PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death a man at HMP Wakefield in November 2011

Report by the Prisons and Probation Ombudsman for England and Wales

September 2012

This is a report into the death of a man in November 2011 at HMP Wakefield. He was 78 years old and died from a brain haemorrhage. I offer my condolences to his family and friends.

The investigation was carried out by two investigators. The local PCT appointed a clinical reviewer to review the man's clinical care. Staff at Wakefield co-operated fully with this investigation. I apologise that this report is late.

The clinical review found that, while the man was at Wakefield, he received a standard of care that was equivalent to that which he could have expected to receive in the community. His death was sudden and nothing could have been done to prevent it. The prison was appropriately supportive to his wife after his death.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **September 2012**

CONTENTS

SUMMARY

1. The man was convicted of sex offences and sentenced to ten years imprisonment on 1 May 2009 and sent to HMP Leeds. He had a history of heart disease and high blood pressure and was prescribed medication. He also suffered from hearing loss in his left ear and tinnitus.

2. On 23 July 2009, he transferred to HMP Wakefield. While at Wakefield he was monitored regularly by healthcare staff. He was allocated a ground floor cell to assist his mobility.

3. On 15 February 2011 a prison doctor referred him to an orthopaedic consultant for an assessment of his right shoulder as he had severe pain and his mobility had greatly reduced. He declined to attend three appointments with the orthopaedic consultant.

4. One morning in November 2011, at approximately 8.15am, the man was found in his bed unconscious and not breathing. Healthcare staff immediately responded and paramedics were called but he was pronounced dead at 8.35am. The post–mortem found that his death was caused by a subarachnoid haemorrhage (when blood leaks out of blood vessels over the surface of the brain).

5. In the days that followed, the prison family liaison officer maintained contact with the man's wife and offered support and financial assistance towards the funeral expenses.

6. We are satisfied that the care and attention he received at Wakefield was equivalent to what he could have expected to receive in the community. We make no recommendations.

THE INVESTIGATION PROCESS

7. The investigation was opened on 16 November 2011, when the initial investigator issued notices announcing the investigation to staff and prisoners. These included an invitation to anyone with information relevant to the investigation to contact her. No one came forward as a result.

8. The investigator requested copies of all documentation relating to the man from HMP Wakefield and this was sent on 6 December. She visited Wakefield on 1 March 2012 and interviewed four members of staff and two prisoners. Two other prisoners declined a request to be interviewed

9. The local PCT appointed a clinical reviewer to review the man's clinical care. The investigator and the clinical reviewer discussed aspects of his treatment during his time at Wakefield. The clinical reviewer interviewed two members of staff.

10. The investigator contacted Her Majesty's Coroner to inform him of the investigation and request a copy of the post mortem report. The investigation report will be sent to the Coroner to assist his enquiries.

11. The investigation was reallocated to another investigator on 28 March. This report has been delayed due to the absence from duty of the original investigator.

12. Our Senior Family Liaison Officer contacted the man's wife to inform her about the investigation and to invite the family to ask any questions or raise any concerns. She had no issues or concerns with the care that her husband received at Wakefield.

HMP WAKEFIELD

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

HM Chief Inspector of Prisons (HMCIP)

14. HMCIP last conducted a full announced inspection of the prison in December 2008. The Chief Inspector noted that since the last full inspection in 2003:

> "Wakefield has improved considerably over the last five years and it is pleasing that in general the improvement has been sustained. There is still work to be done on aspects of safety, staff-prisoner relationships and activities, but the principal issue to be tackled is how to motivate and engage serious sexual offenders, so that their risk is reduced and they can progress through the prison system."

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

Independent Monitoring Board (IMB)

16. Each prison has an IMB whose members are unpaid and 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.

17. In their annual report for the year to April 2011, the IMB made the following comments:

> "The Primary Care Centre pharmacy and GP service is operated by Spectrum Community Health, and during the report year a number of additional facilities have been provided that have built on the comprehensive service outlined in last years report. There are a number of regular clinics in operation dealing with chronic conditions such as diabetes, coronary heart disease and respiratory disorders. These, together with the Primary Care Centre treatment room introduced last year, have uncovered more illness among the offender population. The number of GP hours available has been increased to meet this demand.

> “Overall, the Health Care Unit provides a comprehensive service that meets the needs of the prison population to a level equivalent to that available to the general public via the NHS.

18. The board noted that the number of elderly offenders at the prison continued to increase and that there were specific learning and skills sessions to meet their needs.

19. The man’s death was the fifth attributed to natural causes to have occurred at Wakefield in 2011. There were no significant similarities between any previous deaths except that the age of most reflected the ageing population at Wakefield.

KEY EVENTS

20. The man was born in July 1933 and lived in the Leeds area. He had a history of heart disease, high blood pressure, hearing loss in his left ear and suffered from tinnitus.

21. On 1 May 2009, he was convicted of sex offences and given a ten year custodial sentence. He was sent to HMP Leeds and on arrival had an initial healthscreen conducted by a nurse. (A first reception healthscreen takes place every time a prisoner arrives at a prison) He told the nurse that he suffered from heart disease and was prescribed bisoprolol (for high blood pressure), ramipril (for heart disease) and warfarin (to prevent blood clots). He said that he was a non-smoker, he had not been in custody before and he had no thoughts of self harm or suicide. The nurse took the details of his community GP and requested his community medical records.

