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 Pinderfields Hospital, Wakefield in April 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 at Pinderfields Hospital, Wakefield in April 2013 while in the custody of HMP Wakefield. The man was 66 years old and died from an intra-ventricular haemorrhage (a severe bleed on the brain). I offer my condolences to the man's family and friends.

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

The man had several health problems, but in particular he had been diagnosed with vascular dementia, caused by a lack of blood to his brain, thought to have been caused by high blood pressure and previous strokes.

On 29 March around 5.40am, an officer found the man lying on the floor of his cell. He seemed dazed and did not know where he was. The man was helped to his bed and asked to lie there until a nurse came to check him. The officer heard a loud crash approximately 15 minutes later and found that the man had got up and fallen against the cell door and badly injured his head. A prison nurse treated the injury and the man was taken to hospital by emergency ambulance. He died in hospital on 5 April.

This is a sad and troubling example of an older prisoner whose complex health and social care needs were poorly met at Wakefield. A number of professionals saw and assessed the man and identified his needs, but no one appeared to take overall responsibility for ensuring these needs were met. This need for better coordinated care of prisoners with age related conditions, both at Wakefield and across the prison system, is an issue that will only become more pressing as the prison population continues to age. I am also concerned that, once again, the investigation identified that Wakefield used restraints on a frail, infirm and confused prisoner without the justification of a considered risk assessment. This is a matter I have drawn to the attention of Deputy Director of the High Security Estate.

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

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SUMMARY

1. The man was sentenced to nine years imprisonment in January 2011, and was sent to HMP Manchester. He suffered from a number of mental and physical health problems and was diagnosed with vascular dementia. He was supported by the prison mental health team.

2. The man transferred to Wakefield in September 2011, which was considered more suitable for his needs. During his time at Wakefield he lived on a standard wing and was allocated a number of prisoner carers to help him. However, the man became increasingly unable to carry out routine daily activities.

3. The man's deteriorating mental health was attributed to physical factors, such as high blood pressure and previous strokes. He was assessed by the mental health team on 11 September 2012, a year after he arrived at Wakefield. They decided that he should continue being treated by the primary care team and that a mental health nurse would visit him weekly to monitor his condition. Wakefield requested information from the mental health team at Manchester and received a letter explaining the man's diagnosis and history in March 2013.

4. On 29 March, an officer was carrying out the early morning roll check when he found the man lying on the floor of his cell, dazed and confused. Officers helped him on to his bed and suggested that he lie down. Another officer asked a prison nurse to check the man. Before the nurse arrived, the officer heard a loud crash and found the man on the floor against the cell door. His head was bleeding profusely.

5. A nurse treated his injury and an ambulance was called quickly and the man was taken to Pinderfields Hospital, Wakefield. His family was informed of his hospital admission and visited him the next day. His condition deteriorated and the man died on 5 April with his family at his bedside.

6. The principal concern raised by the investigation was the lack of coordinated care for the man. His personal hygiene was allowed to deteriorate in a way that was neither decent nor dignified. We make four recommendations in this report.

THE INVESTIGATION PROCESS

7. Notices were issued to staff and prisoners at Wakefield inviting anyone with information to contact the investigator. No one came forward.

8. The investigator visited Wakefield on 10 April and obtained the man's prison and clinical records. She visited the wing where the man lived and spoke to three prisoners who had cared for him. She also spoke to the prison family liaison officer the Head of Healthcare, and a member of the Independent Monitoring Board (IMB). The investigator also contacted West Yorkshire Police.

9. The investigator interviewed staff at Wakefield on 23 May and 13 June. She gave preliminary feedback to the Governor about the findings of the investigation.

10. The clinical reviewer reviewed the clinical care the man received at the prison.

11. HM Coroner for West Yorkshire Eastern District provided a copy of the post mortem report. A copy of our report has been sent to the Coroner.

12. One of the Ombudsman's family liaison officers contacted the man's family to outline the purpose of this investigation and to ask if they had relevant issues they wished the investigation to consider. His family said that they were grateful that they had been told that the man was in hospital so that they could be with him when he died. They said that the escort officers had given them privacy at the hospital and that the family liaison officers had been compassionate.

