Investigation into the circumstances surrounding the death of a prisoner at HMP Wakefield on 22 December 2005

Report by the Prisons and Probation Ombudsman for England and Wales

April 2007

This is the report of an investigation into the circumstances of the death of a prisoner at HMP Wakefield who died in hospital on 22 December 2005. Following a post mortem examination, the man's cause of death was recorded as intracerebral haemorrhage due to essential hypertension (stroke). He was 71 years of age.

I extend my sincere condolences to the man's family and friends. I must apologise for the delay in completing this report.

The man had been in prison for 21 years at the time of his death. He had spent much of his sentence at Wakefield. A particularly pleasing aspect of this investigation is that, while Wakefield prison was in the early stages of embedding its policies on family liaison, the appointed Family Liaison Officer's contact with the family was both sensitive and respectful.

I would like to thank the Governor of Wakefield. I am also grateful to those members of his staff who assisted us, particularly the Principal Officer who acted as a liaison officer for the investigation team.

I must also thank Wakefield West Primary Care Trust for their clinical review of the man's care whist he was at Wakefield, the findings of which have informed this report. The clinical review has identified a number of areas for improvement in the prison's management of chronic long term illnesses. However, it finds that the man received an appropriate standard of clinical care.

A review of the response to the man's collapse on 20 December has identified a number of learning points for the prison. I make eight recommendations and draw a number of other matters to the Governor's attention.

Stephen Shaw CBE
Prisons and Probation Ombudsman **April 2007**

Contents

Summary	5
The investigation process	7
The man who died	8
HMP Wakefield	9
The events leading up to the man’s death	10
Events on 20 December 2005	15
Discussion of the issues	21
Findings and conclusions	26
List of recommendations	27

Summary

1. In 1984, the man who is the subject of this report was given a life sentence and sent to Winchester prison. He was transferred to HMP Wakefield in 1985, where he remained until 1990 when he was transferred to another high security prison, Long Lartin.

2. The man had initially been given a category “A” status (the highest security category). In 1995, while he was a prisoner at Long Lartin, his security category was downgraded to category “B”.

3. During 1995, the man underwent tests at outside hospital as it was suspected that he had suffered a myocardial infarction (heart attack). During this assessment, the man suffered a cardiac arrest and remained in hospital for ten days. He was prescribed medication and discharged back to prison. He was admitted to outside hospital for similar symptoms a further twice in 1995.

4. In December 1999, the man was transferred back to Wakefield. Treatment for his ongoing heart condition continued and in May 2000 he was referred to a cardiologist at outside hospital.

5. In July 2004, the man was admitted to hospital again suffering from a myocardial infarction. He was also found to be suffering from atrial fibrillation (an irregular heartbeat) and was prescribed Warfarin (a blood-thinning medication (to reduce the risk of blood clots) and a cholesterol lowering drug. He remained in hospital for ten days. Following his discharge from hospital, he continued to attend appointments at the hospital’s cardiology clinic.

6. On 14 December 2005, the man complained to prison staff of extreme pain in his legs. He was taken to outside hospital where he was treated overnight for inflammation to the veins in his legs. His dosage of Warfarin was also altered. The man returned to the prison on 15 December and went back to his single cell on the ground floor level of B wing.

7. On 20 December at approximately 13.20, a fellow B wing prisoner found the man collapsed in his cell. An officer was standing nearby and immediately came to assist. As she was not carrying a radio, she asked an officer in the nearby Senior Officer’s (SO’s) office to make a “code blue” call to healthcare staff dedicated to responding to emergencies. (A “code blue” is the emergency code used to indicate to healthcare staff that someone is experiencing breathing difficulties. The healthcare staff who are designated to respond to an incident are known in Wakefield as “Hotel 5”.)

8. The officer who first attended to the man, and an SO from the office, then looked after him while they waited for Hotel 5 to arrive. The man appeared to have hit his head when he fell, was incoherent and seemed to have some paralysis to his face and left hand side.

9. A further “code blue” call was put out for Hotel 5 as they had not yet arrived (some 6-8 minutes after the initial request). They then arrived within a few minutes. It appeared that the first call had not gone out to Hotel 5. The officer who had made the initial request had telephoned the Control Room. He could not remember whether he had used the term “code blue” and he did not use dial the designated emergency number which notifies the Control Room that a situation is urgent.

10. When the two healthcare staff acting as Hotel 5 arrived, one of them immediately requested an ambulance. The Control Room operator did this at 1.43pm. The ambulance service operator recorded the call as a category “B” (amber) response. Two separate ambulances en route to the prison were diverted to more urgent response calls. The ambulance arrived approximately 28 minutes after it was requested. The man was taken by ambulance to a local hospital.

11. The man’s daughter had contacted the prison’s Control Room on the evening of 21 December after hearing from the relative of another prisoner that her father was in hospital. Staff in the Control Room regularly updated her of the man’s condition and, on hearing that it was deteriorating, she arranged to visit the hospital the following day.

12. Sadly, the man’s condition worsened and he died on 22 December at 10.35am shortly before his daughter arrived at the hospital.

