PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man at HMP Wakefield in May 2012

Report by the Prisons and Probation Ombudsman for England and Wales

January 2013

This is the report of the investigation into the death of a man, who was found unconscious in his cell at HMP Wakefield in May 2012. He was 66 years old. The post mortem found his cause of death was chronic obstructive pulmonary disease [1](COPD) and ischaemic heart disease[2]. I offer my condolences to his family and friends.

A review of the man's medical care in prison was commissioned by the local PCT and carried out by a clinical reviewer. HMP Wakefield cooperated fully with this investigation.

The man had been in prison custody since September 1999 and had suffered from poor health for some years, with COPD, emphysema[3] and shortness of breath. He was under the care of the prison's respiratory consultant and his conditions were generally well managed.

While the use of restraints during a hospital visit shortly before the man died does not appear to have been fully justified by a risk assessment, overall I am satisfied that he received a good standard of care during his time at the prison. His family also received commendably good support from the prison's family liaison officer, both during his illness and after his death.

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 **January 2013**

[1] Chronic obstructive pulmonary disease (COPD) is an umbrella term for people with chronic bronchitis**,** emphysema, or both. With COPD the airflow to the lungs is restricted (obstructed). COPD is usually caused by smoking**.** Symptoms include cough and breathlessness.
[2] Ischaemic heart disease is a disease of the blood vessels supplying the heart muscles with oxygen that's severe enough to cause temporary strain on the heart or even permanent damage to the muscle.
[3] Emphysema is a long-term, progressive disease of the lungs that primarily causes shortness of breath.

CONTENTS

Summary

The investigation process

HMP Wakefield

Key events

Issues

Recommendations

SUMMARY

1. The man was remanded to prison in 1999. In January 2001 he was sentenced to life imprisonment and arrived at Wakefield in April 2002.

2. In June 2002, he was diagnosed with Chronic Obstructive Pulmonary Disease (COPD). The disease causes a gradual decline in a person's health, never fully recovering their previous level of health and wellbeing after each exacerbation

3. In March 2009, he was issued with a nebuliser[4] during an acute exacerbation of COPD and was referred to the respiratory consultant at HMP Wakefield. (An acute exacerbation of COPD is a sudden worsening of COPD symptoms that typically lasts for several days.) He was later diagnosed as having Severe COPD, emphysema and panic attacks.

4. The man's illnesses were generally well controlled but during 2011 and 2012 he experienced frequent periods when his conditions worsened. On the 3 May 2012, he was found struggling to breathe. He was taken urgently to hospital where his condition settled. He was discharged later the same day.

5. The next day he said he felt better. There are no further records of health care interaction until he was discovered collapsed in his cell. Healthcare staff attempted resuscitation but this was unsuccessful.

6. The investigation found that staff were responsive to the man's increasing needs and care was delivered sympathetically. We make one recommendation about risk assessments for the use of restraints. Overall, we consider he received a good level of care and his family was well supported during his illness and after his death.

[4] A nebuliser is a device used to administer medication in the form of a mist inhaled into the lungs.

THE INVESTIGATION PROCESS

7. The investigator visited Wakefield on 10 May 2012. He met relevant staff and visited the wing and cell where the man died. He was provided with copies of the prison and health records and other documentation relating to his time in custody. Notices were issued to staff and prisoners at Wakefield informing them of the investigation and inviting them to contact the investigator. As a result the investigator interviewed two prisoners.

8. A review of the clinical care the man received at Wakefield was undertaken on behalf of the local PCT by a clinical reviewer.

9. The investigator carried out interviews with prison and healthcare staff in July 2012. The Governor was provided with verbal and written feedback following the interviews.

10. HM Coroner for Wakefield was informed of the investigation. A copy of this report will be sent to him to assist his enquiries.

11. One of the Ombudsman's family liaison officers (FLO) contacted the man's family shortly after his death. She explained the investigation process. The family had no specific issues they wished the investigation to address.