13. However, the man's daughter said that she had written to the Governor in January 2012, to express concern about her father's condition. She did not consider that the reply had addressed her concerns. She was upset that her father had not been found on the floor of his cell until the morning and said that she had asked for him to have a personal alarm in case he was ill.

14. The man's daughter was also concerned about the social and personal care he received at Wakefield. She said that when she saw him in hospital his toe nails had grown so long that they had curled underneath his toes and that when she had visited him in prison he told her that he had complained about it but nothing had been done. His family had been told that the man had moved to Wakefield from Manchester because this was better for someone with his medical issues, but they did not believe that he was assessed correctly or treated properly for his medical conditions.

15. The man's family received a copy of the draft report. The solicitor representing them wrote to us raising a number of questions that do not impact on the factual accuracy of this report. The solicitor also requested a set of redacted documents. We have provided clarification by way of separate correspondence to the solicitor and have asked the prison to provide a set of redacted documents as soon as possible.

HMP WAKEFIELD

16. HMP Wakefield is one of eight high security prisons in England and Wales. It holds approximately 750 Category A and B 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 D wing at the time of his death. All cells are single.

17. Healthcare services at Wakefield are provided by a number of contractors. Mental health services and older prisoners care is delivered by Nottinghamshire Healthcare. Primary Care nursing and doctors are provided by Spectrum Healthcare and inpatient and intermediate care by Humberside National Health Service Trust.

Her Majesty's Inspectorate of Prisons

18. The last report published about Wakefield by HM Inspectorate of Prisons (HMIP) followed an inspection in May 2012. Inspectors were concerned about the high rate of misuse of prescribed medication, but 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. Inspectors found that support for disabled prisoners was good, but that this support needed to be extended to older prisoners. HMIP recommended that the prison should consider opening a day care centre for older prisoners.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure prisoners are treated fairly and decently. In its most recent annual report to April 2012, the IMB noted that the healthcare provision at Wakefield had improved but they added that for a third year in a row there were underlying problems, in this case the negative impact that staff suspensions was having on staffing levels.

Previous deaths at Wakefield

20. During 2012 and prior to the man's death in 2013, there were seven deaths at Wakefield. Of these seven, six were the result of natural causes. We made recommendations about the use of restraints in four of these investigation reports.

KEY EVENTS

21. On 29 October 2010, before his imprisonment, the man saw a consultant psychiatrist. The psychiatrist concluded that the man suffered from mild cognitive defects, which were likely to have been a result of strokes he had suffered. After he had completed neuropsychological tests, the psychiatrist said that there was insufficient evidence to diagnose vascular dementia (a condition where a loss of mental ability is caused by reduced blood flow to the brain. Symptoms include difficulty with planning, memory loss, trouble with language and mood and behavioural changes.).

22. On 24 January 2011, the man was sentenced to nine years imprisonment, for sexual offences committed some years previously. He was initially sent to HMP Manchester.

23. The man moved to Wakefield on 19 September 2011. A move from a local prison like Manchester would be usual. The man's family said they were told that Wakefield was a better prison for someone with his health problems. When the man arrived at Wakefield, he had a routine health screen. He told staff that he was very forgetful and had been supported by the mental health team in the community and at Manchester prison. He had previously undergone heart surgery and had a pacemaker fitted. He also suffered from sleep apnoea (a condition where breathing is affected and can stop during sleep) and had epilepsy, impaired eyesight and mobility problems. His left leg had been affected by a stroke. The clinical record indicates that Manchester sent a summary sheet of the man's health problems. He was assessed by a nurse and was prescribed the following medication to keep in his possession:

    - Lansoprazole (for stomach problems)
    - Epilim Chrono (for epilepsy)
    - Ramipril (for high blood pressure)
    - Aspirin (for heart problems)
    - Amlodipine (for high blood pressure)
    - Clopidogrel (to thin the blood)
    - Atorvastatin (for high blood pressure)

24. The man was considered fit to live on a standard prison wing. He was given advice on stopping smoking and assessed by a disability officer. A disability careplan and evacuation plan were put in place for the man should he need help getting out of the building in an emergency. The health screen notes indicate that the man had not received treatment from a psychiatrist and was not receiving medication for mental health problems. He was described as being in a stable mood and there were no concerns about his mental state. The man was referred to the doctor.