13. Wakefield West Primary Care Trust conducted a review of the man’s clinical care whilst he was at the prison. They also liaised with West Yorkshire Metropolitan Ambulance Service (WYMAS) who conducted a review of the emergency response to the man’s collapse on 20 December. The clinical review contains a number of findings which have informed this report.

14. My report includes eight recommendations and brings a number of other matters to the Governor’s attention.

Investigation process

15. One of my investigators visited Wakefield and met with a member of the Independent Monitoring Board and a representative of the Prison Officers' Association (POA). My investigator also visited B wing, where the man had been located at the time of his death.

16. My investigator issued notices to staff and prisoners informing them of the investigation and inviting comment.

17. Access to the man's prison records, including his medical records, was provided to my investigator.

18. Formal and informal interviews were conducted with several officers, members of healthcare staff and prisoners. A number of these interviews were jointly carried out by two investigators from my office.

19. One prisoner who asked to speak to the investigation team preferred to remain anonymous. He did not offer any information that was relevant to the man's death and the content of his interview is therefore not referred to in this report.

20. One of my family liaison officers wrote to the man's daughter to explain the purpose of the Ombudsman's investigation and to discuss any questions the family might have had. The man's daughter has subsequently told another of my family liaison officers that she had received a letter from her father expressing concerns that he had been handcuffed on a previous visit to hospital. The man had also told his daughter that he did not always receive his medication on time.

21. The man's daughter has been given the opportunity to comment on a draft of this report. The Prison Service has also had this opportunity and, where appropriate, their comments have been included. We have not yet received any response to our recommendations from the Prison Service.

The man who died

22. The man who died had spent much of his sentence at Wakefield. He had a long history of heart problems and was therefore well known by healthcare and discipline staff as well as prisoners.

23. He lived on the ground floor landing of B wing (referred to as the "twos"). Many older prisoners are located on this wing and several cells on the ground floor landing have been adapted for disabled access.

24. The man was described by those who knew him as an extrovert and approachable person and was clearly well liked.

HMP Wakefield

25. Wakefield is one of eight high security prisons. It is the main Lifer Centre within the high security estate, meaning that it holds many prisoners who are serving long sentences and who will spend several years in Wakefield. The prison can accommodate 561 prisoners.

26. Wakefield was last inspected by HM Chief Inspector of Prisons in April 2005. The inspection report acknowledged that a new Governor and senior managers were making considerable efforts in moving the prison forward. However, it also noted that many prisoners spent a high proportion of their time in their cells and were not given adequate opportunity to engage in purposeful activity. In addition, the inspectors expressed concern that recommendations from an earlier investigation into a self inflicted death at the prison had not been implemented. The inspection report also commented that a shortage of healthcare staff was affecting prisoners with chronic illnesses.

27. There have been nine deaths at Wakefield prison since April 2004. Three of these deaths were apparently self-inflicted and six were due to natural causes.

28. Wakefield is a Victorian prison, with four main wings each comprised of four landings. The Healthcare Centre and Segregation Unit are located separately from the main residential wings.

The events leading up to the man's death

1984-2005

29. The man was sentenced to life imprisonment in November 1984 at Oxford Crown Court. He was sent to Winchester prison, transferring to Wakefield in March 1985. Robert was transferred to Long Lartin in 1990 and returned to Wakefield in 1999.

30. In April 1995, when he was a prisoner at Long Lartin, the man went to outside hospital to undergo tests for a suspected myocardial infarction (heart attack). Shortly after completing one of the assessments, he suffered a cardiac arrest and was rapidly resuscitated. He remained in hospital for ten days and was prescribed medication to treat myocardial infarction. He was to be reviewed after three months. The man was admitted to outside hospital experiencing chest pains a further two times during 1995.

31. After his conviction in 1984, the man had remained as a category "A" prisoner (the highest security category). In June 1995, his security category was down graded to category "B". It was noted in his Category "A" Review report that he was still considered to be a threat to females if he was released, but that it was not thought that he had the means or ability to escape.

32. On 7 December 1999, the man was transferred back to Wakefield. His history of myocardial infarction was recorded by the doctor who assessed him and it was noted that he was taking Aspirin EC 75mg daily, Isosorbide 40 mgs daily and Amilodipine 10mg daily[1]. The clinical reviewer was surprised that the man did not appear to have been prescribed a beta blocker as this medication would have reduced the symptoms from which he was suffering, and the likelihood of death following a myocardial infarction.

33. On 4 May 2000, the man was admitted to the Healthcare Centre at Wakefield following concerns about his low mood and possible risk of self harm. He was admitted again on 11 May for the same reason and was seen by a consultant forensic psychiatrist. After explaining to the prison doctor that he was having problems on his wing, arrangements were made to move him to another location in the prison.

34. Also during May 2000, an Electro Cardio Gram (ECG) was carried out on the man. It revealed that he should continue with the same treatment and a note was made to refer him to a cardiologist. The clinical reviewer noted that there was no copy of the referral letter in the medical records, nor were the reasons for the referral documented.

[1] These medications are for the prevention and treatment of angina.

35. At the end of May 2000, a review of the man's medication was conducted by one of the prison doctors. The clinical reviewer noted that these reviews appear to have been carried out at regular three month intervals which is good practice. However, the reviews were usually recorded by no more than a stamp in the medical records and so there is no evidence of their depth or content.

