

**Investigation into the circumstances  
surrounding the death of a man in June 2011,  
whilst in the custody of HMP Wakefield**

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

**December 2011**

This is a report into the death of a man in June 2011, whilst he was in the custody of HMP Wakefield. He was 79 years old when he died. The post mortem result showed that the cause of his death was pneumonia.

We offer our sincere condolences to the man's family and friends for their loss. One of our Family Liaison Officers contacted the family to tell them about the investigation and give them the opportunity to raise any issues about the care he received in custody.

The investigation was carried out by an investigator. We would like to thank the Governor and her staff for their co-operation during the course of our enquiries.

We also thank the local Primary Care Trust for appointing a clinical reviewer to review the man's clinical care.

The findings of the clinical review play an important part in this report in relation to the man's care. The review shows that he received a standard of care which was equitable to that which he could have expected in the community. We make one recommendation concerning the appropriate use of emergency response codes.

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.

**Thea Walton**  
**Acting Deputy Ombudsman**

**December 2011**

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## SUMMARY

1. The man was convicted and sentenced to ten years imprisonment on 29 March 2005 and was sent to HMP Manchester. He was a life long smoker had a history of chronic obstructive pulmonary disease (COPD) and was prescribed inhalers. Due to the nature of his conviction he became estranged from his family.
2. On 6 February 2006, the man was transferred to HMP Wakefield. Whilst at Wakefield he was monitored regularly by healthcare staff and he saw the visiting respiratory consultant for reviews of his COPD.
3. The man's condition deteriorated and on 10 August 2010 as his COPD was assessed as severe. In the months that followed, he continued to be monitored by healthcare staff and he saw the visiting respiratory consultant for reviews of his COPD. He was also referred to the ophthalmic consultant (eye specialist) for cataract surgery on his left eye on 25 November 2010 and his right eye on 6 June 2011.
4. In June, the man was found unconscious in his cell and emergency medical assistance was called. Healthcare staff began cardio pulmonary resuscitation (CPR) until the paramedics arrived and took over his care who confirmed that he had died at 8.31am.
5. In the days that followed the prison family liaison officer maintained contact with the man's family and offered support and financial assistance towards the funeral expenses.
6. We are satisfied that the care and attention the man received at Wakefield was equitable to what he could have expected to receive in the community. We make one recommendation concerning the appropriate use of emergency response codes.

## **THE INVESTIGATION PROCESS**

7. The investigation was opened on 24 June 2011 when the investigator issued notices announcing the investigation to staff and prisoners and inviting anyone with any information relevant to the investigation to contact him. No one came forward as a result.
8. The investigator visited HMP Wakefield on 29 June 2011. During his visit he was given copies of all documentation relating to the man and visited where he had lived. The investigator returned to Wakefield on 21 July and 18 August 2011 and interviewed four members of staff. Written feedback on the progress of the investigation was sent to the Governor on 24 August 2011.
9. The local Primary Care Trust appointed a clinical reviewer to review the man's clinical care. The investigator and the clinical reviewer discussed aspects of his treatment at Wakefield. We are grateful to the clinical reviewer for her timely and considered report.
10. The investigator contacted Her Majesty's Coroner 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.
11. One of our Family Liaison Officers contacted the man's son to inform him about the investigation and to invite the family to ask any questions or raise any concerns. The family have made no contact at this stage; they will however have the opportunity to comment on the draft report if they wish.

## HMP WAKEFIELD

12. HMP Wakefield is one of eight high security prisons in England and Wales. It is located between the city centre and a residential district, accommodating approximately 750 prisoners of Category A, B, and high security remand. There are 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.

13. HM Chief Inspector of Prisons last conducted a full announced inspection of the prison in December 2008. The 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.”

14. Each prison has an Independent Monitoring Board (IMB) whose members are unpaid and 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.

15. 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.”

16. 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.”

