PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in December 2013 while in the custody of HMP Wakefield

Our Vision

'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution
to safer, fairer custody and offender supervision'

This is the investigation report into the death of a man, in December 2013, while a prisoner at HMP Wakefield. The man died from a gastrointestinal bleed as a result of a stomach ulcer. He was 57 years old. I offer my condolences to the man's family and friends.

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

The man was sentenced to life imprisonment in 1998 and moved to HMP Wakefield in September 2000. He had a number of pre-existing health conditions which were managed by throughout his time in prison.

Between December 2012 and October 2013, the man reported suffering from heartburn on five different occasions and had been prescribed antacid medication. On 21 October, the man felt unwell and nauseous and on 23 October was diagnosed with a urinary tract infection. Five days later he collapsed in his cell and was taken to hospital as an emergency. He remained in hospital and was diagnosed with an active duodenal ulcer. Despite an apparent improvement in his condition, he had a massive bleed and died on 7 December.

The clinical reviewer was satisfied that, overall, the man received a good standard of care at Wakefield. However he noted that nurses needed to record full observations and assessment when using an electronic consultation tool and refer patients to a GP when necessary. If this had been done, the man might have been investigated earlier in relation to his continuing heartburn. The use of a recognised early warning assessment tool might also have led to an earlier admission to hospital.

The man was unrestrained during his emergency admission to hospital. However despite his limited mobility and poor health, restraints were applied when he regained consciousness and were in place until shortly before he died. I am not satisfied that this decision was based on appropriate risk assessment which fully took into account the man's health and mobility. This is a matter I have raised with the prison before and I expect the governor to satisfy himself that lessons are being learnt.

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 **July 2014**

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SUMMARY

1. The man was sentenced to life imprisonment in 1998 for serious sexual offences, with a minimum period to serve of 10 years. He had a number of pre-existing health conditions including hypertension, type two diabetes, asthma, heart disease, obesity and depression. He transferred to HMP Wakefield in September 2000.

2. The man's medical conditions were managed appropriately throughout his time in prison. In June 2011, he complained of chest pain and was referred for further tests. The results showed his pain was not cardiac related and he received medication for heartburn.

3. Between December 2012 and October 2013, the man complained of heartburn on five occasions and was prescribed gaviscon (antacid medication). The medical entry relating to three episodes is identical and the clinical reviewer concluded that a facility on SystmOne (the electronic medical record) known as 'auto consultation' was used. There is no evidence that the man was referred to a GP on these three occasions.

4. On 21 October, the man said he was suffering from nausea and vomiting, but no health assessment was recorded. Two days later he was diagnosed with a urinary tract infection and prescribed an antibiotic. His pulse rate was recorded as high and his blood pressure was low.

5. On 28 October, the man collapsed in his cell. Nurses attached a defibrillator and began resuscitation. He was taken to Pinderfields Hospital by ambulance accompanied by three prison officers (later reduced to two.) Initially, the man was not restrained, but an escort chain was used as his condition improved.

6. On 23 November, after an episode of gastrointestinal bleeding, an active duodenal ulcer was detected. The man remained in hospital and his condition appeared to improve. He remained restrained by an escort chain until an hour or so before his death.

7. On 7 December, the man suffered a massive upper gastrointestinal bleed; he did not recover and died the same day. A post-mortem recorded his death was due to gastrointestinal haemorrhage, a duodenal peptic ulcer and ischaemic heart disease.

8. The clinical reviewer was satisfied that the overall level of care the man received at HMP Wakefield was of an equivalent standard to that which he could have expected in the community. However, he found that healthcare staff using the 'auto consultation' function of SystmOne need also to record their observations and assessments and that an early warning tool might have led to an earlier hospital admission. We are concerned that the risk assessment for the ongoing use of restraints in hospital did not take into account the man's condition at the time. We make three recommendations.

THE INVESTIGATION PROCESS

9. The investigator issued notices to staff and prisoners at HMP Wakefield informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.

10. The investigator obtained copies of the man's relevant medical records and extracts from his prison records. He interviewed four members of staff at HMP Wakefield on 5 March 2014. The investigator gave the Governor's representative feedback about the initial findings of the investigation and followed this up in writing.

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

12. We informed HM Coroner for West Yorkshire (Eastern District) of the investigation, who provided the results of the post-mortem examination. We have sent the Coroner a copy of this investigation report.

13. One of the Ombudsman's family liaison officers contacted the man's sister and explained the investigation process. The man's sister said that the presence of two uniformed officers at the hospital was excessive. She asked whether consideration had been given to releasing the man before he died. She also said that his family had experienced difficulty obtaining information about his health when he was in hospital.

