Investigation into the circumstances surrounding the death of a man at HMP Wakefield in December 2007

Report by the Prisons and Probation Ombudsman for England and Wales

October 2008

This is the report of an investigation into the death of a man who died of natural causes on 9 December 2007, in HMP Wakefield. He was 40 years old. The man had been serving a sentence of life imprisonment since November 2002.

One of my family liaison officers contacted the man's mother to explain our role. I would like to reaffirm what my family liaison officer said by way of condolences to his family.

I apologise for the delay in issuing this report. There was a considerable delay in us receiving the clinical review, which resulted in secondary delays to parts of our investigation.

This investigation was undertaken by one of my investigators. Both he and I would like to thank the Governor of Wakefield and her staff for their participation in the investigation. Wakefield District Primary Care Trust undertook nursing and medical reviews of the man's clinical care. I appreciate their assistance through the investigation process and their final reports.

In a case such as this, when someone has died from natural causes, the findings of the clinical reviews play a large part in my report. The clinical reviewers found that, broadly speaking, the man received a good standard of care in prison. There are issues around clinical leadership, and there was some concern among staff as to whether the man should be resuscitated. In their respective reports the reviewers make a number of recommendations which I endorse.

Like the clinical reviewers I also find that the man received a good standard of care. This reflects the views of his family, who were able to be with him in his final days. I make three recommendations, and one commendation relating to the professionalism and compassion shown by staff. I am pleased to see that the Prison Service have accepted two of my recommendations and partially accepted the other.

Jane Webb
Deputy Prisons and Probation Ombudsman October 2008

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SUMMARY

The man was 40 years old and had been serving a sentence of life imprisonment since 2002. At the time of his death he had been in HMP Wakefield for four years.

The man settled well in Wakefield. He was temporarily transferred out on three occasions. In November 2004, he went to HMP Pentonville to allow him to attend his appeal. Then in April 2007, he went to HMP Cardiff on two occasions: firstly to visit his father, who was terminally ill, and then to attend his funeral.

The man had contact with prison healthcare services in the summer of 2007 and was referred to hospital for tests. Further tests followed, and in October the man was told he had cancer.

Whilst still in hospital, on 12 November, the man's condition deteriorated rapidly. Medical staff completed a Do Not Resuscitate notice (designed to prevent unnecessary suffering). Usual practice would be for a patient to be consulted in such a decision, but the man was too ill to be part of such a discussion. In the following days the man improved, but hospital staff do not seem to have gone on to discuss the issue of resuscitation with him.

In mid-November, the man returned to Wakefield. Staff there contacted both HMP Swansea and HMP Cardiff to see if they would be able to take the man to allow easier family visiting. Unfortunately neither prison could provide the care he needed. Staff in the healthcare centre at Wakefield ordered an air mattress to improve the man's comfort. The door to his room was unlocked to allow staff easier access to treat him. Palliative care nurses came in weekly, and nursing staff in the healthcare centre at Wakefield rearranged shifts so that a nurse was available 24 hours to care for him.

The man was described by staff as very independent, and only allowed people to help with a task when he was unable to do it himself. But early in December his condition again deteriorated. Staff arranged for extended visiting hours to allow his family to be with him during the day. Discussions took place about resuscitation, and on 7 December, the prison doctor discussed this with the man and with his mother. However, no conclusion was reached.

On 9 December, the man's mother, sister, and brother-in-law were visiting him. In the early afternoon his brother-in-law told staff that they thought the man had died. Staff tried to resuscitate him, and an ambulance was called. Sadly they were unsuccessful.

The man's funeral was held in his native South Wales, but a memorial service was held in prison. His family were invited and attended. The man's mother told my family liaison officer that the prison looked after her son very well, and that they kept her informed of developments at all stages.

THE INVESTIGATION PROCESS

1. My investigator visited the prison and spoke to staff who came into contact with the man during his imprisonment. He interviewed seven members of staff. Six of these interviews were tape-recorded and transcripts are annexed to this report. Copies of these transcripts were sent to the interviewees to check and agree the accuracy. Four signed copies were returned. The other interview was conducted over the telephone and a note of the interview is also annexed to this report. The interviewee signed a copy of this note agreeing its accuracy.

