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 July 2014 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 man who died of bronchopneumonia and complications relating to diabetes in July 2014, at HMP Wakefield. He was 57 years old. I offer my condolences to those who knew him.

A clinical review of the care the man received at HMP Wakefield was undertaken. The prison cooperated fully with the investigation.

The man suffered from type 2 diabetes but, for many years, had not complied with treatment, which caused serious health complications. He began to take his medications in late 2013, but there was already significant damage to his kidneys. In February 2014, his kidney function was very poor and, by June 2014, he needed dialysis three times a week. His condition steadily deteriorated and in July, doctors decided to treat him palliatively. He died in the prison's healthcare centre in July.

The clinical reviewer was satisfied that healthcare staff appropriately supported and encouraged the man to engage in treatment. He concluded that he received a good standard of care at Wakefield and I agree.

The man had a history of very challenging behaviour and had been regarded as an exceptionally high risk prisoner. In some respects it is, therefore, understandable that prison staff struggled to achieve the right balance between security and humanity as he reached the end of his life. Nevertheless, on the evidence, I do not consider that his seriously deteriorating health and lack of mobility was always fully taken into account when assessing his risk of escape and the need for restraints when he went to hospital.

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 **February 2015**

CONTENTS

SUMMARY

1. In September 1985, the man was sentenced to life imprisonment. He arrived at HMP Wakefield in September 2002. He had type 2 diabetes, but would not engage with healthcare staff or manage his medication correctly. As a result, he experienced severe complications associated with poorly managed diabetes.

2. Healthcare staff implemented a diabetes care plan and healthcare staff and officers reminded the man to take his medications as prescribed. He had regular blood tests to monitor his condition and kidney function. A blood test, on 10 February 2014, showed his renal function had deteriorated significantly and a prison doctor referred him to a specialist.

3. As a result of the man's poor physical condition, and damage done by poor diabetic control, he had three significant hospital admissions between March and June 2014, including for a leg amputation and penectomy. Each time he was restrained by an escort chain. Staff removed this for surgery and MRI scans, but reapplied it straight after. After his leg was amputated, officers did not restrain him, but used the escort chain again when nurses said they did not feel safe.

4. On 10 June, the man started dialysis three times a week at Seacroft Hospital, Leeds. He was restrained by an escort chain, which officers did not remove while he was undergoing dialysis treatment.

5. The man's condition steadily deteriorated and, on 10 July, doctors decided that no further active treatment was possible and he would be treated palliatively. A doctor decided that he should not be resuscitated in the event of a cardiac or respiratory arrest. She thought he would be too distressed to discuss this at the time, but he agreed to the decision the next day.

6. The man continued to deteriorate and nurses checked him every half hour, day and night. A few days later, a nurse noted that he was no longer breathing. Paramedics attended and confirmed that he had died.

7. The clinical reviewer is satisfied that healthcare staff made appropriate attempts to encourage the man to take his medications and control his diabetes and referred him promptly to secondary services when needed. We agree with the clinical reviewer that his care at Wakefield was equivalent to that he might have expected to receive in the community.

8. We are not satisfied that the prison fully took into account the man's medical condition when assessing his risk for hospital escorts. We make one recommendation.

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 her. No one responded.

10. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. She and the clinical reviewer interviewed two members of staff at HMP Wakefield on 3 September. She interviewed three more staff by telephone and spoke to three others informally. She wrote to the Governor about 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 the County of West Yorkshire of the investigation, who provided the results of the post-mortem examination. We have sent the Coroner a copy of this report.

13. The man did not have a nominated next of kin and, despite the efforts of the prison, Coroner and this office, no family has been traced.

14. The draft report was shared with the Prison Service. There were no factual inaccuracies and the action plan has been added to 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 close supervision centre for exceptionally high risk prisoners. The man lived in the close supervision centre.

16. Spectrum CIC (Community Interest Company) provides primary healthcare services during normal working hours. Humber NHS Foundation Trust (intermediate care) employs the nurses in the inpatient unit, which also provides overnight and weekend care for prisoners with physical health problems. There is a palliative care suite in the healthcare centre. Nottinghamshire Healthcare NHS Trust provides Mental Health Services.

HM Inspectorate of Prisons

17. The most recent inspection of Wakefield was in July 2014. Inspectors found that health services were good overall but some parts of the healthcare environment, including the inpatient unit, were poor. Primary care services were very good and had an appropriate emphasis on the care of patients with long-term conditions. Pharmacy services and medicines management were very good as were mental health services. The Macmillan Gold Standard Framework (a good practice model for working with people nearing the end of their lives) was used for patients with palliative care needs.

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 published 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. The board highlighted the efforts of prison managers and staff in providing a satisfactory regime for prisoners on the CSC. However, the IMB had ongoing concerns about the poor physical environment in the CSC.

