PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the death of a man whilst in the custody of HMP Wakefield in March 2012

Report by the Prisons and Probation Ombudsman for England and Wales

September 2012

This is the report into the circumstances surrounding the death of the man in March 2012 at HMP Wakefield. The man died as a result of pneumonia caused by heart disease and lung cancer. I extend my condolences to his family and friends, and all those affected by his death.

The investigation was carried out by my investigator. NHS Wakefield District commissioned a clinical reviewer to conduct a review of the clinical care the man received in custody. Wakefield prison cooperated fully with the investigation.

The man was sentenced to 11 years imprisonment in 2006. After initially being held at HMP Exeter, he transferred to Wakefield. When he arrived in custody, he had already started to experience ill health and was regularly seen and treated by healthcare staff and outside hospital. On 20 January 2012, he was taken to hospital with breathing difficulties. He was subsequently diagnosed with a possible lung tumour but did not want further investigations or active treatment. He was discharged from hospital on 26 January 2012 but was admitted again on two further occasions in February. On 7 March 2012, the man returned to the healthcare centre at Wakefield where he was nursed on a palliative care pathway until his death.

I do not think it was necessary for the man to have been subject to restraints when he went to hospital in January and February. However, overall, it is very pleasing to reflect the high standard of care shown to him by prison and healthcare staff. He and his family were treated with care and compassion. He was well looked after during his time in custody, his chronic medical conditions were well managed and when he chose not to have active treatment for his final illness, he was nursed appropriately and treated with dignity.

The recommendation made in the draft report has been accepted by HMP Wakefield. I have included the prison's response to the recommendations at the end of this report.

The 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.

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Prisons and Probation Ombudsman **September 2012**

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SUMMARY

1. The man died in the healthcare centre at HMP Wakefield. He was convicted at Exeter Crown Court and sentenced to 11 years imprisonment. He arrived in HMP Exeter on the same day and later transferred to Wakefield.

2. During the man's first reception health screening interviews it was recorded that he had Type 2 diabetes, heart disease, hearing problems, chronic pulmonary disease and he could walk short distances with a zimmer frame but at other times used a wheelchair.

3. The records show that during his time at Wakefield, the man's chronic health conditions were well managed and he had regular contact with healthcare staff at Wakefield and at hospital.

4. On 20 January 2012, the man was admitted to hospital with urinary sepsis and breathing difficulties. He was very ill and a subsequent chest X-ray and scan showed a mass on his lung. The man was informed that this could be a tumour, but he refused to have any further tests to assist the diagnosis of his condition or any further active treatment. Records do not show if he gave any reason for declining further treatment.

5. The man was discharged from hospital in January and, on the following day, a consultant physician discussed his decision not to have any further treatment and his wish not to be resuscitated should he stop breathing or his heart stop. The man was admitted to hospital again in February, as he had an irregular heart beat and his limbs were swollen. He was discharged on 10 February and returned to the prison. The man was admitted to hospital again on 20 February, as he was experiencing breathing problems and needed treatment for a chest infection. On 7 March, he was discharged from hospital for the last time and again returned to the prison.

6. The man was nursed on a palliative care pathway and regularly checked by healthcare staff. Healthcare staff checked him in his cell at around 5.15am and found that he had died. Paramedics were called and confirmed his death at 5.39am. The post mortem examination found that he had died as a result of pneumonia caused by heart disease and lung cancer.

7. Prisoners were informed of the man's death during the morning of his death and given appropriate support, including access to Listeners (prisoners selected and trained by the Samaritans to offer confidential emotional support to fellow prisoners in distress). All prisoners who were being monitored as at risk of self-harm and suicide were reviewed. Prison managers also held a "hot debrief" for staff immediately involved to share information and provide reassurance and support.

8. Although the investigation found a need for more proportionate use of restraints when taking infirm prisoners to hospital, overall we found that staff at Wakefield cared for the man with compassion and dignity. Both he and his family were kept fully informed about issues relating to his health. The clinical review carried out by the clinical reviewer on behalf of NHS Wakefield District found that the quality of care given to him was "more than equitable" to that he would have received in the community.