36. The man was seen as an out-patient at the cardiology department of a local hospital in September 2000.

37. In July 2001, the man was transferred to Grendon where he remained for only one day. Following his return to Wakefield, the man was keen to partake in employment and also wanted to be involved in psychology programmes aimed at addressing his offending behaviour. The man's records indicate that he was not found to be suitable for these courses, something which caused him frustration.

38. In November 2001, he was admitted to the Healthcare Centre at Wakefield after complaining of chest pains. An ECG revealed nothing of clinical significance.

39. During the early months of 2003, the man experienced a difficult period. Procedures were instigated twice in January to ensure that he did not harm himself. (At that time, Wakefield – in common with the rest of the Prison Service – used a system of monitoring prisoners at risk of self harm which required them to open what was referred to as a F2052SH document.) The same procedures were instigated for him the following month (February 2003). The man was referred to see a member of the psychiatric outreach team.

40. On 9 July 2004, the man was admitted to outside hospital suffering a myocardial infarction. The clinical reviewer noted that his treatment was appropriate and that he was also found to be suffering from atrial fibrillation (irregular heartbeat). Due to the risk of blood clotting as a result of this condition, the man was prescribed Warfarin to thin his blood. He was also prescribed a cholesterol lowering drug. He remained in outside hospital until 19 July when he was discharged back to Wakefield. It is not clear from the medical records whether he then spent some time in the prison's Healthcare Centre or whether he returned to the wing. On discharge from hospital he was taking the following medications:

    Isosorbide Monoitrate 20mg BD
    Bisoprolol 2.5mg OD
    Glyceryl Trinitrate 1 Spray PRN
    Perindopril 4mg once nightly
    Frusemide 40mg once each morning
    Omeprazole 20mg OD
    Warfarin as per INR

Simvastatin 20mg once nightly.[2]

41. The man was admitted to the Healthcare Centre on 23 September, suffering from a suspected myocardial infarction. Investigations showed that there had been no change to his condition. He was advised to remain in the Healthcare Centre but wanted to return to the wing and did so the following day.

42. On 13 December a specialist registrar in cardiology at a local hospital, wrote to the prison doctor. The letter summarised the man's medical history and advised that he continue on the medication prescribed.

43. An entry in the man's medical records on 28 February 2005 indicates that an ECG had been performed and that the man needed to have a chest xray and to be referred to a cardiologist. The medical records indicate that this referral letter was written on 29 February, although there is no copy of the letter or any notes indicating the reason for the referral.

44. On 10 March, a locum consultant cardiologist at the same local hospital, wrote to the prison doctor following the man's referral to the hospital due to an irregular pulse. The consultant noted that the man appeared to be asymptomatic and commented that he should attend a routine appointment at the clinic, or to be returned sooner if he became symptomatic.

45. The hospital consultant wrote a further letter on 26 July 2005 following another referral to the cardiology clinic. The letter described the man's symptoms as being fairly well controlled by his medication.

December 2005

46. The next significant entry in the man's medical records appears on 14 December 2005. The man asked to see a member of Healthcare staff as he was experiencing severe pain in his legs. He was seen by a nurse at 7.00pm who considered that he should be assessed by a doctor. At 9.10pm, one of the prison doctors assessed the man and took the decision that he should be sent to outside hospital for further tests. The man was taken to the local hospital at 9.50pm.

---

[2] The British National Formulary (BNF) indicates that NursinIsosorbide Monoitrate is used for the prevention and treatment of angina; Bisoprolol is used to treat hypertension and angina; Glyceryl Trinitrate is used for the treatment of angina and left ventricle failure; Perindopril treats hypertension and symptomatic hear failure; Frusemide treats hypertension and oedema; Omeprazole is usually used to treat gastric reflux; Warfarin is a blood-thinning medication and Simvastatin can be used to slow the progression of coronary atherosclerosis (narrowing of arteries) in patients with coronary heart disease.

47. Prior to his escort to hospital, a Risk Assessment for Hospital Bedwatch form was completed for the man by an officer. (Every escort from prison should be preceded with an assessment of the number of escorting officers needed and the level of restraints required to ensure that the prisoner does not present any risk of harm to himself or others.) The man's assessment said that he was to remain in double handcuffs throughout the time he was away from the prison and that he should be accompanied by two officers. There is an option on the form for authorisation to be given for handcuffs to be removed when the prisoner needs the toilet and for an "escort chain" to be used instead. The use of an escort chain allows the prisoner to use the toilet without being directly handcuffed to an officer. This was not authorised for the man. It is surprising to note that the form has not been endorsed by a senior manager.

48. On the morning of 15 December, while still at the hospital, the man expressed his upset at being in double handcuffs. A note in the man's Prisoner Escort Record (PER)[3] indicates that a telephone call to the prison confirmed that he was to remain in double handcuffs, but that these could be removed when he needed to use the toilet or if he was eating a meal. Shortly after this conversation took place, nursing staff at the hospital advised that the man could be discharged as soon as his medication had been arranged.