12. The family received a copy of the draft report as part of the consultation period. They had no further comments to make about the investigation.

HMP WAKEFIELD

13. HMP Wakefield is one of eight high security prisons in England and Wales. It holds around 750 Category A, B, and high security remand prisoners. There are four main residential wings, a healthcare centre segregation unit and close supervision centre.

Her Majesty's Inspectorate of Prisons (HMIP)

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

15. The report noted that some of the health services accommodation was not fit for purpose, but the main health care centre was well resourced. Some prisoners waited too long for routine GP appointments. Emergency resuscitation equipment including automated external defibrillators were located around the prison and regularly checked. A physiotherapist had been appointed and assessed prisoners who used walking aids and saw patients on referral. There was a policy for older prisoners and work to meet their specific needs was being developed, but many older prisoners told inspectors they did not get enough support. Some cells had been adapted for prisoners with mobility difficulties.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who monitor day-to-day life in the prison to help ensure that proper standards of care and decency are maintained.

17. In their annual report for the period ending 30 April 2011, the Board reported that, overall, the health care unit provided a comprehensive service that met the needs of the prison population to a level equivalent to that available to the general public.

Previous deaths at HMP Wakefield

18. There have been 6 deaths from natural causes at Wakefield since the beginning of 2012, reflecting the number of older prisoners held at Wakefield. Although there are no direct similarities between the death of the man and these previous deaths, this report identifies the need for more considered risk assessments for the use of restraints when taking older and infirm prisoners to hospital, a matter we have identified before at Wakefield.

KEY EVENTS

19. The man was born in Chelmsford. He had a number of convictions for offences committed over a 41 year period and had served several custodial sentences.

20. On 16 September 1999, the man was remanded to HMP Bedford at which time there was no reference to any respiratory difficulties in his medical record. He was noted to smoke between ten and 15 cigarettes a day.

21. He was sentenced to life imprisonment on 25 January 2001, with a minimum period to serve of eight years and 233 days, before he could be considered for release.

22. In August 2001, the man was examined by a hospital consultant after he had reported symptoms including small amounts of frothy white vomit. No significant abnormality was found and his symptoms were related to sputum production. The following month he was prescribed a salbutamol inhaler for asthma.

23. After spending some time in a number of different prisons, he transferred to Wakefield on 9 April 2002. During his reception health screen it was noted that he was concerned about repetitive cough and cold symptoms. Following investigations, he was diagnosed with COPD in June 2002. One of his symptoms was breathlessness on exertion.

24. The man was advised to stop smoking on several occasions and referred to the prison's clinic to help people stop smoking. In 2006, it was noted that he had emphysema and bronchitis. Later, he also experienced coughing and wheezing.

25. In March 2009, he was given a nebuliser to use during an acute exacerbation of COPD and was referred to the respiratory consultant at the prison. In April, he had a comprehensive respiratory assessment by a respiratory consultant. His diagnosis was confirmed as severe COPD, emphysema[5] and panic attacks. Later that year, his diagnosis was discussed with him by a hospital respiratory consultant. The consultant attended the prison every Friday to run clinics and the man was under his care. The consultant provided education and instruction for breathing control and relaxation to help him manage his condition.

26. In 2010, the man refused pulmonary rehabilitation[6]. He received appropriate medication for the stage of disease and symptoms he experienced including a combination long acting beta agonist[7] and

[5] Emphysema is a long-term, progressive disease of the lungs that primarily causes shortness of breath.
[6] Pulmonary rehabilitation is an exercise and educational programme designed to help patients with limiting symptoms due to respiratory conditions.
[7] Long-acting beta agonists relax the muscle bands that surround the airways (bronchodilation) and allow you to breathe in and out more easily.

inhaled steroid to reduce risk of exacerbation. He was compliant with his medication. His COPD remained severe in 2011 and, although it was generally well controlled, he had several periods when his condition worsened. He continued to be under the care of the respiratory consultant.