25. On 4 October, the man attended the blood clinic. A nurse recorded the man as being 'pleasantly muddled'. He said that he did not know if he was taking his medication correctly and was given a dosset box, (which has compartments for daily medication) so that he would know which medication to take each day. He was allocated a cell on the ground floor. A prison carer

(another prisoner who helps with tasks such as cleaning cells and getting meals) was allocated to the man. The man was referred to the doctor, as the results of some tests conducted at Manchester prison had arrived. A doctor noted in his medical record on 6 October that she had seen the man, but there is no mention of whether she had examined him or what she had concluded.

26. In January 2012, some prisoners told wing officers that the man had been doubly incontinent in the shower. They were concerned about his physical and mental health and his hygiene. A nurse from the primary healthcare team visited the man on the wing the next day, but he said that he had not been incontinent. She also noticed that the man had not collected his weekly medication and collected it for him and asked his carer to collect it each Monday from the medication hatch for him.

27. The man did not attend an appointment on 30 January for his pacemaker to be checked. The reasons for him not attending are not recorded but a doctor noted that he did not need to see the man as he did not have a recent history of chest or breathing problems. However, he referred him to the cardiology department of the local hospital for a further check.

28. On 2 February, the nurse manager recorded that she had spoken to the matron in primary care about the man's condition and officers' concerns about the man's personal hygiene and ability to live on the wing. They decided that the man should see the doctor to rule out any physical causes and to consider if he should attend a memory clinic and then be assessed by the mental health team if necessary.

29. Another doctor examined the man on 9 February. He recorded that the man had a history of confusion and memory impairment. He noted that the man had not suffered from any epileptic fits for two years and requested blood checks and an electrocardiogram (ECG) to check his heart. The man still smoked and he advised him to stop. The man said that he had cut down from ten cigarettes a day to five since arriving at Wakefield.

30. The doctor examined the man again on 8 March, and the man told him that he suffered from sleep apnoea. The doctor noted that the man was not suffering from shortness of breath and had no chest pain but had problems with his balance. He reviewed the man's medication and increased the dose of ramipril for his blood pressure.

31. On 17 May, the doctor examined the man because he was complaining of painful legs. He noted that the man's circulation was normal but his left foot was warm. He noted that this was due to poor hygiene and referred the man to see the podiatrist (a specialist in foot care) There is no record of the man seeing a podiatrist. A healthcare manager at the prison, told the investigator that the man would have had to put in a written application if he wanted to be treated.

32. After the National Offender Management Service (NOMS) had considered the draft report, they commented that the healthcare manager's comment was factually incorrect and was based on a generalisation that applications are submitted to access certain services. However, podiatry referrals were made through a health care professional. That clinician is then responsible for progressing the referral. They said that where an individual is unable for whatever reason to complete an application form they would be assisted by the primary care staff. Nevertheless, it would seem that on this occasion the man did not see a podiatrist. It is therefore difficult to ascertain whether a referral was made or whether the man was helped to make the application.

33. On 31 August, a doctor saw the man and noted he needed to have another mini-mental state examination (a test which measures brain function).

34. On 5 September, wing staff contacted the healthcare team to ask for a mental health assessment for the man, as his mental health was deteriorating and he was becoming less able to care for himself. A member of the mental health team went to see the man on 8 September but was unable to undertake the assessment because of a shortage of staff on the wing.