Previous deaths at HMP Wakefield

19. The man's death was the fourth death from natural causes in the last year at Wakefield. We have made previous recommendations about prisoners being restrained without comprehensive risk assessments to justify their use.

KEY EVENTS

20. The man was sentenced to life imprisonment on 27 September 1985 after being convicted of robbery, actual bodily harm and wounding with intent. In 1997, he received another life sentence for the manslaughter of a prisoner. On 20 September 2002, he transferred to Wakefield from Woodhill. He was considered an exceptionally high risk prisoner.

21. The man had type 2 diabetes and for most of his time in prison did not take his medication as prescribed. He said the medication made him feel unwell and he would try to control his diabetes through diet. Healthcare staff warned him of the risks of not taking medication. Despite advice, he did not eat a healthy diet and his blood sugars remained high (which indicate poor diabetic control). This resulted in associated complications such as water retention, leg ulcers, renal and cardiovascular problems. Healthcare staff saw him frequently to dress his leg ulcers and continued to encourage him to take his medication. An ophthalmologist visited him in prison to check his vision, as part of regular diabetic checks.

22. From August 2013, the man adjusted his diet and began to take his medication more regularly. Healthcare staff began a diabetes care plan and frequently reminded him to take his medication as prescribed. Records show his blood sugar levels began to reduce.

23. On 23 August, a prison GP reviewed the man and noted that his legs were swollen, he was pale and had a slight cough. The doctor arranged an urgent blood test and referred him for a chest X-ray. The results of the blood test showed that he had a reducing blood platelet count (which can indicate infection, viral conditions or anaemia) and a deteriorating liver function. The blood test also showed that the long term uncontrolled high blood sugar had caused chronic changes to his kidney function. The doctor advised a nurse that there were no immediate concerns but there was a need to continue to monitor his blood tests.

24. The results of a blood test on 5 September were abnormal and the doctor asked nurses to repeat the test a week later. Nurses continued to test the man's blood regularly. The results were often abnormal, because of the extent of damage caused by his uncontrolled diabetes.

25. On 16 September, a prison GP reviewed the man. He noted that his blood sugar level was the lowest it had been for a long time and the swelling to his legs was improving. The doctor asked for continued regular blood tests to monitor his renal function. The doctor said that the better control the man had of his diabetes, the better chance he had of maintaining his kidney function.

26. The man had a chest X-ray on 5 November, which showed he had pneumonia. A doctor prescribed antibiotics and asked for a repeat X-ray. He had a follow up chest X-ray on 28 January 2014. It showed some inflammation in his lungs, but the doctor considered this would clear on its own. Staff arranged a further X-ray for 8 weeks later.

27. On 10 February, a blood test showed the man's renal function had deteriorated and a doctor referred him to an endocrinologist. It is not clear when he saw the

specialist, but on 7 March, the doctor received a letter from a consultant in diabetes and endocrinology. He said the man's condition was complex and he needed an urgent referral to a renal consultant as his kidney function was declining quite rapidly.

28. Later that day, a prison GP explained to the man that his renal function was deteriorating and the doctor referred him to a kidney specialist.

29. On 14 March, the man said he had a dry cough and right sided chest pain. He said he was finding it difficult to sleep. The doctor noted that his last chest X-ray had showed some left sided issues. The doctor prescribed medication. He later refused to take his medication until he was given something to help him sleep and on 19 March, the doctor prescribed a sleeping tablet. Over the next few days healthcare staff saw him frequently. He was having trouble sleeping despite the sleeping tablet. He was short of breath and had a dry cough. The swelling to his legs was worse and his health was deteriorating.

30. On 26 March, a doctor saw the man in his cell. The swelling had increased, he was short of breath and he was suffering from nausea and vomiting. He was taken to hospital at 4.38pm and admitted for tests. Records show he was restrained by an escort chain. (A long chain with a handcuff at each end, one attached to the prisoner the other to an officer.)

31. Tests showed the man had chronic kidney disease and possible sepsis. On 27 March, a hospital doctor told him that an infection in his ankle had spread to his kidneys. The doctor treated him with intravenous antibiotics.

32. The man's renal function continued to decline and on 3 April, he transferred to hospital for specialist treatment. A diabetes consultant, podiatrist and vascular surgeon reviewed him. An MRI scan showed that he had osteomyelitis (a bone infection, which left untreated can be fatal) in his right leg and he had more antibiotics. He remained in hospital, and on 17 April, had an operation to removed dead tissue from his right heel.

33. The man returned to the inpatient unit at Wakefield on 20 April. Nurses took regular blood tests to monitor his kidney function and noted that he was well in himself and his basic observations were stable. On 1 May, staff noted his legs had swelled more and he had a low blood pressure, but fast pulse. He told a doctor that he felt fine. The doctor diagnosed cellulitis (a tissue infection) and prescribed antibiotics.

34. On 5 May, the man was given an air mattress to minimise the risk of pressure sores. The increased swelling on his legs reduced over the next few days. On 11 May, nurses noted his legs were red and hot to the touch. A doctor prescribed antibiotics.

