A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Wakefield in June 2014

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 of kidney failure, on 20 June 2014, at HMP Wakefield. He was 66 years old. I offer my condolences to the man's family and friends.

An investigator carried out the investigation and 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 1995 and moved to HMP Wakefield in 2006. He suffered from chronic renal failure and type two diabetes, which healthcare staff managed throughout his time at Wakefield. He also had poor eyesight and limited mobility. In March 2014, the man started dialysis treatment but he often refused to attend appointments. On 7 May, despite attempts to persuade him otherwise, the man declined any further treatment. His condition deteriorated, and in June he moved to the prison's palliative care suite, where he remained until he died.

I agree with the clinical reviewer that the man received a good standard of care at Wakefield, equivalent to that he could have expected to receive in the community. However, I am concerned that prison staff restrained the man while he was having dialysis treatment, which was not appropriate or justified by fully considered risk assessments based on his actual risk at the time.

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 **November 2014**

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SUMMARY

1. The man was convicted of murder in 1995 and sentenced to life imprisonment. He moved to HMP Wakefield in 2006. He had a history of chronic renal (kidney) failure and type two diabetes which led to poor eyesight and limited mobility. His conditions were managed with medication and hospital treatment which continued throughout his time at Wakefield. He spent long periods as an inpatient in the prison's healthcare centre.

2. The man's kidney condition deteriorated and on 27 March 2014 a renal specialist at St James's Hospital, Leeds, told him he needed dialysis treatment three times a week. He arranged for treatment to begin the next day.

3. The man refused to attend hospital for his dialysis treatment the next day. Although he then began to attend some dialysis sessions, he told staff that, despite taking painkillers and having local anaesthetic around the fistula in his arm (a surgically created access point), dialysis was too painful.

4. On 7 May, the man came back from dialysis treatment and said he would not go again, despite attempts to persuade him otherwise. He was fully aware of the consequences of stopping treatment. The man also occasionally declined to take his insulin. Despite this his blood/glucose levels remained reasonably stable.

5. On 23 May, a multidisciplinary team meeting comprising the Governor, healthcare staff, his hospital consultant and a Macmillan nurse discussed the man's decision with him. The man understood the consequences but continued to refuse dialysis.

6. On 14 May, the man signed an order to indicate he did not want to be resuscitated in the event of a cardiac or respiratory arrest. On 29 May, he signed an advance decision to refuse treatment. A nurse explained that this was his last opportunity to change his mind as he would soon become too ill to begin dialysis again. The man was adamant that he did not want any further treatment.

7. As the man's condition deteriorated, he moved to the prison's inpatient healthcare unit and later to the palliative care suite in the unit. He remained there until his death from kidney failure on 20 June.

8. The clinical reviewer is satisfied that the care the man received at HMP Wakefield was of very good quality and at least equivalent to that he could have expected to receive in the community. We agree, but are concerned that the man was restrained without proper justification for some of his dialysis appointments. We make one recommendation about this issue.

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 prison medical records and relevant extracts from his prison records. He interviewed one member of staff at Wakefield on 29 July. He gave the Governor initial feedback on the preliminary findings of the investigation.

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 a copy of the post-mortem report. We have sent the Coroner a copy of this investigation report.

13. One of the Ombudsman's family liaison officers contacted a friend of the man, his nominated next of kin, to explain the investigation. She told the family liaison officer she was enormously impressed with the way the prison had dealt with the man and the care she saw at HMP Wakefield was extremely good. The family liaison officer also spoke to the man's sister who did not raise any specific questions or concerns. Both spoke highly of their contact with the prison's family liaison officer.

14. The man's friend received a copy of the draft report. She pointed out some omissions. This report has been amended accordingly. She also raised some issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence. The man's family received a copy of the draft report and indicated that they were 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 men. There are four main residential wings, a healthcare centre, segregation unit and a close supervision centre. The healthcare centre has a palliative care suite for end of life care.

16. Spectrum CIC (Community Interest Company) runs primary care services 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 prisoners with physical health problems at Wakefield. Nottinghamshire Healthcare NHS Trust provides mental health services.