35. The mini mental state examination was completed on 11 September. It was noted that the man was clean and tidy and engaged well in conversation but his speech was incoherent. The mental health team discussed the man on 12 September, and decided that a secondary care assessment should be completed. A mental health nurse, assessed the man on 19 September. She described the man as polite, jovial and chatty and appeared kempt but that he had a strong smell of body odour. The man struggled to answer questions and could not remember the reason for her visit. He also found it difficult to remember his name, age and date of birth and thought that he was in Manchester prison. The man told her that other prisoners were taking advantage of his memory problems and coming to him for tobacco.

36. After her assessment, the mental health nurse spoke to the wing officers. They told her that they were concerned that the man was vulnerable to bullying and theft, and that they were monitoring the situation. They added that the man was becoming increasingly aggressive and prone to verbal outbursts when he had forgotten something. They were also concerned that the man did not take his medication correctly. The mental health nurse telephoned the primary care team and asked for the man to be given his medication daily and for it to be supervised when administered.

37. On 27 September, the man's carer told the mental health nurse that the man had been doubly incontinent in bed which he had tried to hide. The man's carer said that his cell had become very unhygienic and it was becoming increasingly difficult to care for him. The man was not showering or changing his clothes and became aggressive when his carer prompted him to do so. Officers also said that his aggressive outbursts were happening more frequently. The mental health nurse passed this information to the primary care team and asked them to review their ongoing care plans. On 3 October, The mental health nurse spoke to the primary care team who told her that the

man was not currently receiving any specific treatment or interventions from them.

38. A consultant forensic psychiatrist, assessed the man on 3 October. The man told him that he was not being bullied and was settled on the wing and grateful to his carers. The consultant forensic psychiatrist thought that it was most likely that the man was suffering with vascular dementia. He requested information from the Manchester Memory Clinic, where the man had previously been treated. The plan was for the mental health nurse to continue seeing the man weekly. The mental health nurse contacted a member of staff from the primary care team who had responsibility for older prisoners care, and asked her to complete an assessment of the man's needs.

39. On 4 October, the mental health nurse tried unsuccessfully to get information from the Manchester Memory Clinic. The same day, a nurse decided that the man should be supervised when taking his medication, as the mental health nurse had previously requested.

40. Primary care staff examined the man in the elderly prisoner assessment clinic on 15 October. He told her that he was not being bullied and was settled on the wing. He said that he was managing his personal hygiene well. He told primary care staff that he was looked after on the wing and his carers helped him keep his cell tidy and collect his meals for him.

41. The mental health nurse saw the man on 16 October and he told her he had suffered from mild pain close to his pacemaker over the previous two weeks. She made an appointment for him to see the doctor the next day, and noted that his clothes were stained and dirty and he appeared unwashed and unshaven. She noted that he seemed low in mood and made only minimal eye contact. He asked if he could have his medication in possession again because he felt like he was wasting staff time as he had so many tablets to take. The mental health nurse explained why he could not. She said the man accepted this but maintained that he preferred his medication in possession. The mental health nurse tried to contact the Manchester Memory Clinic several times but did not get an answer.

42. A doctor examined the man on 17 October. The man told him that the pain had settled. The doctor asked for the man's pacemaker to be checked. The mental health nurse finally spoke to the Manchester Memory Clinic and asked them to send information about the man to the prison.

43. The consultant forensic psychiatrist examined the man on 18 October. The mental health nurse discussed his ongoing care with the consultant forensic psychiatrist and they agreed that there needed to be a multi disciplinary team meeting to consider how best to manage the man's treatment. After staff had completed the elderly prisoner assessment it was decided that moving the man to the prison's inpatient unit was not in his best interests and they did not consider there to be a clinical need. They believed that the man would receive the same care on the wing as he would in the healthcare unit so he remained living on the wing.

44. On 24 October, the consultant forensic psychiatrist examined the man again and made a referral to Old Age Psychiatry in Manchester. The immediate plan remained for the mental health nurse to monitor the man on the wing each week.

45. The mental health nurse visited the man every week for the next seven weeks. She told the investigator that the man continued to have problems remembering, often appeared unwashed and unshaven and his cell was dirty. Wing staff and his carers told her that he was becoming increasingly irritable and accident-prone, possibly because of poor eyesight. Other prisoners on the wing were becoming impatient with the man's angry outbursts and while they had originally accepted his apologies they were now becoming less tolerant of his condition and his poor hygiene.

