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 HMP Wakefield in May 2013

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 in May 2013 of a man at HMP Wakefield. He was 60 years old. The cause of death was established by post-mortem as acute bronchopneumonia due to end stage pulmonary fibrosis (scarring of the lung). I offer my condolences to those who knew him.

The investigation was carried out by one of my investigators and a review of the man's clinical care in custody was carried out by a clinical reviewer. HMP Wakefield cooperated fully with the investigation.

The man was diagnosed with terminal lung disease some years before he died, which led to a gradual decline in lung function and mobility. I find that he received very good medical care and support throughout his illness for which staff deserve commendation. However, I am not satisfied that the use of restraints when he was admitted to hospital two months before his death was justified by a properly considered risk assessment – a matter I have previously raised with HMP Wakefield.

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 2013**

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SUMMARY

1. The man first reported symptoms of chest infection, chronic cough and hoarseness in spring 2009 and was promptly referred to a respiratory consultant. Various tests took place over the following 18 months – some of which were delayed by the man's reluctance to undertake them – before a diagnosis of emphysema and pulmonary fibrosis was confirmed. He was told that there was no cure for his lung disease and that any treatment would be to delay the decline in his lung function.

2. By autumn 2011, the man's lung function had deteriorated to the extent that he was considered a candidate for a lung transplant. However, after some research and discussion, the man decided that his faith as a Jehovah's Witness prevented him from accepting the transplant. As a result, he was told that he could now be considered as terminally ill. In February 2012, his care began to be kept under review by a specialist end of life care team at Wakefield.

3. The man's symptoms were well controlled and few changes were made to his care and treatment plans. His lung function continued to deteriorate and, in November 2012, he started 24 hour oxygen therapy. As a result, he moved into a cell in the healthcare inpatient unit. Other than a sudden deterioration in late March 2013, which resulted in an emergency hospital admission, the man's health remained relatively stable for the remainder of his life. Although he was terminally ill, his death, in May, was unexpected.

4. The clinical reviewer finds that the man received care of a consistently high standard at Wakefield. However, we do not consider that the use of restraints was justified during his five night hospital admission in March 2013. He was a wheelchair user with very poor mobility and the risk assessment was not reviewed during his stay in hospital. We make a recommendation on this matter.

THE INVESTIGATION PROCESS

5. On 31 May 2013, notices were issued announcing the investigation to staff and prisoners at Wakefield, inviting anyone who had relevant information to contact the investigator. No one came forward.

6. The investigator visited Wakefield on 7 June. During the visit, he saw the healthcare unit where the man lived for the last six months of his life. He spoke to a nurse who knew the man well, and the prison's head of litigation. He also met the Chair of the local Independent Monitoring Board[1] (IMB).

7. The investigator returned to Wakefield on 23 July and interviewed one member of staff and two prisoners who knew the man. He later spoke by telephone to the prison's lead nurse in palliative care.

8. The investigator contacted the local Coroner to inform him of the investigation and request a copy of the post-mortem and toxicology reports. A copy of this report has been sent to the Coroner.

9. A clinical reviewer carried out a review of the man's clinical care in custody on behalf of NHS West Yorkshire.

10. The man's sister, his formal next of kin, could not be located after his death and has not therefore been involved in our investigation. His ex-wife chose not to be involved with any of the procedures that follow a death in custody.

[1] Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained.

HMP WAKEFIELD

11. 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. All cells are single occupancy. The man was a category A prisoner and lived on A wing before moving to the healthcare inpatient unit in November 2012. The inpatient unit contains a dedicated cell for end of life care.

HM Inspectorate of Prisons

12. The inspectorate conducted an unannounced full follow-up inspection of Wakefield in May 2012. They found that health services had significantly improved since their last inspection and older prisoners and those with life long conditions were well supported. They also found that the inpatient unit was well managed and its residents were well cared for. Inspectors noted that efforts had been made to develop palliative care arrangements and an end of life programme for terminally ill patients.

Independent Monitoring Board

13. In its most recent annual report, the Independent Monitoring Board (IMB) found that healthcare staff provided a comprehensive service that met the needs of the population. The investigator met the Chair of the local IMB during his visit on 7 June, who said that they had previously identified issues about the pharmacy and prescribing of medication but that this had improved significantly.