THE INVESTIGATION PROCESS

9. This office was informed of the man's death on 12 March 2012. The investigator issued notices to staff and prisoners at HMP Wakefield informing them of the investigation process and asking anyone who had relevant information to contact him. No one came forward. The investigator examined all the man's prison records including his medical records.

10. The investigator visited Wakefield on 15 March and spoke to staff involved in the man's care. He returned to Wakefield on 1 and 2 May and interviewed a prisoner located in the healthcare centre, Healthcare Officer, Principal Officer and a nurse. Initial feedback was given to the Governor on 2 May and was subsequently confirmed in writing.

11. NHS Wakefield District commissioned the clinical reviewer to review the man's medical care during his time in custody. The purpose of the review was to establish whether the care which the man received in prison was comparable with that he would have been offered in the community and to identify any points of learning. The report was received on 23 May 2012.

12. One of our family liaison officers contacted the man's family. She informed them about the purpose of the investigation and offered them the chance to raise any concerns or questions that they wanted to be addressed. The man's family did not wish to raise any issues. However, they did pass on some positive feedback saying they were very satisfied with the care the man received. They were also extremely grateful for the support they had received from the prison's family liaison officer. The man's family received a copy of the draft report and they raised no further issues in light of the findings. They noted the recommendation of "applying common sense" when using restraints as the man's age and mobility were a "clear barrier" to him being able to escape. The family also confirmed they were confident that the man was being cared for and this was reflected in the report although it was difficult to forget the sad circumstances in which he died.

13. The investigation has assessed the main issues involved in the man's care including his diagnosis and treatment, liaison with his family, his location and security arrangements, whether compassionate release was considered and whether appropriate palliative care was provided.

HMP WAKEFIELD

14. HMP Wakefield is one of eight high security prisons in England and Wales. 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. The prison holds over 750 category A and B prisoners. Category A prisoners are those whose escape would be highly dangerous to the public. Category B prisoners do not require the highest security conditions; however, the potential for such prisoners to escape must be made very difficult.

Her Majesty's Inspectorate of Prisons (HMIP)

15. The last published inspection report by HMCIP is of an inspection in December 2008. The report of an inspection in 2012 has yet to be published. The 2008 inspection found that, in the five years since the previous inspection, Wakefield had improved considerably.

16. The 2008 report identified some issues with healthcare, including that prisoners had to wait too long to see the doctor. Nurses could arrange an urgent referral to the doctor, but the wait for a routine appointment was ten days, which was too long. The report also noted that, despite provision for five hospital visits per day, too many outside hospital appointments were cancelled with no record kept of the reasons why. Inspectors also found that many older prisoners and those with disabilities were dissatisfied with the support they received in the prison.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) appointed by the Secretary of State for Justice. IMB members are independent and unpaid. They monitor day-to-day life in their prison and ensure that proper standards of care and decency are maintained.

18. In their annual report for the period ending 30 April 2011, the Board reported that overall, the health care unit provided a comprehensive service that met the needs of the prison population to a level equivalent to that available to the general public. There were, however, underlying problems relating to the staff shortages which the Board had also raised in the previous year's report.

Previous deaths at HMP Wakefield

19. There have been 12 deaths from natural causes at Wakefield since January 2011, reflecting the number of older prisoners held at Wakefield. Apart from being elderly, there are no direct similarities between the death of the man and these previous deaths.

ISSUES

The diagnosis of the man's terminal illness

20. The man was born in July 1930 and died in March 2012 in the healthcare centre at HMP Wakefield.

21. During his first reception health screen interview in 2006, the man reported that he had Type 2 diabetes (controlled with medication and diet), ischaemic heart disease, angina, hearing problems (required a hearing aid), chronic pulmonary disease and chronic renal impairment. The man had a heart attack in 1994 and a year later had an angioplasty (a procedure to widen the arteries in the heart) with a right coronary artery stent (which is a tube fitted in the artery to keep it open). He could walk short distances with a zimmer frame but at other times used a wheelchair.

