conditions. The Unit also provides a number of regular clinics for the management of chronic illnesses and the detoxification of drug misusers.

> ”The in-patient unit contains 15 beds and is normally working to full capacity with a mixture of elderly, infirm, chronic illnesses, and psychiatric cases … overall the Health Care Unit provides a comprehensive service that meets the needs of the prison population.”

HM Inspectorate of Prisons

16. HM Chief Inspector of Prisons last conducted a full announced inspection of the prison in December 2008. The then Chief Inspector noted that since the last full inspection in 2003:

> “Wakefield has improved considerably over the last five years and it is pleasing that in general the improvement has been sustained. There is still work to be done on aspects of safety, staff-prisoner relationships and activities, but the principal issue to be tackled is how to motivate and engage serious sexual offenders, so that their risk is reduced and they can progress through the prison system.”

Escort risk assessments

17. On each occasion when a prisoner is escorted outside the prison to hospital, a risk assessment considers the risk to the public, potential for escape and likelihood of outside assistance. The assessment informs the decision about the number of escorting officers and the type of restraint to be used (single cuffs or two metre long escort (closet) chain with a cuff at either end). It also determines the circumstances and the authority required for the restraints to be removed. The risk assessment is reviewed by prison managers each day that a prisoner is in hospital and amended where necessary.

Incentives and Earned Privileges (IEP) Scheme

18. The Incentives and Earned Privileges, or IEP scheme is used to encourage and reward good behaviour in prisons. Governors have devolved responsibility to draw up their own schemes however the scheme must operate on at least three tiers: Basic, Standard and Enhanced. Prisoners move between levels according to their behaviour and performance. The key earnable privileges/incentives are: extra and improved visits, eligibility to earn higher rates of pay, access to in-cell television, opportunity to wear own clothes, more private cash to spend and time out of cell for association. The man was on standard at the time of his death.

Previous deaths in custody at Wakefield

19. There have been five previous deaths at Wakefield in the past year. The investigator reviewed the Ombudsman’s reports into these deaths and found no issues in common between the earlier deaths and that of the man’s. His death was one of 31 to have occurred at Wakefield since April 2004 when the Ombudsman began investigating all deaths in prison custody in England and Wales. Twenty of the previous deaths were due to natural causes, the remainder self-inflicted.

KEY EVENTS

20. The man was born in the 1930s. Following his arrest, he spent his time on remand at HMP Exeter. He was sentenced to 15 years imprisonment at Crown Court on 3 March 2005, and he was moved to HMP Wakefield on 8 March 2006, where he remained until he died. He had little contact with his family and did not receive regular visits.

21. On arrival at HMP Exeter on 7 May 2004, the man had an initial health screen where he disclosed that he been diagnosed with tablet controlled type 2 diabetes (a long-term, chronic condition caused by too much glucose, a type of sugar, in the blood), angina (pain in the heart muscle), and bladder problems. He was also a smoker. Initially, he was admitted to the healthcare centre as his diabetes was not stable, but moved to C wing three days later. His blood pressure was recorded as 130/90 (the normal range for blood pressure is 100/70 to 140/90, although the pressure varies throughout the day depending on the individual's activities. A blood pressure reading of greater than 140/90 is classed as high and a reading of 90/60 or below is classed as low). His medication upon reception was recorded as:

    - Acarbose (prevents blood sugar levels from becoming very high after eating so it can help people with diabetes to keep their blood sugar level under control)
    - Metformin (helps the body to control blood sugar)
    - Glipizide (lowers blood sugar by helping the pancreas make more insulin)
    - Aspirin (used as a painkiller and to lower the risk of forming a blood clot in the arteries of the heart (coronary arteries) or brain. This lowers the risk of having a heart attack or stroke)
    - Gliclize (used to stimulate the pancreas gland to produce more insulin, thus lowering blood glucose)
    - Perindopril (used to treat high blood pressure)
    - Simvastatin (used to lower cholesterol). Cholesterol is a fatty substance known as a lipid. It is mostly made by the liver from the fatty foods we eat and is vital for the normal functioning of the body. Having an excessively high level of lipids in the blood (hyperlipidemia) can have a serious effect on health as it increases the risk of having a heart attack or stroke. The government recommends that cholesterol levels should be less than five
    - Adizem (slows down the rate at which the heart beats and it allows the blood vessels in the body to widen. When the heart beats more slowly, the pressure at which the blood is pumped out of the heart is reduced)
    - Diprobase (for dry skin).

