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**

## *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 prisoner at HMP Wakefield. The man died of a heart attack. He was 50 years old. I offer my condolences to the man's family and friends.

An investigator carried out the investigation. A doctor reviewed the man's clinical care at Wakefield. The prison cooperated fully with the investigation.

The man was a life sentenced prisoner who had been at Wakefield for a number of years. On the evening of 19 June 2013, the man told an officer that he had severe pains in his chest. Officers requested medical assistance and a nurse examined the man. While the nurse was conducting some background checks on his medical history, the man suddenly collapsed and hit his head as he fell. An ambulance was called but resuscitation efforts were unsuccessful and the man was pronounced dead at 11.35pm.

The clinical reviewer is satisfied that the overall standard of healthcare The man received at Wakefield was equivalent to that he could have expected to receive in the community. However, it took staff too long to realise the seriousness of the man's condition on the night he died and there was a general lack of awareness of the prison's protocol for dealing with a medical emergency. While the clinical reviewer concludes that this did not affect the outcome for the man, whose sudden death would have been difficult to foresee or prevent, the Governor needs to ensure that staff are fully aware of emergency procedures which could be critical in a future incident.

**Nigel Newcomen CBE**
**Prisons and Probation Ombudsman** **January 2014**

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## SUMMARY

1. On 17 September 1992, the man was sentenced to life imprisonment for murder and sexual offences. He spent time in a number of prisons before he moved to Wakefield in 2005.

2. The man accessed healthcare on a number of occasions at Wakefield, variously receiving treatment for a collapsed lung, back and joint pain, chest infections and hay fever, as well as support to stop smoking. On 4 June 2013, he was referred for physiotherapy after he pulled a muscle in his back while lifting weights in the gym.

3. On 19 June, after evening lock up, the man pressed his cell bell at 10.09pm, and told officers that he had chest pains. Officers waited for a nurse to attend who examined the man at around 10.25pm. He said that he had vomited, that he had severe pain in his chest and could not breathe properly. The nurse took his medical observations and then left the cell to check his clinical history. The man's condition suddenly deteriorated and he collapsed and hit his head. An emergency ambulance was requested at 10.46pm and paramedics arrived at 10.54pm. Despite efforts by staff and paramedics to resuscitate him, the man was pronounced dead at 11.35pm.

4. In light of the clinical reviewer's findings, we are satisfied that the man received a generally satisfactory level of health care during his time at Wakefield. However, we do not consider that there was a sufficiently quick response to his complaint of chest pains. Although it appears the man's sudden death would have been difficult to predict or prevent, we repeat concerns raised after a death in September 2012, about the need to ensure that all staff know when to use an emergency code and that an ambulance is called immediately in such situation. After the man's death, the prison did not follow the correct protocol for breaking the news to his family and used the police rather than a member of prison staff.

## THE INVESTIGATION PROCESS

5. The investigator issued notices informing staff and prisoners at HMP Wakefield of the investigation and asking anyone with relevant information to contact her. One prisoner came forward. The investigator obtained all relevant prison and medical documents relating to the man.

6. NHS England (West Yorkshire Area Team) appointed a doctor to review the man's clinical care at the prison. .

7. The clinical reviewer visited HMP Wakefield on 30 July, with another investigator. They met the governor's representative, visited the wing where the man lived, the healthcare unit and spoke to staff and prisoners who knew the man. The clinical reviewer and the investigators interviewed five members of staff and one prisoner at Wakefield. The investigator gave her initial findings to the Governor during the investigation and followed this up in writing on 6 August.

8. The investigator contacted Yorkshire Ambulance Service who provided details of their contact they had with the prison on 19 June.

9. The investigator informed HM Coroner for West Yorkshire Eastern District about the investigation. The Coroner provided a copy of the post-mortem report and toxicology findings. A copy of this report has been sent to the Coroner.

10. One of the Ombudsman's family liaison officers contacted the man's next of kin on 15 July, to explain the purpose of the investigation. They did not have any specific matters they wished the investigation to cover.

11. The man's family received a copy of the draft report. They raised an issue that did not impact on the factual accuracy of this report which has been addressed through separate correspondence.

## HMP WAKEFIELD

12. 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 man was a category B prisoner and lived on D wing. All cells are single occupancy. Primary care services are provided during normal working hours by Spectrum CIC (Community Interest Company). 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.