Previous deaths at HMP Wakefield

14. The man is the ninth of 11 prisoners to die of apparent natural causes at HMP Wakefield since January 2012. Many of these men were older prisoners diagnosed with life long conditions. On the whole, we found that the men received satisfactory healthcare in prison. However, in a number of investigations we found that the use of restraints during hospital escorts was not justified by a fully considered risk assessment.

ISSUES

The diagnosis of the man's terminal illness

15. The man was sentenced to life imprisonment in 2000 and spent time in several high security prisons before moving to Wakefield in October 2008. At the time of the move he had little significant medical history, other than recent treatment for a hernia.

16. Following a chest infection, chronic cough and hoarseness in spring 2009, the man saw a consultant in respiratory medicine who holds a regular clinic at the prison. He referred the man for a chest X-ray, which took place in June and showed a potential abnormality. A scan was arranged for August, the results of which indicated pulmonary fibrosis[2]. The consultant explained these results to the man at his prison clinic on 24 September. He referred him for a bronchoscopy[3] to confirm the diagnosis and ensure there was no further underlying cause (such as a cancerous tumour) for the man's hoarseness.

17. The bronchoscopy took place on 27 November and found nothing abnormal. At his prison clinic on 24 December, the consultant explained this result to the man and that the next step was to carry out various tests of his lung function and, more significantly, a surgical lung biopsy. The man was initially reluctant about the biopsy and asked for some time to think about it. He agreed to the lung function tests.

18. In June 2010, the man agreed to the biopsy and this was arranged for 25 October. The results were available in November, and confirmed a diagnosis of emphysema[4] and pulmonary fibrosis

19. The clinical reviewer comments that it took several months to undertake the various tests that confirmed the man's diagnosis, which was partly due to the complexity of the investigation process. Another contributory factor was the man's reluctance to undergo some of the tests. Nevertheless, we find that he was referred appropriately by prison doctors when he initially presented with respiratory symptoms.

Informing the man about his condition and treatment

20. The results of the man's various scans were explained to him each time at either a hospital clinic or at the consultant's prison clinic. When he was unsure about whether to have the lung biopsy, the consultant explained why this was important and the man was given time to consider his decision.

21. An appointment was made for 10 January 2011 for the man to discuss the results of his biopsy and treatment plan with a second consultant. (This was noted to be the first available appointment.) At the appointment, the

[2] Pulmonary fibrosis is commonly described as 'scarring of the lung'. Its symptoms include shortness of breath and it leads to a gradual deterioration in lung function.
[3] A bronchoscopy is an examination of the inside of the lungs with fibre optic tube.
[4] Emphysema is a disease of the lungs that affects a patient's breathing.

consultant explained that there was no cure for the man's lung disease and any treatment would be to delay the decline in lung function. The man said he understood the aims and likely side effects of his treatment plan.

22. Although it took some time to confirm the man's diagnosis, we are satisfied that he was informed throughout of his latest test results and plans for future investigations. When his diagnosis was confirmed, he was given full information about his likely prognosis and treatment plan. The clinical reviewer comments that there is extensive documentation of detailed discussions between the man and healthcare staff of various disciplines and he clearly understood the seriousness of his condition. We are satisfied that he received appropriate information and support both before and after his diagnosis.

The man's medical appointments and treatment

23. At the January 2011 appointment at which the man's diagnosis was confirmed, the second consultant explained his treatment plan. This initially involved the prescription of a combination of medications to treat the illness (known as 'triple therapy' medication), which the man agreed to start immediately. The consultant explained that a transplant would be considered if the man's lung function deteriorated further.

24. After assessing the man at his prison clinic in August 2011, the first consultant recorded that his condition was getting gradually worse. He was now breathless after minimal exertion. A chest X-ray taken earlier in the month showed that his fibrosis had worsened. A week later, after discussing the man's deterioration with colleagues at an outside hospital, the consultant decided that it was now time to consider a lung transplant.

25. At his next prison clinic, on 16 September, the first consultant spoke to the man about his recent deterioration and the benefits of a transplant. He told him that his condition was very likely to deteriorate further and shorten his life expectancy, whereas a successful transplant would improve his symptoms and increase his life expectancy. The man was cautious about the procedure as he was a Jehovah's Witness and could not therefore agree to a blood transfusion which was a requirement for the operation. The consultant agreed that he would discuss this with specialists at the Transplant Unit.