2. Notices were posted to staff and prisoners about the investigation, inviting contributions if necessary. None were received. My investigator studied all relevant prison records relating to the man. These include his main prison record, medical records and statements made by staff. My investigator also visited the healthcare centre at Wakefield and saw the palliative care suite where the man was housed when he died.

3. The Wakefield District Primary Care Trust identified a clinical reviewer to carry out a nursing review of the man's clinical care, and a clinical reviewer to carry out a medical review. I am grateful to them for undertaking these reviews. My investigator discussed aspects of the man's treatment with both healthcare staff at Wakefield and with the reviewers.

4. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and request a copy of the post mortem report. Upon completion, my report will be sent to the Coroner to assist in his enquiries into the man's death.

5. One of my Family Liaison Officers (FLOs) spoke to the man's mother. She did not raise any concerns for my investigation to consider. She felt that the prison looked after her son well and kept in good contact with her. The man's mother saw my draft report and commented that prisons will have other cases such as her son's. In the future there would be benefit in the prison service having training and facilities for palliative care in place so it would be available when required.

HMP Wakefield

6. HMP Wakefield is a high-security prison for men typically in security categories A and B. It is one of eight high-security prisons within the prison estate. Wakefield was originally built as a house of correction in 1594. It is now a main lifer centre. The average number of prisoners is approximately 700, including 100 Category A and 10 High Risk Category A prisoners.

Healthcare

7. Wakefield has a separate healthcare block. There is an out-patient section, and at the time of the man's death had an in-patient facility with capacity to take 21 patients. Nursing care is available 24 hours, seven days per week. A doctor is in the prison Monday to Friday 9.00am to 5.00pm. Outside these hours care is provided via Local Care Direct (the local provider of out-of-hours primary health care). The in-patient facility contains a palliative care suite which allow staff to care for patients in advanced stages of serious illness.

Do Not Resuscitate Notices (DNRs)

8. A Do Not Resuscitate order (DNR) on a patient's file means that a doctor is not required to resuscitate a patient and is designed to prevent unnecessary suffering. The United Kingdom medical profession has guidelines for circumstances in which a DNR may be issued:

    - if a patient's condition is such that resuscitation is unlikely to succeed
    - if a mentally competent patient has consistently stated or recorded the fact that he or she does not want to be resuscitated
    - if there is advanced notice or a living will which says the patient does not want to be resuscitated
    - if successful resuscitation would not be in the patient's best interest because it would lead to a poor quality of life.

Prison Service policy on resuscitation

9. Prison Service policy on resuscitation of prisoners is contained in the Prison Service Order (PSO) 2700. This PSO, which relates primarily to suicide prevention and self-harm management, states:

   "**Resuscitation**: Policy remains that staff should continue to attempt resuscitation – as appropriate to the injury – until told to stop by a healthcare professional, e.g. a member of the Ambulance Service or a doctor, or rigor mortis has clearly set in…"

Previous deaths at Wakefield

10. This is the tenth death at Wakefield I have investigated since I took over responsibility for investigating deaths in custody. In one of my reports, in 2006, I recommended that a formalised case management approach to the care of prisoners with long term conditions be adopted, with a clearly identified person taking the lead in reviewing and co-ordinating that care. The Prison Service accepted this recommendation.

11. In another report into a death at Wakefield earlier this year I recommended that the Primary Care Trust should appoint a lead clinician to provide leadership and guidance on important clinical areas. Again the Prison Service accepted this recommendation.

Her Majesty's Inspectorate Of Prisons (HMIP)

12. The most recent HMIP inspection was an unannounced inspection in April 2005. The report identified a lack of strong clinical leadership in healthcare. The report also recommended resuscitation training at least annually, and "other relevant training should be made available to all (healthcare) staff".

