



**Investigation into the circumstances surrounding
the death of a man
in April 2011 at HMP Wakefield**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

May 2012

This is the report of an investigation into the circumstances surrounding the death of, a prisoner at HMP Wakefield. The cause of death was listed as sigmoid volvulus (bowel obstruction) and chronic obstructive pulmonary disease (lung disease).

I extend my condolences to his family. I hope that my report goes some way to answering any questions they may have. I regret that the report has been delayed and apologise for any additional distress that this may have caused to his family.

The investigation was carried out on my behalf of one of my senior investigators I would like to thank the Governor of Wakefield and her staff for their co-operation during the course of the investigation.

A clinical reviewer was appointed by Wakefield District Primary Care Trust to conduct a clinical review into the standard of healthcare the man received whilst in custody at HMP Wakefield. .

The man was already very unwell by the time he entered custody but the investigation found that his complex health needs were generally managed well over a number of years, particularly in the healthcare centre at Wakefield. It is therefore disappointing that on the day before he died he had to wait an unacceptably long time to access a doctor and obtain appropriate pain relief, and recommendations are made accordingly. The report also concludes that, although efforts were made to obtain a less secure and more appropriate location than Wakefield for him the process could have been managed more effectively.

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Prisons and Probation Ombudsman

May 2012

CONTENTS

Summary 4

The investigation process 5

HMP Wakefield 7

Issues 9

Conclusion 22

Recommendations 23

SUMMARY

1. The man was remanded into HMP Nottingham in October 2003, charged with serious offences. He received a 12 year sentence and was transferred to HMP Full Sutton in January 2004, before moving to HMP Wakefield in May, where he stayed until his death in April 2011. Formatted: Indent: Left: 0 cm, Hanging: 1.16 cm, Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0 cm + Tab after: 1.27 cm + Indent at: 1.27 cm, Tabs: 1.16 cm, List tab + Not at 1.9 cm
2. The man had been diagnosed with chronic obstructive pulmonary disease (COPD) prior to entering custody. When he moved to HMP Wakefield, he was accommodated within the inpatient unit in the healthcare centre. Efforts were made to find him more suitable accommodation in a prison that was not in the high security estate. There were very few establishments that would have been able to provide the level of care that he received at Wakefield. Discussions about the man's most suitable location continued up until he died. Formatted: Indent: Left: 0 cm, Hanging: 1.16 cm, Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0 cm + Tab after: 1.27 cm + Indent at: 1.27 cm, Tabs: 1.16 cm, List tab + Not at 1.9 cm
3. Appropriate medications and resources were obtained to treat his condition and care plans were implemented to ensure his care needs were met and his comfort was maintained. As his condition deteriorated, these care plans and risk assessments were reviewed and amended and palliative care was discussed. On 3 April 2011, he began to experience severe abdominal pain. Basic pain relief did not control the pain and advice was sought from Local Care Direct who provide healthcare services to the prison. A doctor said that he would attend Wakefield to examine him, which would have allowed staff to administer stronger pain relief if it had been prescribed. Formatted: Indent: Left: 0 cm, Hanging: 1.16 cm, Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0 cm + Tab after: 1.27 cm + Indent at: 1.27 cm, Tabs: 1.16 cm, List tab + Not at 1.9 cm
4. However, there was a delay of some seven hours between the initial request for a doctor and when they eventually arrived. Once the man had been assessed by the doctor, he was prescribed opiate pain relief and a sedative to help him relax and to stop the spasms he was experiencing. The clinical reviewer found that this was an unacceptable amount of time for a patient to be without appropriate pain relief, although healthcare staff did all they reasonably could to keep him comfortable while they were waiting. The outcome of this investigation supports that view. Formatted: Indent: Left: 0 cm, Hanging: 1.16 cm, Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0 cm + Tab after: 1.27 cm + Indent at: 1.27 cm, Tabs: 1.16 cm, List tab + Not at 1.9 cm
5. After the man fell ill, his daughter was contacted and made aware of the situation. A visit was arranged for her to see her father the following morning. However, he died that night at 11.42pm, with healthcare staff at his bedside. Formatted: Indent: Left: 0 cm, Hanging: 1.16 cm, Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0 cm + Tab after: 1.27 cm + Indent at: 1.27 cm, Tabs: 1.16 cm, List tab + Not at 1.9 cm
6. The investigator found that the process for gathering and forwarding parole documentation could have been dealt with better, and that prisoners' medication should be regularly reviewed. Consequently, recommendations are made in these areas. Formatted: Indent: Left: 0 cm, Hanging: 1.16 cm, Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0 cm + Tab after: 1.27 cm + Indent at: 1.27 cm, Tabs: 1.16 cm, List tab + Not at 1.9 cm

