PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the circumstances surrounding the death of a man at hospital in September 2012, while a prisoner at HMP Wakefield

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 of an investigation into the death of a man, a prisoner at HMP Wakefield who died in hospital in September 2012, after suffering a heart attack. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. The local Primary Care Trust (PCT) commissioned a clinical reviewer to carry out a review of the man's clinical care. HMP Wakefield cooperated with the investigation.

The man had no major health problems, although he was taking medication to lower his cholesterol and had taken aspirin for a number of years to alleviate persistent leg cramps. In July 2012, he began a programme to help him stop smoking, which included a course of medication.

On the morning of 23 September, one of the man's friends went to his cell and found him unresponsive and apparently not breathing. He alerted officers, who called for emergency assistance. Healthcare staff attended very quickly and an ambulance was called. Healthcare staff and paramedics treated him, and he began to breathe again. He was taken to hospital by ambulance but died a few days later after his life support was switched off.

The investigation has identified a need for some procedural improvements including checks on prisoners' wellbeing at unlock, but overall I agree with the clinical review that the man received an excellent standard of care in Wakefield. In response to the draft report, the National Offender Management Service (NOMS) accepted two recommendations and rejected the third. After consideration I have agreed to remove the third recommendation.

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

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

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SUMMARY

1. The man was a 67 year old man who had been in prison since the 1970s. He had been at Wakefield since 1994.

2. After he complained of cramps in his legs in 2006, there were concerns that the cause could be related to his heart and he was prescribed aspirin. From April 2008, he was also prescribed medication to lower his cholesterol.

3. In July 2012, the man began a smoking cessation course. Part of this course involved taking a drug called varenicline. He did not report any side effects and said he quickly felt better for not smoking.

4. A roll check was carried out after prisoners were locked into their cells on the evening of 22 September and, as a category A prisoner, the man was checked five times during the night The prison officer responsible did not notice anything untoward. The officer who unlocked his cell in the morning saw him lying on his bed and assumed he was asleep.

5. Shortly after the cells were unlocked, a friend of the man's went to his cell to see him. He was dressed and his bed made, but he was lying back across the bed. His friend could get no response from him and he appeared not to be breathing, so he alerted an officer. Officers went to the cell but were unable to find a pulse and called for healthcare assistance. Nurses gave emergency first aid and asked the officers to make sure that an ambulance was called. After a while he began to breathe and was taken to hospital. He lived for a further few days, but died after his life support was switched off. He was accompanied by prison officers but was not restrained.

6. Before he collapsed, there had been no indication that the man was unwell. When he was found unresponsive, officers called healthcare staff without delay, and they arrived very quickly. Emergency care managed to get him breathing again, but he died in hospital a few days later. The clinical reviewer considered that the care that he received exceeded that which he could have expected in the community.

7. While we are satisfied that the man received appropriate care at Wakefield, the report makes recommendations for improved practice in unlock procedures, and calling emergency ambulances.

THE INVESTIGATION PROCESS

8. This office was informed of the man's death on 26 September 2012. The investigator issued notices to staff and prisoners informing them of the investigation and inviting anyone with relevant information to contact him. No one came forward.

9. The investigator visited the prison on 2 October and obtained the man's prison and medical records. He spoke to prison staff and a prisoner who knew him, the police liaison officer, and to members of the Independent Monitoring Board. He visited his wing and the cell where he had lived.

10. The local PCT commissioned a clinical reviewer to carry out a clinical review of the man's care and treatment in custody. The investigator spoke to members of the Yorkshire Ambulance Service.

11. The investigator interviewed five members of staff and one prisoner. Another investigator interviewed a further member of staff. He provided feedback to the Governor during the investigation.

12. HM Coroner for West Yorkshire Eastern District was informed of this investigation and provided a copy of the post-mortem report. A copy of this report has been sent to the Coroner.

13. One of our family liaison officers contacted the man's brother to outline the purpose of the investigation and gave him the opportunity to raise any matters he wished the investigation to address. He did not have any specific issues to raise, but asked that the report should reflect how helpful he felt that prison staff had been since his brother's death and his gratitude for their support. He did not have any comments to make on the draft report other than to confirm that it had been a television company that had first contacted him about his brother's death.

HMP WAKEFIELD

14. 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 A prisoner and lived on C wing. All cells are single occupancy.