22. In his first year in custody, the man had significantly impaired renal (kidney) function and was monitored at the nephrology (kidney) clinic at St James Hospital, Leeds. He had only one fully functioning kidney and developed bladder problems meaning he had to be catheterised (a catheter is used to drain urine from the bladder). The man had continuing problems over the next two years due to his kidney condition and had frequent admissions to hospital with swollen legs and urinary infections.

23. In July 2009, he was fitted with a permanent suprapubic catheter. (This catheter is inserted directly into the bladder under anaesthetic through a small incision in the bladder.) The catheter was monitored and changed regularly in the prison.

24. The man did not smoke but had problems with his chest (occasional wheeziness and chest infections). Chest X-rays were taken during 2008 and 2010 which were clear. A chest infection in June 2011 was cleared with a course of antibiotics.

25. The man was also slightly deaf and used a hearing aid, he was overweight and had a chronic back problem, and this combined with his medical problems meant he used a wheelchair. He could walk short distances and was encouraged to do so by regular physiotherapy input. During the last year of his life he became more motivated to move around and used a zimmer frame to walk around the healthcare centre.

26. The records do not indicate that the man suffered from any mental illness. He had occasional short periods of confusion due to the toxic effects of urinary sepsis but was generally alert and in control of his faculties. Urinary sepsis is a serious infection that can result in septic shock and premature death if treatment is delayed or absent. Urinary sepsis may occur in individuals who have a urinary catheter or those diagnosed with a severe urinary tract infection (UTI).

27. Throughout his stay at Wakefield, the man was seen regularly by healthcare staff and monitored by outside hospital consultants. On 19 January 2012, he attended a routine review at the nephrology clinic at a local hospital where a staff grade physician examined him and reported that his diabetes was under control and his kidney condition was stable. However, the next day, 20 January, the man became very ill with urinary sepsis and breathing difficulties and was again admitted to hospital. A chest X-ray identified a mass in his lung and to confirm the findings he also had a Computerised Tomography (CT) scan, which provides a more detailed image.

28. On 27 January, the man was seen at the hospital by a consultant respiratory physician at a local hospital. The consultant respiratory physician discussed the possibility of a tumour with the man, who declined any further investigation of the mass. The man also clearly indicated that if he deteriorated he did not wish to be resuscitated, but he wanted to be kept comfortable. The man completed a do not attempt resuscitation (DNAR) form.

29. Three days later, on the 31 January, the man's case was considered at the hospital's lung cancer multi-disciplinary meeting. The consensus was that he could have a possible malignancy, though atelectasis (collapse of a portion of the lung) could not be excluded. It was noted that he did not wish any further investigations or active treatment.

Informing the man about his condition and treatment

30. The man was an inpatient in hospital when he was told that an X-ray had identified a mass on his lung. He was told by the hospital staff investigating the cause of the symptoms he was presenting. This provided the man with the opportunity to ask the medical professionals questions regarding his diagnosis and prognosis, ensuring that he was fully aware of the possible seriousness of his condition. The man decided that he did not want any more tests and refused further treatment.

31. There is clear evidence from his records that the man was given full information at each stage of his illness and the reasons for investigations and consultant referrals. He spent almost five years on the hospital wing at Wakefield and had daily nursing input. When the (possible) terminal diagnosis was reached he was told in a timely and sympathetic manner. Psychological support was provided and assessment of his mental state was undertaken. His family were informed of his condition and updated at regular intervals.

The man's medical appointments and treatment

32. Following his diagnosis the man was discharged back to Wakefield in January 2012. On his return to prison appropriate monitoring was undertaken and well recorded. The consultant from the local hospital runs a weekly clinic at the prison which aided communication and continuity of care for the man. Communication between the hospital and prison healthcare staff was regular, consistent and well documented.

