

**Investigation into the circumstances surrounding the
death in May 2007 of a man in hospital, whilst a prisoner at
HMP Wakefield**

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

February 2008

This is the report of an investigation into the circumstances surrounding the death of a man in May 2007 in hospital. The man was a prisoner at HMP Wakefield.

The man had been exercising in the prison gymnasium when he collapsed onto the floor. Healthcare staff attended to him, paramedics arrived and he was transferred to hospital. The man died shortly after being admitted to the Accident and Emergency Department. A post mortem was held at the request of the Wakefield Coroner and it revealed that his death was due to apparent natural causes. The cause of death was given as a severe heart attack and his death was considered unavoidable.

I extend my sincere condolences to the man's family and friends. I would like to thank the Governor of Wakefield and his staff for their help and assistance in this investigation. I am especially grateful to a member of staff, who acted as prison liaison officer with my office.

I commissioned a clinical review of the care afforded to the man whilst he was in Wakefield from Wakefield and District Primary Care Trust. At the time of writing this report, I have still not received the clinical review and I am therefore unable to comment on the medical care afforded to him.

I have made three recommendations. One requested Wakefield and District PCT to complete a clinical review. The others are in respect of the prompt care offered by a prisoner after the man collapsed, and the support his bereaved family received from two members of staff. I also make one housekeeping point.

In this version of the final report I acknowledge a draft clinical review has now been received from Wakefield and District PCT and is annexed to this report. I note the recommendations from that review. The man's sister has viewed the draft report and commented that she wished to see the clinical review to find out whether her brother had had a previous heart attack whilst at Wakefield, and if this was the case, did he receive appropriate medical intervention.

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

Stephen Shaw CBE
Prisons and Probation Ombudsman

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SUMMARY

The man had been sentenced to life imprisonment in 1996 for murder. He transferred to Wakefield in April that year. The man made two unsuccessful appeals to the High Court and was considering making a third appeal. He had always denied his offence.

The man was a popular prisoner with both prison staff and prisoners. He was described as a polite and respectful man, with a good sense of humour. The man had a good relationship with all staff.

In May, the man was attending remedial exercise classes in the weights room. After completing his exercises he moved upstairs to the large gymnasium. He acknowledged a member of the gym staff, a Physical Exercise Instructor (PEI) who was leading a power walking group. A few minutes later the man seemed to trip and fell onto the floor in front of the PEI. The PEI believed the man was play acting and continued with his class.

Less than a minute later, a prisoner went over to where the man was lying on the floor. He was then joined by the PEI. The man was unresponsive and his breathing was abnormal. The prisoner and PEI moved the man upright, then into the recovery position. The PEI called for assistance and healthcare staff were asked to attend.

Two nurses arrived at the gym. The man was drifting in and out of consciousness. His heart stopped and one of the nurses carried out Cardio Pulmonary Resuscitation (CPR). Paramedics then arrived and took over the care of the man. He was transferred by emergency ambulance to hospital, and died shortly after arriving in the accident and emergency department.

When the man first fell to the floor, it was believed that he was having a joke. When it became obvious he was very unwell, he received prompt and appropriate care and support. The post mortem report indicates that the man had suffered a severe heart attack and that his death was unavoidable.

THE INVESTIGATION PROCESS

The man's medical records and prison file were sent to the Ombudsman's office shortly after his death.

The investigation was opened by one of my investigators in May 2007 when she visited HMP Wakefield. My investigator met with the Deputy Governor, the Family Liaison Manager, the Healthcare Clinical Manager, a Physical Exercise Instructor, a representative of the Prison Officers' Association (POA), and the Chair of the Independent Monitoring Board (IMB). Notices of the investigation and terms of reference had been sent to the prison in advance of my investigator's visit for display around the prison.

My investigator visited D wing where the man was located and spoke to two prisoners. My investigator also spoke to an officer who was the man's personal officer.

A review of the man's medical care was commissioned from Wakefield and District Primary Care Trust in accordance with my terms of reference. At the time of circulation of the draft report, no clinical review into his healthcare had been received. A draft clinical review was received in time to be incorporated into this final report.

My investigator returned to Wakefield in June to carry out interviews with prison staff. She also interviewed prisoners who had responded following the display of notices.

One of my Family Liaison Officers made contact with the man's sister. The man's sister did not raise any specific issues into her brother's care.

HMP WAKEFIELD

Wakefield is a male prison for those serving four years or over (including many life sentence prisoners). It forms part of the high security estate holding prisoners who potentially pose the greatest risk the public. It specialises in the treatment of serious sex offenders.

The prison provides workshops and an education department offering both full and part time education. The programmes department offers a range of offending behaviour courses including FOCUS (a drug programme), Sex Offender Treatment Programme (SOTP) and the Enhanced Thinking Skills (ETS) programme.

