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 in September 2013 while in the custody of 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 investigation report into the death of a man who died in September 2013 at Pinderfields Hospital while in the custody of HMP Wakefield. He was 78 years old. The man died of respiratory disease. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. A clinical reviewer reviewed the clinical care the man received at Wakefield. The prison cooperated fully with the investigation.

The man was sentenced to ten years imprisonment in 2010 and transferred to HMP Wakefield in June 2011. He had high blood pressure and angina. In May 2011, the man was diagnosed with chronic obstructive pulmonary disease. The man's health deteriorated in July 2012, and he was admitted to the prison's healthcare centre. The man remained there until he was taken to Pinderfields Hospital on 12 September 2013. He died the next day. I am pleased to note that a proportionate and humane approach was taken to security and restraints were not used.

The clinical reviewer considers, and I am satisfied, that the man received a high standard of care at Wakefield.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **May 2014**

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SUMMARY

1. The man was sentenced to ten years imprisonment in 2010 and was sent to HMP Durham. When he arrived, it was recorded that he had high blood pressure and angina. In April 2011, the man was referred for a lung function test and in May the results confirmed that he had chronic obstructive pulmonary disease (COPD – a term used to describe a number of lung diseases). In June, he transferred to HMP Wakefield.

2. On 7 August 2012, the man was admitted to Pinderfields Hospital with breathing problems and a urine infection. Ten days later, he was discharged and admitted to the prison's healthcare centre for long-term nursing care, including oxygen therapy. A nursing care plan was drawn up. In December, after discussion with doctors, nurses and his family, the man agreed he did not want resuscitation to be attempted if he had a cardiac or respiratory arrest.

3. A healthcare officer tried to arrange for the man to transfer to HMP Frankland, so he could be nearer to his family. However, Frankland's healthcare unit was undergoing building work until July 2013. In mid-July, the man's health began to deteriorate and a transfer was not possible. On 12 September, his condition became suddenly worse and he was taken to Pinderfields Hospital, Wakefield. The prison contacted his wife and offered to help her visit. Doctors agreed that the man should be put on a ventilator for no more than 24 hours to stabilise his condition. The man's condition continued to deteriorate and he died at 5.45am on 13 September.

4. The clinical reviewer considers that the man received a good standard of care at Wakefield. He was well informed about his treatment, involved in decision making and received appropriate palliative care. We are pleased to noted that when the man was taken to hospital on 12 September, restraints were not used, which allowed him to die with dignity.

THE INVESTIGATION PROCESS

5. The investigator issued notices informing staff and prisoners at HMP Wakefield of the investigation and asking anyone who had relevant information to contact her. No one responded.

6. The investigator obtained copies of the man's relevant prison and prison medical records. On 24 October, she spoke to one of Wakefield's Healthcare Officers by telephone. The investigator gave the Governor initial feedback on the investigation, and followed this up in writing.

7. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.

8. The investigator informed HM Coroner for West Yorkshire Eastern District of the investigation and the Coroner provided the post-mortem report. We have sent the Coroner a copy of this investigation report.

9. One of the Ombudsman's family liaison officers contacted the man's wife, his nominated next of kin, to explain the purpose of the investigation. The man's wife did not have any concerns that she wanted the investigation to consider.

10. The investigation has assessed the main issues involved in the man's care, including his diagnosis and treatment, whether appropriate palliative care was provided, liaison with his family, his location and whether compassionate release was considered.

11. The man's next of kin was informed the draft report was available, but did not wish to receive a copy or make any comment. The prison considered our draft report and made no further comment.

HMP WAKEFIELD

12. 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 healthcare centre has 14 cells, including a palliative care suite. Primary care services are provided by Spectrum CIC (Community Interest Company) during normal working hours. The inpatient unit is staffed by nurses employed by Humber NHS Foundation Trust (intermediate care), who also provide overnight and weekend cover for patients with physical health problems at Wakefield.

HM Inspectorate of Prisons

13. The most recent inspection of Wakefield was in May 2012. Inspectors found that health provision had significantly improved since the last inspection. The range of primary care services was considered to be of a good standard and appropriate for the population, including older prisoners.

Independent Monitoring Board

14. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recent annual report for the year to May 2013, the IMB noted that there was a comprehensive healthcare service that met the needs of the population.

Previous deaths at HMP Wakefield

15. The man's death was one of seven from natural causes at Wakefield in 2013. There are no similar issues raised in this report.

ISSUES

The diagnosis of the man's terminal illness and informing him of his condition

16. The man was sentenced to ten years imprisonment in 2010 and transferred from HMP Durham to HMP Wakefield in 2011. Records show that he had been diagnosed with high blood pressure and angina for several years.

17. On 19 April 2011 a prison doctor, asked for a spirometry test (for respiratory function), because the man was short of breath. In May 2011, the results of the spirometry test confirmed that the man had chronic obstructive pulmonary disease (COPD).

18. The man was transferred to Wakefield prison in June. He saw the visiting respiratory physician who holds regular clinics in Wakefield's healthcare centre. The physician concluded that the man did not need regular follow up appointments, unless he developed more problems with his breathing. The man continued to be monitored by a consultant cardiologist.

19. The man was admitted to Pinderfields Hospital on 7 August 2012, with low oxygen levels and a urine infection. A scan indicated that the man had emphysema (a lung disorder) and fibrosis (scarring) of the lungs. He was discharged from hospital on 17 August, and required constant, long-term oxygen therapy, which was provided at the prison.

20. The physician then saw the man regularly in his clinic at Wakefield. In September, the doctor told the man that his condition would not improve and was terminal.

