PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man at outside hospital in August 2011, whilst in the custody of HMP Wakefield

Report by the Prisons and Probation Ombudsman for England and Wales

June 2013

This is the report of an investigation into the death of a man in August 2011, at outside hospital, while he was a serving prisoner at HMP Wakefield. He was 57 years old when he died from complications arising from pancreatitis. I offer condolences to those touched by his death.

The investigation was undertaken by a senior investigator. Wakefield District Primary Care Trust appointed a clinical reviewer to conduct a review into the man's clinical care. I am grateful for his report and for the assistance provided by the Governor and staff at Wakefield. I apologise for the delay in issuing this report.

The man had been at HMP Wakefield since June 2007. After being in good health for the first few years of his sentence, he became unwell in June 2011 and was taken to hospital with chest pain. Staff responded with appropriate treatment and referrals for further investigations were conducted in a timely manner. Overall, the investigation has found that he was well managed and supported by healthcare and prison staff.

As is the case in many of my investigations, the clinical review has played an important part in these findings. The clinical reviewer concludes that the man received an excellent standard of care at Wakefield and that his care was more than equitable to that which he could have expected in the community. In particular, healthcare staff responded promptly to the man's symptoms, enabling his condition to be diagnosed, as well as quickly arranging for him to be taken to hospital on the occasions that he needed emergency treatment. They worked cooperatively with staff at outside hospitals and managed him well in the prison's inpatient unit. The standard of record keeping was good. However, there was an instance of a failure to record the details of an external locum doctor who attended the man in prison at an important point in his illness, shortly before his final admission to hospital. This did not impact on his care, but a recommendation is made to address this departure from good record keeping and allow for proper clinical accountability.

Overall, I am pleased that the investigation was able to conclude that staff displayed a high standard of professionalism in their management of the man.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **June 2013**

CONTENTS

SUMMARY

1. The man was sentenced to 15 years' imprisonment in March 2007. He was initially sent to HMP Chelmsford, before transferring to HMP Wakefield. He settled into his sentence quickly and prison records show him to have been a polite and respectful prisoner who posed no management problems to staff.

2. At the end of April 2011, the man reported feeling unwell with chest pains. He was taken to outside hospital and discharged with a diagnosis of gastritis. He was asked to return to hospital to undertake an exercise tolerance test. He refused to return and signed a disclaimer, citing his reason as his unhappiness at being handcuffed in hospital.

3. The man's health continued to deteriorate and, in June 2011, he experienced abdominal pain. The prison healthcare team monitored his response to treatment. However, in July he was admitted to a local hospital, where a scan revealed he was suffering from gallstones and pancreatitis. He remained in hospital between 30 June and 13 July, during which time he was diagnosed with diabetes and started on insulin injections. A plan was made for him to return to hospital to have his gall bladder removed.

4. The man deteriorated further and, on 5 August, he was again taken to outside hospital before transferring to a second outside hospital for surgery. On 7 August, he underwent surgery for the removal of his gall stones and his pancreas. Escort staff removed his restraints two days later. Unfortunately, he developed a bacterial infection of the blood and died shortly thereafter.

5. Immediately after the man's death, a family liaison officer was appointed. However, his family declined contact so the prison arranged and paid for the funeral. Prison managers ensured that staff were offered support, as well as personally breaking the news to a prisoner who had been a close friend of the man and also offering him support.

6. The investigation has found that the man was well cared for by healthcare staff at HMP Wakefield and referred promptly and appropriately to specialists. Good judgement was exercised in the use of restraints. The clinical reviewer comments that he was well monitored in the inpatient facility at the prison. The medical staff interviewed during this investigation said that they were supported, have access to clinical governance meetings as well as individual and clinical supervision and guidance.

7. During the course of the investigation, it came to light that the details of a locum doctor who had attended the man, just before his final admission to hospital, had not been recorded. This did not impair the man's care, but for preventive reasons, a recommendation is made on this issue.