THE INVESTIGATION PROCESS

7. The investigation into the man's death was opened by our senior investigator on 12 April 2011. Notices were issued to staff and prisoners at Wakefield informing them of the investigation and inviting them to contact the investigator should they wish to talk to her regarding the investigation. No-one came forward with regard to the notices.
8. The investigator met with senior prison managers, the Independent Monitoring Board (IMB) and the prison's family liaison officer, and received copies of all documentation relating to the man's time in custody.
9. The investigator wrote to Wakefield District Primary Care Trust (PCT) to ask them to commission a review into the clinical care received by the man. This was undertaken by a Clinical Reviewer. This report relies heavily on her findings. It was received on 28 July 2011. We apologise that this investigation report has been delayed owing to workload pressures within the Ombudsman's office.
10. The investigator liaised with the Governor's representative throughout the course of the investigation, informing him of preliminary findings and highlighting any issues that had become apparent and that would be investigated further. A feedback letter was sent to the Governor on 1 July. It reported that the investigator had found few issues at that time, aside from the length of time taken for a doctor to visit the prison.
11. Her Majesty's Coroner for West Yorkshire Eastern District, was contacted and informed of the nature and scope of the investigation. On completion, a copy of the report will be sent to him to assist his enquiries into the man's death.
12. One of the Ombudsman's family liaison officers contacted the man's family and explained the remit and purpose of the investigation. She also offered them with the opportunity to raise any questions or concerns they may have had. His family said they had a number of issues they wished to be considered during the investigation:
- They were concerned about the treatment of his wrist.
 - They were concerned that they were not informed his hospital visits.
 - They were unhappy that they were not informed when he broke his hip.
 - They were concerned that officers did not appear to offer any help to him during family visits.
- His family received a copy of this report as part of the consultation period. We are grateful for their consideration of this.
13. The investigation assesses the following aspects of the man's care and treatment:
- Whether his diagnosis was made in a timely fashion
 - Whether he was told about his condition and the treatment which followed
 - Whether he was treated properly and attended hospital appointments as necessary
 - Whether the liaison with the family was appropriate
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- Whether he was accommodated in the most appropriate part of the prison
- Whether consideration was given to compassionate release from prison
- Whether appropriate palliative care was provided

HMP WAKEFIELD

14. HMP Wakefield is a high security prison (holding some prisoners who require the highest security conditions in the country). The operational capacity of the prison is 751 men, many who are serving sentences of over five years for sexual offences. There are four main residential units, with each wing holding around 185 prisoners in single cells.
15. Health services are commissioned by Wakefield District Primary Care Trust. There is a new primary care centre in the residential block, consisting of the prison doctor's consulting room and a treatment hatch (where prisoners' collect their medication). The main healthcare centre has consulting rooms for the dentist and optician, as well as a 19 bed inpatient unit.

Her Majesty's Chief Inspector of Prisons (HMCIP)

16. Her Majesty's Chief Inspector of Prisons last inspected Wakefield in December 2008. The report noted that many older prisoners and those with disabilities complained about a lack of support and felt they were not consulted about their individual needs and care. It was also noted, however, that there was a committed member of staff who worked as a disability liaison officer and coordinator for older prisoners. The report added that prisoners had to wait too long to see the prison doctor and too many outside hospital appointments were cancelled with little monitoring of the reasons.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) whose members are appointed by the Secretary of State for Justice from members of the community. Their role is to satisfy themselves that the prisoners are treated humanely and justly and that there are adequate programmes for preparing prisoners for release. The IMB report directly to the Secretary of State for Justice if they have any concerns. They also submit annual reports about how the prison has met the standards and requirements placed on it. Members of the IMB have access to every prisoner, every part of the prison and every prison record.
18. In their annual report for the period 1 May 2009 to April 2010, the IMB made the following comments:

"The ageing population of Wakefield does raise our concerns regarding available accommodation and purposeful activity not just for the ageing but for the prisoners of limited abilities. Simple activities we feel should be more available for the prisoners of limited ability."

19. In respect to the provision of the healthcare centre:

“The in-patient unit contains 15 beds and is normally working to full capacity with a mixture of elderly, infirm, chronic illnesses, and psychiatric cases. A useful addition to the service provided by the centre during the year was the introduction of a mobile x-ray unit that is brought in when required. Overall the Health Care Unit provides a comprehensive service that meets the needs of the prison population.”

Previous deaths in custody at Wakefield

20. Since the Ombudsman took responsibility for investigating deaths in custody in April 2004, there have been 35 deaths at Wakefield, 25 of which were due to natural causes. There are no matters of direct similarity between any previous investigations and that of the man.

