PRISONS AND PROBATION OMBUDSMAN for England and Wales

Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at hospital, while in the custody of HMP Wakefield in February 2013

Our Vision

‘To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’

This is the report into the death of a man, a prisoner at HMP Wakefield. He died from heart disease at hospital in February 2013. He was 77 years old. I offer my condolences to his family and friends.

A clinical reviewer was appointed to conduct a clinical review of the standard of healthcare the man received at HMP Wakefield.

The man had a number of chronic medical conditions when he first arrived in custody, including heart and kidney disease, a respiratory condition and diabetes. After his health deteriorated in December 2012, he was admitted to the prison's healthcare unit as an inpatient. On 24 February, he was found slumped in his cell and was taken to hospital where he was pronounced dead shortly afterwards at 12.55pm.

The clinical reviewer concludes that the man received appropriate care at Wakefield and staff responded efficiently to his sudden collapse. Overall, I am satisfied that he received satisfactory care at Wakefield that was equivalent to what would be expected in the community.

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 **November 2013**

CONTENTS

SUMMARY

1. The man was sentenced to 11 years imprisonment on 28 December 2008 and was taken to HMP Lincoln. It was his first time in prison.

2. He was identified as a diabetic with heart, respiratory and kidney disease. He was 73 years old and obese, with poor mobility. Throughout his time in prison, he had regular blood tests and was seen by specialists to manage his chronic medical conditions.

3. On 17 March 2010, the man transferred to Wakefield to access offending behaviour programmes. His medical history was reviewed and arrangements were made for him to have assistance with his day to day living, physiotherapy to address his restricted mobility and attend regular diabetes and respiratory clinics.

4. Over the next two years, the man's health deteriorated and he went to hospital several times after falling in his cell and after suffering shortness of breath. After a fall on 19 December 2012, he was admitted to the inpatient unit when he got back from hospital because his health could not be effectively managed or monitored on the wing. A nursing care plan was opened on 25 December.

5. The man's health stabilised for a short time, but he preferred to sleep in a sitting position on the edge of his bed which caused him to fall several times.

6. The man complained of stomach pains during the night of 23 February 2013, and nurses increased their observations. Around 11.25am he was found with laboured breathing, slumped on his toilet. Healthcare staff requested an emergency ambulance and carried out cardiopulmonary resuscitation (CPR). Paramedics arrived and he was taken to hospital. Despite further resuscitation attempts in hospital, he was pronounced dead at 12.55pm.

7. The clinical reviewer concludes that the man received a satisfactory level of care in custody. Healthcare staff responded promptly to his collapse.

THE INVESTIGATION PROCESS

8. The Ombudsman was notified of the man's death in February 2013. The investigator issued notices informing staff and prisoners of the investigation and asking anyone with any relevant information to contact the Ombudsman's office. No responses were received.

9. The investigator obtained copies of the man's relevant medical and prison records. She met a Detective Inspector of West Yorkshire Constabulary on 3 April 2013, who confirmed that there were no suspicious circumstances. On 18 April 2013, she visited Wakefield's healthcare unit and spoke to the prison's family liaison officer.

10. The local PCT appointed a clinical reviewer to review the man's clinical care in prison.

11. HM Coroner for West Yorkshire Eastern District was informed of the investigation and a copy of the report has been sent to him.

12. One of the Ombudsman's family liaison officers contacted the man's daughter to explain the purpose of the investigation. She did not have any specific issues for the investigation to consider. His family received a copy of the report in draft before it was finalised.

HMP WAKEFIELD

13. HMP Wakefield is one of eight high security prisons in England and Wales. It holds 750 Category A, B, and high security remand prisoners. There are four main residential wings, a healthcare centre, segregation unit and close supervision centre. The man was a Category B prisoner and lived on C wing. All cells are single occupancy.

Her Majesty's Inspectorate of Prisons (HMIP)

14. HMIP last inspected Wakefield in May 2012. The report found that the healthcare facilities had significantly improved since the last inspection, and there was a good skill mix among nurses. Older prisoners and those with lifelong conditions were well supported.