26. Over the next three months there were various discussions between the consultant in respiratory medicine at the prison (first consultant), the man and transplant specialists. Eventually, in December 2011, the specialists wrote to both consultants to confirm that the procedure could not take place unless the man agreed to a blood transfusion as the chance of success and survival was significantly lower without this agreement. The man discussed this with Jehovah's Witness elders and, in February 2012, confirmed that his religious beliefs precluded him from accepting a blood transfusion. Therefore, he did not wish to go ahead with the procedure.

27. At the same time, the consultant in respiratory medicine at the prison stopped the man's triple therapy medication as recent studies had shown that the treatment could potentially do more harm than good for patients with pulmonary fibrosis. Also, because of the man's deteriorating lung function, the consultant thought there was little benefit in continuing. He added that the man's deterioration over the previous year meant that he could now be described as terminally ill and with a poor prognosis.

28. The man continued to attend the consultant's prison clinic around once a month over the remainder of the year. His lung function continued to deteriorate and, by October 2012, he found it difficult to walk due to his breathlessness. After further assessment, it was determined that he had now deteriorated to the extent that he would benefit from long term oxygen therapy[5]. This started on 16 November and he received oxygen 24 hours a day. He now used a wheelchair, even for short distances.

29. At the next prison respiratory clinic, the consultant and a specialist nurse discussed with the man the change in his treatment and that it meant he was now considered suitable for palliative care only.

30. We are satisfied that the man received appropriate treatment after his diagnosis, his wishes were respected and he was able to attend all appointments. There was evidence of good communication between healthcare and hospital staff, and it is particularly beneficial for patients such as this man that the respiratory consultant holds a regular clinic in the prison. We agree with the clinical reviewer's conclusion that the man received medical and nursing care of a consistently high standard throughout his terminal illness.

Palliative care plans

31. On the same day that he stopped triple therapy medication, the consultant in respiratory medicine at the prison told the man that he was terminally ill and his prognosis was poor. As a result, he began to be monitored by the prison's Gold Standards Framework[6] group and a care plan was initiated. The lead nurse in palliative care at Wakefield told the investigator that the man's symptoms were well controlled and therefore his care plan often did not change from month to month.

32. On 21 November, at his first clinic since the start of long term oxygen therapy, the consultant in respiratory medicine at the prison spoke to the man about resuscitation if he stopped breathing. He explained it would be futile due to

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[5] Long term oxygen therapy is the provision of oxygen, usually through a tube in the nose from a portable oxygen canister. It is usually given for at least 15 hours a day but can be used 24 hours a day.

[6] The Gold Standards Framework aims to optimise care for patients approaching the end of life, by improving the quality and organisation of care in line with the patient's needs and preferences. At Wakefield, a panel meets monthly to discuss any changes that might be made to the patient's care. The panel includes prison doctors and nurses, palliative care specialists from the community, and the respiratory consultant.

his terminal condition. The man agreed that the consultant should complete a 'do not attempt to resuscitate' (DNAR) order[7].

33. The man thought more about the DNAR order over the following week and decided that he could not commit to it on religious grounds. It was therefore cancelled on 29 November. Further discussions were held later in December, involving the consultant at the prison, the man, the lead nurse in palliative care at the prison and a Jehovah's Witness chaplain. The consultant explained that if the man were to stop breathing this would be classed as a terminal event, meaning it would lead to a natural death and that resuscitation in these circumstances would not be beneficial. The chaplain agreed that there were no religious implications and the man therefore agreed that the DNAR order should be re-established. This was completed on 19 December.

34. The man remained stable in early 2013, and no changes were suggested to his care plan at Gold Standards Framework meetings. In late March, he was reported to be deteriorating slowly and was more breathless. By 31 March, he was very short of breath and was admitted to an outside hospital for assessment and treatment. He returned to the prison on 5 April, having been prescribed a course of antibiotics and had his oxygen concentration increased. He was very unwell for around a week before he recovered to his previous stable condition.

35. In a report for the Parole Board on 29 April, the consultant in respiratory medicine said that the man had a prognosis of around 12 to 18 months. Although he deteriorated slowly over the following month, the man's death, in May, came unexpectedly.

36. The clinical reviewer concludes that the use of the Gold Standards Framework ensured that the man received high quality care in the final year of his life and was an example of good practice. He goes on say that the prison and medical staff at Wakefield should be commended for the care they provided. We agree.