ISSUES

The diagnosis of the man's terminal illness

21. He was remanded into HMP Nottingham in 2003. He had been diagnosed with chronic obstructive airway disease (COPD) prior to coming into custody and was under the care of a respiratory consultant at the local hospital. He was a smoker, despite being advised this was detrimental to his health and also suffered from ischaemic heart disease, epilepsy and osteoporosis (bone disease). He had moderate hearing loss and used hearing aids. He became short of breath on exertion, which had a significant impact on his mobility. He was also unsteady on his feet, resulting in frequent falls.
22. In May 2004, the man transferred to HMP Wakefield. He was admitted to healthcare for a period of assessment to enable medical staff to observe him and determine the most appropriate accommodation for him. Due to his complex medical needs and limited mobility, he stayed in healthcare for the duration of his time at Wakefield.
23. The man had been diagnosed with COPD prior to going into custody. He was fully aware of his condition and was already receiving treatment appropriate to the symptoms he was presenting with at the time.

Informing the man about his condition and treatment

24. The man was aware of his condition as he had been diagnosed with COPD prior to entering custody. Staff interacted with him as he declined in health. During a review on 22 July 2010, a doctor gave advanced care planning documentation to the man regarding his future care management needs due to his deteriorating condition. This provided him with the opportunity to look at his care options and to think of any questions he may wish to ask, enabling him to make an informed decision.
25. A further review was held with the doctor and a Senior Nurse on 5 August. It was explained that the man was not a candidate for ventilation, intensive care or resuscitation if he deteriorated. The doctor told him the options of palliative care and he said that he wanted to stay in prison if he deteriorated.
26. The Clinical Reviewer notes in her clinical review that: "the man was seen regularly by the Respiratory Consultant and as his COPD deteriorated he was fully informed regarding his prognosis and options for treatments."
27. It is clear from the prison record, and the Clinical Reviewer's review, that staff interacted with the man regarding his treatment options and prognosis as his condition deteriorated. They kept him fully informed at all times and provided him with the opportunity to ask questions and to make decisions relating to his care.

The man's medical appointments and treatment

28. The majority of the man's care was provided by medical professionals in the healthcare centre at Wakefield. He did, however, attend hospital appointments and follow up clinics. There were no concerns regarding the arranging of escorts for these visits or cancellation of any appointments.
29. A walking frame was obtained for the man in 2005 to assist his balance and mobilisation and to reduce the risk of him suffering falls. On 4 October, appropriate resources were obtained such as a special mattress and extra oxygen to ensure that he was comfortable and his needs met appropriately.
30. In July 2006, the man was found on the bathroom floor by his cell mate. He said that he had slipped off the toilet while trying to have a wash. He fractured his hip as a result of the fall and had a dynamic hip screw fitted to his left hip. A foam cushion was ordered to help make him comfortable while resting and to ensure that he did not suffer from pressure sores.
31. The man suffered from another fall in August and broke his wrist. He attended the accident and emergency department of the local hospital, where his wrist was repositioned and set in a cast. He was also prescribed medication to help prevent further fractures due to the fragility of his bones. His family highlighted his hospital treatment as one of their concerns, but the actions of the hospital fall outside of the Ombudsman's remit.
32. On 25 September, the man fell from his chair as he was trying to stand up. His Zimmer frame had slipped on the rug. An entry in his medical record says that he had fractured his right leg and he was admitted to hospital. He was discharged back to the inpatients unit in healthcare on 4 October. Appropriate resources had already been given such as extra oxygen to ensure that he was comfortable and his needs could be met appropriately. It was noted in his medical record that he needed to be sat up in bed to prevent him getting pneumonia (an inflammatory lung condition).
33. Care plans were created to ensure that staff met the man's particular needs such as maintaining his comfort and appropriate maintenance of his catheter (a tube inserted into his body to allow drainage or administer fluids). On 5 October, '24 hour unlock' was approved as he kept trying to get out of bed and was falling. (This meant that staff were able to observe him closely and enter his cell without delay.)
34. During the first few months of 2007, the man was treated appropriately for chest infections and was admitted to hospital due to COPD. Staff continued to tend to his needs and provided him with appropriate resources and care. He also had a carer (another prisoner) on the wing who would clean his cell and collect his meals. This also provided him with some company throughout the day. In April he received a wheelchair to enable him to mobilise independently around the wing (although it was noted in his medical record that he was able to walk with assistance).