## HM Inspectorate of Prisons

13. The Inspectorate carried out an unannounced full follow-up inspection of Wakefield in May 2012. Inspectors were concerned about the high rate of misuse of prescribed medication, but found that health provision had significantly improved since the last inspection. The range of primary care services was considered to be of a good standard and appropriate for the population, including older prisoners.

## Independent Monitoring Board

14. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure prisoners are treated fairly and decently. In its most recent annual report, the IMB found that healthcare provided a comprehensive service that met the needs of the population.

## Previous deaths at Wakefield

15. The man's death was one of five deaths from natural causes at HMP Wakefield in the last year. We repeat a concern raised in one of those cases about staff's response when there are serious concerns about a prisoner's health.

## KEY EVENTS

16. The man was born in July 1962. He was remanded into custody on 10 October 1991 and was taken to HMP Brixton. During his initial healthscreen he told the prison doctor that he had suffered from pneumonia as a child, smoked and had no current physical or mental health issues. The man later moved to Belmarsh and Wandsworth prisons. He was assessed by prison and healthcare staff each time he transferred. On 17 September 1992, the man was sentenced at Maidstone Crown Court to life imprisonment with a minimum tariff of 18 years for murder and sexual offences. He was taken to HMP Elmley.

17. The man first transferred to Wakefield in May 1995. On 28 June 1995, he was admitted to Pinderfields Hospital as he had breathing problems and chest pain. An X-ray showed that he had a collapsed lung. After he was treated, the man was discharged back to Wakefield on 3 July. He transferred to HMP Full Sutton on 4 November 1999.

### HMP Wakefield

18. On 6 December 2005, the man transferred back to HMP Wakefield from Full Sutton. When he arrived, he told the nurse that he had been receiving pain relief because of an ankle injury and was attending physiotherapy. Over the next few years, the man was treated for a number of chest infections, acute hay fever, was seen by the prison podiatrist and optician and prescribed pain relief for back and joint pain.

19. A prison doctor examined the man on 14 June 2010 when the man said he had been gasping for air and that he had put on over a stone since giving up smoking six weeks before. The doctor gave him dietary advice and exercises to avoid more weight gain.

20. On 11 August 2011, the doctor diagnosed the man with sciatica (nerve pain) and prescribed pain relief medication. The man was frequently reviewed by prison doctors and healthcare staff. His pain relief medication was reviewed and adjusted as he continued to suffer back and joint pain.

21. In April 2013 a nurse prescribed the man cetrizine medication for hay fever. The nurse examined the man on 13 May as this medication had made him feel unwell and she prescribed beclomethasone as an alternative.

22. Another nurse asked to see the man on 4 June, as his weight had not been recorded for some time. She recorded the man's weight as 98kg (which was overweight). On 6 June, another nurse referred the man for physiotherapy, as he was suffering from back pain. On 15 June, the man, accompanied by a gym officer, told the nurse that he hurt his back in the gym lifting weights. The gym officer agreed to show the man some stretching exercises and the nurse gave him pain relief.

**Events of 19 June**

23. The man's cell was on the fourth landing, two floors up from the ground floor on D wing. There is no CCTV on the wing. On Wednesday 19 June, the man worked on the wing all day as a cleaner. Officers did not recall anything unusual about his behaviour and he did not raise any concerns with them. A friend of the man told the investigator that during evening association (when prisoners are free to leave their cells between 4.45pm and 7.00pm) the man obtained another prisoner's prescribed medication. The man did not mention feeling unwell, and his friend said that he had never known him complain of chest pain (although he knew he had back pain). The man's friend said that The man had often taken other prisoners' medication in this way in order to get a 'high'.

24. At 10.09pm, the man pressed his cell bell because he was feeling unwell. An officer answered at 10.11pm. During the night, cells remain locked for security and the officer spoke to the man through the observation panel. The man told the officer that he thought he was having a heart attack, could not breathe and had chest pains. The officer's radio battery had discharged, so he went to the wing office and telephoned the healthcare centre. He was told to contact the duty nurse. The officer asked the senior officer (SO) who was on the wing at the time, to help him find the duty nurse. The senior officer telephoned F wing, where the duty nurse was dispensing medication, and described the man's symptoms. The duty nurse left F wing and went to D wing, accompanied by a prison dog handler, who had keys. This took about nine minutes, as it involved going through a number of secure electronic gates.