17. Prisons in England and Wales are assessed for performance by the National Offender Management Service (NOMS). For public prisons, NOMS use a combination of the Prison Performance Assessment Tool (PPAT, which looks at 33 indicators) and the public prison weighted scorecard (which looks at a set of 44 indicators). Each establishment is then given a rating between one and four; 4 = Exceptional performance, 3 = Good performance, 2 = Requiring development, 1 = Serious concerns. For the last three performance reports, HMP Wakefield has been given a rating of 3.
18. Prisoners are risk assessed when they come into prison and given a category based on their offence and the risk that they pose to the public should they escape. There are four levels of category: A, B, C and D, with category A prisoners being the most dangerous. A category B prisoner is one for whom the highest security conditions are not necessary but for whom escape must be made very difficult. Prison Service Order (PSO) 0900, gives guidance on appropriate assessment.
19. The Incentives and Earned Privileges, or IEP scheme was introduced in 1996 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.
20. The man's death was the 4th attributed to natural causes to have occurred at Wakefield in 2011. There are no significant similarities between any previous deaths and that of him other than in age, which reflects the ageing population at Wakefield.

## KEY EVENTS

21. The man was born in October 1931 and lived in the Rochdale area. He was a life long smoker and before his retirement he had been a plumber by trade. In 1992 he had been diagnosed with COPD (COPD is a progressive condition which causes irreversible damage to the lungs and produces symptoms such as wheeze, breathlessness and increased sputum production making the patient at increased risk of chest infections. The disease is characterised by periods of stability with intermittent worsening of symptoms and the lungs will deteriorate over time.).
22. On 29 March 2005, aged 73, the man was convicted of sex offences and given a 10 year custodial sentence. Due to the nature of his offences he became estranged from his family and he had no contact with them throughout his time in prison.
23. Following his conviction he was sent to HMP Manchester and on his arrival he had a healthscreen check conducted by a nurse. He told the nurse that he was registered with a community doctor in Rochdale and was prescribed salbutamal (inhaler for asthma and COPD), Becotide (a steroid inhaler for asthmatic conditions) and Atrovent (for COPD). He said that he had no other concerns about his physical health, had no mental health problem and no thoughts of harming himself. The nurse recorded that this was the first time that he had been in prison.
24. Manchester obtained written confirmation from the man's community doctor that he had been diagnosed with COPD, was on a repeat prescription of the inhalers but had not seen a doctor since 2002. He saw a prison doctor at Manchester who continued with the same prescription of inhalers.
25. On 6 February 2006, the man was transferred to HMP Wakefield where another healthscreen was conducted by a nurse. The nurse recorded the medical information that had been transferred from Manchester, including his prescribed medication. The nurse also noted that he said that he felt well, had settled into prison life and had no thoughts of harming himself.
26. From his arrival at Wakefield to the end of July 2010, he had 43 separate interventions with healthcare staff. This included prison doctors, nurses, the visiting optician and the visiting respiratory consultant. During this period his prescribed medication changed to salbutamol, Seretide (inhaler for COPD), bendroflumethiazide (for blood pressure) and doxazosin (for high blood pressure and urinary retention). The optician had also referred him to the ophthalmic consultant as his sight was impaired by cataracts in both eyes.
27. The visiting respiratory consultant saw him on 9 July 2009, 31 December 2009 and 8 April 2010. On each occasion the doctor recorded that he had moderate COPD, was able to walk without difficulty and his weight and appetite were good. He was advised to give up smoking but he refused.