THE INVESTIGATION PROCESS

8. The investigation was opened on behalf of the investigator by his colleague on 19 August. The Head of Litigation at HMP Wakefield acted as liaison for the investigation and provided the investigator with all the documents relating to the man. The delay in completing the investigation was due to workload pressures in this office.

9. Notices were issued announcing the investigation to staff and prisoners, inviting them to contribute to the investigation. No prisoners came forward.

10. Wakefield District NHS Primary Care Trust (PCT) asked a clinical reviewer to review the man's clinical care on their behalf. He was provided with all relevant medical documents to assist this review. The investigator and the clinical reviewer jointly interviewed two prison medical staff at HMP Wakefield and provided feedback to the prison liaison following the interviews.

11. The investigator contacted Her Majesty's Coroner for West Yorkshire Eastern District to inform him of the nature and scope of the investigation and request a copy of the post mortem report. Upon completion, the investigation report will be sent to the Coroner to assist his enquiries into the man's death.

12. A family liaison officer at this office wrote to the man's next of kin, his wife, to inform her about the investigation and invite the family to ask questions or raise concerns about the care of her husband whilst he was at Wakefield. She told her that the family did not wish to be involved in the investigation.

HMP WAKEFIELD

13. 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 730 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.

14. Wakefield has four residential wings, A, B, C and D, of which B houses prisoners remanded by the courts. The prison also has a healthcare centre, a segregation unit and a close supervision centre. The segregation unit provides temporary accommodation for prisoners who have become violent or disruptive, committed offences against prison rules or require protection if they are under threat from other prisoners. A close supervision centre is a unit for managing the most disruptive, challenging and dangerous prisoners. A number of outside agencies provide services including the local primary care trust (PCT) which provides healthcare.

HM Inspectorate of Prisons

15. Her Majesty's Chief Inspector of Prisons reports on all Prison Service establishments. The majority of inspections are pre-announced. The most recent inspection was carried out in December 2008.

16. In the introduction to the report of the inspection, published in February 2009, the former Chief Inspector said the prison had improved considerably over the previous five years and that she was pleased the improvement had been sustained. However, there was still work to do in aspects of safety and staff prisoner relationships and activities, including engaging offenders in treatment programmes.

17. In the main body of the inspection report, it was 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. The inspection team also noted that many "older prisoners and those with disabilities were dissatisfied with the support they received". Some disabled prisoners complained of excessive noise and bullying and intimidation, although they could find few comments in wing files to evidence such occurrences.

Independent Monitoring Board

18. Each prison in England and Wales has an Independent Monitoring Board (IMB). The Board consists of members of the local community who have full access to prisoners and all areas of the prison. IMB members undertake a variety of activities in prison including the consideration of complaints made by prisoners, visits to individual prisoners, reporting on the condition of the prison and examining the treatment prisoners receive in healthcare.

19. In their annual report for the period May 2009 to April 2010, the IMB made the following comments concerning healthcare at Wakefield:

> "The Primary Care Centre at Wakefield has now been in operation for a full year and is providing a comprehensive first contact service throughout the time that cells are unlocked. Medication is dispensed three times a day with up to 100 prescriptions being filled at each morning session. Seasonal immunisations are administered when appropriate. A GP [general practitioner] is available from 8 o'clock in the morning until 6 pm, with an average of 30 prisoners on call up each day for the treatment of acute conditions. The unit also provides a number of regular clinics for the management of chronic illnesses and the detoxification of drug misusers.
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> "The in patient unit contains 15 beds and is normally working to full capacity with mixture of elderly infirm chronic illnesses and psychiatric cases….overall the Health Care Unit provides a comprehensive service that meets the needs of the prison population."

Escort risk assessments

20. When prisoners are escorted to local hospitals, a risk assessment is completed which considers the risk posed to the public by the prisoner, their potential for escape and the likelihood of outside assistance. The assessment informs the decision about the number of escorting officers and the type of restraint to be used (single cuffs or a two metre long (closet) chain with a cuff at either end). It also determines the circumstances and the authority required for the restraints to be removed. The risk assessment is reviewed by prison managers each day that a prisoner is in hospital and amended when considered to be necessary.