The gymnasium is a popular area of the prison. A well-equipped weights room and large gymnasium is used on a daily basis. Remedial exercise is prescribed for prisoners to improve their life style and manage medical conditions. Following a referral for remedial exercise, a member of the gym staff will interview the prisoner. An exercise programme will then be developed focusing on the prisoner's individual needs.

The most recent report by HM Chief Inspector of Prisons in April 2005 followed an unannounced follow up inspection. The report said of healthcare:

“There had been little change in healthcare facilities since the last report. Wakefield provided 24 hour care for prisoners and had a 20 bed inpatient facility. Staff were enthusiastic and committed to improving services but there appeared to be a lack of strong clinical leadership particularly in primary care area.”

The annual report by the prison's Independent Monitoring Board in August 2004 praised the jail's healthcare department, responsibility for which was about to pass to the local Primary Care Trust.

KEY FINDINGS

The man was received into HMP Wakefield in April 1996. A first reception health screen indicated no specific health problems. He reported sick on a number of occasions with minor ailments, for which he was prescribed appropriate medication and treatment.

In February 2001, the man saw the medical officer and was referred to the gym for remedial exercise to help with pain in his lower back. In September, he went to the healthcare unit complaining of chest tightening and sweating after running for one mile. The man told the medical officer that the tightness was severe and he had experienced two episodes of chest pain during the run. The medical officer advised the man to stop smoking, and to take gentle exercise, and arranged for blood tests. The doctor wrote a letter of referral to hospital requesting an investigation. However, the prison's primary care manager and security manager are unable to find any record of the doctor sending this referral or any evidence of a letter being received by the hospital.

In October 2001, the man was prescribed Simvastatin as his cholesterol was noted to be 7.4 (this well above the average reading). It was also noted that he had a family history of angina. In August 2004, the man was prescribed aspirin of 75mgs daily to help with his blood circulation.

In May 2006, the man attended healthcare with a dental infection. He was referred to the dentist and given amoxicillin, an antibiotic. Later in May, the man was seen again by the medical officer as his dental infection had returned. The man was prescribed more antibiotics and a mouth wash. In September, the man was seen again in the healthcare unit. One of his teeth had broken and an infection was present. He was again prescribed antibiotics and mouth wash.

On a morning in mid May 2007, the man attended the gym for a remedial exercise class. These classes took place in the weights room. Near to the end of the session, the man was approached by one of his friends. The friend was also using the gym. The man was kneeling, with his head down, on the floor close to his friend. The friend asked him if he was okay. The man said he would be alright in a minute. He then left the weights room.

About 9.50am, a physical education instructor (PEI) was leading the power walking session in the gym. The PEI was in front of a group of prisoners in the gym who were in the 'cooling down' part of the session. The PEI noticed the man who had come into the gym from the weights room. He was standing behind the barrier boards on the right hand side of the gym. The PEI acknowledged the man, with whom he had a good relationship. The man acknowledged him back.

The PEI continued to lead his class around the gym floor. Several minutes later he saw the man walk onto the gym floor. He crossed in front of the PEI. The man then seemed to stumble as if he was tripping over. He fell onto the floor near to the barrier boards and in front of the gym office. The PEI had to side-step the man to avoid falling over him. The PEI first thought that the man was having a "joke", as the

manner in which he had fallen seemed to be “play acting”. The PEI continued with the class and it ended less than a minute later.

A fellow prisoner had been participating in the power walking class and had observed the man stumble and fall to the floor in front of the class. The prisoner also initially assumed that the man was “messaging around” or had tripped and stayed down because he “felt silly”. The prisoner went to the man’s side. The prisoner tried to talk to the man but he was unresponsive and rigid. The prisoner noted that the man’s breathing was coarse and rasping. The prisoner was then joined by the PEI.

The PEI saw the man was lying on his front, his eyes were open and he was breathing. At this point the PEI still believed that the man was play acting. The PEI said to the man, “Come on, that’s enough”. He repeated himself twice. When the PEI got no response from the man, he bent down to him on the floor and saw his eyes were open, but his breathing was heavy. There was still no verbal response from the man.

The prisoner checked the man’s pulse. (the prisoner had completed a first aid course for prisoners.) The prisoner noticed a nasty bump on the man’s head which had appeared consistent with his fall to the floor. The man appeared to show signs of consciousness, and started to wriggle around trying to get up. The PEI and the prisoner moved the man to a sitting position against the barrier board. The man was going in and out of consciousness and his body became floppy. The PEI and the prisoner then moved the man onto his side into the recovery position. The PEI had alerted other gym staff and requested the attendance of healthcare staff. He then fetched a towel to go under the man’s head, whilst the prisoner stayed with the man talking to him and monitoring his pulse.