Her Majesty's Inspectorate of Prisons (HMIP)

15. The last report published on Wakefield by HMIP followed an inspection in May 2012. The report found that the prison was reasonably safe and security arrangements were appropriate for a high secure prison. There were some concerns about the high rate of diversion and misuse of prescribed medication.

16. In relation to healthcare, the report noted that healthcare services had significantly improved since the last inspection. The range of primary care services was judged as good. In general pharmacy services had improved but inspectors considered that the oversight and management of the medications prisoners were allowed to keep in their possession needed attention to prevent the diversion of drugs subject to abuse.

Independent Monitoring Board (IMB) report

17. Each prison in England and Wales 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. The most recent IMB report for Wakefield is for the year ended April 2012. The report noted that healthcare provided a comprehensive service that met the needs of the population.

Previous deaths at Wakefield

18. There were 15 deaths from natural causes at Wakefield in the two years before the man's. There are no obvious similarities between the findings of the investigations into those deaths and those in this report.

KEY EVENTS

19. The man was born in June 1945. He was convicted of serious offences and sentenced to life imprisonment in 1977. He had a "whole life tariff" which meant he would never be considered for release. He had been at Wakefield since 1994, and had spent some time there earlier in his sentence.

20. The man denied his offences and refused to undertake any offence-related work, but otherwise was regarded as compliant with the regime. He did not socialise widely with other prisoners, but interacted with staff as required,

21. The man suffered no major health issues. After complaining of leg cramps, he had been prescribed aspirin since 2006. He had been prescribed simvastatin medication for high cholesterol since April 2008 and had a medical review every six months. In May 2012 he had day surgery at a local hospital to remove a lymph node from his forehead which was performed under local anaesthetic.

22. The man's last prescription for simvastatin was on 14 July 2012 and covered 84 days of which he was given a month's supply. He was also able to keep a month's supply of aspirin in his cell.

23. In July 2012, the man began to attend a clinic to help him in the latest of several attempts to stop smoking. The course was managed by external NHS staff. In order to counteract the effects of nicotine withdrawal, he took varenicline tablets. One of the conditions which might preclude people from using varenicline is severe cardiovascular disease but, even though he was being prescribed aspirin, there was no reason to consider that this might apply to him. A nurse authorised the use of these tablets. On 27 July, he was given an initiation pack of varenicline tablets (brand name Champix) which contained 28 tablets, one tablet to be taken twice a day for 14 days. As with his simvastatin and aspirin, he was allowed to keep these himself. A further 14 day supply was prescribed on 3 August.

24. On 9 August, the man's personal officer[1], wrote in his case notes that he was a reliable worker in the workshop where he was employed, and was always polite and behaved appropriately on the wing. If he had any problems, he exercised patience while they were resolved. There was nothing in the record to indicate any problems.

25. During the smoking cessation course, participants see the course administrators each week. The man said he could feel the benefits of stopping smoking and did not report any side effects. He was prescribed further 14-day supplies of varenicline on 16 August, 30 August, and 19 September.

26. The records for 22 September do not indicate that the man reported any problems that day. At 7.00pm, prisoners were locked into their cells for the night. A roll check was made at 7.40pm to ensure that all prisoners were present. When the staff shifts changed at approximately 8.45pm, the oncoming night staff conducted a further check on the prisoners.

[1] Each prisoner has a personal officer to support them, interact with the regularly and act as a main point of contact for any queries or problems.

27. The man was a category A prisoner and subject to five checks through the night. Officers open the observation panel in the cell door and if necessary put on a night light to assure themselves the prisoner is there. These are not wellbeing checks, but if an officer identifies any welfare concerns they would be expected to investigate. After each check, officers press an electronic button outside the cell door which registers that they have been to the cell. The officer who was on duty on C wing on the night of 22-23 September conducted checks on him at 7.22pm, 10.26pm, 12.31am, 2.52am and 5.14am. At interview she said that she recalled seeing him in bed and under the covers during the night. A full wing roll check was made at 5.40am. All cells have emergency call bells and records indicate that he did not use his cell call bell during the night.

28. An officer came on duty on C wing at approximately 8.15am. He attended a wing briefing and then, shortly before 9.00am, he and other staff began to unlock the prisoners. He told the investigator that he always checked the prisoner through the observation panel when unlocking the bolt. He said he saw the man lying on his bed. He was dressed, and his bed was made, but he was leaning back with his eyes closed. The officer assumed that he was sleeping and continued to unlock other prisoners.