Independent Monitoring Board (IMB)

13. Each prison in England and Wales has an Independent Monitoring Board responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are maintained. The last report published by the IMB before the man's death does not raise any issues which are relevant here.

KEY FINDINGS

14. The man was convicted in November 2002, and sentenced to life imprisonment. He was taken to HMP Bristol.

15. In May 2003, the man expressed concern to staff that his cellmate might harm him, and was subsequently moved to a single cell. There were no apparent further problems and on 18 December, he transferred to HMP Wakefield.

16. On 10 August 2004, the man was granted leave to appeal against his conviction, and on 3 November, went to HMP Pentonville to allow him to attend his appeal. His appeal was dismissed the following day and he returned to Wakefield.

17. Whilst at Wakefield the man undertook an Enhanced Thinking Skills course and an alcohol education programme. He settled well, though in October 2005, he was sacked from his job as a cleaner for refusing to empty bins. He had some minor contact with healthcare in connection with a skin rash, but reported no serious health problems.

18. In order to allow him to visit his father, who was in a hospice having been diagnosed with cancer, the man was temporarily transferred to HMP Cardiff in April 2007. The following month he once again temporarily moved to Cardiff to attend his father's funeral. He returned thereafter to Wakefield.

19. In June, he complained of a facial rash, and had lost a tooth and a filling. The man's records do not show whether he had any contact with the dental team.

20. On 27 June, the man complained of altered bowel habits and of pain in his side, which on occasion prevented him from sleeping. He was prescribed medication, and his record was noted to the effect that he needed to see the prison doctor. His records do not, however, show whether he did in fact have an appointment. He was referred for an ultrasound scan (imaging of the internal organs) some time between June and July, but by 9 August was still complaining of pain. He was again recommended to see the prison doctor.

21. The ultrasound scan was undertaken at Pinderfields Hospital on 22 August, and the following day a letter of referral was sent to the consultant urologist at St James' Hospital. The prison received the ultrasound scan results on 24 August, telling them that further scans and investigation were required. The man again complained of pain, nausea and vomiting on 27 August. The prison doctor agreed to speak to the hospital the following day for advice. In the meantime, the man was content to remain on ordinary location. However, the following day he agreed to move to the healthcare centre and he moved there on 30 August.

22. The man developed a swelling in his right leg and was referred to Accident and Emergency (A&E) at Pinderfields Hospital on 4 September. This was diagnosed as deep vein thrombosis (DVT). After being prescribed medication he returned to Wakefield the following day.

23. On 10 October, the man was taken again to Pinderfields Hospital. Whilst there he had an MRI scan (magnetic resonance imaging: strong magnetic waves producing detailed internal pictures of the body). Following these tests, the man was told on 16 October that he had inoperable cancer. Although the news understandably came as a shock and caused the man some anxiety, staff said that he did not seem to fall into depression.

24. The man went temporarily to Seacroft Hospital for further tests on 1 November. In the days following this appointment he was informed that he had a very limited life expectancy. His notes indicate that despite the gravity of the news, he had a good understanding of the diagnosis.

25. During the night of 12 November, the man was very ill, to the extent that his family were contacted and advised to come to the hospital. Staff at the hospital completed documentation for a DNR notice. Usual practice is for such a course of action to be discussed with the patient, but the man was too ill to be involved in the decision made at the time. His condition improved during the morning, but there is no evidence that the DNR notice was discussed with him any further in the following days.

26. The man returned to Wakefield on 15 November, and was located in the healthcare centre. The discharge letter from the palliative care team recommended that a DNR notice be in place.

27. When first transferred to the in-patient unit in the healthcare centre the man was still independent and able to look after himself, and he was principally in healthcare to remain under observation. But from this point staff at Wakefield began to notice a significant deterioration in his condition. Palliative care nurses began to visit the man in the prison on a weekly basis, and from here on were involved in his careplan. Multi-disciplinary meetings, which included palliative care nurses, were also held weekly.