46. The consultant forensic psychiatrist examined the man again on 5 December. He noted that there was little change from his previous assessment and they were still waiting for an appointment from the Old Age Psychiatry service in Manchester. After the examination, staff chased the appointment and were told that that assessment was likely to be held in early 2013.

47. The mental health nurse continued to see the man every week. Wing staff reported that the man's personal and cell hygiene remained poor and his confusion and forgetfulness persisted. One of the man's carers told the mental health nurse that it had taken three carers to clean the man's cell one morning. The man became tearful and upset when the mental health nurse spoke to him about this and said that he could not help it and was finding it harder to cope. The mental health nurse discussed the man's careplan with him which he agreed and signed. The careplan included a number of objectives, all for the man:

- to continue contact with mental health team,
- to continue contact with primary care team and fully comply with medication regime and any tests,
- to fill his time with purposeful activity and to engage with sentence planning.

48. On 24 January, the mental health nurse and a registered mental health nurse (RMN) met the man to discuss the careplan. Although other staff such as primary care workers and the man's personal officer were invited they did not attend or supply any information. The man said that his memory continued to be a problem and he struggled to know where he was or what time it was. He said that he felt that he was going "mental" and this caused him to feel depressed, frustrated and upset. The man's personal officer later told the mental health nurse that the man's personal and cell hygiene continued to be problematic but that it had improved recently because of his carers. (A personal officer is expected to get to know a prisoner, support him and act as first point of contact to help with any concerns.) The man said that he was not being bullied. Wing staff monitored him closely to check that he was not

being exploited by other prisoners. It was agreed that the careplan would be reviewed 12 months later.

49. Around 5.40am on 29 March, an officer was carrying out an early morning roll check. This requires officers to check each cell and account for all prisoners. The officer said that, when he arrived at the man's cell, he saw him lying on the floor in a peculiar position. He called for assistance and a Senior Officer (SO) arrived within two minutes. The SO opened the cell door and the man started to get up. The officer described the man as being dazed and unable to talk properly. He did not know where he was or how he had come to be on the floor.

50. The officers stayed with the man for a short while and helped him to his bed. They said the man said that he would stay on his bed and thanked them. The SO called the healthcare team and a nurse told him that she would need to examine the man. The nurse first checked the man's medical records.

51. The officer continued with his roll check. About 20 minutes later he heard a loud crash. He went back to the man's cell and found that he had fallen against the cell door and had badly injured his head and was bleeding from the wound. The officer called a code red emergency over his radio and the SO returned to the man's cell. (A code red emergency is called when someone is bleeding.) They unlocked the cell door and got a response from the man. They went into the cell and put a towel under the man's head.

52. The nurse responded to the emergency call. When she heard the code red call she was in the inpatient unit, a separate building at the other side of the prison. She had to be escorted by a dog handler and dog. When the officer arrived, to take her to the wing she went to the primary care unit (which is in another building) to collect an emergency bag.

53. The nurse told the investigator that there are two emergency bags, one for incidents where there is an injury involving blood loss and one for emergencies where there are breathing problems. (She described this as the main emergency bag.) She said that the main emergency bag was very heavy and orange in colour and the other was lighter and coloured red. She was concerned that a prison officer might bring the wrong bag as they look very similar so wanted to get it herself.

54. The nurse said that it took her between 5 and 10 minutes to get to the man's cell. When she arrived, the man was sitting in a chair and the bleeding from his head wound had almost stopped. However, she was very concerned when she examined him, particularly as his balance was badly affected and he was slurring his speech and asked for an emergency ambulance to be called.