49. The man returned to the prison that afternoon. The discharge note from the hospital gave the diagnosis as "heart failure, thrombophlebitis". Changes were made to the man's medication and he was prescribed Flucloxacillin penicillin and commenced on Tramadol. The clinical reviewer noted that the man was suffering from inflammation in the veins in his legs and that the antibiotics to treat this, in addition to adjustments to the amount of Warfarin given, were entirely appropriate. The reviewer goes on to add that treatment of this sort does not require inpatient care in hospital. The clinical reviewer did not consider that this admission to hospital, or the way in which it was managed, is in any way linked to the stroke suffered by the man on 20 December.

50. The man returned to B wing after his discharge from hospital. The wing records on 18 December indicated that he continued to feel unwell:

> "Has not been himself recently, he was admitted to outside hospital suffering from severe pains in his legs. He returned the following day after the medics decided to change his medication. He told me he is getting lots of pain in his legs. Hospital staff are monitoring him closely."

[3] A PER form must be completed whenever a prisoner leaves an establishment. The form records important information about the person, including details of risk they may pose to themselves or others. The form is also used to record the time the person leaves prison and all the events that happen thereafter.

51. On 19 December, the man completed a complaint form about his admission to outside hospital a few days earlier. He said that he felt the use of double handcuffs during his time outside prison had been excessive and disproportionate. He had also felt it degrading as he had not been able to go to the toilet, feed or wash himself. In addition, he had concerns that if hospital staff had needed to “shock” him (use a defibrillator) the cuffs would have preventing them from doing so.

52. A Principal Officer (PO), who worked in Wakefield’s security department, replied to the man’s complaint on 21 December. He said that prisoners at Wakefield are subject to policies consistent with it being a high security prison and that, as such, double cuffing is considered to be the usual requirement for an outside escort. However, he went on to explain that each escort is individually risk assessed and continually re-assessed as circumstances change. The PO added that conditions of the cuffing arrangements could be amended by the Governor and that, in the event of emergency medical treatment being required, hospital and prison staff liaise to ensure there is no risk to the prisoner’s health.

Events on 20 December 2005

53. All prisoners at Wakefield are locked up over the lunch time period and are unlocked at approximately 1.15pm. In interview a fellow B wing prisoner and friend of the man's, described how, immediately after being unlocked, he made his way down one set of stairs to the man's cell on the 'twos' landing (located on ground level). It has not been possible to clarify who unlocked the man's cell that afternoon but his door had been unlocked by the time the fellow B wing prisoner reached it and he described it as being "two thirds open"[4]. He immediately saw that the man was lying collapsed and called out to an officer who was on the landing outside.

54. The officer who was on the landing outside was a B wing officer but is also a registered nurse. She told the investigation team that she heard the man's friend call out that the man had fallen and so went immediately to his cell. She checked that he was conscious, told him to stay still and went to the Senior Officer (SO)'s office immediately across the landing. The officer was not carrying a radio and so asked the officers in the SO's office to contact the Control Room and ask for a "code blue" call to be put out for Hotel 5 (the two designated members of healthcare staff who respond to emergencies). The officer explained that a "code blue" call indicates that a person is experiencing breathing difficulties, and is intended to give the medical staff an indication of what equipment they will need.

55. There were several officers in the SO's office, including the wing's Principal Officer (PO) and an SO. The medically trained officer who first attended to the man and the SO returned to his cell. The officer checked again that the man was still conscious. He was able to tell her that he had hit his head when he fell and that he was feeling very sick. The officer noticed that the right side of the man's face was drooping slightly and that there was very little strength in his left hand when she asked him to squeeze her own hand. The man's right leg was tangled up in the bed sheets from where he had fallen. The officer and the SO untangled his leg and placed him into the recovery position.

56. The officer placed a pillow under the man's head and checked his head for cuts or bumps. Finding no obvious injuries, the officer and SO covered him with blankets and took his pulse. In her Incident Report, the officer noted that this had been strong and regular (at 76

[4] Wakefield allows some prisoners who are not able to work to associate freely on their wings during the day. The man who died was 70 years old and had retired from work on medical grounds in April 2003. He was therefore one of the prisoners who had been approved to be allowed out of their cell during the day when other prisoners would be at work or education.

beats per minute). She had no equipment to enable her to take the man's blood pressure but kept him talking to ensure that he did not lose consciousness.

57. Another officer was in the SO's office when the medically trained officer initially came in and asked for a "code blue" call to be made. The second officer explained that he called the Control Room and asked for a call to be put out for Hotel 5 indicating that they were urgently needed on B wing. Although the second officer was able to explain the meaning of the different emergency codes used in the prison, he could not remember whether he said that the call was a "code blue" when he spoke to the Control Room operator.

58. Only a small proportion of staff at Wakefield carry radios and so the second officer telephoned the Control Room. In interview, the officer explained that he had not dialled the designated emergency number to get through to the Control Room. A call to this number indicates to the operators in the Control Room that an urgent or emergency situation is taking place within the prison. The officer said that he instead dialled a Control Room extension which he believed would have been available at that time of day (owing to prisoners moving around the prison). He explained to the investigation team that he was aware of the purpose of the emergency number and that his reason for using the other number was simply that it was the first one that "came into his head".