28. He saw Nurse A, respiratory nursing specialist, on 1 August and 8 August 2010 for blood pressure checks. The first check was recorded by the nurse as 171/74 and the second check as 158/75. (The normal range for blood pressure is 100/70 to 140/90, although the pressure does vary 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.)
29. Two days later the nurse saw him and conducted a spirometry (breathing) test. The test results showed that his COPD had worsened from moderate to severe. He was again advised about the benefits to his health by not smoking, he but refused.
30. On 20 October, the man saw the nurse for a further review of his COPD. He told the nurse that he had stopped smoking completely some five weeks earlier. He said that he became breathless at the slightest exertion, even getting up in the night to use the toilet. The nurse recorded that he had a cough that produced a moderate amount of clear sputum but did not have any chest pain. He was given advice on to how to use his inhalers effectively and encouraged not to return to smoking.
31. Two days later he saw Prison Doctor A for a general health and medication review. The doctor recorded that he was generally well, his prescribed medication remained unchanged and he was told to contact healthcare at any time. The doctor also told him that he was on the waiting list for a cataract operation.
32. The man attended the Specialist Eye Centre as a day patient on 25 November. A risk assessment was completed which authorised him to be accompanied to hospital by two officers with the use of an escort chain (two metre chain with single cuff at either end) which was to be removed for treatment purposes. The consultant ophthalmologist performed a successful cataract operation on his left eye and prescribed maxitrol eye drops to be used four times a day for two weeks.
33. The respiratory consultant conducted a review with the man on 23 December. The doctor recorded that he had severe COPD and was only able to walk about 30 yards before he became breathless. The doctor also noted that his appetite was good and he had not lost weight. The doctor prescribed theophylline (for COPD) in addition to his other prescribed medication.
34. On 26 January 2011, the man saw the visiting optician, who recorded that his vision had slightly improved following the cataract operation on the left eye. However the sight in his right eye had deteriorated and she referred him to the consultant ophthalmologist for a cataract operation on his right eye.
35. He saw the nurse on 3 April for a review and blood pressure check. The nurse recorded that his blood pressure was 137/75 (within normal limits) and that there were no other concerns at that time.

36. The respiratory consultant next saw him for a review of his COPD on 13 May. The doctor recorded that the prescribed theophylline had benefited him, however, he suffered from increased breathlessness. The doctor prescribed prednisolone (a corticosteroid drug for the treatment of a wide range of inflammatory and auto-immune conditions) for a seven day period. His other prescribed medication remained unchanged.
37. On 1 June, the man saw the nurse for a blood pressure check. The nurse recorded his blood pressure as 120/70 (within normal limits)
38. Five days later he attended the hospital as a day patient. A further risk assessment was completed which authorised him to be accompanied to hospital by two officers with the use of an escort chain which was to be removed for treatment purposes. The consultant ophthalmologist performed another successful cataract operation on his right eye and maxitrol eye drops were again prescribed to be used four times a day for two weeks.
39. On Saturday 18 June, the man complained to wing staff that he was feeling breathless and they requested assistance from healthcare. A nurse responded and saw him in his cell. He told the nurse that he was more breathless than usual. When questioned about his medication he said that he had not used all of his inhalers. The nurse advised him on the proper use of his inhalers and to contact healthcare immediately if his condition became worse. The nurse also referred him to be seen by the doctor.
40. Two days later the man saw Prison Doctor B, who recorded that he said that he felt much better than he did at the weekend. The doctor examined him and noted that there were no signs of a chest infection, his chest was clear and there was no further action to take at that time.
41. Officer A, C wing officer, explained to the investigator at interview that the man was a well behaved prisoner who adhered to wing rules and regulations, was polite and interacted well with staff and his peers. The officer went on to explain that his cell was on ground floor level, next to the area where food was served, so that he did not have to walk distances or go up and down stairs. The officer said that it was not unusual for him to be up and dressed in the morning either sitting at his table in the cell or sitting on his bed.
42. Officers appear to have been attentive to him, updating his prison computer records on a regular basis noting his wellbeing and his interaction with other prisoners. It was noted that he tended to keep himself to himself preferring to remain in his cell watching television.
43. The man was known to have a close friendship with another prisoner. The officer said that it was normal for this prisoner to go into his cell first thing in a morning to have a chat and collect his breakfast. He would also help him keep his cell tidy.
44. Officer B was the officer on duty on C Wing from 8.00pm on 21 June through to 7.00am on 22 June. The officer undertook a full roll check of all prisoners on

the wing at 8.00pm and 5.35am and there were no concerns raised regarding the man.