55. The nurse said that paramedics arrived quickly. At first, they did not think it was necessary to take the man to hospital, but the nurse persuaded them that he needed to go. A security risk assessment was completed, which concluded that the man was a high risk of harm to the public, a medium risk of

harm to hospital staff, of escape and hostage taking. The risk of outside assistance to escape was regarded as low. The assessment was based on the offences the man had committed 40 years previously, that he was in a high security establishment and would be in an insecure vehicle (an ambulance) moving to an insecure establishment (the hospital). There was no reference to his health or mobility. Two escort officers travelled with the man. They were told to use an escort chain (a chain which has a handcuff at each end, one attached to the escorting prison officer and the other to the prisoner) unless a member of healthcare staff said that double handcuffs could be used without affecting the man's recovery.

56. The man was taken to Pinderfields Hospital, Wakefield at 6.50am and arrived at 7.00am. The prison family liaison officer who was on duty at the time the man was admitted to hospital, noticed that he had a visiting order for his family to see him at Wakefield on 30 April, the day after his hospital admission. She asked for authorisation to contact his family and for them to be allowed to visit him in hospital instead. His family visited him in hospital the next day.

57. On 1 April, prison healthcare staff contacted the hospital to check on the man's condition. They were told that he was improving slowly but was still disorientated and would remain in hospital. The security arrangements were reviewed on 1 and 2 April and he remained restrained by an escort chain with two officers present. At 3.40pm on 3 April, the man's condition deteriorated. The man's family were informed and arrangements were made for them to visit him. A risk assessment was completed and at 5.15pm it was agreed that the escort chain could be removed.

58. The man's family visited him at 6.00pm. They stayed throughout the night and the next day. At 4.36pm on 5 April, the man died. His family were at his bedside. An officer kept in touch with the man's family and subsequently made arrangements for a memorial service at Wakefield prison. The prison offered to contribute to the funeral expenses in line with national guidance.

59. A post-mortem examination established that the cause of death was an intra-vascular haemorrhage (bleeding in the brain). Secondary causes of death were given as anti-coagulation medication (warfarin, which is used to thin the blood) and coronary artery atheroma (furring up of the arteries).

ISSUES

Clinical and personal care

60. When the man arrived at Wakefield, healthcare staff decided that, as the cause of his dementia was largely physical, the primary healthcare team would be responsible for managing him. This meant that the man did not receive any mental health treatment or assessment for almost a year after he arrived at Wakefield.

61. The man clearly found it very difficult to complete routine daily activities, such as personal care and keeping his cell clean and tidy. His personal hygiene was allowed to deteriorate and he did not always remember to take his medication as prescribed. Although prison carers were assigned to help the man, this was not an adequate response to his needs. An example of the lack of attention to some of the man's basic needs is reflected in the fact that although the doctor referred the man to see a podiatrist, this never happened. The man was expected to make an application himself which was inappropriate and neglectful for a man with the man's capacity and demonstrates the lack of a coordinated approach to the man's care. Although a number of people were involved in assessing the man, no one took practical steps to ensure he got the care he needed. .

62. Because of his significant physical and mental health problems as well as his personal care needs, the clinical reviewer considers that there should have been a clear plan to manage his health, led by a senior clinician. We agree that there was a lack of a clear responsibility and coordination of the man's care. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that there is a coordinated multi-disciplinary approach to meeting the needs of prisoners with complex physical, mental and social care needs.

Emergency response

63. When officers first found the man on the floor of his cell on the morning of 29 March they called helped him back to bed and called a nurse. We do not know how long the man had been on the floor. A member of staff did not stay with the man until the nurse arrived. While this would have been best practice, and in retrospect appears regrettable, we do not consider this was unreasonable. The officers believed that the man was settled and they had other duties to complete. When they subsequently found him collapsed on the floor with a bleeding head injury they appropriately called an emergency code red requesting immediate healthcare assistance.

64. The nurse had already been informed that the man had been found collapsed on the floor of his cell earlier, but this had not been considered an emergency. She told the investigator that she wanted to check the man's notes before going to see him. When the emergency was called, the prison was in night security state and the nurse had no keys so she had to call a dog handler to

escort her to the man's cell. She then had to go to the primary care unit to pick up an emergency bag. She said that it took her up to ten minutes to get to the man's cell.