    The man was regularly reviewed by healthcare staff over the next few months, his medications were reviewed and he was treated for a number of minor ailments.

22. The man was sentenced on 3 March 2005. He was expecting a long sentence and there were no concerns regarding his mental health. He was assessed as a category B prisoner. During his time in custody, he remained

on the standard level of the incentives and earned privileges (IEP) scheme, as he did not complete specific offending behaviour work

23. In June 2005 the man had surgery to address the deterioration of the arteries in his heart. This involved having 'stents' inserted into his arteries (a stent is an artificial tube inserted to increase blood flow).

24. Over the following months, the man and his prescribed medication were regularly reviewed by healthcare staff. The clinical reviewer finds that he received appropriate care for all his medical conditions.

25. The man was transferred to Wakefield in March 2006. He underwent a health assessment upon reception. His blood pressure, following his diabetes assessment on 23 March, was recorded as 140/80 (at the high end of the normal range) and his weight as 87kg. His medications were the same as previously recorded, and in addition he was prescribed clopidogrel (used to reduce the stickiness of blood and the potential for blood clots to form, for patients who are at risk of suffering from a heart attack or stroke).

26. Over the following years, the man's medical conditions continued to be well managed. He received regular diabetes checks, treatment for various ailments and was seen by a chiropodist and optician. The man raised concerns with staff about his mental health, as he was anxious that he was developing 'Alzheimer's', as there was a family history of the illness. He was referred by the mental health team (MHT) to a psychiatrist, although the MHT had no specific concerns regarding his mental health. The man had a number of psychiatric assessments during this period, which were inconclusive. Early signs of dementia 'could not be ruled out', as it was established that he had some difficulties with his short term memory, but no formal diagnosis was made. The clinical reviewer notes that there was no formal diagnosis.

27. In addition, over this period of time, the man had increasing mobility difficulties. He was assessed by the prison doctor, referred to the disability officer, and an individual care plan was completed. He was provided with walking sticks, hand rails in his cell and a specialist mattress. In December 2007, following increased mobility difficulties, the man was assigned a specific peer carer to facilitate collection of meals and he was provided with a wheelchair. This care plan was reviewed regularly and revised according to his needs and he was granted core daily unlock (prisoners who are not fit to work due to their medical condition can associate with other prisoners during the day). The man reported to a member of wing staff that he felt reassured, and was confident in moving around the wing.

28. On 19 February 2009, the man was seen by a nurse as wing staff had reported that he had been unwell for two days with sickness and diarrhoea. He was examined and his blood pressure was recorded as 155/77 (higher than the normal range). Due to his history of coronary heart disease and as he was diabetic, a doctor from local care direct (a community owned service provider delivering Primary Care within the prison) was contacted. Following examination, the doctor diagnosed a possible viral infection and prescribed

paracetamol and the man was advised to drink plenty of fluids. The following day, he reported that he had been sick during the night, but felt better. His blood pressure was recorded as 138/82 (within normal range). The man was reassessed on 23 February by a nurse and reported that he still felt a little unwell, but he refused to be admitted to the healthcare centre.