27. A nurse told the investigator she regularly assessed the man. She said that he could usually manage general activities in a small area, but when he was unwell, he was mainly confined to his cell. Most of the time he was able to care for himself but, when he was not well, he had a lot of friends on the wing who helped him. Prison and healthcare staff were there if needed. He also had an assigned prisoner carer who assisted him with collecting his meals and cleaning his cell.

28. As a nurse prescriber she responded when the man experienced an exacerbation of his symptoms. She would prescribe antibiotics and steroids to assist him until he was assessed by a doctor. She said his condition never got to the point where he was debilitated or dependant.

29. The B Wing Senior Officer (SO) said that because of his illness the man was given a cell on the ground floor landing close to the wing office. Most facilities he needed were on this landing. His cell was kept open throughout the core periods of the day making it easier for staff to monitor him. He was able to leave his cell whenever he wanted to, although he did not regularly go far because of his ill health. He was able to walk and collect his breakfast, albeit slowly. The SO said he preferred to be on the wing because he had lot of friends there.

30. The SO said because of the man's condition and his refusal to stay in the healthcare centre, measures to support him were put in place. He was allocated a carer who helped clean his cell and collect his meals when he was not able to. The prisoners in neighbouring cells told the investigator they checked on him daily. Prisoner A said that prisoners were extremely supportive of him and would alert prison officers when his health declined. He had also told Prisoner A that he preferred to be on the wing rather than the healthcare centre, as he wanted to stay with his friends.

31. In November 2011, a nurse noted that the man's shortness of breath and cough had increased in recent months. A review of his medication was undertaken. It was noted he was also still smoking. He was given a flu vaccination.

Events during 2012

32. On 20 January, the man had an acute episode of shortness of breath. A respiratory consultant examined him, who continued to deteriorate and an ambulance was called.

33. As part of the Prison Service's duty to protect the public prison escort staff routinely use restraints when prisoners are taken out of the prison. An individual risk assessment should be completed on each occasion. The assessment will consider the offences and the risk of further offending (rated as low, medium and high) while out of the prison, as well as the prisoner's health and mobility. The man's risk to the public was considered high. His risk to hospital staff, hostage taking or escape, were considered as medium. There was no medical objection to the use of restraints noted on the risk assessment. He was seriously ill and unconscious. It was decided that no restraints were to be applied to him at that time.

34. An officer was appointed as a family liaison officer (FLO). He telephoned the man's brother and told him of the seriousness of his brother's condition. His brother had not seen him for over 20 years, but said they spoke on the phone monthly. He was unable to travel because of health reasons but asked to be kept updated.

35. The prison received regular updates from the hospital. The man had a "cardiac episode" on 21 January but then made steady progress, and was discharged back to Wakefield on 26 January.

36. The hospital's discharge letter said that he had had respiratory arrest[8] due to exacerbation of COPD. He was on steroids and antibiotics. He was described by healthcare staff as alert and cheerful. As he experienced shortness of breath, he was encouraged to use a wheelchair and admitted to the healthcare centre for observation and assessment.

37. The FLO had spoken to the man's brother daily. As he was improving, the FLO told the man's brother that he would contact him should his health deteriorate again.

38. On 30 January, after continued improvement, and in line with the man's wishes, he was moved back to his cell on the wing. Wing staff were asked to check him regularly and contact healthcare staff if needed.

39. The respiratory consultant saw him in his Friday clinic regularly. He continued to improve and by 24 February had given up smoking and been able to walk unaided and play snooker on the wing. During March, there were no reported instances of him having any adverse health problems.

40. On the evening of 3 April (approximately 6.45pm), a nurse was called as the man was breathless. He was given erythromycin[9] 250mg gastro-

[8] Respiratory Arrest is caused by airway obstruction, decreased respiratory drive, or respiratory muscle weakness.
[9] Erythromycin is used to treat and prevent infections affecting the mouth, intestine, urinary tract, respiratory-tract and skin.

resistant tablets (to be taken 4 times/day) and prednisolone[10] 5mg tablet to take immediately. His observations were recorded as blood pressure 141/70, pulse 87, respiratory rate 24 and oxygen saturation level of 97%.