35. His condition began to deteriorate in 2008 and he continued to suffer from chest infections as his COPD worsened. Another doctor reviewed the man on 23 July. It was noted in his medical record that he had stopped smoking although he had poor air entry in both his lungs. It was agreed that continuous oxygen therapy would be beneficial to him and this would be facilitated.
36. There were no further significant entries in his medical record until 2010 as his condition remained stable during that time. However, on 25 January 2010 it was noticed that he had begun to suffer from bed sores on his buttocks and hips. Dry dressings were applied and he was told how he could help to alleviate the symptoms and prevent them becoming worse by regular rotation in bed and being as mobile as possible. A tissue viability nurse (a nurse specialising in wound care) was contacted on 2 February who gave further advice and said that they would visit the man to assess him. It is not clear from the prison records whether this happened.
37. On 16 May, he was examined by an out of hours doctor. He had pain to his right rib area and was diagnosed as having a cracked rib. Pain relief and antibiotics were prescribed.
38. On 10 September, it was recorded that the man appeared increasingly confused. He was pulling his cannula (a small tube inserted into a vein) out and was panicky and anxious when he became breathless. During the night he displayed signs of hypoxia (reduction of oxygen to tissue). The out of hours doctor was contacted and came to examine him. The doctor was unable to get any coherent conversation from him but noted that his breathing was quiet. He prescribed antibiotics and pain relief. He was already being nursed using an open door policy with an officer sitting outside his door so nursing staff could have full access to him at all times. He was more animated and alert after medication, although he was still confused at times.
39. A doctor made an entry in the man's medical record on 6 October. He said that he continued to slowly decline physically and was now struggling to maintain a seated position while sitting in a chair. He was also confused at times. A further entry on 20 October said that his condition was quite variable and he was struggling to recognise the doctor and other members of staff.
40. During the early hours of 3 April 2011, he said that he felt sick and had stomach pains. It was noted that he had been sick at approximately 5.00am. He was examined by a healthcare officer who took his temperature, blood pressure and other general observations which were within "normal" limits. The healthcare Officer noted that he had a good appetite and was alert and orientated.
41. The man continued to complain of feeling unwell and lethargic. The Healthcare Officer assessed him again at 11.58am. He said that his abdomen was firm to touch and that he appeared unwell in his appearance. He contacted Local Care Direct (an organisation providing out of hours and weekend healthcare to the prison) who said that a doctor would make contact

within ten minutes. The healthcare Officer recorded his general observations again.

42. At 12.43pm, healthcare advice was sought from NHS direct. A Nurse Manager also spoke with a doctor from Local Care Direct who said they would visit that day. The doctor advised that if the man's condition deteriorated and the pain in his abdomen increased to contact them again. A urine sample was taken to be tested for a urinary tract infection and he was encouraged to drink plenty of fluids.
43. Another healthcare Officer contacted Local Care Direct again at 2.39pm and requested that a doctor attend as soon as possible. Due to the seriousness of the man's condition, an ambulance was called. Paramedics attended and examined him. They said that he needed to go to the accident and emergency department at the local hospital, however he refused to go. The healthcare Officer discussed this information with the doctor again over the telephone and the doctor said again that they would visit.
44. The healthcare Officer contacted Local Care Direct again at 5.45pm to inform them that the man had deteriorated further. The doctor gave an estimated time of arrival of 7.30pm. The Nurse Manager made an entry in his medical record at 7.15pm. She noted that he felt cold, but that he would not keep any blankets on him. He was restless and his breathing was shallow and tolerated nebulisers for a short period of time. He was awake and knew that staff were there, but would shut his eyes and drift off to sleep. He had taken sips of water, but had not urinated and his abdomen remained distended. He was not able to say if he was in pain or not and staff were still waiting for the doctor to arrive. It was noted that he tolerated oxygen and took paracetamol for pain relief.
45. The doctor from Local Care Direct arrived at 7.45pm and examined the man..A Nurse made an entry in his medical record on behalf of the doctor. He was said to have looked emaciated and very weak, his breathing was laboured and he gasped for breath. He received oxygen and was alert. There were no masses felt in his stomach, although his abdomen remained distended. When asked if he would go to hospital, he shook his head to indicate that he did not want to go. The doctor noted that he had terminal COPD and was dying and was not to be resuscitated.
46. The Nurse made another entry at 8.44pm. She noted that the man remained weak and continued to gasp for breath. He had been given 2.5mg of diamorphine (a strong opiate pain relief), to help ease his breathing. Healthcare staff changed his position in his bed to make him more comfortable and he was told that his daughter had telephoned and was thinking of him. The Nurse said that he was able to understand what was being said to him, but he was only able to respond with one word answers. His skin was cold to touch and he was pale.
47. He was noted to breathe more easily at 10.55pm, and did not gasp as much as he had been previously. As he had some leg spasms, he was given

Midazolam (a sedative) to relax him. Nursing staff sat with him to provide support and comfort and, although his awareness was said to have diminished, he was aware of their presence.