The man's pain relief and medication

37. At a Gold Standards Framework meeting on 20 November 2012, morphine sulphate (a strong painkiller) was added to the man's prescription. This was for him to use when he needed it, if experiencing pain from shortness of breath and to help relax his breathing.

38. The lead palliative care nurse at Wakefield told the investigator that the man's symptoms were well controlled for the duration of his terminal illness. Few changes to his medication were therefore required. He began to lose weight in 2013, as he found eating difficult and was therefore given nutritional drinks that he found easier to consume.

[7] A DNAR order means that in the event of cardiac or respiratory arrest no attempt at resuscitation will be made. All other appropriate treatment and care will be provided.

39. Towards the end of May, consideration was given to prescribing medication that could be administered through a syringe driver[8]. A prison doctor and palliative care specialist nurse discussed the possibility and decided that the man was some way off requiring this type of medication. He continued to use morphine sulphate to ease his symptoms for the remainder of his life.

40. Pain control was not an issue for the man for much of his illness and the medication he was prescribed was sufficient to control his symptoms. The clinical reviewer comments that he received appropriate palliative care medicines. We agree.

Liaison with the man's family

41. Prison Service national instructions[9] direct prisons to engage with the next of kin of prisoners who are terminally ill. When he started 24 hour oxygen therapy in November 2012, the consultant in respiratory medicine asked him if he would like his family to be contacted. The man said he had no next of kin and did not want the prison to contact anyone.

42. The prison's then healthcare manager spoke to the man about his family on 5 March 2013. He reiterated that he had no next of kin. A month later, on 6 April, he told a prison chaplain that he had a sister. However, he said that he did not want her to be contacted until he had died and that he would like any contact to be made by a Jehovah's Witness chaplain rather than prison staff. (The man said his sister was also a member of the Jehovah's Witness faith.) He added that he did not know where his sister lived as he had not had any contact with her for some time.

43. In May, the man was approached by the lead nurse in palliative care at the prison to see if he would like his sister to be contacted. He repeated his previous request that this should not be done until after he had died.

44. After the man's death, the police were asked to help locate his family. His ex-wife and daughter were found and a prison family liaison officer spoke to them about the man and the procedures that follow a death in custody. After some consideration, the man's ex-wife and daughter decided that they did not want any further involvement.

45. Various other means were tried to find the man's sister, including asking his solicitor and probation officer to check their records. None were successful. A Jehovah's Witness chaplain tried to locate the man's sister through the faith network, but was also unable to do so.

46. The man's funeral was held on 21 June 2013 and was arranged and funded by HMP Wakefield. A Jehovah's Witness chaplain from the prison led the service. A memorial service was also held at the prison, which the man's friends were able to attend.

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[8] A syringe driver is a small portable pump used to provide a continuous dose of painkiller or other medication.

[9] Prison Service Instruction (PSI) 64/2011.

47. We are satisfied that the man was given the opportunity to engage with his family. Although he chose not to do so, he was reminded and given the opportunity to initiate contact on several occasions.

The man’s location

48. The man lived on A wing for much of his time at Wakefield. He worked as a wing cleaner and was very keen to continue this work for as long as he could, even when his illness meant he became breathless very quickly. He had a cell on an upper floor of A wing and was asked if he would like to move to a cell on the ground floor. Even though he noticeably struggled with the stairs, the man always said he preferred to stay where he was.

49. Once he started 24 hour oxygen therapy in November 2012, the man agreed to move to the healthcare inpatient unit, where it was easier to administer the therapy. He used a wheelchair to move around the unit, but usually preferred to stay in his cell. Several of the man’s friends from A wing were able to visit him frequently after his move and those to whom the investigator spoke said that these visits were easy for them to arrange.

50. When he returned from hospital on 5 April 2013, the man moved to the inpatient unit’s end of life cell. Permission was given for the cell to remain unlocked overnight, as he required regular observations and nursing input and was unable to get out of bed unaided. This order was cancelled three days later, as he had improved and was now reportedly able to get out of bed into his wheelchair unaided.

51. The order for the man’s cell to be unlocked overnight was not re-established and, when he died at around 4.55am on 30 May, it was behind a locked door. This was evidently not ideal. However, while he was acknowledged to be terminally ill, the man’s death was unexpected and he had recently been given a prognosis of 12 to 18 months and a recent assessment had determined that he was still capable of moving from his bed to his wheelchair.