33. The man was admitted to hosptial on 4 February with tachycardia (an irregular heartbeat) and peripheral oedema (retention of fluid in the body). He returned to the prison on 10 February. He was admitted to hospital on 20 February with respiratory failure. The man received intravenous treatment for a chest infection but after three days in hospital all active treatment was discontinued in keeping with his wishes and he was placed on the Liverpool Care Pathway. The Liverpool Care Pathway is a best practice model to improve the care of the dying in the last days or hours of life. However, after seven days he became more responsive and started taking a light diet and fluids. On 8 March, he was transferred back to the prison where he wanted to spend his last days.

The man's pain relief and medication

34. The man did not appear to be suffering much pain and declined pain relief medication until three days before his death. As his condition deteriorated he was given appropriate pain relief by injection, diamorphine. Diamorphine is a powerful opiod pain relief which is often used in preference to morphine for patients who are terminally ill because it is considered less likely to cause nausea or lower blood pressure than morphine and can be injected in smaller volumes. Hyoscine butylbromide was also used to clear respiratory secretions (this is an antispasmodic medication most usually used for stomach cramps, but sometimes used to reduce secretions in the lung). The man was nursed on an airflow mattress and turned at regular intervals as his condition deteriorated.

The man's location

35. When the man first arrived at Wakefield he lived in a single ground floor cell of a wing because of his medical and physical mobility problems. In December 2007, because of issues relating to the management of his diabetes, the man moved to the healthcare centre where he remained for the rest of his time at Wakefield. On his return from hospital on 26 January 2012, he moved to the palliative care suite in the healthcare centre. The cell he was nursed in is a spacious, purpose designed suite suitable for end of life care. During the last few days of his life the suite was left unlocked to ensure easy access and from the day before his death the door remained open at all times. The man was regularly visited by staff and fellow prisoners.

Compassionate release

36. Early release on compassionate grounds is a means by which prisoners who are seriously ill can be permanently released from custody before their sentence has finished. Prison Service Order (PSO) 6000 – Parole, Release and Recall, states that:

> "Any other reports which are available, for example from hospital consultants, must also be forwarded. It is essential that an indication of

likely life expectancy is included in the report… a decision will usually be made within two weeks, but more quickly if the circumstances require it."

37. The compassionate release process was not pursued for the man because medical staff were not able to give a clear diagnosis of his condition or life expectancy, due to his decision not to have further tests. He understood the implications of his decision and had made it known in any event that that he wanted to die in familiar surroundings. The Acting Head of Residence said that an application for compassionate release would not have been progressed as there was no prognosis that his death was imminent.

Palliative care plans

38. Palliative care is the active holistic care of patients with an advanced progressive illness, such as cancer. A palliative care pathway is used to help manage a patient's pain and any other symptoms that they may be experiencing. It also helps to provide psychological, social and spiritual support. Overall, it aims to provide the best quality of remaining life for patients and their families.

39. Although the man's diagnosis of cancer could not be confirmed as he refused further tests, he was clearly terminally ill on his return to the prison in January 2012. Staff at Wakefield therefore implemented a palliative care pathway. He received a full assessment by a Palliative Care Consultant including advice on management and pain relief. He was also visited in prison by a Macmillan Palliative Care Nurse.

40. An end of life care pathway based on the Gold Standard Framework (GSF) was introduced for the man. GSF is a model that enables good practice to be available to the patient nearing the end of their life and aims to raise the level of the care to the very best standards. This includes constantly listening to the patient, helping them think ahead with the use of advance care planning discussions, organising and pre-planning care in response to these needs, and at all times treating them with due respect and dignity . There is particular attention to control of symptoms, continuity of care, carer support and intensive support and input in the final stages of life. In the man's case care plans were well documented, very detailed and paid attention to both his physical and emotional needs.

Restraints, security and bedwatch

41. When the man was taken to hospital in January 2012 it was decided that he should be accompanied by two officers and restraints should be used. He was initially restrained by an escort chain, a 1.8 metre length of chain with one cuff attached to an officer and the other to the prisoner. We accept that the Prison Service has a primary duty to protect the public and prison escort staff routinely use restraints when prisoners are taken out of the prison for any reason. However, there is also a responsibility to balance the need to hold prisoners securely with the duty to treat them with humanity and to maintain their dignity and privacy. The level of restraints used should be necessary in

all the circumstances. The risk assessment should consider the risk of escape and the risk to the public, taking into account factors such as the prisoner's health and mobility.