59. The medically trained officer who was the first to attend to the man estimated that approximately six to eight minutes had now passed since she asked for Hotel 5 to be called. The SO had been repeatedly going to the cell door to watch for medical staff arriving and he now went back into the SO's office to ask for another call to be put out.

60. It has not been possible to establish who contacted the Control Room to make the second call for a "code blue" following the SO's request. The Control Room Log records only one "code blue" request and this was received at 13.36. The medially trained officer believed that, following the SO's request for a "code blue" call, the medical staff arrived within a few minutes.

61. On 20 December, two nurses were the members of staff designated to act as Hotel 5. In emergencies, both Hotel 5 staff attend but one is responsible for carrying the radio and the other has the responsibility to take the equipment. The investigation team interviewed the nurse who believed she was carrying the radio on 20 December. She explained that she was in the Healthcare centre when she received a "code blue" call to attend to a collapsed prisoner on B wing. She and a second nurse immediately made their way there, taking the emergency bag with them. She estimated that the journey would

have taken two or three minutes and does not recall receiving more than one request to attend B wing.

62. On arriving at the man's cell, the first nurse (who was carrying the radio) quickly realised that he needed an ambulance. She asked the SO to contact the Control Room and request that an ambulance be sent as soon as possible. The nurse told the investigation team that she had a good relationship with the man and was aware of his medical problems. She noticed some paralysis in his mouth and left side and that his speech was incoherent. She believed that he had suffered a stroke.

63. The PO believed that the medically trained officer had requested an ambulance at the same time she first asked for a "code blue" be put through to the Control Room. The officer confirmed that this was not the case and that it was the nurse who had asked for the ambulance to be summoned as soon as she arrived at the man's cell.

64. Despite efforts by my investigator, it has not been possible to the SO. Although I cannot be certain who made the call to the Control Room to request the ambulance, the Log records the call being made by the prison at 1.43pm. (Enquiries made by the West Yorkshire Metropolitan Ambulance Service (WYMAS) showed that this call was made at 1.42pm.) The nurse who was carrying the radio believed that when she asked SO to contact the Control Room and request an ambulance, she asked for him to request a "999 ambulance".

65. The nurse described how the man was given oxygen from the emergency bag. His condition began to deteriorate; his breathing became very laboured and he stopped speaking. She estimated that this was approximately 15 minutes after they first arrived at the man's cell. She explained that she was worried that he was losing consciousness and asked that the ambulance was chased up. She and the second nurse continued to monitor the man's vital signs throughout. He then seemed to improve a little although there was still evidence of paralysis on his left side.

66. The nurse with the radio, the medically trained officer and the wing PO all commented to the investigation team that the ambulance took a long time to arrive. The Control Room Log shows that it arrived at the prison at 2.11pm, some 28 minutes after it was first requested.[5] The initial call from the prison was logged by WYMAS as a category "B" (amber) incident. The first two ambulances that were dispatched to the prison were diverted to other, category "A" incidents. WYMAS's

[5] The clinical reviewer liaised with West Yorkshire Metropolitan Ambulance Service (WYMAS) to conduct a review of their response to the man's collapse on 20 December. The review by WYMAS is produced as part of the full clinical review of the man's care and appears as part of Annex 1. The WYMAS review is also summarised in the discussion section of this report.

records show that a follow up call was received from the prison at 2.04pm, enquiring how long the ambulance would be and they were advised that a third ambulance was on its way. The PO confirmed that he contacted the Control Room to ask about the delay and was told by the operator that an ambulance had been dispatched but then diverted to another incident.

67. According to the WYMAS records, the ambulance arrived at the prison at 2.12pm (one minute later than is indicated on the prison's Control Room Log). It is not clear from the records how long it took the paramedics to get from the prison gate to the man's cell.

68. The nurse who was carrying the radio recalled accompanying the man and the ambulance crew back to the ambulance as he was still receiving oxygen from the portable cylinder she had taken from the emergency bag.

69. At 2.15pm, a Risk Assessment for Hospital Escort form was completed by an officer in the prison's security department. In assessing the risk that the man might pose, the officer noted that his convictions included offences against children and that there was very open access to the Accident & Emergency Department at Pinderfields General Hospital.

70. It is not entirely clear from the officer's assessment whether double or single cuffs were to be used on the man during his time out of the prison. However, it is evident that the man was to be accompanied by two officers and that the restraints could only be removed for urgent medical treatment, and only then with the duty governor's permission. The form was stamped with a note to indicate that an escort chain must be used for the man if he needed to use the toilet. The assessment also indicates that Release on Temporary Licence was considered appropriate for the man.

71. The Risk Assessment has to be signed by a senior manager. On that day the form was signed by the duty governor (the designated governor in charge of operations in the prison). He signed the assessment and made the following note:

    > "Double cuffs to be attached when appropriate, meanwhile single cuff and escort chain."

72. A Prisoner Escort Record (PER) was started for the man. This indicated that handcuffs were applied to the man at 2.35pm and he was then placed into the ambulance. The ambulance made its way through the prison, exciting the gates at 2.40pm and arriving at Pinderfields General Hospital ten minutes later.