48. At 11.42pm, the man's breathing stopped. The Nurse examined him and recorded in his medical record that there were no signs of life, such as a pulse or pupil reaction. No resuscitation attempts were made, as previously discussed, to maintain his dignity. Local Care Direct and paramedics were informed. Paramedics were called and arrived to certify that he had died at 12.19am on 4 April.
49. The clinical reviewer, concluded in her clinical review that "the man had complex health needs prior to entering the prison system, all of which were subsequently managed appropriately." There did not appear to be any issues in regard to arranging escorts and he was attending hospital appointments. The majority of his care was provided within the healthcare centre at Wakefield, however when he needed extra support or treatment, advice was sought from Local Care Direct as to the most appropriate medications to be prescribed and whether he needed outside hospital treatment. The clinical review shows that the doctor who reviewed him on 5 August held weekly clinics within Wakefield for patients with respiratory disease. He also worked closely with medical and nursing staff within the healthcare centre, which provided a good level of care and treatment to the man. There was evidence of good communication with outside agencies who provided additional support.
50. However, despite the general good level of care he received, the clinical reviewer has concerns about the level of treatment provided on 3 April. The issue of medication is discussed below, but the lack of access to a doctor for such a length of time is concerning. The clinical reviewer writes: "It is difficult to understand why it took over seven hours ... for a visit from a Doctor." We therefore recommend:

The Head of Healthcare should review the events of 3 April and ensure that timely access to a doctor is always available to patients.

The man's pain relief and medication

51. The man used inhalers and nebulisers to help ease his symptoms of COPD. He was prescribed appropriate medication in relation to ischaemic heart disease and epilepsy. He was compliant with his medication. From 2008, he was provided with a constant supply of oxygen to use as needed, which helped to ease his breathing.
52. The man suffered from many chest infections. He was prescribed antibiotics to treat the infection as well as basic analgesia to help alleviate the symptoms. This appeared to be sufficient in controlling and treating the infections. Advice and support was regularly sought from Local Care Direct with regard to prescribing medication to help ease any symptoms and ensure his comfort was maintained.

53. Anticipatory medications (medication prepared for a patient in anticipation of their condition worsening) were prescribed on 22 July 2010. This was to make sure that any medication he may have needed when his condition deteriorated were available within the healthcare setting. This ensured his symptoms could be managed appropriately.
54. On 25 September the man fell from his chair and was taken to hospital where it was discovered he had broken his leg. However, on admission to hospital it was noted that the level of anti-epileptic drugs he was taking was of a toxic level and this could have contributed to his falls. The dosage was immediately reduced. It is important that healthcare staff regularly review a prisoner's medication to ensure the correct medication and dosage is prescribed:

The Head of Healthcare should ensure that prisoners' medication is reviewed on a regular basis.

55. The man began to experience severe pain on 3 April. Basic pain relief did not control his pain and advice was sought from Local Care Direct. As he did not want to be admitted to hospital, healthcare staff were limited to the treatment and care they could provide. They telephoned Local Care Direct and requested an out of hour's doctor to examine him in the healthcare centre. However, there was a significant delay of seven hours for the doctor to attend, which meant that his care needs were not appropriately met at that time.
56. This is an unacceptable amount of time for a patient to be without the appropriate pain relief, although Wakefield healthcare staff did all they reasonably could to keep him comfortable while they were waiting for the doctor to arrive. Once the man was assessed by a doctor, he was prescribed an opiate pain relief medication and a sedative to help him relax and stop the spasms he was experiencing. The clinical reviewer writes:

"his condition deteriorated during 3 April 2011 and on occasions he appears to have been in a significant amount of pain. The nursing staff in the prison attempted to make him as comfortable as possible whilst waiting for a doctor to visit to prescribe appropriate pain relief."

The Head of Healthcare should ensure that prisoners receive appropriate pain relief in a timely manner.

57. The clinical reviewer finds that the man was provided with the appropriate medications to control his symptoms of COPD. His chest infections were appropriately managed with antibiotics and pain relief and he had open access to nebulisers and oxygen: "he was provided with appropriate medication to manage his COPD, including the use of long term oxygen therapy."

58. His pain was managed effectively, apart from on 3 April, as mentioned above, when a significant delay in a doctor attending Wakefield meant that he was not provided with adequate pain relief.