42. Following the discovery of the mass in his lung, the man returned to hospital on two occasions. The risk assessment was revised on 9 and 29 February and the restraints were removed while he was in hospital. His bedwatch log shows on both occasions the removal of restraints was authorised as they were causing restriction to his circulation. He was to remain to be supervised by two escort officers and he was to be reviewed daily. Once removed, the restraints were not re-applied.

43. Although it is accepted that the man was convicted of serious offences, the most relevant factors to consider were his likelihood of escape and his risk to the public. At the times he was taken to hospital in January and February the man was a very ill, an old man in a wheelchair and had had very restricted mobility for some years. In these circumstances, it is very hard to see how any use of restraints was justified. There is no evidence that he was a risk of escape and, while he had committed serious offences, these had occurred over 30 years ago. The presence of two officers should have been more than an adequate security precaution. The medical condition and mobility of a prisoner needs to be fully considered as part of the decision making process and levels of restraint must be proportionate to actual security risks, balanced by considerations of care and decency. We make the following recommendation:

The Governor should ensure that a prisoner's health and mobility and actual risk at the time are fully considered and that these factors are fully taken into account in deciding the level of escort and whether restraints are needed.

Liaison with the man's family

44. Wakefield appointed a Senior Officer (SO) as the prison's family liaison officer after the man was initially admitted to hospital on 20 January. He ensured that the man's family was informed and consistently updated about his condition and his decision to refuse treatment. The SO provided a direct contact number to ensure the man's family were able to speak to someone at the prison at any time, and he also told them of the support that was available to them.

45. After the man's death, the SO maintained contact with the family and assisted with the arrangements for the funeral. The prison offered financial assistance towards the funeral costs in accordance with national guidance. There are clear and informative notes about the liaison with the man's family in his records.

CONCLUSION

46. The man arrived at Wakefield in March 2006 and was seen regularly and treated by healthcare and hospital staff for a number of ongoing chronic medical conditions. He lived in the prison's healthcare centre from December 2007. He became very ill and was informed that he had a suspected tumour on 22 January 2012. He declined to allow any further investigations to be carried out to confirm the diagnosis of his condition and decided not to have any active treatment.

47. Following the man's diagnosis he continued to receive close monitoring and staff responded quickly when he developed treatable conditions which required him to be taken to hospital for care. The man's computerised medical records were comprehensive and clear and care plans were clear, detailed and well monitored.

48. In his final days, the man was nursed on a palliative care pathway. He died in his cell in the palliative care suite of Wakefield's healthcare centre during the morning of 12 March 2012.

49. In his review, the clinical reviewer concludes that the man's chronic health problems were well managed by both prison and healthcare staff. He wrote:

> "When his condition became terminal his care was well planned and delivered …Overall the man received an excellent standard of care whilst at HMP Wakefield. His care was more than equitable to that which he could have expected in the community."

50. We found that staff at Wakefield treated the man with care and compassion and where appropriate, in line with national guidance. However, we consider that the use of restraints for hospital visits were unnecessary and make one recommendation about this. Overall, we agree with clinical reviewer, that the man received excellent care at Wakefield.

RECOMMENDATION

At the draft report stage, the National Offender Management Service (NOMS) responded to the recommendation. That response is included in italics below the recommendation.

To the Governor of Wakefield

The Governor should ensure that a prisoner's health and mobility and actual risk at the time are fully considered and that these factors are fully taken into account in deciding the level of escort and whether restraints are needed.

Accepted: The Governor will confirm that the Risk Assessment processes consider a prisoner's health and mobility and actual risk at the time of any escort and that these factors are fully taken into account in deciding the level of escort and whether restraints are needed. These decisions will be balanced against the Prison Service's additional responsibility of protecting the public by considering the individuals offence profile. This will be achieved by amending the Risk Assessment paperwork to this effect and by issuing instructions to Duty Governors, Control room staff and the Head of Security and Healthcare Managers.