Events following the man's escort to hospital

73. The man was accompanied by two members of prison staff at all times while he was in hospital. Detailed Bedwatch Logs were completed during this time, recording any changes in the man's condition and any treatment administered by medical staff. An entry in the Bedwatch Log indicates that at 9.15am on 21 December the security department officer contacted the escorting staff at the hospital. Following a new Risk Assessment, the man was now only to have an escort chain attached to him. At 6.05pm, medical staff asked that the restraints be removed in order to administer emergency treatment. The Bedwatch Log indicates that the man's restraints were removed and the prison was informed.

74. An entry in the Bedwatch Log at 7.50pm records that the man's condition had deteriorated and was described as critical; no restraints were being used at this time. An entry at 11.00pm indicates that his next of kin were to be advised of the seriousness of his condition and confirms that no restraints were to be applied.

75. The SO on duty in the Control Room on 21 and 22 December explained that, in addition to the Bedwatch Log completed by the staff escorting the man at the hospital, the Control Room SO would also complete a log detailing the contact from the escorting prison staff. The SO made an entry into the Control Room Bedwatch Log on 21 December at 6.26pm. It read "Contact the prisoner's daughter to update her."

76. In interview, the Control Room SO said that he could not remember whether this entry in the log meant that he had contacted the man's daughter or she had made contact with the prison. However, the SO completed a memo after his contact with the man's daughter and the information he records therein suggests that the contact was initiated by her. (The SO confirmed in interview that the conversation took place on 21 December, despite the memo referring to it happening on the following day.)

77. In the Control Room SO's memo, he noted that the man's daughter said she had heard about her father being in hospital from another prisoner's relative. His memo details how he received the initial call from her at 6.00pm and that he promised to call her back with as much information as he could. Approximately ten minutes later, the Control Room SO was advised by the escorting officers at the hospital that the man's condition was worsening. He contacted the duty governor (the same governor who had signed the Risk Assessment form) and sought advice on what information to disclose to the man's daughter. The duty governor confirmed that the man's daughter could be told of the seriousness of her father's condition but that his location should not be disclosed unless she was intending to visit.

78. In view of the Control Room SO's memo, it appears that the call at 6.26pm referred to in the Control Room Bedwatch Log is the return call that the SO made to the man's daughter. She explained that she did not plan to visit at that time but it was agreed that the prison would contact her with any updates as necessary.

79. At 7.14pm, the Control Room SO was informed by the escort staff at the hospital that the man was experiencing heart failure. He contacted the duty governor who advised that the Deputy Governor should be informed. The Control Room SO did this and also arranged for the duty governor to speak to the man's daughter to convey the severity of her father's condition.

80. Entries in the Control Room Bedwatch Log indicate that the man's daughter was contacted again at 10.30pm and advised of his deterioration. She also called the prison for an update a few hours later, at 00.46am on 22 December. During the second call, she advised that she would be visiting her father that day and would arrive at the hospital at 2.00pm.

81. The man's condition did not improve throughout the night and at 10.35am on 22 December he was pronounced dead by a hospital doctor.

82. On 22 December, another governor had taken over as duty governor. The Control Room SO was advised at 10.29am that the man had died. The duty governor advised the Control Room SO that the man's daughter would be informed of his death by one of the prison's POs, who was trained as a Family Liaison Officer (FLO).

83. This FLO telephoned the man's daughter at 11.03am to break the news of her father's death. The FLO arranged for herself and one the governors to meet the man's daughter at the hospital's Chapel of Rest.

84. Staff broke the news of the man's death privately to some of the prisoners who were his close friends. Notices were also placed around the rest of the prison. The investigation team spoke to several prisoners on B wing. While the majority said that they knew where to seek support after Robert's death if they had needed, not all felt that support had been proactively offered.

85. The Governor of Wakefield sent a letter of condolence to the man's daughter on 23 December. The man's funeral took place on 6 January 2006. The prison contributed to the cost of the service.

86. The prison's FLO made arrangements for the man's daughter to visit the prison and collect her father's belongings.

87. Although most of the staff to whom the investigation team spoke were aware that the prison had a Care Team, none had been approached by them with offers of support after the man's collapse, or following his death two days later.

88. Of all the prison staff who were involved in caring for the man on 20 December, only the medically trained officer who was the first to respond to the man the nurse who was carrying the radio completed Incident Reports. The Control Room SO also completed a memo detailing his contact with the man's daughter on 21 December.

Discussion of the issues

The man's clinical care at HMP Wakefield

89. The clinical reviewer considers that the man received good standard care from the healthcare team in prison and specialist NHS services. The reviewer judges that some aspects of secondary prevention of his coronary heart disease could have been initiated earlier (such as commencing cholesterol lowering drugs), although this would have been unlikely to have made a significant difference towards the course of his illness.

90. The clinical reviewer finds that the quality of healthcare received by the man in Wakefield was good. However, the reviewer also finds there to be no evidence of a systematic approach to the management of chronic diseases within the prison. There were no active disease registers, no consistent approach to review and management and no evidence of clinical audit. The clinical reviewer believes that such systems are essential to ensure that prisoners with chronic illnesses receive the best care possible.

91. The man told his daughter that he did not always receive his medication on time. It is not clear which medication he was referring to: some of his medications were dispensed to him at specific times (according to the doctor's instructions), others were prescribed as "in possession". In either event, the clinical reviewer makes no criticism of the way in which the man's medication was dispensed to him.