29. Prison Doctor A reviewed the man's physical health on 5 March. His blood pressure was recorded as 131/87 (within normal range), and his weight as 76kg. His medication was reviewed and, in addition to that already recorded, he was prescribed diltiazem (this is used to slow down the rate at which the heart beats and it allows the blood vessels in the body to widen) and glyceryl trinitrate (to help manage angina, a muscle pain in the heart) and a referral for an electrocardiogram test (ECG) was made (an ECG measures the electrical activity of the heart to help with diagnosis). There is no record of when this ECG was completed or of the results. The clinical reviewer comments that this omission was not significant and that a recent ECG in January 2009 was normal.

30. Over the next eighteen months, the man was monitored by healthcare staff, his medications were regularly reviewed by prison doctors and there were no further recorded bouts of sickness and diarrhoea or problems with his heart.

31. The man began a smoking cessation course in September 2010. Following a consultation and assessment with a community health officer, he was prescribed champix (a medicine used to help people who are addicted to nicotine) by Prison Doctor B. Through September, he attended weekly smoking cessation groups and was moving towards a 'quit' date. He reported no side effects to the champix medication during this time. However, a nurse was asked by wing staff to examine him on 3 October, as they had observed he was not 'his usual self' and reported feeling sick. Following examination, the man's blood pressure was recorded as 150/77 (within normal range) and all other observations were satisfactory. The nurse referred him for a general review with the prison doctor and at his next smoking cessation group, the community health officer advised him to take his champix medication with food, to avoid feeling nauseous.

32. On 24 October, the man again experienced feeling sick, due to the champix medication. He was assessed on the wing by a health service worker and he was advised not to take his champix medication that night and to half his dose. The smoking cessation advisor was informed of this change. The man is noted as being an ex-smoker on 22 November.

33. A physiotherapist undertook a mobility assessment review with the man on 29 November. Due to his increasing mobility issues, he was given exercises to help promote greater movement, and to assist in controlling swelling to his ankles (known as oedema, this is a clear fluid and is usually a sign of an underlying medical condition or being immobile for long periods of time). The man was reviewed by the physiotherapist every week and on 17 December, it was recorded that there had been an improvement in his mobility. These weekly sessions continued.

34. Prison Doctor B examined the man on 20 January 2011, and recorded that 'has a degree of ankle oedema in ischaemic feet' caused by left ventricular failure (ischaemia is caused by an inadequate supply of blood to a part of the body, caused by partial or total blockage of an artery and can result in pain. Treatment usually includes stopping smoking, exercise and medication to lower cholesterol and blood pressure. Medicines to open up the arteries may also help. Ventricular failure is where the heart loses ability to pump blood through the body with the energy it needs to operate normally). The man also reported that due to an increase in the metformin medication he had experienced increased issues with wind and diarrhoea. The doctor altered the dose of his metformin medication and prescribed amlodipine instead of diltiazem (an alternative medication for lowering high blood pressure). Bumetanide was also prescribed (used to treat oedema (water retention), caused by conditions such as heart failure. It is sometimes referred to as a water tablet).

35. During his regular physiotherapy session on 24 January, the man advised that following the changes in his medication, his ankles were less swollen.

36. On 13 February at 4am, a nurse was called to see the man on D wing as he had been unwell, suffering from sickness and faecal incontinenece (the inability to control bowel movements). The man was distressed and told the nurse that he had pains in his stomach, felt sick and was frustrated by his forgetfulness. He was admitted to the healthcare centre for showering and observation. His blood pressure was recorded as 157/94 (higher than normal range), and pulse 97 (a normal pulse after a period of rest is between 60 and 80 beats per minute). Over the next few days, he was regularly monitored by healthcare staff and was discharged back to D wing on 15 February.

37. During the man's regular physiotherapy session on 4 March, he advised the physiotherapist that he did not have any water tablets left and that his ankles were beginning to swell. Also, that the previous night he had experienced another epsiode of incontinence. He was referred to Prison Doctor B; although there is no record of a consultation, there is a record that blood tests were requested and the results of these were recorded on 14 March. There was nothing significant recorded.