29. A friend of the man's on C wing always exchanged his daily ration of fresh milk with him for powdered milk. After he was unlocked each morning, he collected his milk and took it to the man in his cell. On the morning of 23 September, he arrived at the cell at approximately 9.00am.

30. The man's friend told the investigator that the man was always up and dressed as soon as his cell was unlocked in the morning. This morning was no different, and he was dressed and his bed made. However, he was lying back on his bed with his legs hanging over the side, as if he had been sitting on the bed and fallen back. His head was towards his pillow, and his hands were drawn up above his chest. He wondered if he might have fallen asleep, and called him a few times from the doorway. When he got no response, he went closer, and saw that his face was purple and there was no sign of movement.

31. He found two officers and a Senior Officer (SO) together on the wing and told them he could not wake the man. The SO and an officer went to the cell.

32. When the SO went into the cell she noted that the man was not moving, looked very pale and had urinated. She radioed for assistance using the emergency call sign Code Blue, to indicate a prisoner with breathing difficulties. The officer felt for a pulse and used a mirror to check whether the man was breathing but he could detect neither.

33. The healthcare emergency responder that morning was in the prison's central hub, with a health support worker and a nurse when the emergency call came over the radio. They were very close to the C wing gate so the nurse ran to collect the emergency medical bag, while the two other nurses went straight onto the wing and to the man's cell. The nurse estimated that they were in the cell within a minute of the emergency call.

34. The nurses moved the man's legs so he was lying flat on the bed, and began cardiopulmonary resuscitation (CPR)[2]. They asked the wing staff to call an ambulance and explain that the patient appeared to have had a cardiac arrest. An ambulance was requested at 9.04am. The nurse arrived with the emergency equipment, including an external automated defibrillator[3]. The nurses used the defibrillator and continued to administer CPR. Officers waited at the door in case their help was needed. An operational manager, who was the acting Head of Residence, attended.

35. A first response paramedic arrived at approximately 9.20am, followed shortly afterwards by an ambulance crew. Together with the nurses they continued to provide medical aid to the man. He began to show a faint pulse and to breathe sporadically on his own, though healthcare staff continued to assist his breathing.

36. When prisoners are taken outside the prison, a risk assessment must be made. This was done while medical staff were attending to the man. It was decided that three prison officers would accompany him in the ambulance. As he was not conscious and paramedics were still working to revive him, the duty governor agreed that no handcuffs or other physical restraints needed to be used, but that restraints should be applied if his condition improved.

37. The man was moved to the ambulance at 9.30am and, after further treatment in the ambulance, the ambulance left the prison at 9.45am and took him to the accident and emergency department at hospital. Once stable enough to be moved, he was transferred to an infirmary, which has better facilities for treating heart patients. He arrived there at 12.39pm.

38. From that point the man was in a medically induced coma. Prison staff remained with him, but physical restraints were not applied. At 11.35pm on 24 September one of the hospital doctors requested the next of kin details as he considered his family needed to be informed of his serious condition. After checking, prison staff told him that the prison had no contact details for his next of kin.

39. At 1.10am the man stopped breathing. After treatment he began to breathe again with the aid of breathing support equipment. During the course of the day, hospital staff met to discuss an end-of-life plan and agreed there was no possibility of him recovering. The duty governor was informed that the man was not expected to survive beyond the evening. At 6.11pm, his medication was stopped and he was taken off the breathing support machine. He died at 10.52pm.

Informing the man's family

40. When the man died the duty governor asked an officer to obtain contact details for the next of kin. The man had been estranged from his family for some time. All available prison documents were checked, but no information was held. Staff then went through his file to see who he had corresponded with. His

[2] CPR - a combination of chest compressions and rescue breaths – sometimes called mouth-to-mouth – in order to restart the heart and lungs

[3] A machine which detects electrical activity in the heart and, if appropriate, delivers shocks to attempt to restart the heart into its proper rhythm

correspondence was almost exclusively legal. The next morning an officer contacted the Greater Manchester Probation Trust, with whom the man had had some dealings, but they too had no next of kin details.

41. On 27 September Greater Manchester Police contacted the prison to say that the man's brother had gone to a police station for information after being contacted by a journalist from a television station about his brother's death. The relationship was confirmed and an officer contacted him the next day and informed him that that he would be the family liaison officer. They remained in contact about his brother's property and the funeral arrangements, which the prison took responsibility for at his brother's request.