92. The clinical reviewer acknowledges that healthcare staff said that limited resources made it difficult to provide a more systematic approach to chronic disease management. However, the reviewer considers that improvements could be achieved by deploying medical and nursing workforce more efficiently and through developing the role of healthcare professionals.

93. The reviewer's report also comments on the quality of documentation and the timeliness and effectiveness of reviews. In general, the clinical reviewer considers the nursing assessments, care plans and

reviews to be adequate. The clinical notes in the man's medical records were factual and accurate. However, some of the entries provide insufficient detail, some were not legible and few had the name and designation of the author printed. The reviewer considers the medical record to be disorganised, with no chronological date filing.

94. The clinical reviewer notes that, following a previous death at Wakefield, there had been an audit of clinical record keeping which highlighted a number of areas for improvement. These included the need for clearer entries in the medical record and the need to record names, signatures and dates. The reviewer concludes that there is a need for further improvement in clinical record keeping at the prison.

95. In relation to the man's clinical care while in Wakefield, the clinical reviewer makes a number of recommendations which I endorse. I therefore recommend:

A systematic evidence based approach to the management of patients with coronary heart disease and other chronic diseases should be developed. This should include disease registers, standardised interventions, review and clinical audit.

The standard of clinical record keeping should be improved. An audit of the standard of record keeping should be undertaken and an improvement plan developed. A computerised clinical information system should be procured and staff trained in its use.

I recommend the implementation of a structured approach to recording medication reviews in medical records. This would be supported by the procurement of a clinical information system.

I recommend a review of the role and deployment of all the healthcare staff at HMP Wakefield to enable the development of systematic chronic disease management and a more proactive anticipatory approach to healthcare. This should include developing the role of all health professionals in the team.

96. Although it is outside the remit of my investigation, I acknowledge that the clinical reviewer comments on the treatment given to the man at Pinderfields General Hospital during the final stages of his illness. The reviewer considers that the care was appropriate and of a good standard.

The response to the man's collapse on 20 December

97. On the afternoon of the man's collapse, the medically trained officer responded swiftly and appropriately. In interview, she explained that in retrospect she perhaps should have asked for an ambulance to be

called when she asked for Hotel 5 to attend. She explained that, while she was aware that she did not have to wait for medical staff to arrive before summoning an ambulance, there was sometimes a feeling that discipline officers should not do this in case they misjudged the severity of a situation and called an ambulance unnecessarily.

98. Although it is unlikely that summoning the ambulance faster would have changed the outcome for this man, it is important that discipline staff feel able to request an ambulance if they judge this is necessary, and are aware that they have the authority to do this. The Governor may wish to remind all staff of this.

99. The officer who made the original call to the Control Room following the man's was uncertain whether he used the term "code blue" when he called the Control Room to request Hotel 5. He did not dial the designated emergency number which would have alerted the operator that there was an emergency somewhere in the prison. The Control Room SO was able to explain to the investigation team that, if a call comes through to the Control Room on the emergency line, the operators automatically abandon other calls and respond to it. It is unfortunate if, as seems likely, the officer who made the orginal call following the man's collapse did not state that the call for Hotel 5 was a "code blue" request. It is also unfortunate that he did not use the designated emergency number. Had he done both, or even one of those things, it might have made a difference of seven to eight minutes to the time it took Hotel 5 to arrive. In response to this report, the officer who made the call said that he was concerned and upset about the inference that he caused a delay by not ringing the emergency number. He said that he had acted in the way he had thought most appropriate.

100. In additional comments received in February 2007, the Prison Service told me that the officer is extremely concerned and upset about the above paragraph and the inference it makes. He maintains that he acted in the most appropriate way he thought possible

I recommend that all staff are reminded of the importance of using emergency codes when requesting medical assistance.

I recommend that all staff are reminded of the importance of using the designated emergency telephone number when contacting the Control Room for assistance with an urgent or emergency situation.

101. The nurse who was carrying the radio on 20 December requested that a "999 ambulance" be called as soon as she arrived at the man's cell. Based upon the information that was given to the West Yorkshire Metropolitan Ambulance Service (WYMAS) operator, the call was graded as a category "B" (amber) request. The first two ambulances

despatched to the prison were diverted to more urgent calls, resulting in delay of almost 30 minutes. The clinical reviewer considers that, although the delay in the ambulance's arrival was regrettable, it did not have any adverse effect on the man's condition and did not change the eventual outcome.

102. In interview, the clinical reviewer explained to the nurse carrying the radio that WYMAS had recently introduced a slightly different call classification system and that this should have been communicated to all staff within the West Yorkshire area. The nurse was unaware of this and the clinical reviewer considers that news of the new process may not have been shared with the prisons.

103. In accordance with the recommendations made by the clinical reviewer, I recommend that:

The Prison healthcare team should be briefed regarding WYMAS call categorisation. Medically trained staff should utilise the red, amber, green categorisation procedure when requesting ambulances.