38. A consultant and a nurse from the diabetic clinic examined the man on 14 March. As a consequence of his recent bouts of incontinence, they advised him to stop taking his acarbose medication and that if his symptoms persisted, his metformin medication should be reviewed. The man told the doctor that he had not taken his bumetanide medication for a week and he was advised to restart as his ankles were observed to have 'significant' swelling.

39. The man was examined on 29 March by Prison Doctor B and, following the change in medication, there was an improvement in the circulation to his feet. The doctor noted that there was 'little evidence of peripheral ischaemia today – feet warm with good capillary refil'. As he had advised that he was experiencing an urgency in passing urine as a result of the bumetanide, his

prescription was changed to bendroflumethiazide (used as a water tablet and to reduce blood pressure) as an alternative. The following day, the man attended his regular physiotherapy appointment and reported that he was able to move around the wing using his walking sticks.

Events of 19 April

40. Officer A was on night duty on D wing overnight on the evening of 18 April and the morning of 19 April. At 5.25am, whilst carrying out her normal duties of carrying out the roll check (a process of confirming the correct number of prisoners present on each wing), she looked through the observation window of the man's cell D2-26 and observed that he was lying on the floor and was clearly unwell. He had been sick and there was a large amount of faeces on him and the floor, apparently following another bout of incontinence. The officer described being disturbed by the scene that she saw, feeling immediately sick and fearing that the man had died. She shouted to him and banged his cell door to get a reposnse and he was able to lift his arm and she could see him breathing.

41. The officer reassured the man that she would get help (during the night officers do not carry keys. There is an emergency cell key held in a sealed pouch for which permission must be sought from a senior officer to break prior to opening a cell). Due to discovering her radio had a flat battery, she quickly went to the centre (a short distance away at the end of D wing where staff are able to observe several wings at once) and alerted a Senior Officer (SO) who was the assistant Night Orderly Officer (NOO – the designated member of staff in charge during the night shift) and Officer B. The SO telephoned the healthcare centre and requested immediate medical assistance. All three uniformed staff then went back to the cell. They did not enter the cell immediately but stood observing and reassuring him. The investigator asked the officer about the decision not to immediately enter the cell. In interview she said:

> "We did consider it but due to the extent of the condition, I've also got to think about my health and safety. And because we could see that he was breathing we came to the conclusion/the decision as a group that we'd have to wait for healthcare to come and bring us actual proper clothing to go in. Because he was breathing, if I didn't feel as though he was breathing I would have gone in no matter what. But because I could see that he was alive I felt that it was better personally; and I think it was a group choice as well."

42. Whilst waiting for medical assistance, Officer B went and obtained some Personal Protection Clothing (PPC - white boiler suits used for health and hygiene reasons) and blankets from the centre office.

43. Nurse A arrived at cell at 5.35am, escorted by Officer C, a prison dog handler (this is usual practice in high security prisons during the night). The SO broke the sealed pouch and opened the cell door. The nurse entered; she had no protective clothing other than surgical gloves. She assessed the man who

told her that he had slipped. He had no visable signs of injury, his colour was good but he appeared confused. During interview she said:

> "No he [the man] didn't complain of any pain, any other problem apart from he said he felt a bit nauseous, a little bit sick, but he was lying in all his faeces and one of the officers was actually sick outisde…his colour [the man's] was good, there was no cause for concern at that time"

44. Due to the level of contamination in the cell, the nurse made the decision to move the man to the healthcare centre so he could be cleaned and full observations could be completed.