41. As no prison doctors were on duty, the out of hours GP service was contacted and arrived at the prison within approximately 30 minutes. By this time, having used his nebuliser and taken the erythromycin tablet, the man said he felt better than he had earlier. The GP instructed that his dose of erythromycin should be doubled to 500mgms and prescribed a course of prednisolone. These were to be taken alongside his normal use of the nebuliser.

42. On 19 April, a doctor saw him, who was initially very short of breath but this improved quickly. His respiratory rate was raised and the doctor noted he was tachycardiac[11]. He said that he experienced persistent shortness of breath on minimal exertion. He also said he had not used his nebuliser that day. The doctor advised him to use his nebuliser medication every four to six hours. He also prescribed further prednisolone. The doctor noted that he would a need palliative care assessment at some stage.

43. By 30 April, there had been some improvement and the respiratory consultant noted the man could climb up to 10 steps on a good day. His observations were also good and the doctor noted that there was no current need for oxygen therapy. He advised him to use his nebuliser four times a day and he would be reviewed in three months time.

44. After his diagnosis of COPD, the man was seen regularly by healthcare staff and the respiratory consultant. His condition and the treatment he received to manage it, were fully explained to him. He was aware that his health would deteriorate and told healthcare staff on occasions that he did not expect to live into the next the week.

Events during May 2012

45. On the morning of 3 May, the man experienced severe breathing problems. He was examined by a doctor, who subsequently requested an ambulance. He was taken to hospital. As on his previous visit to hospital, no medical objection to the use of restraints was recorded on his risk assessment. His risk to the public, to hospital staff and of escape remained assessed as medium. On this occasion an escort chain restraint was applied (a 1.8 metre length of chain with handcuffs at each end attached to the prisoner and a prison officer).

46. By midday he had settled and nothing abnormal had been found on his chest X-ray. He was advised to continue his normal treatment regime and was discharged back to the prison after a few hours.

[10] To help control inflammatory and allergic conditions such as asthma, rheumatoid arthritis and colitis.
[11] An excessively rapid heartbeat, typically regarded as a heart rate exceeding 100 beats.

47. The man arrived back at Wakefield around 2.00pm. He was breathless when he walked from the escort vehicle to the prison reception where he was examined by a nurse. He was asked to stay in the healthcare centre so that he could be monitored more closely by nursing staff. He refused, wanting to return to his wing and cell and signed a disclaimer to this effect.

48. A nurse went to see him later that day, around 5.45pm. His mobility was limited, his oxygen saturation level was recorded at 93% and he still complained of feeling breathless. He was supported by other prisoners on the wing and prison staff checked on him regularly.

49. Healthcare staff checked on him on 4 May. He said he felt relaxed and would contact prison and healthcare staff if he felt unwell. This was the last entry in his medical record until 8 May.

50. Prisoner B was with the man just before all prisoners were locked into their cells at about 7.00pm. He described him as not looking well, although he had seemed this way for some time. No concerns about him were raised during the evening or night.

51. The following morning, an officer started duty at around 6.35am. He received a handover from the night duty officer, who had completed a roll check before 6.00am. He described the night to the officer as quiet with no problems to report.

52. The officer began his roll check after this. When he got to the man's cell, he turned on the night light, opened the flap and shouted his customary good morning to him. He saw he dressed and sat on his bed. Fellow prisoners and staff told the investigator that this was not unusual for him, as he usually got up and dressed early. The officer initially moved on to check the occupant in the next cell, but returned immediately to the man's cell as he realised that he had not responded. .