22. Later that evening, the man saw a prison doctor, who recorded his blood pressure as 150/90 which was classed as high. The doctor prescribed the same medication he received in the community and requested that regular International Normalised Rates (INR) checks be undertaken (blood tests to check the level of warfarin dose required).

23. In the days that followed, he had regular INR checks. When received, his community records indicated that he had been under the care of a consultant cardiologist at hospital. He last saw the cardiologist on 20 February 2009 when the doctor diagnosised that he was suffering from atrial fibrillation (irregular heart beat) and hypertension (high blood pressure) and the prescribed medication of bisoprolol, ramipril and warfarin were appropriate. The cardiologist confirmed that he did not require regular cardiology check ups and he was therefore was discharged from hospital.

24. On 27 May, the man saw a doctor as he complained of breathlessness on mild exertion and climbing stairs. The doctor recorded that he had a slight swelling in his legs and signs of pulmonary oedema (fluid accumulation in the air spaces of the lungs). His blood pressure was recorded as 122/74 (within the normal range). The doctor prescribed him furosemide (for high blood pressure and oedema) in addition to his other medication.

25. Between 28 May and 22 July, the man had 15 separate interventions with healthcare staff at Leeds which included checks on his warfarin levels and reviews of his medication. This included having a chest X-ray at hospital on 24 June, the results of which showed that there were no problems with his heart and his lungs were clear.

26. The man transferred to HMP Wakefield on 23 July 2009. On arrival at Wakefield he saw a nurse, who conducted an initial healthscreen and confirmed that medical records had been received from Leeds detailing his medication and treatment. The nurse recorded his blood pressure as 114/78 (within the normal range) and that he appeared relaxed and settled.

27. The following day he saw a prison doctor for a routine check. In the months that followed, he had 57 separate face to face interventions with healthcare staff including nurses and doctors to review his warfarin levels and other prescribed medication. He attended exercise sessions, the library and chapel services as well as being visited by his family.

28. On 9 June 2010, the man saw another prison doctor, as he complained of dizziness. The doctor recorded that there were no signs or symptoms of vertigo, however due to his hearing loss and tinnitus the doctor referred him to the Ear, Nose and Throat (ENT) specialist at hospital. In addition, the doctor prescribed cinnarizine (for dizziness and motion sickness). He had two outpatient appointments with the ENT specialist on 13 and 29 July.

29. The man saw a nurse on 17 August as he complained of pain in his right shoulder. The nurse examined him and prescribed ibuprofen (pain killer and anti-inflammatory) for two weeks with a follow up appointment with a doctor and made a referral for a physiotherapist assessment.

30. He saw another prison doctor on 1 September who diagnosed that he had a frozen shoulder (when the connective tissue surrounding the the shoulder, becomes inflamed and stiff, greatly restricting motion and causing chronic pain). The doctor noted that he had already been referred to a physiotherapist and gave him a methylprednisolone injection (anti-inflammatory steroid).

31. Between 2 September and 25 January 2011, the man regularly saw healthcare staff for warfarin level checks. He also had four sessions with a physiotherapist, who had prescribed heat patches as well as giving him exercises to improve his shoulder.

32. During this period he had two outpatient appointments at hospital, one for his hearing on 22 October, and one on 19 January 2011 for an ultrasound scan which showed damage to one of the tendons in his shoulder.

33. On 26 January, the man saw a doctor as he had suffered with a cough for two weeks and still experienced shoulder pain. The doctor prescribed a one week course of amoxicillin (antibiotic) and made another referral to the physiotherapist.

34. He saw the physiotherapist on 4 February, who recorded that as physiotherapy had little or no affect on his symptoms he required a referral to an orthopaedic surgeon. A doctor referred him to an orthopaedic consultant on 15 February.

35. On 23 May, the man had a fall in his cell and a nurse came to see him. The nurse recorded that he had a very small superficial graze to the first knuckle on his right hand which did not require any treatment. There was no limb weakness or dizziness; however, there was some involuntary shaking of the hands. The nurse made an appointment for him to see a doctor.

36. On the same day, he had been due to attend hospital for an appointment with the orthopaedic consultant but because of the fall he did not feel up to attending. He signed a disclaimer recording his decision.

37. Four days later, he saw another prison doctor, as arranged by the nurse. The doctor recorded that his blood pressure was 157/99 (above normal range) and that he had mild memory problems and suffered from intermittent shakes and tremors. The doctor noted that, if these symptoms persisted, he should be referred for a neurological assessment.

38. On 9 June, the man saw another doctor to review his hearing loss and tinnitus. He told the doctor that he was aware that his hearing had deteriorated but he did not want to be referred to the hospital. The doctor recorded that his ear canals were clear and that a referral to hospital would be made if he reconsidered.