Independent Monitoring Board (IMB)

15. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. In its most recent annual report, the IMB noted that healthcare provided a comprehensive service that met the needs of the population. In particular, the IMB found that care for diabetic prisoners had been improved by the introduction of a specialist diabetic clinic, run with a consultant from a hospital.

Previous deaths at Wakefield

16. There were 16 deaths from natural causes at Wakefield in the two years before the man's. There have been two more since his death. There are no significant similarities between the findings of the investigations into those deaths and those in this report.

KEY EVENTS

HMP Lincoln

17. The man was sentenced to 11 years imprisonment on 28 December 2008 and taken to HMP Lincoln. He had not been to prison before. At his initial health screen, he told a nurse that he suffered from heart disease, angina, respiratory disease, kidney disease and type two diabetes, for which he was prescribed daily insulin injections. He was obese and had poor mobility. He was assessed by a doctor and his medication was reviewed. Over the next two years, he attended regular outpatient appointments with a cardiologist at hospital.

HMP Wakefield

18. On 17 March 2010, the man transferred to Wakefield to access offending behaviour programmes. At his initial health screen at Wakefield, his medical history was recorded and his medication was reviewed. On 22 March, his disability needs were assessed and he was allocated a carer (a prisoner who supports disabled or elderly prisoners by assisting with their day to day living). He was allocated a cell near the wing office and the kitchens so he could collect his meals and easily access the showers.

19. The man settled into the wing routine and kept in regular contact with his family. His personal hygiene was noted to be poor, because of his poor mobility and because he was uncomfortable showering with other prisoners because of his age and disabilities. Officers arranged for him to shower at different times from other prisoners to allow him more time and privacy.

20. The man attended monthly diabetes clinics and frequently attended the healthcare centre for treatments and consultations. His medication was reviewed monthly for repeat prescriptions and he attended a special respiratory clinic in the prison. A physiotherapist saw him regularly in 2012 and encouraged him to be more mobile. He walked around the wing with a walking stick, but needed a wheelchair to get to other areas of the prison.

21. On 4 April 2011, the man was waiting to go to a hospital appointment when he started struggling to breathe. He was examined by a nurse, then refused to go to his appointment despite encouragement from staff. He signed a disclaimer form about his refusal to attend the hospital.

22. A respiratory consultant who holds regular clinics at Wakefield saw the man on 9 September. He told the consultant he had breathing problems and was unable to sleep. The doctor diagnosed sleep apnoea (interrupted breathing during sleep) and told him he would request a continuous positive airway pressure (CPAP) mask for him to use at night. (This mask covers the face and assists the flow of air into the air passage way. CPAP masks are ordered by doctors via the NHS and a specialist nurse has to make an assessment.) It is not recorded exactly when he received his mask and there was a long

wait for a specialist nurse to assess him, but in December 2012 it was noted in his medical record that he would not wear the mask.

23. Healthcare staff were called to the man's cell at 1.42am on 18 July 2012, when he complained to the night officer that he had chest pain. After an electrocardiogram (ECG, to monitor the heart rhythm) he was taken to the emergency department at hospital, where he remained until 21 July.

24. Three weeks later, the elderly prisoner assessor carried out a full assessment of the man's physical and mental health. The nurse noted that he was still having mobility problems and he was concerned about short term memory loss, which was associated more with his age than illness. No adjustments were made following this assessment. He was seen by healthcare staff at least weekly for treatments, to monitor his physical and mental health.

25. The man was taken to hospital on 19 December, after falling in his cell. He returned to the prison six hours later and was admitted to the healthcare inpatient unit for observation. It was written in his medical notes that he did not use his CPAP mask and he sat on the edge of his bed to sleep, which caused him to fall. Healthcare staff advised him to lie down to sleep and use his mask, but he would not do so.

26. On 25 December, a nursing care plan was added to the man's medical notes. Healthcare staff were instructed to take regular blood pressure and temperature checks, and encourage him to move around.