28. On 12 November, Wakefield had contacted HMP Swansea to see if they would be able to accept the man to allow easier family access. Swansea were unable to provide 24 hour care, so on 16 November, Wakefield contacted HMP Cardiff to see if they could provide the care the man needed. Unfortunately Cardiff were preparing to open a new healthcare facility in March 2008, and were unable to provide the palliative care the man would require.

29. The man developed a swelling in his lower leg and was taken to A&E at Pinderfields Hospital on 19 November. It was noted that he was at risk of haemorrhaging if he continued on the medication he was taking at the time, and that from that point on he should receive palliative treatment. An

air mattress was ordered for him to reduce the risk of pressure sores. An open-door policy (the man's room to be unlocked to allow quick and easy access) was requested to allow staff to be able to treat him whenever required.

30. Healthcare and palliative care staff continued to provide treatment. The man was described by prison staff as very independent, and would only accept assistance when he was unable to perform a task himself. But in a short space of time his condition got considerably worse. Staff rearranged their shifts to ensure that an extra member of staff was on duty so someone could be with him during the nights, and the open-door policy was agreed.

31. On 29 November, a member of the nursing staff asked if it was appropriate to broach the subject of resuscitation with the man. On 5 December, prison staff contacted Treasury Solicitors to clarify whether they could put a DNR notice in place for the man. The solicitors said that they would contact the Ministry of Justice for guidance. There followed a number of communications between Ministry of Justice officials, legal advisers and the prison. The advice from the Ministry of Justice legal directorate was that the team of people responsible for the man's healthcare should consider the case. But the overarching point was that this was a question for individual clinicians to make at the time if such a situation arose and common sense and decency should prevail. Staff should not be issued with instructions not to resuscitate.

32. At a clinical review meeting held on 6 December it was noted that the man's condition had seriously deteriorated. He could no longer get out of bed himself, and needed a wheelchair to move around. The following day the man's family were granted permission to remain with him through the day. This is good practice and the prison should be commended for allowing the family this degree of closeness.

33. On the afternoon of 7 December the prison doctor discussed the issue of resuscitation with the man and his mother. However, they found it a difficult subject to discuss, and the prison doctor told them that the choice was entirely theirs and they were under no pressure to make a decision.

34. The man's condition continued to deteriorate. On 9 December, his mother, sister, and brother-in-law came into the prison to be with him in the palliative care suite. A nurse and healthcare officer were on duty in the healthcare centre that day. Apart from delivering the medical care that the man needed, staff gave the man and his family as much privacy as they could. Shortly after 1.00pm the healthcare nurse and healthcare officer were in the day room, and a prison officer came in. He told his colleagues that the man's brother-in-law had come out of the palliative care suite and told him that he thought the man had died. The healthcare nurse went into the man's room and checked him for signs of life. The man was initially breathing very faintly but stopped almost immediately. The family were taken into another room.

35. A nurse was on duty in the prison that day, and at this point she came back into the healthcare centre and was immediately directed into the man's room. The healthcare nurse told her that she thought the man had died and was no longer showing any signs of life. The nurse asked the prison officer to call for an ambulance, and to tell them that he had had a respiratory arrest. The ambulance was called at 1.19pm. The healthcare nurse told my investigator that the man had previously indicated to her that he would wish to be resuscitated if the need arose. Earlier that day, in view of his rapidly-deteriorating condition, an emergency resuscitation bag had been placed in the room. As the prison officer went to call an ambulance, the nurses began to perform cardio pulmonary resuscitation (CPR). The nurse told my investigator that she did not hold out much hope that it would be successful, but she said that staff did their best nonetheless.

36. At approximately 1.30pm the acting Senior Officer came on duty in the healthcare centre and immediately saw that something was happening in the palliative care suite. He went straight in and began to assist the nurse with the ambu-bag (a piece of equipment to artificially assist with breathing) then relieved the prison officer, who had returned to the room, in performing chest compressions.

37. At 1.30pm the ambulance crew arrived and took over. Healthcare staff handed the man's medical notes to them and explained the background. The paramedics applied a defibrillator (a machine which measures electrical activity of the heart and advises on resuscitation) to the man and checked for signs of life. Sadly, they could find none. It was agreed that the man had died.