Liaison with the man's family

59. As the man had been diagnosed with COPD prior to entering custody, his family were already aware of his condition. He telephoned his daughter and received visits from her, during which he was able to inform her of his condition including any treatments he had.
60. His daughter wrote a letter to Governor Brook on 14 March 2008. She said that due to the deterioration in his health, she did not feel that staff were able to provide him with adequate care and felt that he would have been better suited to a secure nursing home. A reply was sent from the head of healthcare on 6 April. The letter said that a sentence management board meeting was to be held to discuss the issues regarding the man's health and his location at Wakefield. It said that he was well looked after and extra resources had been obtained to help enhance his care needs.
61. The man's daughter contacted the healthcare centre on 21 January 2011. She told the healthcare **Officer who contacted the Local Care Direct for a doctor** that the man's brother had died. She also asked about her father's end of life care and was given a brief explanation on what would be provided. The man's daughter said that she wanted to be involved and was upset that personal circumstances had prevented her visiting him more often.
62. His daughter was contacted during the early evening of 3 April and was told that her father was very unwell. She requested to come to visit him that evening, but was told this was not possible as the prison would be in patrol state. A visit was arranged for 10.00am the following morning. His daughter was contacted again at 6.00pm by the Nurse Manager. She explained that the man was extremely unwell and outlined the role of the family liaison officer (FLO) and the support they could provide. He was told that his daughter had telephoned and had passed on a message. He died later that night before his daughter could visit him.
63. It is clearly unfortunate that his daughter was unable to see her father before he died. However, he was very clear that he did not wish to be taken to hospital at any stage of his illness and this had consequences for him and his family. The investigator discussed this matter with Wakefield who explained that security precautions precluded out-of-hours visits. The 10.00am visit was outside of usual visiting hours and indicates that the prison sought to be as flexible as they could.
64. Although the man's daughter was unable to visit her father, a Senior Officer contacted her shortly after he passed away. She confirmed the time that he died and answered her questions. She was informed of the procedures that would take place over the next 24 hours and it was explained that a woman would make contact and visit her, in her role as prison's FLO. .

65. The prison chaplain and the family liaison officer visited the man's family to provide information, support and offer assistance with funeral arrangements. The funeral was conducted by the prison chaplain on 19 April and the prison contributed to the cost of the funeral.
66. His family raised a number of issues which they wanted considered as part of this investigation. Most of these are covered throughout this report. However, they asked why they had not been informed when the man broke his hip. Prison rule 22 states that the Governor should inform the family if a prisoner dies, becomes seriously ill or sustains a serious injury (although it does not specifically state what constitutes a serious injury). It seems that the prison did not think his injury fell in this category, and although the Prison Rule does not define a broken hip as a serious injury, it seems common sense that a break such as that in an elderly man could have severe consequences. .

The Governor should ensure that a prisoner's family are informed if they sustain a serious injury, such as a broken hip suffered by an elderly and infirm patient.

67. His family also said they had visited him in 'closed visits' and staff did not assist him in any way, which they found distressing. The investigator found no evidence of this, or that the visits took place anywhere other than in the healthcare centre.

The man's location and compassionate release

Transfer to a different prison

68. Due to the man's complex medical needs and limited mobility, he stayed in healthcare for the duration of his time at Wakefield. An entry in his medical record on 24 November 2005 said that he needed total nursing care as he was now incontinent, unsteady on his feet and was becoming increasingly confused and paranoid. A sentence planning board meeting was also held that day where the option of him being moved to HMP Norwich was discussed as a more appropriate location.
69. A chartered forensic psychologist sent an email to the prison on 28 March 2008 to say that they thought the man would be better suited to a prison nearer to his home probation area, particularly as he only had three and a half years left of his sentence. As he would need specialist care in the community upon release, they said that the probation service would be able to find him suitable accommodation and the sooner they could look for places the better, particularly as he would be closer to his family.
70. The Governor wrote a letter to the high security briefing casework team on 14 April. He said that the man's care needs had to be addressed and there were concerns whether he needed the level of security that Wakefield provides. A sentence planning board meeting was held on 2 June. The board considered him suitable for re-categorisation to category C, however it was recognised

that this could hinder an opportunity for a transfer to an appropriate establishment. It was decided to retain him at category B while enquiries were made as to where he might be transferred. If a category C establishment were to be identified, then he could immediately be re-categorised to category C to enable the move.

71. A letter was sent to HMP Norwich on 23 July, referring him. It was believed that Norwich would be an appropriate establishment to meet his complex needs. Various emails were exchanged between the prison and a member of healthcare staff at Norwich during August. It was said that Norwich were unable to accept him at that time as they had just received an urgent palliative care patient. They also said that, as a life sentenced prisoner, his categorisation would need to be reduced before he could be referred. Wakefield explained that the man could be re-categorised if needed and this had been agreed with the offender management team.
72. A risk assessment and management case report on 6 September noted that he was not ready for open conditions. However, due to the decline in his health, he did not require high security conditions. It was advised that every effort should be made to find a suitable a category B or C establishment closer to his probation area.
73. During a review on 5 August, 2010, the man said that he did not want to go to hospital if he became unwell and wanted all treatment to be facilitated in healthcare where he felt he was looked after well.