42. The funeral was held on 12 October 2012. The officer brought the man's brother to the prison and showed him where his brother had lived. They then went to the crematorium, accompanied by one of the prison managers, and the prison chaplain conducted the funeral service.

Debrief

43. It is usual after the death of a prisoner to hold a debrief meeting with staff involved to ensure they have an opportunity to discuss any issues arising, and to provide them with support. Staff who had been involved in the emergency response were all invited to a debrief and no substantive issues were raised.

Informing prisoners

44. When the man was taken to hospital, the SO spoke to the man's friend and another prisoner, who was nearby when he was found, to check on they had not been adversely affected by the incident. They were told of the support available should they need it. When he died, prisoners on C wing were informed and reminded that support was available if required. Those who were subject to monitoring because of risk of suicide and self-harm were specially reviewed.

Informing staff

45. When the man died, staff were informed when they began their next shifts. Support was made available for anyone who felt that they might need it.

Post-mortem

46. A post-mortem examination was carried out, which concluded that the man's death was due to:

    1(a) Acute myocardial infarction
    (b) Coronary artery atheroma and thrombosis

47. In layman's terms, the man had a heart attack due to a blockage in the arteries around the heart, which had become narrowed over time.

ISSUES

48. The man had been in prison for many years and had had little contact with healthcare services. He had been prescribed aspirin since 2006 and simvastatin since 2008, but had no major health concerns. The clinical reviewer notes that the major risk factors for heart disease are smoking, high cholesterol and high blood pressure. He had regular blood tests to check his cholesterol levels. His blood pressure was also monitored and remained within normal limits. The clinical reviewer writes that he had a full medical review every six months and his health was well monitored.

Varenicline

49. The use of varenicline has been the subject of discussion among clinicians, which is covered in detail in the clinical review. The clinical reviewer notes that the use of varenicline (Champix) was approved and recommended by the National Institute for Health and Clinical Excellence (NICE) in 2007. Guidance states "varenicline is recommended as a possible treatment to help smokers who have said they want to stop smoking. Varenicline should normally be used only as part of a programme that includes advice from a healthcare professional or other types of support".

50. The man was prescribed a normal dose of Champix 1mg tablets commencing 27 July 2012. He was still taking this medication at the time of his death. While he has been treated for slightly raised cholesterol and leg cramps, there was no other indication or history of significant heart disease. He was well monitored during his treatment by the smoking cessation service in accordance with NICE guidelines. He attended weekly sessions and stopped smoking on 11 August 2012. He reported that he felt well and was breathing much better. Notes do not indicate that he complained of any side effects while taking the medication, apart from on one occasion mentioning a metallic taste in his mouth. The clinical reviewer is satisfied that the use of varenicline was appropriate.

Unlock procedures

51. An officer had seen the man asleep in his bed during the night. When another officer unlocked his cell on the morning of 23 September, he was dressed and his bed made, and he was apparently resting on his bed. He was in the same position shortly afterwards when his friend realised that there was a problem. It is not possible to know when he had the heart attack, but it could have been before the second officer unlocked his cell. We consider that it is important that prison staff ensure that they gain a response from prisoners or otherwise satisfy themselves of the prisoner's welfare when they unlock their cells

52. Officers are told in their initial training that they should check the safety of prisoners when they unlock cells and Prison Service Instruction (PSI) 10/2011 contains guidance for officers unlocking prisoners. Paragraph 2.3 says:

> "Where prisoners are not necessarily expected to leave their cell, staff will need to check on their wellbeing, for example by obtaining a response during the unlock process."

53. Although we accept that the officer did not have any reason to suspect that there might be a problem, he did not discharge the duty under the PSI to confirm the man's wellbeing. In this case it was unlikely to make a difference to the outcome as he was found by his friend very shortly afterward. Nevertheless, it is desirable that officers are first on the scene to deal with any emergency.

The Governor should ensure that when a cell door is unlocked, officers satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

Emergency Response

54. Once staff were told that the man was unwell, they went to his cell immediately. This was at approximately 9.00am. They called for medical assistance and healthcare staff were in the cell very quickly, providing emergency care. CPR should usually be provided on a firm hard surface if possible, but a nurse said that she was satisfied that his bed provided suitable resistance. We also note the paramedics did not move him.