Bed watch log

21. The bed watch log is the official prison record of events concerning an individual prisoner's time in hospital. Escort staff must record information on the log about any security issues that may arise, the identity of visitors, management checks and any interaction between staff and the prisoner. Staff also prepare a handover check list for the change of escort staff as well as a briefing about what happened during their watch.

Previous deaths at HMP Wakefield

22. This man's is the 35th death of a serving prisoner at HMP Wakefield since 2004 when the Ombudsman began investigating all deaths in prison custody in England and Wales. Although the number appears high it should be recognised that Wakefield prison holds a number of elderly prisoners, which inevitably brings about a higher incidence of deaths. There are no direct similarities between this death and previous deaths.

KEY EVENTS

23. On 5 March 2007, the man was sentenced to 15 years imprisonment at a Crown court, having been convicted of a number of serious sexual offences. He was 53 years old at the time. He was initially imprisoned at HMP Chelmsford before being transferred to HMP Wakefield on 26 June 2007. This was the first time he had been to prison.

24. The man settled into HMP Wakefield and, apart from a couple of warnings regarding his behaviour in education, he does not appear to have come to the attention of staff in any negative way. He did, however, cease visiting contact with his wife in January 2008, as he found visits to be too upsetting and emotional.

25. Amongst the papers provided to the investigator, was a typed, undated complaint made by the man concerning prisoner data loss by the prison department in August 2008. The complaint focussed on the loss of data on convicted prisoners which included identity, personal and family information and offences. He believed his details were amongst those lost and was seeking an admission of liability and compensation.

26. On 18 August, the Head of Security sent a note to the man advising him to contact the Home Office directly at an address provided specifically for prisoners who wanted to make a complaint about the data loss. His claim was rejected. He appealed against the decision to reject his claim and was again referred to the Home Office. The investigator discussed the matter with the litigation department at HMP Wakefield and confirmed that the man's appeal had been unsuccessful.

27. At a sentence planning meeting held in October 2008, it was noted that the man had not been subject to disciplinary proceedings or warnings and had shown good interaction with staff. He had also received a positive report from prison staff on his wing. His wing history sheets describe him as polite and respectful and noted that he had forged strong friendships with other prisoners.

28. Between May 2009 and May 2010, the man made complaints about several issues, including being overcharged when purchasing personal items; underpayment of wages for his work as an orderly in the education department and waiting time for an optician's appointment. He was given apologies, reimbursement and explanations, as appropriate.

29. On 4 November 2010, the man opted not to attend his sentence planning board. However, the board again commented on his positive conduct as an education orderly, commenting that he was reliable, compliant and always appropriate in his conduct.

30. The man's health was stable during this period. He had some minor health problems which required a referral to a podiatrist and dental treatment but was otherwise healthy.

31. The man began to experience health problems on 30 April 2011, when he reported chest pains. A nurse examined him and carried out an electrocardiogram (ECG), a test that measures the electrical activity in the heart. The results of the ECG were normal, however the nurse was concerned there may be complications and recommended an emergency ambulance be called.

32. The man was admitted to outside hospital, where he had an x- ray and another ECG. His results were normal, however, the doctor thought that he may have gastritis (inflammation of the stomach). He was discharged on 1 May and returned to Wakefield. The discharge summary from the hospital recommended that he should take Lansoprazole (for the treatment of excess stomach acid) for four days and return for an exercise tolerance test. The summary also noted that he refused to return for the test and a letter dated 1 June, from his cardiologist, confirms that he did not attend.

33. On 12 May, the man was examined by a nurse from healthcare and interviewed about his decision not to attend for his appointment. He signed a disclaimer on the same day stating he would not attend hospital. The nurse recorded the man's response as, "Due to being cuffed whilst out of establishment, refuses to attend any out patient appointment". (It seems that he later rescinded this as he attended subsequent hospital appointments.)