45. The restricted conditions in the cell meant that the man's wheelchair could not be used to transport him, and it was moved to outside his cell. Both officers had put on their Personal Protective Clothing before they entered the cell to assist in moving him to his wheelchair. The man was not able to sustain any weight on his legs and the staff had a very difficult time trying to move him. They were eventually able to move him to the outisde of his cell, and lift him into his wheelchair, protecting his dignity with the use of blankets. During the time he was being moved to his wheelchair, the nurse obtained some protective clothing from the centre, as she had faeces all over her own clothing. Once settled in his wheelchair, he remained confused but told her that he was not in any pain. During interview Officer B said:

> "…[the man] couldn't assist us… the wheelchair didn't fit through the cell door and it didn't look nice and it wasn't nice. But I had to literally drag him from inside the cell and lift him onto his wheelchair; it sounds easy but it was extremely difficult… it was very, very hard"

46. A number of prisoners who were in cells near to the man's told the investigator that they believed staff had treated him disrespectfully when he was found on the morning of 19 April. The investigator interviewed each of the prisoners. This issue is dealt with later in the report.

47. On arriving at the healthcare centre at 6.15am, a Healthcare Officer (HCO) was told about the situation and he helped Officer B transfer the man into another wheelchair which could be used in the shower area. Both medical staff assisted him with washing and he appeared more alert, but stated that he still felt sick. The uniformed staff returned to their duties on the wing, and healthcare staff located him in cell H2-05, where he was closley monitored.

48. Initially, following his shower, the man's blood pressure was recorded by the (HCO) as 85/41. During interview he said:

> "…he didn't divulge any pain anywhere. And again his core looked alright, didn't look clammy. So I knew at that time, I heard the gates go, that our morning staff were coming in. So I went upstairs, initially went up to get the emergency bag just in case because it has the defib and everything. And I met a HCSO and a RGN [Registered General

Nurse], who were coming on an early start, so I just handed it all over to them."

49. The HCO briefed the Healthcare Senior Officer (HCSO) and Nurse B when they reported for their day duty at 6.55am, and they then took the lead in the man's care. The nurse recorded his blood pressure as 59/27 (very low). He remained under observation in the healthcare centre, and his blood pressure was subsequently recorded as 61/29 (still very low). He then complained of central chest pains and an ambulance was called by the HCSO at 7.07am. During interview, in response to the timing of the call for the ambulance, he said:

> "I think he seemed to deteriorate very quickly from when the night staff took [his blood pressure] until we took it. There was a significant drop. And the night staff didn't mention chest pains … Although I called an ambulance I asked Control to deal with all the arrangements because I'll be going back to [support] him… I thought there was a good chance he could arrest, so I asked the HCO to go for oxygen, the defibrillator equipment, all the emergency equipment and I got that on standby. I stayed with [him] until I heard that the ambulance crew had arrived and then I went to the bottom of the lift to speak to the ambulance crew and handed over his medical condition."

50. The ambulance and paramedics arrived at Wakefield at 7.15am. Following assessment, the decision was made to immediately transport the man to outside hospital. A bed watch consisting of two officers and the use of a restraint by an escort chain was authorised, although a formal risk assessment was not completed, and two officers were detailed to escort him. (A bed watch consists of two or three daily shifts where officers will stay with a prisoner who has been admitted as an inpatient. A written log is maintained throughout and a prison manager will re-assess the level of restraint used, depending on the circumstances of the situation.) A full risk assessment was not completed at this time as staff of the appropriate level of authority were not available.

51. The ambulance left Wakefield at 7.50am, arriving at hospital at 8.05am. During interview the duty governor explained:

> "Apparently he was very unwell and as I say they had to stop the ambulance to actually resuscitate, to work on him in the ambulance, hence the length of time in between being called and actually leaving the establishment."

52. The man was taken into theatre at 8.20am and the restraints were removed. He had surgery where a pacemaker and a further stent were fitted. Following surgery he was taken to the coronary care ward at 9.45am and the restraints were reapplied. His condition was described as 'very poorly'. At 10.30am the duty governor authorised staff to remove the restraints should he need emergency tretament by a crash team (emergency response for those experiencing a cardiac arrest or heart failure). At 11am, he experienced an

increased heart rate, the crash team were called, and the restraints were removed. At 11.15am, following a further decline, a defibrillator was used (a device that diagnoses rhythms of the heart after cardiac arrest) and resusitation commenced, but to no avail. The man was pronounced dead at 11.28am.