65. The nurse told the investigator that there are two types of emergency bags at Wakefield, one for blood-related injuries and the other for breathing-related problems. She said the emergency bag for code blue (breathing difficulties) contained the prison's only defibrillator. In their feedback to the draft report NOMS said that the nurse's statement regarding the prison having only one defibrillator was incorrect. They said that there were actually five defibrillators within the prison at different locations.

66. Although the delay in this case does not appear to have impacted on the outcome for the man, we consider that up to ten minutes to get a nurse in the prison to a medical emergency is too long and in other cases could be crucial. It is a concern that a defibrillator and other emergency equipment is not easily accessible and led to a delay in the nurse attending. Many other prisons have emergency equipment on each wing or unit, which allows healthcare staff to attend emergencies quickly with equipment nearby. We make the following recommendation:

The Governor and Head of Healthcare should ensure that emergency procedures allow healthcare staff to get to medical emergencies without delay and that all staff can access emergency bags and defibrillators quickly and easily.

67. The officer called a code red emergency when he found the man collapsed in his cell. However, an ambulance was not called until the nurse requested one after she arrived at the cell. Prison Service Instruction 03/2013 about medical emergency response codes states that control room staff should call an ambulance as soon as they receive a code blue or code red message but this was not done. Governors were required to have implemented the mandatory elements of the instruction by the end of February 2013. It is fortunate that the first response paramedic arrived quickly but the control room should call an ambulance immediately when an emergency code is called. We make the following recommendation:

The Governor should ensure that emergency procedures are in line with PSI 03/2013 and that an ambulance is called immediately as soon as a code blue or code red emergency message is received.

Restraints

68. The Prison Service has a duty to protect the public when escorting prisoners to hospital, and a responsibility to balance this by treating prisoners with humanity and decency. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public, the prisoner's category and which also takes into account factors such as the prisoner's health and mobility.

69. 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. The judgement required that risks during stays in hospital needed to be assessed separately and should be reviewed regularly during a hospital stay or when circumstances change.

70. Security Group at Prison Service Headquarters issued guidance in January 2008 in response to the judgement. The guidance included advice specifically about seriously and terminally ill prisoners. It said that "separate risk assessments need to be conducted in relation to the level of restraint used for a) transportation to and from the hospital, and, b) for the prisoner's time at hospital. Any subsequent revision of the original risk assessment MUST have any medical opinion/input clearly annotated."

71. When the man was taken to hospital, prison staff assessed that he should be restrained by an escort chain because he was a prisoner from a high security prison and his offences were of a sexual nature. It was indicated that he should be double handcuffed unless there was a medical objection. The assessment did not take into account the man's current state of health or the fact that the offences had been committed 40 years previously. As all prisoners from Wakefield are from a high security prison this adds nothing to an individual risk assessment and it is a concern that the assessment concluded that double cuffs might be justified. The man remained restrained by an escort chain until 3.40pm on 3 April, when his health deteriorated. We welcome the fact that this was reviewed and he was not restrained after this time.

72. The risk assessment did not adequately take into account the man's deteriorating health, limited mobility or his visual impairment when the decision to use restraints was made. There was no input into the risk assessment from a member of healthcare staff. We have raised the matter of inadequate risk assessments in other investigations at Wakefield a number of times before. Although recommendations have been accepted we have yet to see a change in practice and responses from the prison do not suggest a willingness to do so. We have raised this matter with the Deputy Director of Custody responsible for high security prisons in relation to another high security prison and do so again in this case, specifically in relation to Wakefield. We make the following recommendation:

The Deputy Director of Custody for High Security Prisons should ensure that there are appropriate arrangements and guidance at Wakefield which ensure risk assessments for escorts fully take into account the medical condition of the prisoner and are based on the actual risk the prisoner represents at the time.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should ensure that there is a coordinated multi-disciplinary approach to meeting the needs of prisoners with complex physical, mental and social care needs.

2. The Governor and Head of Healthcare should ensure that emergency procedures allow healthcare staff to get to medical emergencies without delay and that all staff can access emergency bags and defibrillators quickly and easily.