27. During the first ten days of January 2013, the man moved around more and his personal hygiene improved. On 11 January, he was happy to return to the wing from the inpatient unit. He was allocated carers to assist him in his day to day living, but he fell in his cell the next day and returned to the inpatient unit. He was again told not to sleep on the edge of his bed in a sitting position as this was the cause of his fall.

28. Over the next five weeks, the man remained in the inpatient unit. He walked short distances, was able to shower and socialise with other patients. He continued to sleep in a sitting position and experienced sporadic memory loss and disorientation.

29. At 6.21am on 23 February, a nurse recorded that the man had complained of stomach pain after taking his medication the previous evening. Throughout the night, the nurse kept close observations on him. Another nurse wrote in the medical record at 2.52pm, that healthcare staff should increase their observations of him as he was still feeling unwell.

24 February

30. At 11.25am the next day, a Healthcare Officer heard a call for help from the man's cell and found him slumped on his toilet, and his breathing was laboured. The officer called for assistance and a nurse responded, taking with her the emergency equipment bag. His blood sugar level was checked

and it was high. A Healthcare Principal Officer heard the nurse's call for help so also went to the cell.

31. The nurse asked for an ambulance at 11.27am. The staff moved him onto the floor and two nurses started cardiopulmonary resuscitation (CPR) and he was given oxygen. A defibrillator was attached to his chest, but the machine indicated that no shock was required. The healthcare staff continued with CPR until paramedics arrived at 11.45am. The paramedics attached their defibrillator and gave shocks twice to help establish an effective heart rhythm.

32. The man was taken to the ambulance on a stretcher at 12.25pm. He was escorted to the hospital by two officers but handcuffs or other restraints were not used. On arrival at hospital he was taken to a resuscitation room in the Accident and Emergency Department. Despite attempts by hospital staff to resuscitate him, his death was confirmed at 12.55pm.

Family Liaison

33. A family liaison officer at Wakefield was informed of the man's death. The officer and two colleagues travelled to Lincolnshire that afternoon to tell his daughter of her father's death.

34. The funeral service was held on 19 March. The family liaison officer and an operational manager attended. The service was conducted by a chaplain at Wakefield. The family also attended a memorial service held in the prison's chapel. Funeral expenses were offered to his family in line with national guidance.

Support for staff

35. A full staff debrief was held following the man's death for those involved in the emergency response and they were made aware of the support available.

Prisoner support

36. Prisoners on D wing were notified of the man's death by notices and information from wing staff. Those prisoners close to him received support from wing staff and members of the chaplaincy. They were invited to participate in his memorial service and meet members of his family.

ISSUES

37. The clinical reviewer's review concludes that the medical care that the man received in prison was appropriate and equivalent to the care he could have expected in the community. The clinical reviewer is satisfied that the response to his collapse was prompt and appropriate.

Clinical care

38. The man was an obese, elderly man with multiple health conditions. The clinical reviewer notes that his diabetes was well monitored, including eye screening and foot care. He was regularly assessed and received treatment from a physiotherapist for his mobility. A respiratory consultant saw him, but recorded that he often did not cooperate with attempts to improve his respiratory condition. For example, he did not wear his continuous positive airway pressure mask provided to help his breathing and sleeping.

39. The clinical reviewer notes that healthcare policies and procedures for the man's care were in keeping with current standards and his medical record was comprehensive and clear.

The man's falls

40. The man had many falls, apparently because he slept in a sitting position on the edge of his bed. There are well-documented efforts to advise him not to do this, and healthcare staff often laid him down in his bed only to find he would revert to a sitting position a short while later.

41. The clinical reviewer notes that falls are the most common damaging incident for older people in hospitals and care homes and Wakefield has an ageing population. There has to be a balance between promoting independence and considering risk. Ongoing assessments of eyesight, medication management and physical health needs affect mobility and balance. The man's balance and mobility was regularly measured by assessments and physiotherapy.