14. The family liaison officer met with the man's sister to discuss the draft report. She indicated that she was satisfied with the findings. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included at the end of the report.

HMP WAKEFIELD

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

16. Primary care services are provided by Spectrum CIC (Community Interest Company) during normal working hours. The inpatient unit is staffed by nurses employed by Humber NHS Foundation Trust (intermediate care), who also provide overnight and weekend cover for patients with physical health problems at Wakefield. Mental Health Services are provided by Nottinghamshire Healthcare NHS Trust.

HM Inspectorate of Prisons

17. The most recent inspection of Wakefield was in May 2012. Inspectors found that health provision had significantly improved since the last inspection. Waiting times to see a GP still needed attention, but the range of primary care services was considered to be of a good standard and appropriate for the population, many of whom were older prisoners. Patients were well cared for in a well managed inpatient unit.

Independent Monitoring Board

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

Previous deaths at HMP Wakefield

19. The man's death was one of seven from natural causes at Wakefield in 2013. We have raised concerns about the use of restraints on seriously ill prisoners before and this still appears to be an issue.

KEY EVENTS

20. The man was sentenced to life imprisonment in 1998 for serious sexual offences, with a minimum period to serve of 10 years. He had a number of pre-existing health conditions including hypertension, type two diabetes, asthma, heart disease, obesity and depression, for which he receiving regular medication and nursing care. He transferred to HMP Wakefield on 21 September 2000.

21. In June 2011, records show the man complained of chest pain. Investigations revealed his pain was not cardiac in nature. His condition was treated as dyspepsia (heartburn) and he was given antacid medication. The man smoked cigarettes and records show he stopped in 2010, but started again in 2013.

22. On 8 December 2012, a nurse saw the man who was complaining of heartburn and indigestion. He examined him and prescribed gaviscon (antacid medication). Over the next few months the man had little further interaction with healthcare staff.

23. On 17 April 2013, another nurse prescribed gaviscon for the man, who again was suffering from heartburn. The nurse did not record any observations.

24. On 21 May, the man reported to the prison's healthcare unit with chest pains. A prison GP saw the man on 24 May, when an ECG indicated no abnormalities to his heart. The GP diagnosed chest wall pain and prescribed gaviscon again.

25. On 23 July, a nurse saw the man who was still complaining of heartburn. He prescribed gaviscon but did not record any observations. On 29 July, another doctor saw the man to review his diabetes medication. She discussed diet and lifestyle changes, but there is no record of any discussion about his recurring heartburn.

26. At 9.08am on 28 August, a nurse saw the man in the primary care clinic. He was sweating heavily, but he did not report chest pain or of feeling unwell or dizzy. His blood pressure, pulse rate, blood sugars and oxygen saturation levels were recorded as normal.

27. Later that day, the doctor saw the man and discussed the episode of sweating that morning. The man said he did not have chest pain, shortness of breath or palpitations and believed this to have been an isolated episode.

28. A nurse saw the man on 11 October, as he had heartburn and acid indigestion. She prescribed gaviscon, but did not record any observations.

29. On 21 October, the man attended the medical treatment hatch. He said he felt unwell with nausea and vomiting and was given three days absence from work. No assessment was recorded. The nurse advised him to seek further help if his condition got worse.

30. At 6.03pm on 23 October, a routine urine dipstick test showed the man had a urinary tract infection and antibiotics were prescribed. A nurse saw him at 6.22pm and the man said he had not eaten for four days. The nurse recorded his pulse rate as high, but his blood pressure was low at 100/70. The nurse recorded that the man's lips were dry and scabby.

31. A nurse checked the man in his cell at 2.28am that night. The man said he still felt unwell, but was able to manage within the confines of his cell. The nurse told him to alert staff during the night if his condition got worse and asked him to report to the primary care clinic in the morning for further investigation. There is no record of him attending the clinic.

32. At 1.34pm on 26 October, a nurse saw the man in his cell. He said he was feeling generally unwell. The nurse noted he had taken just one dose of the antibiotics prescribed three days earlier. She emphasised the importance of taking his medication and explained that the urine infection was the likely cause of his current symptoms. She noted the man's blood pressure and oxygen saturation were normal. His blood glucose level was high and the nurse noted he had not attended for his insulin two days earlier. She took him to the clinic where this was administered. The man was slightly dehydrated and nurses advised him to drink more.