25. The officer returned to the man's cell. He said the man was walking around the cell holding his chest. The officer said that he tried to calm the man down and encouraged him to sit down. The night manager authorised the senior officer the senior officer to open the cell at about 10.25pm. The senior officer and the duty nurse met the officer outside the man's cell and went in accompanied by two other officers who were also on duty on D wing.

26. The man was on the floor. He told staff that he had vomited, that he had pain in his chest and could not breathe properly. The duty nurse and the prison officers helped the man to sit on his bed. The officer got him some cold water to drink, while the duty nurse collected medical observation equipment from the primary care room, near the entrance of D wing. She first had to wait a short time for the night manager to open the gate. The duty nurse returned and recorded the man's blood pressure as slightly high (169/94 - the normal range for blood pressure is 100/70 to 140/90), his pulse was rapid at 87 beats per minute (bpm - normal range is between 60 – 80 bpm), his temperature was normal at 36.1 and he had normal oxygen saturation 97%. The duty nurse left the man to telephone her colleague in the healthcare centre for the man's medical history.

27. While waiting for the duty nurse to return, the officer described the man as talkative and officers tried to reassure him. The officer said he tried to encourage the man to stay seated on his bed but, at about 10.43pm, he suddenly stood up and said that he was not feeling well. He fell to the floor hitting his head on the toilet. The officers could not get a response from him and saw that his head was

bleeding. The senior officer radioed the prison's control room (which coordinates all radio requests) to ask the duty nurse to return. One of the officers then told the senior officer that the man's head was bleeding, so the senior officer radioed a 'code red' emergency (used for medical emergencies related to blood loss) and requested an ambulance at 10.46am.

28. The duty nurse went back to the man's cell, but then went back to the treatment room to collect the emergency response bag. Officers then started cardiopulmonary resuscitation (CPR), under the nurse's instruction.

29. A rapid response paramedic arrived at Wakefield prison gate at 10.54pm and got to the man's cell at 11.02pm. The paramedic assessed him while staff continued with CPR. An ambulance and two further paramedics arrived at the prison at 11.06pm. Despite efforts to resuscitate him, paramedics pronounced the man dead at 11.35pm.

**Liaison with the man's next of kin**

30. The duty governor told the investigator that the police officer who attended the prison after the man's death offered to ask the Metropolitan Police to break the news to the man's mother, his next of kin, who lived in London. She agreed and the police officer was given the man's mother's address from prison computer records.

31. The family liaison officer was appointed at 7.50am on 20 June. The duty governor found that the police had not yet informed the man's mother of his death as they had been waiting to be told the cause of death. She was then worried about the time that had elapsed since his death and asked the Metropolitan Police to break the news urgently. When the police went to the address they had been given, they were told that the man's mother did not live there. The family liaison officer then established the man's mother's address from his letter sheets and informed the police. The family liaison officer and her colleague were on their way there when they received a telephone call confirming the police had broken the news to the man's half sister at 10.15am and that she did not want a visit from the prison. His mother was away from home visiting a relative. The duty governor instructed the officers to return to the prison. The man's daughters told their mother the news of his death, as they had requested.

32. The family liaison officer telephoned the man's mother later that day after her daughters had told her what had happened. The family liaison officer and the duty governor visited the man's family on 21 June and explained the circumstances of the man's death. The funeral was organised by the prison and Wakefield offered a contribution to the funeral costs, in line with national guidance. At the man's family's request, prison staff attended his funeral, which was held on 10 July.

## Support for prisoners

33. The Governor issued a notice announcing the man's death, expressed her condolences and reminded prisoners of the support available. All prisoners subject to suicide prevention monitoring were reviewed and offered additional support, in case the man's death had adversely affected them.

34. A memorial service was held at the prison on 16 July, for prisoners who wished to pay their respects.

## Support for staff

35. The duty governor did not hold a hot debrief for prison and healthcare staff who were with the man when he died (a hot debrief is a meeting immediately after an incident, designed to reassure staff and provide them with support). However, the duty governor remained at the prison until around 6.00am to offer support to prison staff upset by the man's death. On 20 June the duty governor, spoke to all staff involved to check on their well-being. Officers and healthcare staff told the investigator that they had felt well supported.

## Post-mortem report

36. A post-mortem examination concluded that the man died of acute myocardial infarction (a heart attack) and coronary artery atheroma (narrowing of the arteries to the heart resulting in reduced blood flow and causing a heart attack). A toxicology screening detected carbamazepine (an anti-convulsant medication) within a therapeutic range (this drug was not prescribed to the man and it is probable that he had been misusing prescribed medications obtained from other prisoners). No other drugs were detected.