Failure to complete incident reports

104. On the afternoon of the man's collapse, at least six members of healthcare and discipline staff were involved in attending to him or requesting help. It is surprising that only two of those members of staff completed incident reports afterwards. All staff are required to submit an incident report following an event such as prisoner collapsing and being taken to outside hospital. Those members of staff who had not completed incident reports found it difficult to recollect the details of their involvement and of who else was there.

I recommend that all staff are reminded of the importance of completing incident reports after being involved in a situation such as the collapse of a prisoner.

The use of restraints on the man during his escort to hospital on 14 December 2005

105. The man wrote to his daughter and expressed his upset that he had been double cuffed during his overnight stay in hospital on 14 December. He also submitted a complaint to the prison, although sadly he had already returned to hospital before he received the reply.

106. As is required for all escorts, a risk assessment form was completed for the man prior to his visit to outside hospital. The security department officer (who completed the assessment on 14 December) considered that it was not appropriate to authorise an escort chain for the man. However, this assessment was reviewed the following day

and permission was given for one to be used. The Governor may wish to remind all staff that senior management endorsement should be sought when completing a risk assessment for a hospital escort.

107. In respect of the man's final stay in hospital, the risk assessment was, entirely appropriately, reviewed as his condition deteriorated and no restraints were used after 6.05pm on 21 December. This decision was entirely right under the circumstances.

The prison's contact with the man's family

108. The prison's FLO told the investigation team that she had undergone training as a Family Liaison Officer (FLO) approximately a month prior to the man's death. This was the first time she had acting as a FLO for a death in custody, and at the time she was the only trained FLO in the prison (a further two staff were subsequently to be trained). She explained that the prison had now developed a local policy for responding to a death in custody and that this dealt specifically with contacting and supporting the family of someone who has died. At the time of the man's death, the FLO had not had the opportunity to work through the policy to examine how it would be implemented.

109. The prison FLO said that some lessons had been learned from the experience of acting as a FLO for the man's family. She acknowledged the importance of making contact with the family of a prisoner at the earliest possible stage and advised that a notice had been issued to prisoners asking them to ensure that their next of kin details were up to date. She was not personally contacted by anyone from the prison's Care Team following the man's death.

Findings and Conclusions

110. The man who died had been suffering from serious health problems for many years. The clinical review of his care at Wakefield judges that his overall clinical care had been of a good quality, although some secondary prevention measures could have been initiated at an earlier stage. The clinical reviewer suggests that improvements should be made to the systems for managing chronic illnesses and to the efficient deployment of healthcare staff. The review also highlights shortcomings in the quality of clinical record keeping.

111. Following the man's collapse on 20 December, staff responded swiftly and compassionately. However, the officer who made the initial call to the Control Room did not use the designated emergency number and was not certain whether he asked for a "code blue" call to be put out for Hotel 5. In emergencies, it is essential that staff use the systems in place to ensure a swift and appropriate response.

112. On arriving at the man's cell, the nurse carrying the radio immediately realised that an ambulance was needed and she requested that a "999 ambulance" be summoned. The nurse was not aware that West Yorkshire Metropolitan Ambulance Service (WYMAS) had recently changed their procedures for categorising ambulance requests. These changes had not been communicated to prison staff.

113. At least six members of staff were directly involved with responding to the man's collapse on 20 December. Only two of them completed incident reports detailing their involvement.

114. At the time of the man's death, family liaison practices in the prison were under-developed. Despite this, the prison FLO's contact with the man's family has been sensitive and well handled. I welcome the prison's commitment to developing this area through the introduction of a policy and the training of additional Family Liaison Officers.

115. The staff to whom the investigation team spoke were aware of the existence of the prison's Care Team and knew how to contact them. However, none had been directly approached by the Care Team. It is good practice (and may be beneficial to the development of the prison's death in custody policy) if the Care Team are visible to staff following a death. In addition, while prisoners were aware of the existence of support schemes for them, they felt that it would have been helpful to have someone proactively contact them to see how they were coping. The Governor may wish to consider how best to deploy staff and prisoner support networks following a death in custody.

List of Recommendations

1. **A systematic evidence based approach to the management of patients with coronary heart disease and other chronic diseases should be developed. This should include disease registers, standardised interventions, review and clinical audit.**

2. **The standard of clinical record keeping should be improved. An audit of the standard of record keeping should be undertaken and an improvement plan developed. A computerised clinical information system should be procured and staff trained in its use.**

3. **I recommend the implementation of a structured approach to recording medication reviews in medical records. This would be supported by the procurement of a clinical information system.**

4. **I recommend a review of the role and deployment of all the healthcare staff at HMP Wakefield to enable the development of systematic chronic disease management and a more proactive anticipatory approach to healthcare. This should include developing the role of all health professionals in the team.**

5. **I recommend that all staff are reminded of the importance of using emergency codes when requesting medical assistance.**

6. **I recommend that all staff are reminded of the importance of using the designated emergency telephone number when contacting the Control Room for assistance with an urgent or emergency situation.**

7. **I recommend that the Prison healthcare team should be briefed regarding WYMAS call categorisation. Medically trained staff should utilise the red, amber, green categorisation procedure when requesting ambulances.**

8. **I recommend that all staff are reminded of the importance of completing incident reports after being involved in a situation such as the collapse of a prisoner.**