33. The nurse checked the man that afternoon and he appeared to have improved. His blood glucose level was still high, but it had fallen from the earlier reading. On 27 October, a nurse saw the man and recorded that he looked brighter. She supervised his insulin and he said he was taking his antibiotics.

Events on 28 October 2013

34. At 8.44am on 28 October, a nurse went to see the man in his cell after a request from wing staff. The man was on the floor and he said his legs had given way as he got off his bed.

35. The nurse noted that the cell was filthy and smelt. The man was incontinent of faeces. There were medication packets all over his bed and from the medication remaining the nurse calculated that he had not taken his antibiotic as prescribed. She examined the man, recorded his blood glucose level and supervised him taking his medication. She advised him to eat, shower and clean his cell. His medications were removed to be administered later under supervision.

36. The nurse checked the man at 12.25pm. She recorded he was on his bed and had not showered. His blood glucose levels did not give cause for concern.

37. At 1.00pm, healthcare staff discussed the man's condition and a possible move to the inpatient unit. There is no record of any conclusions from this meeting.

38. At about 1.45pm, two officers were unlocking cells for prisoners going to education or work. One officer saw the man through the cell observation hatch and described him as sitting awkwardly on the corner of his bed and not looking right. They went in and found the man slumped against the wall on the corner of his bed. The other officer remained with the man and the officer ran to the nurse's station, a short distance from the man's cell. He alerted the nurse who was at the nurse's station and she went to the cell. The officer also informed the senior officer (SO) on duty on the wing who called a code blue (indicating a medical emergency – breathing difficulties). Records show the code blue was called at 1.49pm and an ambulance was called a minute later.

39. At about 1.50pm, the nurse arrived at the man's cell. She described his skin as cold, clammy and grey. His mouth had dropped slightly on the left side and he was dribbling. He did not respond, his breathing was shallow and his pulse was weak.

40. At 1.51pm, three other nurses arrived with a medical emergency bag. They applied the defibrillator pads to the man's chest and cardiopulmonary resuscitation (CPR) was advised. They moved the man to the floor and nurses administered CPR, assisted by one officer.

41. The first paramedic arrived at the prison at 1.58pm and was with the man within twelve minutes. An ambulance arrived at 2.10pm and the crew were at the cell less than five minutes later. CPR and assisted breathing continued until 2.30pm, when the man was taken to Pinderfields Hospital.

42. The man was escorted to hospital by three prison officers, but was not restrained. At hospital, he was placed in a medically induced coma. The next day, after consultation with medical staff a revised risk assessment was completed and the escort reduced to two. Initially, the man remained unrestrained however, at 10.30pm on 3 November, he regained consciousness and an escort chain was applied. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.)

43. An officer was appointed as the prison family liaison officer, as soon as the man was admitted to hospital. He had not listed any next of kin, but staff identified two sisters from his prison record. As the man's sisters did not live nearby, staff at HMP Woodhill visited one sister to inform her of his illness and that he was in hospital.

44. The family liaison officer contacted the man's sister and remained in contact with her throughout and assisted with visiting arrangements. She agreed to keep the man's sister updated by telephone. The family liaison log shows that the family liaison officer remained in contact with the man's sister throughout his stay in hospital and kept her informed about his condition.

45. On 23 November, following an episode of gastrointestinal bleeding, an active duodenal ulcer was detected. The man remained in hospital and his condition appeared to improve. However, on 7 December, he suffered a massive gastrointestinal bleed and died at 11.51pm. On 8 December, the family liaison officer telephoned the man's sister, as previously agreed, and informed her of her brother's death.

46. The man's funeral was held on 3 January 2014. HMP Wakefield offered financial assistance towards the funeral costs in line with national guidance.

Post-mortem

47. A post-mortem found the cause of death was a massive upper gastrointestinal haemorrhage, a duodenal peptic ulcer and ischaemic heart disease.

ISSUES

Clinical Care

48. The clinical reviewer was satisfied that the overall level of care the man received at HMP Wakefield was equivalent to that which he might have expected in the community. However, he noted that the man presented with symptoms of heartburn on four occasions between December 2012 and October 2013 and was prescribed gaviscon each time. On three occasions, the corresponding entries on his medical records are identical and appear to use 'auto consultation,' a time saving process available on SystmOne (the computerised medical record), but no further information was recorded. The clinical reviewer notes that when using this system it is important that individual observations and assessments are fully recorded and patients should be referred to a GP if necessary. There is no record of the man being referred to a GP on these occasions which meant he was not reviewed or referred for further investigation for his ongoing heartburn. We make the following recommendation:

    The Head of Healthcare should ensure that healthcare staff record their observations and full assessment when using 'auto consultation' in SystmOne and refer the patient to a GP if necessary

49. On 23 October, after a routine urine dipstick test, the man was diagnosed with a urinary tract infection and prescribed an antibiotic. The nurse saw him later that day, when he reported he had not eaten for four days. His pulse was recorded as high and his blood pressure was low. The nurse noted that the man's lips were dry and scabby.