## ISSUES

### Responding to chest pain

37. When the man first pressed his cell bell, he told the officer that he was experiencing chest pains and thought he was having a heart attack. The officer told the investigator that he waited for healthcare staff to assess the man, as he was not medically trained. When the nurse arrived, she assessed the man and then contacted her healthcare colleague to get his medical history. As the man was complaining of severe chest pain and described symptoms suggestive of a heart attack, we consider it might have been prudent to have requested an ambulance straight away. However, the clinical reviewer concludes that it would have been difficult to foresee or prevent the man's sudden death and, given the presence of a nurse and the emergency treatment he subsequently received, his care was equivalent to that which he might have expected to receive in the community.

38. Nevertheless, the investigation has identified that there is no chest pain protocol at Wakefield specifying how staff should respond when a prisoner complains of severe chest pain and ensuring that an ambulance is called. Neither healthcare staff nor prison officers were sufficiently clear about their responsibilities. Local policy and training needs to be improved, so that there is an appropriately urgent response when a prisoner complains of severe chest pains. We make the following recommendation:

    **The Governor and Head of Healthcare should introduce a chest pain protocol which gives guidance for all staff on how to deal with cardiac events and ensures that an ambulance is called when prisoners report severe chest pain.**

### Emergency protocol

39. It became apparent during the investigation that the use of emergency codes was not clearly understood by prison and healthcare staff. An emergency code was not called until the senior officer was told the man's head was bleeding, and this meant that the nurse had to return to the treatment room to collect emergency equipment. In the event, a code red was called to indicate bleeding, although the cut to the man's head was not the major concern. A code red should be used when there is severe loss of blood and a code blue should be used to indicate chest pain, difficulty in breathing or unconsciousness. This helps those responding to the emergency code prepare and bring the appropriate emergency equipment.

40. PSI 03/2013 (medical emergency response codes) took effect from 28 February 2013, and gives clear guidance on the use of emergency codes and the mandatory response (that the use of either a code 'red' or 'blue' should prompt the request of an emergency ambulance). We reported concerns about a delay in requesting an ambulance when there were serious concerns about a prisoner's health, after the death of a prisoner at Wakefield in September 2012. Wakefield responded to our findings, as follows:

> "A Local Notice To Staff (266/2012) has been issued highlighting that if there is a clear and present indication that there is a real threat to life and limb, any individual regardless of rank or role should summon an ambulance, via the control room, without waiting for the internal support.
>
> This will be reiterated further in the forthcoming Medical Emergency Response Code Protocol in response to the requirements of PSI 03/2013"

Wakefield issued a Medical Emergency Response Code Protocol in line with the PSI, but none of the staff interviewed by the investigator were aware of the protocol or its contents. We therefore make the following recommendation:

**The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies as outlined in the local Medical Emergency Response Code Protocol so that:**

- **staff efficiently communicate the nature of a medical emergency;**
- **relevant emergency equipment is brought; and**
- **that there are no delays in calling, directing or discharging ambulances**

**Misuse of prescribed medication**

41. A prisoner told the investigator that the man frequently obtained prescribed medications (gabapentin, pregabalin, tramadol and carbamazepine) from other prisoners for a 'high'. The toxicologist identified carbamazepine, a frequently misused drug in prisons, in the man's blood, but no other drugs were detected. The man was not prescribed carbamazepine.

42. Wakefield security department told the investigator that there was no specific intelligence about the man misusing drugs, but trading of prescribed drugs was a problem throughout Wakefield. A number of initiatives have been implemented (gabapentin and pregabalin are now dispensed daily, dissolved in water, and not allowed in a prisoner's possession) to reduce trading of prescribed drugs between prisoners. However, carbamazepine is a drug to prevent epileptic convulsions, so prisoners need to keep it in their possession. The clinical reviewer concludes that any abuse of prescribed medications was unlikely to have contributed to the man's heart attack as they have sedating properties.

**Informing the next of kin**

43. The duty governor, an experienced family liaison officer, was the duty governor who attended the prison on the night the man died. The man's mother, his next of kin, lived in London. The duty governor decided not to

contact a prison local to them to break the news of his death as would be usual, but agreed that the police should act on the prison's behalf. The police did not visit the address they were given until the next morning and it was then discovered that his mother had moved. The correct address was identified from prison documents later the next morning. Police broke the news at 10.15am, nearly 11 hours after his death.