Two members of healthcare staff arrived at the gym within several minutes. They attached a heart monitor to the man and an oxygen mask. He began to struggle and tried to remove the oxygen mask from his face. He also said his stomach was hurting and cried out in pain. The nurses immediately requested that an emergency ambulance be called. The man’s heart stopped and one of the nurses commenced Cardio Pulmonary Resuscitation (CPR). The prisoner assisted the nurses in opening the man’s mouth so he could be intubated.

At 10.07am, the paramedics arrived at the gym and took over the man’s care. The man was escorted from the prison at 10.08, with a three officer escort, the Imam and a nurse. A nurse assisted the paramedics with CPR in the ambulance. The man was given adrenaline on the journey to the hospital by one of the paramedics.

On arrival at the hospital, the man was taken to the Accident and Emergency Department. Despite the efforts of all concerned, they were unable to resuscitate him and he was pronounced dead at 10.40am. The Imam was able to carry out the appropriate religious rituals once the man’s death was confirmed.

The Imam returned to the prison, and with the prison’s family liaison officer, went to the man’s nominated next of kin (his sister). On arrival at the man’s sister’s address, they were told that the man’s wife lived nearby. The man’s wife came to her sister-in-law’s house and the governor informed them of his death. The Imam

accompanied the man's sister, along with other family members, to the hospital to see her brother's body. Along with the Assistant Imam, the Imam attended the man's funeral service two days later at a mosque.

The man's relatives accepted an invitation to visit HMP Wakefield to meet their brother's friends and prison staff. The family has told my office that they greatly appreciated the assistance from the prison towards funeral expenses.

ISSUES

Clinical

In June 2007, Wakefield and District Primary Care Trust was requested to undertake a clinical review into the care the man received whilst at HMP Wakefield. This was in accordance with the standard procedures set out in my terms of reference. At the time of completing the draft report, I had not received the clinical review from the PCT. I was therefore unable to comment on the clinical care the man received.

I recommended that a copy of the draft report should be sent to the Chief Executive of Wakefield and District PCT with a further request that he should commission and complete an urgent clinical review into the standard of care received by the man at HMP Wakefield.

A draft clinical review was finally received before the issue of this final report. I understand that enquires are still being made with Yorkshire Ambulance Service.

The draft clinical review noted that the man appeared to have been well cared for in the vast majority of his medical needs. There is no criticism of the assessment made prior to his referral for exercise. The man's condition was monitored and his cholesterol level treated. He was advised to increase the Simvastatin dose when the level went over 5, and he was repeatedly advised about smoking. The man should have had an exercise Electrocardiogram (ECG), to monitor his heart rate, in 2001. This would have given indication about his fitness to exercise. However, exercise within limits is probably beneficial in heart disease and staff should not be concerned that his death followed a period of exercise.

The most obvious failing is that the man did not attend the hospital physician after the clinical diagnosis of angina. It is not possible to determine whether this was due to administrative error either in prison or in hospital, or a possibility that the man refused to attend. There is one entry on the medical record in October 2001 that may mean that he did not accept the diagnosis of heart disease. It is a further failing that there is no record of any conversation about this referral, or any action that was taken to ensure the man attended.

The entries on the medical notes around this time are illegible and seem to be written by different doctors. There may be a lack of continuity of care, and the notes may not have been read following entries by locum doctors. Many of the prison doctor's notes are of limited use due to the poor legibility.

The medical notes do not say whether the man was being treated for primary prevention on the basis of his raised cholesterol, or for secondary prevention. There is a 'heart' symbol entered in his record on a few occasions by one doctor, though the significance of this is unclear. Had the man had the ECG that was requested, it is possible this would have shown evidence of ischaemic heart disease, although this is not always the case in patients with angina. This would have placed him in a different risk category.

The clinical reviewer noted that having made this criticism, it is possible that the eventual outcome might have been the same had he received a diagnosis of heart disease. The man's management might have included additional medications such as a beta blocker or ACE inhibitor, but he did receive Simvastatin and aspirin, which are important in secondary prevention as well as primary. However, the man may have been more motivated to stop smoking if he had the diagnosis confirmed.

The man's sister read the draft report and told my family liaison officer that she wanted to see the clinical review. The man's sister wanted to know if her brother had a previous heart attack or heart problems, several years ago. There is a family history of heart disease and she had spoken to her brother about maintaining good health, which he supported following their mother's bypass operation in 2004.

The clinical review said that the man had angina, and was seen by the doctor in September 2001, after becoming unwell following exercise. As previously noted there is no record regarding a referral to hospital and there was no firm diagnosis of heart disease. The man was treated appropriately after blood tests confirmed he had high cholesterol.