The Parole Board

74. An OASys risk assessment (Offender Assessment System) and parole assessment was held on 8 May 2009. His OASys assessment noted that his medical condition prevented him from attending any offender behaviour programmes and due to his poor health, his risk may have diminished. It was, however, recorded in the report that there would always be a risk of re-offending if he was left on his own with children. His parole assessment was completed by his offender manager. She said that she was unable to support the man's application for release due to the level of power and control exhibited in his offences. She said that the risk of re-offending could not be eliminated. Throughout the forthcoming years, meetings were held which decided that, without evidence of risk reduction, parole for him could not be supported.
75. A further parole assessment was completed by the man's offender manager on 10 January 2011. It said that there was no change to his attitude to offending and he had not completed any offence related work. His medical condition was said to be a big factor in the risk assessment and licence conditions were outlined, such as to reside in an appropriate 24 hour nursing home. The Parole Board deferred their decision, and reports and information were due to be forwarded to them in 28 days time. However, no decision was reached before he died.

Compassionate release

76. He was given the appropriate compassionate release forms to be completed to start the process on 3 December 2010. It is the responsibility of the prisoner to start the process and it was explained to him that staff within healthcare would be able to help him fill his part of the form in. Once the process had been initiated, it is the responsibility of the prison to take it forward.

77. A doctor completed the medical officer section of the compassionate release paperwork on 19 May 2010. It was noted that he had a severe respiratory illness and would require careful placement in the community to continue his level of care. No specialist report was obtained from any of his consultants and no health targets or life expectancy was given. PSO 6000 – Parole, Release and Recall, states that “Any other reports which are available, for example from hospital consultants, must also be forwarded. It is essential that an indication of likely life expectancy is included in the report”. There were letters from the man’s consultants and discharge letters in his medical record that held vital information and the doctor could have used these to support his medical report. It is unfortunate that some of the important paperwork, which could have had a bearing his application, was not passed on to the appropriate members of staff.

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78. The final stage of the compassionate release process was completed on 2 July. The parole assessment report said that they were unable to support his application for compassionate release due to the circumstances and sustained length of his offences, which could not eliminate the possibility of further re-offending.

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79. An entry in the man’s parole dossier on 17 September said that his case had been re-referred and it was agreed his application for compassionate release should be referred again to the Secretary of State. Over the coming weeks there was some confusion between the review team, the parole board and the team manager of public protection. It was clarified that it was the responsibility of the prison to process applications and they would not be accepted directly from prisoners or solicitors. It was decided to await clarification from the board panel regarding directions for the process and specialist reports could then be requested if deemed appropriate.

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80. The man was visited by his solicitors on 26 January. He was told that in regard to compassionate release, the probation service were finding it difficult to find suitable accommodation for him due to the cost of his care. It was also difficult to determine the area in which to accommodate him due to certain licence conditions. They said that further agencies were being contacted and referrals were ongoing.

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81. On 30 March, his offender manager confirmed that Wakefield Legal Services had agreed to conduct an initial assessment for nursing care, however, they were still some way off of composing a risk and release management plan. No decision had been reached at the time of his death.

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Conclusion

82. The man was appropriately accommodated in the inpatient unit in the healthcare centre when he moved to HMP Wakefield. His care needs were met and he had access to the services he needed. His care needs were complex and were appropriately managed by staff, however there were mixed opinions amongst staff about whether he needed to be in a high security setting given the nature of his condition.
83. Efforts were made to find him suitable accommodation, however there were very few establishments that would have been able to provide the level of care that he received at Wakefield.
84. Conflict between external services caused delays in trying to find an appropriate establishment and held up the compassionate release process. There were also delays between reports being made to complete the various stages of the compassionate release process. There did not appear to be anyone co-ordinating the process or taking a lead to ensure that it was completed in a timely manner with appropriate information included.

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The Governor should ensure a clear system is in place to complete parole and compassionate release paperwork in a timely manner.