34. On 27 June, wing staff asked a nurse to see the man because he was vomiting and suffering from stomach cramps. He was monitored over the next two days but his condition did not improve. On the evening of 29 June, staff called the on-call doctor service for advice and were told that a doctor would visit the prison later that evening. At 8.05pm, a doctor from Local Care Direct (a community-based medical care provider) examined the man. The doctor was concerned that he could not hear any bowel sounds and recommended the man be admitted to hospital for further tests for possible diabetes.

35. Prior to taking the man to hospital, prison staff completed an escort risk assessment. He was assessed as high risk to the public but a medium risk to hospital staff, in respect of escaping and taking hostages. Such an assessment would normally require the use of handcuffs in transportation. However, on this occasion, he was restrained with an escort chain only during the ambulance journey to outside hospital. This was to allow paramedics to treat him in the ambulance. On arrival, he was admitted to the critical care unit, where he stayed for six days.

36. On 30 June at 10.10am, a nurse from the prison healthcare team rang the outside hospital for an update on the man. She was told that he was due to have an ultrasound scan (a painless test that uses sound waves to create images of organs and structures inside the body) and a computed tomography (CT) scan (a diagnostic procedure that uses special X-ray equipment to create cross-sectional pictures of the body).

37. The man's CT scan identified that he had developed necrotising pancreatitis. The ultrasound scan showed that he also had gallstones and, as explained by the clinical reviewer, the gallstones had travelled through his pancreas causing large scale tissue destruction and leakage of enzymes into surrounding tissue. This is known as necrotising pancreatitis.

38. The man was treated in hospital with nutritional support and antibiotics and gradually improved. On 8 July, a nurse from the prison rang the outside hospital and was told that the man had been diagnosed as diabetic. He was being encouraged to manage his insulin use and, if this was successful, it was thought he could be discharged in a day or so.

39. On 13 July, the man was discharged to HMP Wakefield's healthcare centre with the plan to return after a month for further CT scans and the possibility that he would need to have his gall bladder removed. Escort officers noted that he was able to walk unaided into the prison healthcare centre on arrival at the prison. He told healthcare staff that he was insulin dependent, which he was able to self-administer and that he was stable. A doctor working at the prison wrote on the man's medical notes that he appeared to have a good understanding of his illness and wanted to return to his wing as soon as possible.

40. The prison doctor noted, on 15 July, that the man was pale and had a temperature. He also noted that the man continued to suffer from lower abdominal pain but was starting to regain his appetite. He recommended that the man be observed in the prison's inpatient department over the next few days. The next day, he refused to take his prescribed paracetamol and tramadol (a painkiller) as he believed they caused his constipation.

41. On 18 July, a second prison doctor wrote on the man's medical notes that necrotising pancreatitis provoked by gallstones appeared to be the full diagnosis. Over the next few days, he was reviewed and checked regarding his diabetes and screened for depression by a nurse. She wrote that he was appropriate in mood and had accepted his diagnosis. She also commented that he appeared to be taking responsibility for his diagnosis. During interview, the investigator and clinical reviewer explored the reason for the mental health screening. The nurse explained that there is a high incidence of depression amongst people with diabetes.

42. A specialist diabetic nurse from outside hospital visited the man on 25 July, in order to review his response to the insulin treatment. She noted that his blood glucose levels were raised and recommended a slight increase in his insulin dose. A prison doctor saw the man the same day and amended the insulin in line with the nurse's recommendation.

43. The next day, 26 July, a prison doctor wrote in the man's medical notes that a line had been drawn through his prescription for Creon (a digestive enzyme supplement) suggesting the prescription had been cancelled. There was no explanation about this on his medical file and the doctor rectified the matter immediately ensuring no break in his medication.