38. At this stage everyone left the room, which was then sealed pending the arrival of the police. A member of staff stood outside to restrict entry, and staff went back into the day room and were told to write statements. The nurse made arrangements for a doctor to attend, and explained the situation to the duty governor as he arrived in the healthcare centre. She then joined her colleagues in the day room, and a debrief was held, led by a principal officer.

39. Other prisoners in the healthcare centre were informed of what had happened. All prisoners who were thought to be at risk of self-harm were assessed, and Listeners (prisoners who are specially trained by the Samaritans) were made available for any prisoners who wanted to talk to them. It was important that Listeners were available, as staff told my investigator that the Samaritans' phone does not work in the healthcare centre.

40. The chaplain had visited the man in hospital following his initial diagnosis, and since then had been in fairly regular contact with him (a member of the chaplaincy team visits the healthcare centre every day). The man had told the chaplain that even though he was not particularly religious, he

welcomed the contact they had. The chaplain had also been in contact with the man's family.

41. The chaplain was the designated Echo 1 callsign on 9 December, meaning that he was the member of the chaplaincy team carrying a communication radio. He had visited the healthcare centre that morning, but the man had been asleep so they did not speak. At approximately 1.00pm he was preparing to go off duty when he received a call over the radio that the man had died. He made his way to the healthcare centre and spoke to the man's family. With their permission, he then went into the man's room and prayed over his body. He then spent some more time with the family, before going to the prison wings to inform the man's friends of his death.

42. The nursing staff involved were not clear about the support which might be available to them. They were aware that the care team (members of staff specially trained to support colleagues) were available and they could seek them out if required. The record of the hot debrief indicates that staff were offered support of the care team. But apart from a healthcare nurse, who received a telephone call from the care team, none of the staff involved in actually dealing with the man's death specifically recall being offered the support of the care team (or indeed any other support) either at the time or subsequently.

43. The man's funeral was held in his native South Wales, but it is the prison's policy to hold a memorial service for any prisoners who die in prison. The man's family were invited to attend and did so. The man had worked in the kitchens, and as a mark of respect, prisoners working in the kitchen provided lunch for his family.

ISSUES

Clinical care

44. Notwithstanding the comments which follow, I am satisfied, as are the clinical reviewers, that the man received a very high standard of individualised care. It appears to have been very much a team approach. Whilst this sort of approach is to be commended, there does not seem to have been an identified lead person for his healthcare. Nor was there a clear end of life care pathway (such as the Liverpool Care of the Dying Pathway) to ensure care is given in a compassionate yet structured way. The medical clinical reviewer commented on the difficulty in communication between medical staff inside and outside of the prison, which may have been a contributory factor. The lack of a clinical lead also became particularly evident in the issue of whether a DNR notice should be in place for the man and whether staff should attempt to resuscitate him. The clinical reviewers further commented on the poor state of the man's medical records, and an identified lead may well have ensured that they were kept in better order. As mentioned above, I recently made a recommendation in another report about clinical leads at Wakefield, which the Prison Service accepted. The service would not have seen that report at the time of the man's death so it would seem unfair for me to repeat the recommendation here. But I hope that the point is made, and that the healthcare team are aware of and addressing the issue of clinical leadership roles.

    The head of healthcare should consider the use of a clear end of life pathway for prisoners with palliative care needs.

45. There were some issues around pain control between August and October 2007. The medical clinical reviewer notes that the degree of pain the man was suffering may well have justified a more urgent referral for an ultrasound scan. He does go on to point out, though, that it is likely that by this point the man's cancer was already inoperable. The nursing clinical reviewer points out that a pain assessment tool was not used to monitor the man before he was in the palliative care stage. He went into hospital in October and following his discharge pain control improved. The nursing clinical reviewer makes a recommendation that a pain assessment tool be used for patients with pain control needs, and while not making a formal recommendation myself, I would bring this matter to the attention of the head of healthcare.