44. PSI 64/2011 Safer Custody, chapter 13, states:

> "*Wherever possible, the FLO and another member of staff must visit in person the next of kin or nominated person to break the news of the death.* Time will be of the essence in order to try to ensure that the family do not find out about the death from another source.
>
> "*Where the prisoner had been located a long distance from their next of kin, consideration must be given to requesting the assistance of a FLO from the nearest prison.*
>
> "*If a face-to-face prison notification is not possible or where another prison's FLO or the police have visited the family, then a follow up visit by the prison must be arranged as soon as practicable.*"

45. The duty governor was unable to explain why she did not consider asking a prison near to the man's mother to assist with breaking the news in line with the PSI guidance. We consider that, as the PSI recognises, it is preferable for prisoners' families to hear of their deaths from Prison Service staff who should be better placed than the police to answer any questions they may have. We make the following recommendation:

**The Governor should ensure that in the event of a death prisoners' families are informed quickly by a member of Prison Service staff where possible.**

46. Once the man's family had been informed the prison contacted them quickly. The appointed family liaison officer accompanied by the duty governor, visited the man's family on 21 June. We are aware that the man's family have written to Wakefield expressing their thanks for the excellent support they received after his death.

## RECOMMENDATIONS

1. The Governor and Head of Healthcare should introduce a chest pain protocol which gives guidance for all staff on how to deal with cardiac events and ensures that an ambulance is called when prisoners report severe chest pain.

2. The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies as outlined in the local Medical Emergency Response Code Protocol so that:

    - staff efficiently communicate the nature of a medical emergency;
    - relevant emergency equipment is brought ; and
    - that there are no delays in calling, directing or discharging ambulances

3. The Governor should ensure that in the event of a death prisoners' families are informed quickly by a member of Prison Service staff where possible.

**ACTION PLAN**

| No | Recommendation | Accepted/Not Accepted | Response | Target date for completion and Function Responsible | Progress (to be updated after 6 months) |
|---|---|---|---|---|---|
| 1 | The Governor and Head of Healthcare should introduce a chest pain protocol which gives guidance for all staff on how to deal with cardiac events and ensures that an ambulance is called when prisoners report severe chest pain. | Accepted | The HMP Wakefield Cardiovascular Specialist Nurse is revisiting the Chest Pain Protocol with existing healthcare providers to ensure a consistent and collaborative approach including calling an ambulance when prisoners report severe chest pain.<br>The Medical Emergency Response Code Protocol was issued under Notice to Staff (NTS) 211/2013 on 24/10/13 at HMP Wakefield. This instruction sets out the framework for calling a medical emergency consistently over the establishment radio network in all public and contracted prisons and NOMS operated Immigration Removal Centres.<br>The intention is to ensure timely, appropriate and effective response to medical emergencies and thereby to maximise the likelihood of a positive outcome for the patient. It is also designed to ensure compliance with relevant legal (including health and safety) obligations.<br>The NTS is used in conjunction with the existing clinical Chest Pain Protocol, pending a review of the clinical protocol. | January 2014<br><br>The Governor and Head of Healthcare | |
| 2 | The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical | Accepted | The basic guidance issued under NTS 266/2012 on 31/12/12 was subsequently supplemented by more in depth guidance under NTS 211/2013 on 24/10/13 outlining the Medical Emergency Response Code Protocol | Completed and ongoing<br><br>The Governor and Head of | |

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| | emergencies as outlined in the local Medical Emergency Response Code Protocol so that:<br>• staff efficiently communicate the nature of a medical emergency;<br>• relevant emergency equipment is brought ; and<br>• that there are no delays in calling, directing or discharging ambulances | | and clarifying the need for compliance with PSI 03/2013 in relation to the response to Red and Blue Code calls and the associated requirement for an ambulance to be called. | Healthcare | |
| 3 | The Governor should ensure that in the event of a death prisoners' families are informed quickly by a member of Prison Service staff where possible. | Accepted | Guidance has been issued to all Family Liaison Officers and Governors to reiterate that, in accordance with PSI 64/2011, prisoners families should be notified of their death by Prison Service staff where possible and at the earliest opportunity. The use of Police to break the news will only be in exceptional circumstances and the reasons for this are recorded as defined within PSI 64/2011. | Completed<br><br>The Governor | |