21. From January to June 2013, the man stayed in the healthcare centre, where his condition was mostly stable. The man's breathing difficulties got much worse in early July and he became less active. He had a marked deterioration on 12 September and was taken to hospital where he died the next day.

22. We agree with the clinical reviewer that the man's shortness of breath was identified and investigated promptly. His symptoms were monitored appropriately and his condition was identified as terminal as his health deteriorated. The clinical reviewer considers that the man was kept well informed of his condition and his treatment options.

The man's medical treatment

23. Once it becomes evident that a serious medical condition will not be responsive to active treatment, it is appropriate that a palliative care plan is put into place. The NHS document 'The route to success in end of life care – achieving quality in prisons and for prisoners' sets out how an end of life care pathway might be implemented in prisons. Among the benefits of an end of life pathway are that it helps carers plan when and how care will be delivered

and helps patients make choices about how they are cared for towards the end of their lives. There are various examples of end of life care pathways.

24. On 12 September 2012, a Gold Standards Framework template was opened for the man's care. (The National Gold Standards Framework helps doctors, nurses and care assistants to provide the highest possible standard of care for all patients nearing the end of their life.) This framework was updated every two weeks at multidisciplinary team meetings, attended by the physician, and a MacMillan nurse, among others. As the man's illness progressed, he received nutritional support with prescribed supplement drinks and oral morphine to ease his pain and discomfort. The clinical reviewer considers that the man's care was managed well.

25. A Do Not Attempt Resuscitation (DNAR) order means that in the event of cardiac or respiratory arrest resuscitation will not be attempted. On 12 December 2012, the man signed a DNAR after discussion with his family and the physician. The man told the doctor that his wife had been upset, but she accepted his decision.

26. From mid-July 2013 and into August, the man became less active and his health further deteriorated in early September. On 12 September at 11.00am, the man was admitted to hospital for observation. The man was put on a ventilator, which would be withdrawn after 24 hours if his health continued to fail. (The man's DNAR was still active and the form had been reviewed and signed over the previous nine months.) During the evening, the man's condition deteriorated and he died at 5.45am on 13 September.

27. The clinical reviewer considers that the man's treatment was appropriate to his condition and he was involved in making decisions about his care, including the decision not to attempt resuscitation.

The man's location

28. When the man was discharged from hospital in August 2012, he returned to the healthcare centre at Wakefield. He remained an inpatient there for the rest of his time in prison. The man required long term oxygen therapy and monitoring, which could best be accommodated in the healthcare centre.

29. In December 201, the man told Healthcare Officer that he wanted to be nearer to his family in the north east of England. The officer contacted the healthcare unit at HMP Frankland on 22 December, but was told that there were building works underway, and she was advised to contact Frankland again in April 2013. On 18 April 2013, the healthcare officer contacted Frankland's healthcare unit again, but was told that the unit would not be ready for at least another two months. On 24 July, the officer obtained the man's permission to share his medical information with Frankland so that they could consider the appropriateness of a transfer.

30. The man's condition deteriorated in early August. He was on permanent oxygen therapy and became breathless very easily. The man needed

increased nursing care and his condition was not considered stable enough to allow a transfer. Sadly, he did not improve and died before he could be fully assessed for a transfer to Frankland.

31. The clinical reviewer considers that the man was well cared for in the healthcare unit at Wakefield and he told staff that he was comfortable. Although the man would have preferred to move to Frankland to be nearer his family, we are satisfied that this was not possible before his death.

Restraints, security and escorts

32. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity and maintain their dignity. The level of restraints used should be necessary in the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes account of factors such as the prisoner's health and mobility. The man's health was appropriately taken into account in his risk assessment and he was not restrained when he was taken to hospital on 12 September or as an inpatient in the hospital before his death.

Liaison with the man's family

33. The man's wife and step-son visited him while he was an inpatient in Wakefield's healthcare unit and were aware of his condition. With assistance from healthcare staff, the man telephoned his wife daily.

34. When the man was taken to hospital on 12 September 2013, Wakefield's family liaison officer telephoned the man's wife to inform her. Unfortunately, for health reasons, she was unable to travel to see her husband, but asked for the family liaison officer to telephone her if her husband's condition deteriorated.

35. At 5.45pm, the family liaison officer spoke to the man's wife and told her that her husband's condition was critical and that he was in the last hours of his life. The officer offered to arrange a taxi for her, if that would help her visit, but she declined the offer. She asked the family liaison officer to telephone her son if the man died overnight.

36. At 7.30am on 13 September, the family liaison officer telephoned the man's step-son to tell him of his stepfather's death, as agreed. Later, the family liaison officer telephoned the man's wife and offered her support and assistance.

37. On 16 September, the family liaison officer and another officer visited the man's wife and her family at their home. On 25 September, the officer and a prison manager attended the man's funeral. Funeral expenses were offered to the man's family in line with national guidelines.

Compassionate release

38. Any prisoner can be considered for release on compassionate grounds for medical reasons. In order to be released on these grounds, a prisoner must have been diagnosed with a terminal illness and there must be an indication that death is likely to occur soon (usually within three months).

39. The man's condition was considered terminal from September 2012, but at that time there was no clear prognosis. The officer told the investigator that compassionate release was discussed at the multidisciplinary Gold Standard Framework meetings. She said that compassionate release was not applied for as he had no clear prognosis and because his condition did not seem imminently life-threatening until the last day of his life.

40. Unfortunately, it is not recorded in the minutes of the multidisciplinary meetings that an application for a compassionate release was considered. We remind the prison of the need to ensure that such discussions are recorded as part of palliative care arrangements. Nevertheless, we accept that the lack of a clear prognosis would have made it difficult for an application to proceed.