45. Officer C took over from Officer B and conducted a roll check at approximately 7.30am, with again no concerns raised about the man.
46. At approximately 8.05am, following unlock, the prisoner went to the man's cell as usual but found him sitting in his chair but slumped over his cell table. He immediately came out of the cell and closed the door, which locked it, and went over to the Senior Officer's office.
47. At interview Officer A said that he had just completed unlocking the cells on landing 2 and as he approached the Senior Officer's office he saw the prisoner who was in a distressed state. The officer asked what was wrong and he told him that he believed the man had died.
48. The officer went straight over to the man's cell. By this time there was a large queue of prisoners that extended past the cell waiting to be served breakfast. The officer saw that the cell door was locked, looked into the cell, via the observation hatch, and saw him fully dressed sitting in his chair but slumped over his table.
49. Due to the large amount of prisoners that were out on the wing the officer immediately went to Senior Officer's office and asked two Senior Officers (SO) to clear the wing of prisoners and raise the alarm for emergency assistance.
50. SO A told the investigator that when he was told by the officer, he immediately ordered all prisoners to be locked in their cells and went straight to the cell whilst the other SO contacted the control room to request urgent medical assistance.
51. On entering the cell the SO found the man slumped over his table with the right side of his face flat on the table. The SO was immediately followed into the cell by Nurse B who had responded to the call for emergency medical assistance.
52. When interviewed the nurse said that he had received the call on his radio at approximately 8.10am to respond to the emergency incident, however, he was not given any indication of what the nature of the incident was. The nurse explained that the prison had a code system for emergencies which was Code Red for someone found bleeding and Code Blue for someone found not breathing. The nurse decided to take all the emergency equipment, including an automatic external defibrillator (AED) (which monitors the heart rhythm and administers electrical shocks to the heart to restore the normal rhythm when necessary) with him.
53. The nurse said that he found the man not breathing, there was no pulse, his eyes were wide open and pupils dilated. The nurse requested that an emergency ambulance was called. With the assistance of the SO the nurse moved him to the floor and commenced cardiopulmonary resuscitation (CPR) (cardio pulmonary resuscitation is a technique whereby oxygen is pumped

around the body using a combination of chest compressions and rescue breaths) and used the AED, which showed there was no shockable rhythm. Another nurse and a Healthcare Officer arrived within a few minutes and assisted with the CPR until the paramedics arrived.

54. The paramedics arrived at 8.21am and took over the man's care. After undertaking their medical assessment and tests the paramedics confirmed that the man had died at 8.31am.
55. A hot debrief for staff involved in the emergency incident took place at 8.45am and staff and the chaplaincy were available to offer support to prisoners on the wing.
56. Another SO was appointed as prison family liaison officer and he and a chaplain went to visit the man's son to inform him of his father's death. When the prison staff arrived at the nominated address there was no one in. The staff waited at the property for three hours but when no one came a letter was left for the son which asked him to contact the SO as soon as possible. The SO went to the local police station to inform them that he had been to the address and had left a contact letter.
57. The next day the SO had not received any phone call so he attempted to contact the man's son on his mobile number but did not get any answer. Later that morning the man's son rang and spoke to the SO who gave him the news of his father's death and arranged to visit at his new address.
58. In the days that followed the SO maintained contact with the man's son and offered financial assistance towards the funeral expenses. Wakefield abided by the family wishes and arranged for the funeral to be held in Wakefield, with the service being conducted by the prison chaplain.

## ISSUES

### Clinical care

59. The clinical reviewer has considered the care and treatment that the man received whilst at Wakefield. In her review she comments on him having COPD as follows:

“A letter from the man’s GP to HMP Manchester states that he was diagnosed with Chronic Obstructive Pulmonary Disease (COPD) by his GP 2002, but had failed to return for planned reviews. COPD is a progressive condition whose main cause (85% of cases) is cigarette smoking. The condition causes irreversible damage to the lungs and produces symptoms such as wheeze, breathlessness and increased sputum production making the patient at increased risk of chest infections. The disease is characterised by periods of stability with intermittent worsening of symptoms. The lungs deteriorate over time; this process is greatly increased if the patient continues to smoke.