53. He put the main cell light on and saw he was sat on his bed with his back against the wall. The officer described the position as looking slightly unnatural. He was not quite upright, leaning to one side and appeared unconscious. He again shouted his name and knocked on the cell door, but received no response. The officer believed he was dead and radioed the prison's communication room to request medical assistance, using emergency code blue. (This code indicated that the emergency was a life threatening situation and healthcare is also required.) This was timed on the Control Room Log as 6.53am.

54. The officer waited outside of the cell for healthcare staff to arrive. When asked at interview why he did not go into the cell, he said that he could not open the cell door without another colleague present.

55. It took Nurse A about two minutes to get to B wing. Nurse B stopped to collect emergency equipment on the way. The officer told the nurse that he believed emergency equipment would probably not be needed.

56. Nurse A told the investigator that he would have expected the officer to have already opened the cell, gone in to check on his well being and possibly started Cardio Pulmonary Resuscitation (CPR). He told the officer to call an ambulance. The officer unlocked the cell and went in with the nurse. He also contacted the control room and an ambulance was called.

57. The nurse could not get a verbal response from the man. He moved him onto his back and while doing this he noticed that his hands, feet and ears were cold but his body still felt a little warm. His inhaler was next to him on the bed. He showed no signs of life.

58. The nurse started CPR by doing chest compressions. Within less than a minute, Nurse B arrived with the emergency equipment. With the assistance of another officer, who had also arrived, the man was lifted to the floor. Nurse B attached the pads from the defibrillator onto his chest. Its advice was to continue with CPR. The nurses continued with CPR. Paramedics arrived at the cell at 7.10am. Nurse A said that there was no change in his condition while carrying out CPR. Another officer and a SO (the orderly officer) also arrived to support the nurses. When the paramedics examined him they decided that he had died and pronounced his death at 7.18am.

Events following the man's death

59. A hot debrief was carried out and staff were spoken to individually by the duty governor. Staff who had attended the man's cell were offered support from a member of the prison's care team. Prisoners on the wing were also spoken to and reminded of the support available to them.

Contact with the man's family

60. The previously appointed FLO continued to act as the family liaison officer. As the man's brother lived a long way from the prison, the FLO contacted HMP Chelmsford (the nearest prison) and asked for someone to visit him to deliver the news. Chelmsford's prison chaplain and a family liaison officer went to see him and, at 11.10am, confirmed that they had broken the news to him. The FLO then telephoned him and arranged to visit him the next day.

61. During his visit, the FLO explained further the circumstances of his brother's death. In line with Prison Service guidance, financial assistance was offered towards the funeral. The man's brother asked the prison to make all the arrangements. The FLO organised the funeral, which was held on 23 May. He kept in contact with and visited the man's

brother while making the funeral arrangements. Wakefield prison's chaplain conducted the funeral service in Colchester and a memorial service for the man took place later at Wakefield.

62. A few days after the funeral, the FLO contacted the man's brother again to check on his wellbeing and to see whether there was any further assistance he could provide to him. He said he was grateful for the prison's assistance. After the funeral, the FLO was told that the man had a son, who was in HMP Peterborough. He contacted the son and then visited him to discuss what had happened to his father.

ISSUES

Clinical care

63. The clinical review notes that a respiratory in-reach clinic was established in HMP Wakefield in 2009. The consultant maintained responsibility for the man whenever he was transferred to hospital. He was offered appropriate treatment including advice to remain active and take exercise, vaccination, and advice on stopping smoking. His medication and review was in line with national medical best practice guidance. The clinical reviewer notes that the standard of care he received was at least equal to that he could have expected in the community.

64. COPD causes a gradual decline in a patient's health. The man was diagnosed with severe COPD in April 2010 and experienced respiratory failure in January 2012. The clinical reviewer notes that, although his death was expected, the actual timeframe would be difficult to predict.