Training

46. The nurse told my investigator that not all staff in the healthcare centre are trained to use defibrillators. The clinical reviewer also mentions a training point in connection with enabling nurses to maintain and update skills that are used infrequently. This is unlikely to have had an effect on the man's death, and again I do not make a formal recommendation. But the head of

healthcare will wish to ensure that training needs and the updating of existing skills are covered in staff training audits.

Resuscitation

47. Staff who attended the man performed CPR, and did their best to try to revive him. I am satisfied that they did all that they could, and that, sadly there could not have been any other outcome. There is no criticism of the staff involved and no intimation that the outcome could have been different.

48. However, the whole issue of whether the man should be resuscitated caused confusion, and with it a degree of distress, for staff. One of the nurses told my investigator that she was unhappy with having to resuscitate a patient who, had he been in hospital, she felt would not have been resuscitated. Another nurse told my investigator that she thought it was the right decision to attempt resuscitation. As the DNR notice had been made out for the man in hospital without the issue being raised with him, his opinion when he returned to prison was still not known. Staff sought advice from Treasury Solicitors and Ministry of Justice headquarters, and discussed the issue at a multidisciplinary meeting, but were not able to clarify the position. The prison doctor raised the subject with the man and his mother, but when they understandably found the subject distressing, no decision was reached. Yet one of the nurses from healthcare told my investigator that the man had indicated to her that he would want to be resuscitated.

    The head of healthcare should ensure that staff are aware of a clear policy on resuscitation, including the issuing of DNR notices.

Prison staff rearranging shifts

49. Prison nursing staff organised their shifts so that a nurse was always on duty to provide 24 hour care. This is good practice and the staff rearranging their shifts should be commended for doing so.

    I commend the nursing staff who rearranged their shifts to ensure that the man had 24 hour nursing cover.

Family support

50. In the last few days of his life, the prison arranged for the man's family to be with him all day. In the circumstances this was a humane thing to do and the prison should be commended for doing so. I hope this was a comfort to the family, and to the man himself.

Support

51. The death of a patient can be difficult for staff. When my investigator spoke to healthcare staff at Wakefield, there was no consistency to the support offered to them. Some were not offered support, some were unable to remember if they had been offered support at the time, but no support was offered in the days or weeks afterwards. Being involved in

the death of a prisoner can be extremely stressful and upsetting for staff. The availability of good support can be invaluable. The Governor and head of healthcare should ensure that support is available for staff who require it.

The Governor and the head of healthcare should ensure that staff involved in the death of a prisoner are offered appropriate support.

Samaritans' phone in the healthcare centre

52. Although it is not directly linked to this investigation, staff told my investigator that the Samaritans' phone does not work in the healthcare centre. I do not make a recommendation here, but I would urge the Governor to ensure that should a Samaritans' phone be required by prisoners in healthcare then it is indeed available to them.

RECOMMENDATIONS

The head of healthcare should consider the use of a clear end of life pathway for prisoners with palliative care needs.

The Prison Service have accepted this recommendation. They said "The Development of an End of Life Care Pathway was identified within the Joint Prison/PCT Strategic Development Plan. The HMP Wakefield End of Life Care Pathway will be developed in line with PCT Guidelines." The target date is 31 March 2009.

The head of healthcare should ensure that staff are aware of a clear policy on resuscitation, including the issuing of DNR notices.

The Prison Service have accepted this recommendation. They said "The Resuscitation Policy for HMP Wakefield will be revisited in line with the Development of the End of Life Pathway. Te revised Policy will include clear guidance on the use of DNR Notices." The target date is 31 March 2009.

The Governor and the head of healthcare should ensure that staff involved in the death of a prisoner are offered appropriate support.

The Prison Service have partially accepted this recommendation. They said "The record of the "Hot De Brief" clearly state that all staff were offered the support of the local Care Team. However, we do accept that follow up care and support for staff could have been better managed. The head of the local care team will follow up staff involved in such incidents and offer support on an individual basis and record that this has been done."

COMMENDATION

I commend the nursing staff who rearranged their shifts to ensure that the man had 24 hour nursing cover.