55. One of the nurses asked staff to ensure that an ambulance had been called and it does not appear that this had been done before the nurses arrived. The control room log shows that the Ambulance Service was called at 9.04am. There was little delay in this case as healthcare staff attended very quickly but it is important that an ambulance should be requested immediately in an emergency as delays can seriously impact on chances of survival.

56. A letter from the Department of Health and the National Offender Management Service to Prison Service Governors, NHS Primary Care Trust Offender Health Leads and Prison Healthcare Managers, dated 17 February 2011 about emergency access for ambulance services noted that it should not be necessary to wait for a member of healthcare to attend an emergency before calling an ambulance and an ambulance should be called in all cases where there are grave concerns about the immediate health of a prisoner. We consider it important that prison staff are reminded of this guidance.

The Governor should ensure that all staff are instructed to call an ambulance whenever there are serious concerns about a prisoner's immediate health.

57. The prison has a protocol to ensure that emergency ambulances are not delayed when entering the prison. Paramedics arrived at the man's cell at 9.20am. The clinical reviewer writes that staff reacted promptly and professionally to provide immediate resuscitation. When he was first found he had no heartbeat and no respiratory output but, by the time the ambulance took him to hospital, he had both.

58. A previous report from this office identified problems with an ambulance being able to leave the prison. According to staff statements, the man was transferred from his cell to the ambulance at 9.30am. The ambulance did not leave the prison until 9.45am. The investigator contacted the Ambulance Service and one of the members of the ambulance crew explained that they had continued to provide medical assistance to him once he had been moved

into the ambulance, which accounted for the apparent delay. They were not delayed in leaving by any prison procedures.

Escort and restraints

59. When the man was transferred to hospital he was unconscious. We are satisfied the duty governor took an appropriate decision that he should not be subject to any physical restraints. The security assessment noted that the situation should be continually assessed as to whether restraints were required. He did not recover to the extent that this was judged necessary, and he was not restrained at any stage.

Contacting the man's family

60. Guidance to prisons on contacting the next of kin of a seriously-ill prisoner is contained in Prison Service Instruction (PSI) 64/2011. The PSI says:

> "Prisons must ensure that arrangements are in place for an appropriate member of staff to engage with the next of kin or a nominated person of prisoners who are either terminally or seriously ill … where the prisoner is unable to communicate their wishes, the prison must contact the next of kin or a nominated person who must be given an accurate account of what has happened, including treatment given, whether the prisoner is in hospital, and information about visiting the prisoner.

61. The prison had difficulty in identifying the man's next of kin when he died, because he had not been in contact with his family for some time and had left no nominated alternative contact details. It was a Sunday when he was taken to hospital and other official agencies might not have been able to help, but we consider the prison should have at least started to make efforts to locate his next of kin at that stage rather than waiting until after his death. We are satisfied that once this was done, the prison provided good family support reflected in the positive comments of his brother.

62. The draft report contained a recommendation that the Governor should ensure that the prison complied with the PSI in relation to contacting families of seriously-ill prisoners. In their response to the draft report, NOMS rejected this recommendation. We note that the prison did want to contact the next of kin when he was taken to hospital, but their own files did not contain up to date contact details. It was a Sunday, and no further inquiries were made until the following day. While we do feel that the prison could have given further consideration to this on the Sunday, they did make efforts to contact his family first thing on Monday morning. After consideration, the Ombudsman has agreed to remove the recommendation.

RECOMMENDATIONS

1. The Governor should ensure that when a cell door is unlocked, officers satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

   The National Offender Management Service (NOMS) has accepted this recommendation. The following comment was offered:

   "A local Notice to Staff (046/2013) has been issued highlighting the need to check the wellbeing of prisoner on unlock in accordance with PSI 10/2011"

2. The Governor should ensure that all staff are instructed to call an ambulance whenever there are serious concerns about a prisoner's immediate health.

   NOMS also accepted this recommendation, with the following comment:

   "A Local Notice To Staff (266/2012) has been issued highlighting that if there is a clear and present indication that there is a real threat to life and limb, any individual regardless of rank or role should summon an ambulance, via the control room, without waiting for the internal support.

   This will be reiterated further in the forthcoming Medical Emergency Response Code Protocol in response to the requirements of PSI 03/2013"

3. The Governor should ensure that the prison complies with PSI 64/2011 in relation to contacting the families of seriously-ill prisoners.

   NOMS rejected this recommendation. After consideration, the Ombudsman agreed to remove this recommendation.