65. A note was made three weeks before his death that the man would need a palliative care assessment at some point. He was not entered onto a Care Pathway for End of Life Care and there was no record of an advanced care planning documentation being completed. The clinical reviewer notes that the nature of decline in COPD makes it extremely difficult to establish when such discussions should take place. Death during an exacerbation is not uncommon but it is extremely difficult to predict when this will happen. It is good practice for discussions with prisoners with terminal illnesses such as COPD to take place. We note that a need for a palliative care assessment had been identified shortly before his death so make no formal recommendation about this.

Restraints and security

66. The Prison Service has a duty to protect the public when escorting prisoners to outside hospital, and a responsibility to balance this with treating prisoners with humanity, maintaining their dignity. The level of restraints used should be necessary in all the circumstances. The risk assessment should consider the risk of escape and the risk to the public, also taking into account factors such as the prisoner's health and mobility.

67. The British Medical Association guidance is that there should be a presumption that prisoners are examined and treated without restraints, and without prison officers present unless there is a high risk of escape or the prisoner represents a threat to himself, the health team or others.

68. When the man was taken to hospital in January 2012, it was decided that he should be accompanied by two officers. He was unconscious and restraints were not applied. When he returned to prison, he required the use of a wheelchair. Following an exacerbation of his COPD, he

returned to hospital at the beginning of May 2012. On this occasion he was restrained by an escort chain,

69. Although the man was convicted of serious offences, the most relevant factors to consider were his likelihood of escape and his risk to the public. At the times he was taken to hospital in January and May, he was a very ill 66 year old man who had serious chronic disease and very restricted mobility (it was determined that he could climb up to 10 steps on a good day without assistance). In these circumstances, it is very hard to see how any use of restraints was justified when he attended hospital on the second occasion. There is no evidence that he was a risk of escape and he had been convicted 13 years previously when he was a younger and fitter man. It seems likely that the presence of two officers would have been more than an adequate security precaution.

70. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process. In the man's case, there is no evidence that medical opinion about his risk of escape was taken into account when making the risk assessment and we cannot therefore be satisfied that the use of restraints was proportionate. We recently raised this issue in a report following the death of a prisoner at Wakefield in March 2012 and repeat the recommendation:

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

Emergency response

71. An officer told investigators he knew the man was not a well man, and had limited mobility. When the officer found him he thought he was dead. He correctly raised the alarm. However, he did not enter the cell to make any further assessment. Prison Service guidance states that, when making a decision to enter a cell, staff have a duty of care to prisoners, to themselves and to other staff. The preservation of life must take precedence over security concerns but staff should not take action that they feel would put themselves or others in unnecessary danger. In the condition the officer said he was found, he posed no danger.

72. While we think it would have been preferable for the officer to have entered the cell to check on the man, we are satisfied that the emergency response was swift and appropriate. A nurse arrived within two minutes and together with a colleague who brought emergency

equipment to the scene carried out CPR Sadly, he could not be resuscitated.

Contact with the man's family

73. Wakefield appointed a family liaison officer (FLO) in January 2012 when the man was seriously ill and taken to outside hospital. While he was in hospital, the FLO contacted his brother daily and updated him on his condition.

74. The same FLO again resumed contact with the man's brother following his death. As his brother lived over 200 miles from the Wakefield, prison staff from a nearby prison broke the news. The FLO then telephoned the man's brother and visited him at his home the next day. The FLO arranged the funeral, which took place near to the man's brother. The FLO also visited HMP Peterborough to speak to the man's son about father's death once he was learnt that the man had a son.

75. We consider that the sustained input and helpfulness of the FLO in this case was commendable.

CONCLUSION

76. The man had a severe medical condition which was monitored and reviewed regularly by clinicians and appropriately treated. He was also well supported by his friends, healthcare and prison staff. The clinical reviewer considered that he received care which was appropriate and timely for his condition.

77. We consider the use of restraints when the man attended hospital shortly before his death was not fully justified by a risk assessment.

78. When he was seriously unwell and later after he died, his brother received commendably good support from the prison's family liaison officer.

RECOMMENDATION

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

   The National Offender Management Service has accepted this recommendation.