Care plans and palliative care

85. In view of the man's recurrent falls and his serious health condition, care plans were created to ensure that staff were aware of his needs and how they could ensure that they were adequately met. As his needs changed and his condition deteriorated, his care plans were amended as appropriate.
86. On 10 May 2010, a personal evacuation plan risk assessment was made. He was a high priority and an evacuation chair was to be used, should there be a need for an evacuation. The care plan was kept in healthcare which was easily accessible for all staff to refer to. It was noted that he was monitored annually and to have regular contingency tests.
87. The man was told on 5 August that he "was not a candidate for ventilation, intensive care or resuscitation if he deteriorated". A doctor explained the options of palliative care available, so that he was aware of his options before his condition deteriorated to a point of requiring palliative care. He said he wanted to die in prison and not be treated at the hospital. The doctor reviewed him in regard to palliative care on 9 December. He noted that there was a marked improvement in his condition, he was mentally alert, was chatty and had a good food and drink intake. There was no change in his current plan of care at that time.
88. The doctor made an entry in the man's medical record on 6 January 2011 that there were no concerns regarding his care management at that time. There was still an improvement in his condition and his care management was

effective. As his condition was reasonably stable over the coming months, staff did not anticipate that his health was going to deteriorate and he was not at a stage where palliative care was needed.

89. During interview a senior healthcare officer, described how he and the doctor who reviewed him on 5 August had a conversation with the man about being resuscitated. The SO said that the doctor determined that the man had the mental capacity to decide that he did not want to be resuscitated or be taken into hospital should his condition worsen. As his condition did not present any need for palliative care, a 'Do Not Resuscitate' note was documented in his medical record to make staff aware of what had been agreed. Anticipatory medications were prescribed and kept in healthcare so that they were readily available at any time if his condition deteriorated to a stage where he would need them. All parties were aware that he could change his mind at any time.
90. The clinical reviewer writes that: "The palliative care agencies were involved with the man's management and care, attending meetings and being accessible by telephone to provide support." The clinical reviewer also commented that care plans, including a "Do Not Resuscitate" policy, were agreed with him and implemented. However, these were not entered in his electronic medical record or full medical file (IMR), as staff appeared unaware that they were able to enter the plans directly into a patient's record. Subsequently, and in line with the clinical review, the following recommendation is made:

The Head of Healthcare should ensure that all appropriate documents are included in a prisoner's medical file.

91. Appropriate care plans were put in place to ensure that the man's complex care needs were met. They were easily accessible for staff to refer to and were amended when appropriate. Risk assessments were made to ensure he was safe within his environment at all times.

Restraints, security and bed watch

92. The majority of the man's care was adequately provided within the healthcare centre at Wakefield. However, during any hospital consultations he was escorted by two officers using restraints. As he was fully mobile during his hospital appointments, the cuffing arrangements were adhered to in line with the security policy. This meant that they could be reduced during medical procedures and he was able to be restrained using a closet chain while an inpatient at hospital. Appropriate risk assessments were made prior to hospital appointments and during hospital admissions. The personal escort records and bed watch log entries were made to a good standard and were legible.

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93. His family were not informed when he attended these routine hospital appointments, as it could have compromised prison security. This is in line with usual prison procedures.

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CONCLUSION

94. The man entered prison a very unwell man and spent most of his time in custody in Wakefield's healthcare department. He generally received very good healthcare whilst in custody, although some weaknesses in medication arrangements were identified and there was an unacceptable delay in accessing a doctor on the day before he died. The clinical reviewer's overall conclusion was that: "The man had complex health needs prior to entering the prison system, all of which were subsequently managed appropriately". The reviewer also notes that he was kept fully informed of his prognosis and options for treatment.
95. The issue of his' parole application is undoubtedly a complex one. From an early stage attempts were made for him to be moved to another prison, or to a care home, but the nature of his alleged offence made this difficult. It appears that there was a need for better co-ordination from Wakefield and the different departments and agencies involved.

RECOMMENDATIONS

Recommendations to the Head of Healthcare:

1. The Head of Healthcare should review the events of 3 April and ensure that timely access to a doctor is always available to patients.
This recommendation was accepted and the action has been completed.
2. The Head of Healthcare should ensure that prisoners' medication is reviewed on a regular basis.
This recommendation was accepted and the action has been completed.
3. The Head of Healthcare should ensure that prisoners receive appropriate pain relief in a timely manner.
This recommendation was accepted and the action has been completed.
4. The Head of Healthcare should ensure that all appropriate documents are included in a prisoner's medical file.
This recommendation has been accepted and the action has been completed.

Recommendation to the Governor:

1. The Governor should ensure that a prisoner's family are informed if they sustain a serious injury, such as a broken hip.
This recommendation has been partially accepted. They explain that in accordance with PSI 64/2011 where prisoners have suffered sudden life-threatening harm, the prisoner's wishes on who they would like to be contacted are ascertained where possible. In the event that the prisoner is unable to communicate their wishes, the prison contacts the nominated next of kin to provide them with an accurate account of what has happened. Target date for completion of action is June 2012.
2. The Governor should ensure a clear system is in place to complete parole and compassionate release paperwork in a timely manner.
This recommendation was not accepted. The prison said that a clear system already exists to ensure that parole and compassionate release paperwork is completed in a timely fashion.

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