53. A prison family liaison officer (FLO) was appointed. The man had no contact during his time in custody with his family, but had recorded his next of kin as his wife. They were divorced and had not had any contact for many years, and the details held for her were out of date. Devon police were contacted and asked for their assistance in tracing his next of kin. They were able to make contact with one of his daughters, and his son-in-law was nominated by the family as a point of contact. The FLO spoke with him and he was advised of the role of prison family liaison officer, the Coroner and my office's investigation. A letter of condolence from the prison was sent on 5 May.

54. A post mortem was undertaken on 20 April. It was concluded the cause of death was due to acute myocardial infarction (a heart attack). There were no significant findings in the toxicology report.

ISSUES

Clinical care

55. A clinical reviewer was commissioned by the local Primary Care Trust to review the medical care that the man received whilst in prison custody. His clinical review looks at the care and treatment he received at Wakefield and measures whether it was appropriate and comparable to that which is available in the community. The clinical reviewer and the Ombudsman are satisfied that the care he received was comparable. The clinical reviewer makes no recommendations, and concluded:

> "The man was an elderly gentleman with multiple health problems who received a good standard of health care whilst at HMP Wakefield. On the day of his death he was found in difficult circumstances and staff paid high regard to his dignity in attending to his needs. Whilst being transported to Healthcare and being showered he appeared to be improving and complained of no pain.
>
> Subsequent observations identified a lowering of blood pressure. The nurse who took his blood pressure did not call an ambulance immediately but sought advice from a senior colleague who examined him. It was noted that his blood pressure had fallen further and he was now complaining of chest pain. In cases of myocardial infarction delay in hospital treatment does have a negative effect on outcome. In this case there was a possibility that the initial blood pressure reading was a result of fluid loss and there was no chest pain at this time. I would therefore not be critical of the decision to reassess his condition."

56. The clinical reviewer highlights several areas of good practice, which we would endorse. The man was successfully encouraged to stop smoking, received a high level of monitoring and care relating to his diabetes and his mobility issues were well managed and he received regular physiotherapy.

Personal protection and hygiene

57. Uniform staff told the investigator that they did not immediately enter the man's cell when Officer A found him on the floor. This is because there was a large amount of faeces and, as he was obviously breathing, they did not need to administer emergency first aid and could wait for protective clothing to be brought to the cell (see Officer A, paragraph 41). Within a few minutes the uniform staff had obtained protective clothing and Nurse A had arrived at the cell. It was at this point that the cell was unlocked and the nurse and other staff went in to treat him.

58. Nurse A said that she did not know that protective suits were available in the main prison (meaning the four residential wings), but that her priority was to go into the cell and see the man. However, she added that she would have worn a protective suit had one been available and she had been able to check that he was conscious before putting it on.

59. The situation facing staff was challenging and they had satisfied themselves that the man was not in immediate danger as they awaited clinical support. Nurse A told the investigator that when she assessed him on her arrival he was conscious, coherent and she had no cause for concern at the time. It is commendable that she prioritised his medical needs above her own personal safety. We do not make a recommendation, but would expect that protective clothing is made easily accessible to all staff at all times to allow safe early intervention in such cases.

The response to the man on 19 April

60. Five prisoners were interviewed by the investigator, having made allegations that staff attending to the man on 19 April had been disrespectful. The allegations were that staff had been calling him names, using offensive language and making overt gagging noises. The allegations and all available evidence were carefully considered. Officer B responded to the allegations as follows:

> "No one was swearing at him. I can remember myself gagging and I didn't mean to be disrespectful … it was just a natural reaction and obviously after he died a few will probably take that the wrong way … I couldn't cope with it, to be honest, and I did find it difficult and I did gag but it wasn't a disrespect thing, it was a natural thing."