Compassionate release

52. Early release on compassionate grounds is a means by which seriously ill prisoners can be permanently released from custody before their sentence has expired. The criteria for early release for indeterminate sentenced prisoners are set out in Prison Service Order (PSO) 4700. They include that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner’s care and treatment at an outside prison, and release would benefit the prisoner and his family. Prisoners are usually expected to have less than three months to live. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) within the National Offender Management Service (NOMS).

53. On 8 May 2013, the lead palliative care nurse at Wakefield spoke to the man about applying for early release. He was uncertain, and said he thought an application was unlikely to be granted. The nurse later told the investigator that the man was happy to be cared for in the prison, where he could be visited by his friends. One of his friends, who visited him frequently after his move to the inpatient unit, also said he thought the man would be reluctant to move to a hospice as he would not have anyone to visit him.

54. Around a month before he died, the man was given a prognosis of 12 to 18 months by the respiratory consultant. The lead nurse in palliative care at the prison told the investigator that his death came very suddenly and was unexpected. She added that his symptoms were well controlled throughout his illness and at no time did he require hospice admission.

55. It is clear to us that the man did not meet the criteria for early release on compassionate grounds, because of his prognosis and the lack of suitable accommodation for him outside of prison. However, we are satisfied the possibility of compassionate release was given consideration.

Restraints, security and bedwatch

56. 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 maintaining their dignity. 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 and which also takes into account factors such as the prisoner's health and mobility. A judgment 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 judgment indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process. It deemed that handcuffing a prisoner receiving chemotherapy (and, by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.

57. An emergency ambulance was called on 31 March 2013, as the man was very short of breath and had very low oxygen saturation levels (a measure of the amount of oxygen in the blood). His mobility had been poor for some time and he used a wheelchair to move, even over very short distances. The exacerbation of his shortness of breath meant that his mobility was even more restricted than usual and he was unable to get out of bed unaided.

58. An escort risk assessment was completed before the man's admission to hospital. The medical section, completed by a healthcare senior officer (HCSO), contained no details of the man's medical condition, symptoms or

mobility and simply stated "medical emergency, escort chain[10] required and most appropriate". He was assessed as a low risk of escape (on a scale of low, medium, high) but a high risk to the public were he to escape. The assessment was authorised by the head of residence who concluded that a senior officer and two officers should accompany the man and that an escort chain should be used.

59. When interviewed, the head of residence explained that, although there was little information in the medical section of the risk assessment, as the man was a category A prisoner he spoke to the healthcare senior officer to get more information about his medical condition. It was this knowledge that prompted him to authorise the use of an escort chain rather than the two pairs of handcuffs usually applied when a category A prisoner leaves the prison. The head of residence said that he did not consider following the set procedures for authorising the use of no restraints on a category A prisoner (which involves contacting the Director of High Security's Office) because death was not considered to be imminent.

60. The man remained in hospital for five nights. His risk assessment was not formally reviewed during his stay.

61. Prison Service guidance is that restraints are not normally necessary on an escort when the prisoner's mobility is severely limited. This would apply in these circumstances. While we accept that public protection is paramount, security measures must be proportionate to a prisoner's individual circumstances. There is no evidence that the man presented a risk of escape or to the public that could not be managed by the three person escort team. We do not therefore think that the use of an escort chain was justified. This is an issue we have previously raised with Wakefield. We make the following recommendation.

The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances, are based on the actual risk the prisoner presents at the time and are reviewed within 24 hours if they are admitted as an inpatient or when there is a significant change in circumstances.

62. This recommendation was accepted by Wakefield. Their response suggests that they already consider the individual circumstances and actual risk that a prisoner presents. However, our findings in this investigation do not support this statement and we advise the Governor to more carefully consider the risks presented by seriously ill prisoners and those with limited mobility.

[10] An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and another to an officer.

RECOMMENDATION

The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances, are based on the actual risk the prisoner presents at the time and are reviewed within 24 hours if they are admitted as an inpatient or when there is a significant change in circumstances.

Accepted

Risk assessments for prisoners taken to hospital are based on a consideration of the individual's circumstances and the actual risk the prisoner presents at the time. There is an underpinning regard to not only the individual's risk of escape but also their risk to the public.

Risk assessments for prisoners in hospital are dynamic and the use of restraints is reviewed as necessary to take into account any significant changes in circumstances. Specific ongoing consideration is given to medical opinion as to 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.