“It is difficult to differentiate between COPD exacerbation and symptoms of lower respiratory tract infection. However, in 2007 MHRA guidance highlights the similarity of pneumonia and other lower respiratory tract infections and acute exacerbation of COPD and the increased risk of pneumonia in COPD patients using inhaled steroids.”

60. Regarding the treatment the man received treatment for COPD at Wakefield the review states:

“A Respiratory in reach clinic was established in HMP Wakefield in 2009. The man was offered appropriate treatment including pulmonary rehabilitation, vaccination, issuing of a self management plan and advice on stopping smoking. Medication and review was in line with national best practice guidance.

“He was not entered onto an end of life pathway and has no record of advanced care planning documentation being completed. Again the nature of decline in COPD makes it extremely difficult to establish when these discussions should take place.”

61. The clinical review also highlights the following areas of good practice adopted by healthcare staff at Wakefield:

“Weekly Respiratory Clinics are held within HMP Wakefield by the Consultant Physician in General and Respiratory Medicine.

“The service uses the NHS Wakefield template for recording management of COPD which means they are able to demonstrate care to NICE [National Institute for Health and Clinical Excellence] standards.

“The patient was offered pulmonary rehabilitation, a Grade A NICE recommended treatment.

“Stop smoking advice was given frequently and eventually the man was supported to stop smoking.

“Pneumococcal and influenza vaccination was offered in line with best practice.”

62. The clinical reviewer judged that the standard of care and treatment that the man received was “in line with national best practice guidance”. We are satisfied that his care in custody was equitable to that he could have expected to receive in the community.

### **Emergency response**

63. The staff who attempted to save the man’s life acted with great professionalism. The clinical reviewer comments that the decisions taken and the resuscitation attempts were appropriate. The Governor may wish to recognise the professionalism displayed by the staff who provided emergency assistance, in particular that of Nurse B.
64. However, we draw to the Governor’s attention that this action was taken in the absence of any indication of the nature of the emergency incident that the staff faced that morning. On receiving the call for urgent medical assistance Nurse B asked the control room what code of response it was but was simply told to attend. The importance of using response codes informs medical staff what equipment they need to bring and the potential requirement for an emergency ambulance.
65. In this instance the nurse took all the emergency equipment, including the AED, with him, had he not done so there would have been an additional delay whilst the emergency treatment was fetched. Whilst I accept that the use of an emergency code would appear not have affected the outcome in this case, healthcare staff should be made aware of the nature of an emergency that they are requested to respond to. It is clear from the evidence gathered in this investigation that Wakefield does have an emergency code system which, on this occasion was not used.

**The Governor should ensure that all staff adhere to the local emergency response protocol with specific attention to clarity of response codes.**

### **Family liaison**

66. Prison Service Order (PSO) 2710, ‘Follow up to deaths in custody’, requires that next of kin should normally be contacted face to face as soon as possible after a death has occurred. Wakefield appropriately followed this guidance and took all steps possible to break the news to the man’s son on the day that he

died. It is unfortunate that Wakefield were unaware that his son had moved to a different address.

67. The man's son was visited by the prison family liaison officer and in the days that followed contact was maintained, support offered along with the offer of financial assistance towards the funeral expenses. Wakefield appropriately followed the guidance set out in PSO 2710 'Follow up to deaths in custody'.

## **CONCLUSION**

68. It is clear that attention was paid to the man's health needs and appropriate treatment and care was provided. The standard of care received at Wakefield was equitable to that which he could have expected to receive in the community. He continually refused to give up smoking; despite medical advice however it is pleasing to see that staff at Wakefield were eventually successful in supporting him to stop smoking.
69. The man was treated with dignity and respect, both at Wakefield and on the occasions he was taken to hospital. We believe there was no more that staff at Wakefield could have done to prevent his death. Following his death Wakefield appropriately followed the guidance given in PSO 2710, 'Follow up to death in custody'.

## **RECOMMENDATIONS**

1. The Governor should ensure that all staff adhere to the local emergency response protocol with specific attention to clarity of response codes.