44. At 6.13am on 28 July, a nurse reviewed the man and noted that his blood sugar level had been steadily climbing over the previous week. He told her that his insulin had recently been increased. She noted that he may well need a further increase to alleviate the problems associated with his pancreatitis. Later that day, he was seen by a healthcare officer who noted that he was feeling more comfortable but still required laxatives. He still refused to take paracetamol and tramadol.

45. Towards the end of July, the man began to complain of lethargy. Blood tests were ordered which indicated low levels of sodium which can cause muscle cramps and dehydration. The clinical reviewer comments that this might have been a side effect of one of the man's prescribed drugs, omeprazole. This was replaced with a new daily prescription, effective from 1 August, for two tablets of ranitidine, a drug used to treat excess stomach acid.

46. A prison doctor telephoned a consultant to discuss the man's symptoms. A plan was agreed for the following day whereby blood and urine tests would be taken and then transported by taxi to outside hospital the next day for analysis. The doctor received the results of the man's urine tests on 2 August. He noted on the medical record that the results were abnormal but not unexpected.

47. On 3 August, the man was reviewed by a prison doctor. She noted his blood pressure and temperature were stable but that he continued to feel unwell. The following day, she spoke with a consultant at outside hospital, who advised that he be given sodium supplements and also that further blood tests should be taken. The consultant agreed to see the man when he was next in the prison in four days time.

48. At 6.45pm on 4 August, a nurse asked for an outside general practitioner (GP) to visit the prison to see the man. She had become concerned about an increase in his heart rate and thought this warranted further investigation. The GP arrived at around 8.34pm, prescribed an antibiotic and recommended that he be monitored overnight. Unfortunately, the GP's name is not recorded on the medical record. This is an issue that the clinical reviewer has identified in his report.

49. The man's condition continued to cause concern and, on 5 August, his pulse became rapid and his blood pressure had fallen. He was taken by ambulance to an outside hospital's accident and emergency department where he was kept in the surgical assessment unit until he could be transferred to another hospital to have his pancreas removed. He was restrained with an escort chain whilst at hospital.

50. The man was transferred to a further outside hospital on 7 August. The following day, a member of staff from the prison healthcare team rang the hospital and was told that, although he was listed for surgery, the man was under observation to determine whether an operation was needed.

51. At 12.20am on 9 August, an officer was on bed watch duty. He contacted the prison and asked for permission to remove the escort chain, to allow the man to receive treatment in the High Dependency Unit. At 12.30am, a Governor at the prison gave the officer permission to do so. The restraints were not used again after this time.

52. The following day, 10 August, an officer observed the man telling hospital staff that he did not want his family to be informed that he was about to undergo surgery. Later that day, he had his gallstones and pancreas removed.

53. On 11 August, the man was examined by the surgeon who carried out his operation. The officer on bed watch duty wrote in the bed watch log that the man's chances of survival were "50/50". At 10.00am the same day, a Governor and the healthcare manager from the prison visited the man. The healthcare manager noted that he had a bowel perforation, was sedated, ventilated and receiving maximum support. They spoke to his consultant who told them that the man was very ill and unlikely to survive

54. The man died at 11.52am shortly thereafter. The cause of death given at the post mortem was:

    Multiple organ failure
    Generalised sepsis (bacteria in the blood)
    Necrotising pancreatitis
    Cholelithissis (gallstones)

55. Notices were placed around the prison to inform staff and prisoners of the man's death. He had formed a close friendship with another prisoner who was very upset at his death. His friend received a personal visit from a Governor in his cell and was appreciative of the care and attention shown to him. The Governor also activated HMP Wakefield's death in custody contingency plans. This included meeting with the staff who were on bed watch at the hospital when the man died to ensure they were properly supported.

56. A Governor at the prison was appointed as the prison family liaison officer. She contacted the man's nominated next of kin, his wife, to inform her of her husband's death. His wife declined any further contact with the prison. A legal executor was appointed to manage the man's estate and HMP Wakefield organised and paid for his funeral.