3. The Governor should ensure that emergency procedures are in line with PSI 03/2013 and that an ambulance is called immediately as soon as a code blue or code red emergency message is received.

4. The Deputy Director of Custody for High Security Prisons should ensure that there are appropriate arrangements and guidance at Wakefield which ensure risk assessments for escorts fully take into account the medical condition of the prisoner and are based on the actual risk the prisoner represents at the time.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Governor and Head of Healthcare should ensure that there is a coordinated multi-disciplinary approach to meeting the needs of prisoners with complex physical, mental and social care needs.	Accepted	Complex cases are currently reviewed through case management meetings between the three healthcare providers: Humber NHS Trust, Nottinghamshire Healthcare NHS Trust and Spectrum Community Health and the Prison Healthcare and Drug Strategy Governor. However in response to the recommendation a new process will be implemented as follows. At the monthly Healthcare Clinical Governance and Service Improvement Forum a new standing agenda item will be tabled 'Complex Cases'. Individuals that are of concern to any provider because of their complex care needs will be identified and a healthcare provider multi-disciplinary case management meeting convened. The outcome of the case management meeting will be recorded on SystmOne (the patient electronic record) and a joint care plan will be initiated. Recent improvements to the services include a Dementia Lead Nurse within the Mental Health Service who is now working with the Older Peoples Lead Nurse from Primary Care Services to collaborate on providing seamless care to older adults with mental health needs. The prison has discussed social care provision with Health and Justice Commissioners, West	November 2013 Awaiting outcome. Review	

			Yorkshire Area Team, and a business case has been submitted through Humber NHS Trust for the provision of a social care resource for those identified with high levels of need.	in January 2014	
2	The Governor and Head of Healthcare should ensure that emergency procedures allow healthcare staff to get to medical emergencies without delay and that all staff can access emergency bags and defibrillators quickly and easily.	Accepted	There are plans in progress to relocate the emergency response bags and defibrillators to the Residence Centre on level 2 rather than within the Primary Care Centre. This should reduce any potential delays by improving access. Additionally, all prison staff will be issued with a Pocket Reminder card that gives information regarding the definitions of a Code Red and Code Blue and on the reverse there will be the healthcare emergency response contact numbers.	January 2014	
3	The Governor should ensure that emergency procedures are in line with PSI 03/2013 and that an ambulance is called immediately as soon as a code blue or code red emergency message is received.	Accepted	A Medical Emergency Response Code Protocol has now been issued in the form of a Notice to Staff, which has clarified the need for compliance with PSI 03/2013 in relation to the response to Red and Blue Code calls and the associated requirement for an ambulance to be called.	Completed and ongoing	
4	The Deputy Director of Custody for High Security Prisons should ensure that there are appropriate arrangements and guidance at Wakefield which ensure risk assessments for escorts fully take into account the	Accepted	The DDC of High Security reiterated the implications of the Graham Judgement in relation to hospital escorts and bedwatches to all High Security Governing Governors, including Wakefield, at a Senior Managers Board Meeting held on 15 August 2013.	Completed and ongoing	

	medical condition of the prisoner and are based on the actual risk the prisoner represents at the time.		With regards to Wakefield, a new risk assessment processes, including a management checklist, has now been introduced to ensure that risk assessments for attendance at hospital are based on individual circumstances with consideration of all relevant prevailing and historical information with an underpinning regard to the actual risk the prisoner presents; individual's risk of escape and also their risk to the public including nursing staff. The new risk assessment process and a flowchart detailing restraint considerations for prisoners on external bedwatch deemed seriously ill or end of life has now been implemented and added to the existing Bedwatch Logs. Risk assessments for prisoners in hospital are now dynamic and the use of restraints is, as necessary, reviewed to take account of changes in circumstances. Specific ongoing consideration is now given to medical opinion as the use of restraints and the prisoner's condition and treatment, with reductions in the level of restraint as necessary. Such reviews form not only part of the daily management check, but are conducted on the basis of continuous assessment of risk by the escorting staff in attendance.		