61. The circumstances in which the man was found were undoubtedly distressing for staff and nearby prisoners. It was a difficult situation for staff to deal with. We cannot be sure what was said and it is possible that innocent reactions were misinterpreted by those prisoners hearing the events through their cell doors. However, a significant number of prisoners have suggested that staff acted inappropriately and, whilst we have found no additional evidence to support their claims, these events should act as a reminder to staff to remain professional at all times.

62. An emergency ambulance was requested following the specific onset of chest pains. The man had regular observations after his admission to healthcare and the clinical reviewer has concluded:

> "In this case there was a possibility that the initial blood pressure reading was as a result of fluid loss and there were no chest pains at this time. I would therefore not be critical of the decision to reassesses the man's condition."

Restraints

63. The man required emergency first aid during his journey by ambulance to hospital, and following heart surgery remained extremely ill. He was subject to restraint by an escort chain for a significant part of this time. The removal of restraints can only be authorised by a senior prison staff member or in emergency situations (such as if hospital staff demand their removal to enable

them to provide treatment). It was noted that hospital staff did not ask the officers to remove the restraints when they were reapplied after surgery, and they were quickly removed when the crash team were called. However, we do not believe that reapplying the restraints immediately after surgery was necessary.

64. The investigator was mindful of the time of day the man was taken to hospital and that a comprehensive risk assessment was not completed as the appropriate level of authority could not be obtained to countersign an assessment. Whilst it is appreciated that the prison has a duty to ensure that any risk posed by a prisoner is adequately managed, it is hard to conceive why an individual, such as the man, who can be identified as presenting no or only a manageable risk should be subject to restraint in this way.

The Governor should ensure that - whatever the time of day - proper risk assessment processes and arrangements for authorising the removal of restraints are always in place, so that hospitalised prisoners presenting no or only a manageable risk are not unnecessarily restrained.

Support for staff

65. The duty governor held a hot debrief (a meeting immediately after an incident) with all the staff involved with the man. Support was immediately made available to them via the care team. During interview, all staff said that they were contacted by a member of the care team and were aware that, if they chose to, they could contact them at any point for ongoing supoprt.

Support for prisoners

66. A notice to prisoners was issued by the Governor the same day announcing the death of the man and expressing condolences. This notice reminded prisoners of the available support, via wing staff, the prison chaplaincy and the listeners (prisoners trained by Samaritans to offer confidential support their peers). A listener on D wing was also advised personally of his death to ensure that those he knew best were appropriately supported. A memorial service was held on 18 May, for all those wishing to attend.

CONCLUSION

67. The man received appropriate medical treatment at Wakefield. He entered custody with a number of known medical conditions, which he received ongoing treatment. After years in prison he became a frail man, who received individualised care and support. The standard of care that he received whilst at Wakefield ensured that his multiple conditions were well managed. He became unwell on 19 April; staff responded in a generally satisfactory manner and could do nothing to prevent his unexpected death.

68. Despite the generally positive findings in this investigation, attention has been drawn attention to some procedural weakness in ensuring the minimum necessary use of restraints for someone who posed no or only manageable risk, due to their critical condition.

RECOMMENDATIONS

1. The Governor should ensure that - whatever the time of day - proper risk assessment processes and arrangements for authorising the removal of restraints are always in place, so that hospitalised prisoners presenting no or only a manageable risk are not unnecessarily restrained.

   Accepted – A process of risk assessing the use of restraints for prisoners being treated within NHS facilities is in place. This risk assessment is approved by an operational manager who ensures the level of restraint required is appropriately outlined. Additionally, whilst on a bedwatch, prisoners are visited every 24 hours by a manager from the security and operations team and, again, every seven days by an operational manager F or above.

   Supervising bedwatch staff have the opportunity, should a prisoner's condition deteriorate, to contact the duty governor to request a change in the level of restraints used. We endeavour, in all cases where a prisoner has been diagnosed with a terminal illness, to remove restraints subject to an appropriate risk assessment taking place.