HM Inspectorate of Prisons

17. The report of a recent inspection of Wakefield in July 2014 has not yet been published, but in preliminary feedback, the Inspectorate reported positively on healthcare at Wakefield. The previous inspection was in May 2012, and 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, which contained many 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 14 from natural causes at Wakefield since January 2012. One person has died since. We have made recommendations about the need for appropriate risk assessments to justify the use of restraints in a number of previous cases.

KEY EVENTS

20. The man was convicted of murder in 1995 and sentenced to life imprisonment. He moved to HMP Wakefield in 2006. He was not in good health and had a number of medical conditions including chronic renal failure which was a direct consequence of long standing type two diabetes. The man also had poor eyesight and limited mobility. He used a walking frame for short distances but otherwise was dependent on a wheelchair.

21. The man was diagnosed with diabetes while in his twenties. His medical records suggest that this was poorly managed in the early years. Poor diabetic control can cause damage to the kidneys, a well known complication in long standing diabetic patients and the man's kidney function gradually got worse. In 2006, the man had a procedure to prepare for vein dialysis (known as arterio-venous fistula). The clinical reviewer says that the fact that dialysis did not need to start until 2014 shows the good quality hospital and prison health care the man received for his diabetes.

22. On 27 March 2014, the man attended St James's Hospital Leeds for blood tests and examination because of his deteriorating kidney condition. A renal specialist told him he needed dialysis treatment three times a week and arranged his first appointment for the following day. For this, and subsequent hospital appointments, the man was escorted by three officers and restrained with an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer).

23. The man refused to attend his first dialysis treatment on 28 March and signed a disclaimer to that effect. The nurse explained to him that his kidney function was at a critical level and without dialysis he would die. The man said he had not attended because he had felt sick that day and not because he was refusing treatment. He agreed to attend future sessions.

24. The man attended some dialysis appointments in April, but missed some. He told staff that despite having a local anaesthetic and painkillers (which he said made him sick) he found dialysis too painful. On 16 April, after he refused to attend another dialysis session, the prison opened an ACCT document (Prison Service suicide and self-harm prevention procedures). At a review the next day, the man said he did not like the escort staff, dialysis was painful and he found the process boring. The review decided that the man was not at risk of suicide or self-harm and ended ACCT monitoring.

25. On 28 April, the nurse spoke to the man after he missed another dialysis appointment. She told him again what would happen if he continued not to attend dialysis appointments and that it would lead to coma and death. She told the man that the hospital might withdraw treatment if he continued not to attend all appointments. The man repeated that he found it too painful and they discussed the possibility of repositioning the fistula. A prison GP saw the man later that day and confirmed that he had the capacity to understand the consequences of his decisions.

26. The man's mental state and his capacity to make decisions were assessed on several occasions and he was always considered to have the capacity to refuse treatment.

27. On 7 May, the man attended St James's Hospital to see a consultant about a possible admission to have a central or femoral line inserted and his fistula repaired. However, he also had a dialysis appointment and the meeting did not take place. He had initially refused dialysis, but after talking to doctors he agreed. After this he refused to attend any further dialysis appointments.

28. On 14 May, a nurse and a senior manager, and later the GP and another nurse all spoke to the man about his condition and his treatment as a palliative care patient. They explained that he would not be offered any further pre-planned dialysis sessions but he could change his mind. The man was clear that he intended to continue to decline dialysis and understood that he would die, most likely in a matter of days. He refused hospital admission and did not want any support from the prison chaplain or did not want to contact his family.

29. On 14 May, a prison GP saw the man after speaking to a renal consultant at the hospital. They discussed the possibility of hospital admission for dialysis through a central line into his lower neck as a temporary option whilst the fistula in his arm was re-sited. The man declined this and also signed an order to confirm that he did not want to be resuscitated in the event of cardiac or respiratory arrest. The GP requested palliative care anticipatory medication which includes pain relief and anti-sickness medication for use, if needed, towards the end of life.

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30. The palliative care lead nurse at the prison saw the man on 17 May and described him as brighter in mood. He left his cell for an association period (when prisoners have free time to socialise with each other on the wing) and to collect his meals. He later declined to take his insulin. Over the next few days, the man declined his insulin a number of times. Nurses checked his blood sugar levels frequently and these remained within an acceptable range.