ISSUES

The man's clinical care

57. A clinical reviewer was commissioned by Wakefield Primary Care Trust to review the medical care given to the man in prison custody. His clinical review details the care the man received at Wakefield as well as the manner in which prison staff handled the arrangements for treatment in outside hospitals. He considered whether it was equitable to that which he would have expected to receive in the community.

58. The clinical reviewer highlighted the quick and appropriate action by staff when the man presented with serious symptoms which enabled him to be diagnosed and given shared treatment within the prison and outside hospital. Staff, internally and externally, worked closely, consulting each other as necessary. Notably, after a diagnosis of diabetes during an admission to hospital, staff admitted him to the inpatient unit of the prison to ensure he was managing the injection of his insulin and gave him a full mental health assessment because of the incidence of depression amongst diabetics. This screening was regarded as good practice. Staff continued to monitor him closely as his condition deteriorated and arranged for him to be taken to hospital when his condition became severe.

59. The clinical reviewer was satisfied that, overall, the care the man received was more than equitable to expectations in the community and, on the basis of the evidence, we concur with this view.

60. The clinical reviewer also commented that the healthcare records were comprehensive and clear and record keeping was good. However, he identified a significant instance in which the details of an emergency doctor were not recorded. Although there was no negative impact, the importance of precise record keeping cannot be overlooked as it underpins medical accountability. We therefore make the following recommendation:

The Head of Healthcare should ensure that when a prisoner is seen by an external clinician who does not have computer access to the prisoner's medical records, the accompanying member of prison healthcare staff records the name of the person and other relevant details alongside the consultation on the computer system.

Use of restraints, risk assessments and bed watch procedures

61. During hospital consultations, the man was accompanied at all times by two officers. Although the risk assessment determined that his level of risk required handcuffs for visits outside the prison, managers applied discretion in the light of his condition and permitted an escort chain rather than handcuffs. Officers responded to the man's deteriorating health by ensuring that issues were effectively communicated to the prison, including requesting permission to remove restraints to allow medical staff to treat him. His escort chain was removed for the last time on 9 August when his condition declined to the

extent that he required treatment in the High Dependency Unit.

62. We consider that risk assessments were carried out appropriately and note the sympathetic and proportionate use of restraints. We are also satisfied that they were removed at a point which allowed the man dignity in his final days. We found good evidence of timely communication between escort staff and the prison. Bed watch logs and person escort records are legible and appropriate in terms of language and maintained to a good standard.

CONCLUSION

63. The man was 53 years old when he was sent to prison for the first time. He appears to have settled into prison life easily and proved to be a polite and cooperative prisoner. He was employed in the education department and seems to have been highly thought of during his time HMP Wakefield. He was also confident and competent in using the prison's complaints procedure effectively.

64. In the first few years of his sentence, apart from minor chiropody and dental complaints, the man was healthy and does not appear to have had any serious medical ailments. After reporting chest pains in April 2011, his health deteriorated quite quickly and his condition was managed by the prison healthcare team and a local hospital. He then became seriously ill and was diagnosed with necrotising pancreatitis, a rare and life threatening condition. He was admitted to hospital and subsequently had surgery to remove his pancreas. Unfortunately he did not recover. He died in hospital shortly thereafter.

65. The clinical reviewer described the care given to the man as excellent and, "… more than equitable to that which he could have expected in the community." However, he highlighted an important oversight in record keeping. We agree with his conclusions about the standard of care and have made a recommendation in respect of the omission in record keeping.

RECOMMENDATION

The Head of Healthcare should ensure that when a prisoner is seen by an external clinician who does not have computer access to the prisoner's medical records, the accompanying member of prison healthcare staff records the name of the person and other relevant details alongside the consultation on the computer system.

Accepted

Access to S1 for visiting Doctors etc. is via the senior nurse on duty. They log onto the system and the visiting professional makes the entry and notes in that entry their name and any other relevant information. This has been agreed by the Clinical Governance team as best fit.

HMP Wakefield will soon commence the use of 'Smart Card' log on to the system and will review this process as part of that change.