The man's collapse in the gymnasium

The man was well known by gym staff. He had a very good relationship with the staff, enjoying a joke and friendly banter. On the day he collapsed in the gym, the PEI at first believed that the man was joking and play acting. Once it became obvious that he was not play acting, the PEI went to his aid and raised the alarm.

In response to the Ombudsman's notice to prisoners following the man's death, several prisoners wrote to my investigator. My investigator also received two formal complaint forms from the prison in relation to his death.

Two of the prisoners interviewed raised concerns not relating to the man's death. Three prisoners raised issues about what was described as the lack of response from gym staff to the man's collapse and the length of time before healthcare arrived at the gym. The prisoners' main points were based on the fact that, following the man's fall to the floor, there was not an instant response. One of the three prisoners said during interview that they thought, "He was larking around." A second prisoner was not in the gym at the actual moment the man fell to the floor, arriving a few minutes later when the prisoner was at the man's side.

All the prisoners interviewed described the man as a likable and nice man. He had a great sense of humour and got on well with fellow prisoners and prison staff.

Whilst acknowledging the points raised by the three prisoners, it is the prisoner who assisted the PEI on the day the man collapsed, who has given a full account of what occurred. The prisoner indicated that the gym staff, in particular the PEI responded to the man with dignity and respect once it was realised he was not play acting. The prisoner praised the professionalism of the healthcare nurses and the PEI.

The PEI was distressed and upset that he had not reacted to the man's fall immediately. The PEI told my investigator that the man did not show the 'text book' signs of having a heart attack. He did not clutch his chest or complain of tingling in his arms. The PEI believed that the man was having a joke with him.

The post mortem clearly indicated that the man had a massive heart attack, and that his death was unavoidable.

The care shown by the prisoner was exemplary. He offered compassion and kindness to the man and was shocked by his death. They had been friends for many years. The prisoner was dismissive of rumours circulating amongst prisoners criticising the gym staff. He told my investigator he thought that some of the prisoners were using the man's death to further their own agendas and found this contemptible.

I am content that the man was treated in an appropriate and timely manner. The relationship between the man and gym staff was friendly, with mutual respect shown on both sides. The PEI reacted with professionalism once he realised that the man was unwell. He should not attach any blame to himself for not responding immediately to his fall.

Healthcare staff arrived at the gym within a few minutes of being called to attend and gave appropriate care to the man in an attempt to resuscitate him. Sadly, despite their best efforts he could not be revived.

For the prisoner who assisted the man when he collapsed, his prison file should record the help, assistance and care he gave to the man.

Support to Prison Staff

The man's personal officer was shocked by his death. The officer was off duty on the day he died. She was contacted at home by a colleague and friend who told her what had happened. This colleague was aware the officer was the man's personal officer.

Returning on duty two days later, the officer was not informed by line management of the man's death or offered any staff care and welfare service. The officer was aware of those services, but I understand she would have appreciated a more personal touch. Whilst I make no formal recommendation, staff should be informed at the commencement of their shift about the sudden death of a prisoner. In addition, Personal Officers of a deceased prisoner should be spoken to personally and offered support as required.

Family Liaison

It was fortunate that the Imam was in the prison on the day the man collapsed. He responded to the message for him to go to the gym. On arrival at the gym he accompanied the man to the hospital. Following his death, the Imam carried out religious rituals appropriate to the man's faith.

The Imam and the family liaison officer broke the sad news of the man's death to his family with compassion and respect. This was followed by much appreciated support to the man's family. His family have been extremely grateful to the Imam and the governor for their help, kindness and assistance.

As with the involvement of the prisoner, the family liaison officer will wish to acknowledge the work of the Imam and the governor in meeting the needs of the man's family following their bereavement.

The Governor should formally commend the Imam and the family liaison officer for the support and compassion shown to the family of the man.

RECOMMENDATIONS

- 1. I recommended that a copy of the draft report should sent to the Chief Executive of Wakefield and District PCT with a further request that he should commission and complete an urgent clinical review into the standard of care received by the man at HMP Wakefield.**

A draft clinical review was received from Wakefield and District PCT following the issue of the draft report. I have therefore been able to include this in this final report.

- 2. For the prisoner who assisted when the man collapsed, his prison file should record the help, assistance and care he gave to the man.**
- 3. The Governor should formally commend the Imam and family liaison officer for the support and compassion shown to the family of the man.**

Housekeeping Point

On the sudden death of a prisoner, staff should be informed at the commencement of their shift. Personal Officers of a deceased prisoner should be spoken to personally and offered support as required.

ANNEXES

1. Documents considered during the investigation