31. On 23 May, at a multidisciplinary team meeting (which included a Macmillan Nurse) The GP again discussed treatment options, including central line access. The man raised the possibility of peritoneal dialysis (abdominal cavity dialysis not requiring filtration of blood). The GP explained that this was a future possibility but he would need to continue with his present treatment before any operation on his abdomen. The man considered this, but ultimately declined. The man agreed to the prison contacting his nominated next of kin (who was a friend) but not members of his family. Wakefield appointed a prison family liaison officer the same day and staff opened a second ACCT document.

32. The Family Liaison Officer contacted the man's friend at 6.25pm that evening and told her about his condition. They discussed what would happen in the event of the man's death. The Family Liaison Officer explained that she would usually inform the next of kin in person, but the man's friend said a phone call

would suffice. She lived a long way from the prison and wanted to save them the time and money it would have taken to inform her in person. The man's friend asked if she would phone her, which she did the next day. His friend visited him on 27 May and the Family Liaison Officer remained in contact with her.

33. Staff held four ACCT reviews in May. The man said he was not in pain and did not have concerns. A consultant psychiatrist assessed the man and concluded that he did not have mental illness and again confirmed that he had the mental capacity to make informed decisions about his treatment. On 29 May, the ACCT was closed as staff did not consider that the man was at risk of suicide or self-harm. Staff opened a communication book to ensure that all relevant information about the man's treatment and care was shared between healthcare and any visiting staff.

34. Later, on 29 May, the man signed an advance decision to refuse treatment. A nurse discussed with the man how his symptoms would be managed and he asked if he could refuse certain medications. The nurse said he could, but advised against it. The relevant documents about his end of life care plan and his wishes about resuscitation and the advance directive were kept in the healthcare centre office where they were accessible to prison and healthcare staff.

35. On 3 June, the man declined an offer of mental health support. A Macmillan palliative care specialist nurse reviewed the man later that day and noted he had just days or weeks to live.

36. A prison GP reviewed the man on 9 June and noted he was deteriorating but comfortable and responsive when roused. Staff began an end stage of life care pathway, which included medication to control his symptoms. The man vomited after taking oral medication so nurses gave these by injection.

37. The man's condition deteriorated over the next week. Healthcare staff attended him several times a day. He was frail, weak and increasingly unsteady. He slept for long periods, and ate and drank little.

38. On 16 June, the GP examined the man and recorded that he was comfortable with some vomiting, controlled by medication. However, shortly afterwards and throughout the night, the man was increasingly nauseous with episodes of vomiting. He required frequent medication to control his symptoms. On 17 June, the nurse contacted the Macmillan nurse who prescribed a dose of levomepromazine, which is used in palliative care to help ease distressing symptoms such as pain, restlessness, anxiety and sickness.

39. On 18 June, the Macmillan nurse reviewed the man's medication and his end of life plan. She noted that he appeared settled and said he had no pain or nausea. He seemed semi-conscious and was not agitated or distressed. She recorded that staff were managing his symptoms well.

40. Healthcare staff continued to observe the man throughout 19 June when he remained settled, comfortable and pain free. His condition deteriorated and, at 12.20am on 20 June, the nurse noted his breathing patterns had slowed. A nurse and officer stayed with the man. At 12.45am, the man stopped breathing and showed no other signs of life. Paramedics attended and at 1.12am confirmed that the man had died.

Liaison with the man's family

41. After the man died, the Family Liaison Officer repeatedly rang his friend but was unable to get through until 1.00pm when she informed her of his death and offered support and guidance. The Family Liaison Officer offered to visit the man's friend at her home, but she said it was not necessary. Again she was being mindful of the considerable distance and cost involved.

42. The man's closest living relative was his sister and senior managers at the prison decided they should inform her of his death. The police gave the prison her contact details. The Family Liaison Officer telephoned his sister and informed her of the man's death. She agreed to let his other two sisters know.

43. The man's funeral was held on15 July. The prison paid for this, in line with national guidance.

Support for prisoners and staff

44. The Governor issued a notice to prisoners and staff informing them of the man's death, and informing them of the support available if they needed it. Staff reviewed the cases of all prisoners subject to suicide and self-harm prevention procedures, in case they had been affected by his death.

45. A senior manager held a debrief for prison and healthcare staff, to discuss the circumstances of the man's death. He offered staff appropriate support.