39. Between 10 June and 15 November, the man was seen on 23 separate occasions for warfarin level checks. There is no record that he had any further symptoms of memory loss, shakes and tremors. He declined to attend two further hospital appointments to see the orthopaedic surgeon on 15 August and 7 November. On each occasion, he signed a further disclaimer despite encouragement from staff to attend.

40. Following his non-attendance on 15 August, the orthopaedic consultant at hospital sent a letter to healthcare at Wakefield which said that he had reviewed the results of the ultrasound scan and in his opinion the man would benefit from surgery. However, if he could manage with the pain and restrictive movement then no further action needed to be undertaken.

41. The man's personal officer (a nominated officer responsible for particular prisoners and as first point of contact for concerns or issues) noted on his records that during this period he continued to spend some time in the open air, use the library, attend chapel, associate with others on the wing and had visits from his family.

Events in November

42. The officer who had been on duty during the night had conducted the early morning roll check at approximately 5.30am and no concerns about the man were raised. The officer handed over to another officer, who came on duty at approximately 6.45am. This officer did a roll check of prisoners on the landing and recalled that when he came to the man's cell, C2-18, having put the night light on, he could see that he was in bed, apparently asleep, with his body under the covers. The officer turned the night light off and concluded the roll check. Roll checks are a physical count that all prisoners are present and there is no expectation that staff should wake prisoners at this time.

43. At 8.00am another officer had been detailed to unlock cells C2-19 to C2-1. On arriving at the man's cell, the officer noticed that he was still in bed and

appeared asleep, so the officer opened the door and continued unlocking the remaining cells.

44. At approximately 8.15am a prisoner on the wing told two officers that he had been to see the man but he did not look well. One officer went immediately to the treatment room to get the nurses on duty and the other went to the cell.

45. When the officer reached the cell, two other prisoners came out. The officer moved the prisoners away from the cell and went in to check on the man. The officer found him in bed and under the covers. He checked for a pulse but there was none apparent and he felt cold. A Matron and a nurse then arrived with the resuscitation equipment and an automated external defibrillator (AED) (A defibrillator monitors the heart rhythm and administers electrical shocks to the heart to restore the normal rhythm when necessary). The nurse had already requested an emergency ambulance.

46. On examining the man the nurses were unable to find a pulse, there were no sounds of breathing, his pupils were fixed and dilated and there was evidence of rigor mortis (a chemical change in the muscles after death, causing the limbs to become stiff and difficult to move) and rigor mortis (settling of the blood causing a purplish red discoloration of the skin, which is an indication that it would be futile to begin resuscitation). Both nurses agreed that, based on their clinical experience, that resuscitation was inappropriate. The nurses waited in the cell until the paramedics arrived at 8.30am when, following their assessment, they confirmed that he had died.

47. A hot debrief was held for all staff involved in the emergency incident that morning, chaired by a governor, with the services of the care team available for staff. (A hot debrief is a meeting for staff to discuss issues and any lessons learned following serious events.). Staff and the chaplaincy were available to offer support to prisoners affected by the man's death. All prisoners being monitored as at risk of self-harm or suicide were checked by staff.

48. Later that morning, at 9.45am, the prison family liaison officer (FLO) and a chaplain went to visit the man's wife to break the news of his death. During the visit, she was offered condolences, support and, in line with national guidance, financial assistance towards funeral expenses. In the following days, the FLO maintained contact with her and attended his funeral service.

ISSUES

Clinical Care

49. The clinical reviewer considered the care and treatment that the man received from healthcare at Wakefield, and his review concludes:

> "His anti-coagulant therapy [warfarin] was well monitored in close conjunction with the local hospital in accordance with good practice guidelines. His blood clotting (International Normalised Ratio, INR) was monitored regularly and it was ensured that the INR level was safe before prescriptions for anti-coagulants were dispensed.
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> "He had a shoulder injury and hearing problems and after initially attending hospital for tests he subsequently refused all outside hospital appointments.
>
> "He had the capacity to refuse appointments and investigations and did so despite concerted efforts by medical and nursing staff to persuade him otherwise.
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> "He was last seen by a health professional two days before his death for his regular blood test to monitor his warfarin dose. On that occasion the nurse noted that he was in good spirits and said he was feeling well.
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> "Nursing staff responded promptly on the day of his death with the necessary resuscitation equipment.

50. The clinical reviewer explained to the investigator that the cause of the man's death from a subarachnoid haemorrhage, caused by a berry aneurysm, could not have been predicted. His prescribed medication was closely monitored and appropriately adjusted and the treatment he received at Wakefield would not have prevented his death.

51. When considering the overall care that he received while at Wakefield the clinical reviewer said:

> "The man was an elderly gentleman with multiple health problems who received a good standard of health care whilst at HMP Wakefield. His care was equitable to that which he could have expected in the community."

Family liaison

52. The prison provided appropriate support to the man's family, including promptly visiting his wife in person to give her the news of his death, and offering support as well as financial assistance with funeral expenses.

CONCLUSION

53. It is clear that attention was paid to the man's health needs and appropriate treatment and care was provided. The standard of care received at Wakefield was equivalent to that which he could have expected to receive in the community. He exercised his right to not to attend appointments for his shoulder problems and had the capacity to make an informed decision. His death could not have been foreseen.