50. The clinical reviewer commented that, given his general medical condition, these symptoms could indicate that the man was seriously unwell. He considered that a further assessment, such as the use of the National Early Warning Score (NEWS) might have led to an earlier hospital admission and should have been considered. We make the following recommendation:

    The Head of Healthcare should ensure an early warning score such as NEWS is used when assessing a patient presenting with acute symptoms

Restraints, security and escorts

51. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as 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 judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks

posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process. It also deemed that restraining by handcuffs of 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.

52. On 28 October, when the man was found collapsed, he was escorted to hospital by three officers, but not restrained. A risk assessment was completed and the nurse completed the healthcare section and advised no restraints due to his medical condition. The man was a category B prisoner and the risk assessment directed that his condition should be continually assessed and restraints applied when he improved.

53. On 29 October, while the man was in an induced coma, an operational manager attended the hospital and authorised a reduction from three to two escorting officers. The man remained unrestrained at this time. However, restraints were reapplied on 3 November due to "nurses trying to bring the man out of sedation." Restraints were used intermittently after that, but the test used seemed to be whether he was conscious rather than he had the ability to escape. They were usually, but not always, removed for treatment. At 10.20pm on 7 December, hospital staff asked for the restraints to be removed as the man needed a blood transfusion. The man died at 11.51pm.

54. Throughout the time that the man was in hospital he had limited mobility; he drifted in and out of consciousness, was fed through a tube and was subject to regular medical procedures. Records show that the need for restraints was regularly reviewed, but the input from hospital staff was usually about whether there was any objection to their use. There is no evidence from the records that medical staff were asked whether and how the man's condition impacted on his risk of escape, which is what is what the 2007 High Court judgement requires. We cannot therefore be satisfied that the use of restraints, in addition to a two officer escort, was justified. We make the following recommendation:

The Governor should ensure that risk assessments for prisoners in hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents at the time

Compassionate release

55. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.

56. The man's sister was concerned that he was not considered for compassionate release. The man did not have a terminal diagnosis. Although he was very ill in hospital, records show that his condition had

improved and his death was sudden and unexpected. He would not have met the criteria for compassionate release.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that healthcare staff record their observations and full assessment when using ‘auto consultation’ in SystmOne and refer the patient to a GP if necessary

2. The Head of Healthcare should ensure an early warning score such as NEWS is used when assessing a patient presenting with acute symptoms

3. The Governor should ensure that risk assessments for prisoners in hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents at the time

ACTION PLAN

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and **function responsible**
1	The Head of Healthcare should ensure that healthcare staff record their observations and full assessment when using 'auto consultation' in SystmOne and refer the patient to a GP if necessary.	Accepted	The Record Keeping Audit Tool will be adjusted to incorporate additional criteria for the use of the auto consultation function on SystmOne. All staff will receive feedback regarding this recommendation at staff meetings and awareness will be raised in the inter-provider Clinical Governance Meeting.	July 2014 Healthcare providers: Spectrum Community Health and Humber NHS Trust
2	The Head of Healthcare should ensure an early warning score such as NEWS is used when assessing a patient presenting with acute symptoms.	Accepted	A review will be undertaken of the current method for observations during the onset of acute symptoms. NEWS will be looked at with a view to determining how it can be appropriately implemented across healthcare providers at HMP Wakefield.	December 2014 Healthcare providers: Spectrum Community Health and Humber NHS Trust
3	The Governor should ensure that risk assessments for prisoners in hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents at the time.	Accepted	Further guidance will be issued to all operational managers responsible for completing and reviewing Bed Watch Risk Assessments. The guidance will remind staff of the need to properly record their consideration (on an individual basis) for the use of restraints, having taken medical assessments of mobility into consideration, when assessing each prisoner's risk of escape and/or risk of causing harm to others.	June 2014 Head of Security and Intelligence

			When issuing this guidance, direct reference will be made to the Senior Leaders' Bulletin from the Director of Public Sector Prisons and the Deputy Director of Contracted Prisons issued in January 2014.	