Post Mortem

46. A post-mortem report concluded that the man died of renal failure and diabetes mellitus.

ISSUES

Clinical Care

47. We agree with the clinical reviewer that the man received good quality care at Wakefield, at least equivalent to that he could have expected to receive in the community.

48. The clinical reviewer found that the man had well documented palliative care plans and staff discussed and fully involved him in decisions about his care. A specialist palliative care nurse reviewed him regularly, and healthcare staff at Wakefield followed her advice on treatment. The clinical reviewer concluded there were good palliative care plans and an effective end of life plan for the last 11 days of the man's life. There was good communication about his care at every stage. The clinical reviewer made no recommendations.

Restraints, security and escorts

49. 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 prison staff should make a distinction 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 assessments should take into account medical opinion about the prisoner's ability to escape. It found restraining a prisoner by handcuffs who was receiving chemotherapy (and by implication, other life saving treatment) was degrading and that such restraint would be likely to be regarded as inhumane unless justified by other relevant considerations.

50. The man moved to Wakefield from HMP Full Sutton in 2006. At the same time he was re-categorised from category A to B security status (Category A prisoners are those that would pose the most threat to the public, the police or national security should they escape.) At the time it was considered that his poor eyesight and deteriorating health meant he posed less of a risk to the public and was less likely to escape.

51. In June 2013, the Prison Service made the man category A again, after receiving intelligence reports and information suggesting that his eyesight and mobility were better than previously believed. Prisoners and staff had witnessed the man performing a number of tasks, which had previously been considered beyond him. But it is clear from the records that the man had poor eyesight and limited mobility.

52. From 27 March 2014 until 7 May, the man attended hospital thirteen times, mostly for dialysis treatment. Each time a supervising officer and two prison officers accompanied him, the standard procedures for category A prisoners, Each time staff used an escort chain to restrain the man.

53. Each risk assessment records the man as a high risk to the public and hospital staff, a high risk of hostage taking, and a medium risk of escape and of outside assistance to escape. These assessments appear to be based on his category A status and offence rather than his condition at the time. The healthcare input into each of the risk assessment, states that an escort chain should be used for both escort and treatment due to the man using a wheelchair and pointing out the need to attach any restraint to his right arm only because of the fistula in his left arm. The assessment did not mention the man's poor eyesight.

54. A senior manager at Wakefield, told us the man was over 6 feet tall, at least eighteen stone and powerfully built. He highlighted the predictability of the man's hospital appointments and the need to protect and reassure hospital staff, members of the public and other patients. Though he accepted that it was unlikely the man had the means to escape, he said that it was not beyond his capability to rise from his wheelchair and cause damage or injury. There is no evidence that the man ever behaved in this way or that staff had a reason to consider he would. In any event an escort chain would not have prevented it.

55. It is evident that the man had very limited mobility and poor eyesight at the time he was attending these hospital appointments. The man was accompanied by three prison officers and it is difficult to see why that was not sufficient security. The use of restraints was unjustified during dialysis treatment, which is life saving treatment. The Prison Service has a responsibility to protect the public, but security must be balanced with humanity and measures must be proportionate to a prisoner's individual circumstances.

56. We have made previous recommendations to Wakefield about the unjustified use of restraints. There is need for all those involved in making decisions to ensure that they take a prisoner's health and mobility fully into account in risk assessments and that staff follow the guidance in the 2007 High Court judgment. Ultimately, it is the Governor's responsibility to ensure that the process is managed properly, but the Head of Healthcare also needs to ensure that healthcare staff understand their responsibilities when assessing how health and mobility impacts on the risk of escape. We make the following recommendation:

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

RECOMMENDATION

The Governor and Head and Healthcare should ensure that risk assessments for prisoners attending hospital appointments 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 Governor and Head and Healthcare should ensure that risk assessments for prisoners attending hospital appointments fully take into account individual circumstances and are based on the actual risk the prisoner presents at the time	Accepted	The Head of Security and Head of Healthcare will work together with relevant Clinicians to ensure that appropriate risk assessments take place prior to restraints being used during hospital escorts. Each prisoner's medical condition will be considered during the risk assessment process. The escort level and application of restraints will be proportionate to the assessed security risks and justified by taking into account the prisoner's individual circumstances and the risk of escape to the public, nursing staff and escorting staff.	30 November 2014 Head of Security and Head of Healthcare