35. A doctor reviewed the man on 14 May. He recorded that the man did not have any urgent medical issues and was taking his medications as prescribed. His most recent blood test had showed some abnormalities as expected, but his kidney function was improving.

36. On 23 May, the man lost consciousness in his cell. A member of healthcare staff helped him back to bed and he seemed to recover. A doctor assessed him and

considered his symptoms suggested heart disease. Another doctor also reviewed him. An urgent blood test showed his kidney function was normal but there was an ongoing infection. He said he felt fine, but had a headache. A doctor prescribed an alternative antibiotic and healthcare staff closely monitored him. The doctor advised that he should go to hospital if his condition got worse.

37. On 24 May, the man collapsed while standing to have his blood pressure taken. A nurse helped him back to bed. The nurse discussed this with senior healthcare staff and arranged for him to go to hospital. While waiting for the ambulance, healthcare staff carried out an ECG, which showed ectopic beats (where the heart skips a beat) and a possible first degree block (where there is disruption to electrical pulses that control the heart). Healthcare staff gave the ECG results and his medications to the paramedics. Escorting staff restrained him with an escort chain.

38. The man was admitted to the cardiology ward at hospital. He had fluids via a drip to alleviate dehydration. The hospital diagnosed him with osteomylitis and sepsis of the wound on his foot and treated him with intravenous antibiotics.

39. The man transferred to another hospital on 27 May. The next day he had surgery to amputate his right leg due to the infection. The escorting officers removed the escort chain for the surgery and did not reapply it afterwards.

40. The man refused all medications. He was passing very little urine and was dehydrated, but he demanded hospital staff remove a catheter. His kidney function continued to deteriorate and the renal team at the hospital reviewed him daily. The prison healthcare manager visited him in hospital on 4 June. She noted his stump was healing well and he had agreed to start intravenous antibiotics for possible urinary sepsis.

41. The man's kidney function continued to deteriorate and he started dialysis on 11 June. Later that day, the escort officer reapplied the escort chain to him at the request of nurses who said they felt unsafe. There is no evidence that he behaved inappropriately in hospital or was any risk to hospital staff, but it appears they were aware of his offences.

42. On 13 June, the man went back to the prison inpatient unit. He was now confined to bed and his condition was deteriorating. He was taken in a wheelchair to hospital three times a week for dialysis. Officers used an escort chain to restrain him for the appointments, including during dialysis treatment.

43. On 16 June, a doctor assessed the man and found his blood sugars were high as the hospital had stopped his diabetic medication because his kidney function was so poor. The doctor told him he needed an assessment by the vascular surgeon at hospital, but he refused to go. The doctor noted that he had the mental capacity to make the decision and informed him of the risks. However, he agreed to go to hospital the next day. A urology registrar told him that his penis was necrotic, possibly due to poor diabetic control. A doctor prescribed him insulin to stabilise his blood sugars and admitted him.

44. Staff continued to restrain the man with an escort chain and prison managers reviewed the risk assessment regularly. The level of risk or restraint did not change.

45. On 19 June, the man had a penectomy. Officers removed the escort chain for the surgery and reapplied it as soon as the surgery was finished. He had a catheter fitted and was prescribed opiate pain relief. He returned to the healthcare centre at Wakefield on 24 June. A doctor reviewed him the next day. He was completely immobile and needed assistance with all care needs such as washing and dressing. Staff put a bar above his bed so that he could pull himself into a sitting position.

46. On 2 July, a vascular surgeon reviewed the man. His leg wound was healing well, but the penectomy site was healing slowly. The heel on his left foot was becoming necrotic and he was advised to keep it elevated as if it got worse he might need that leg amputated as a life saving measure. The surgeon noted that he was not well and that further intervention was not ideal. On 6 July, he went to hospital for a replacement catheter, after which he returned to Wakefield healthcare centre.

47. On 7 July, the man went for his scheduled dialysis appointment. Shortly after the dialysis started, he took the line out and said he had had enough. Back at the prison, he explained that he had had enough of being in pain, which was everywhere. A nurse gave him morphine, which he said helped. He refused to attend a dialysis appointment on 9 July. A nurse explained the importance but he refused to go. He signed a disclaimer about this.

48. A doctor assessed the man during the afternoon. He said that since the penectomy he had been in pain in his abdomen and thighs. He was sleeping most of the time, but was orientated to time and place. The doctor discussed his wishes about resuscitation and he said he wanted resuscitation if he had a cardiac or respiratory arrest. A urine test showed he had a urine infection and the doctor prescribed antibiotics, oramorph and an opiate pain relief patch for the pain. She told healthcare staff to monitor him frequently.

49. On 10 July, staff noted the man was drowsy and confused. A doctor discussed him with staff at hospital. They considered that no further active treatment was possible; he was at the end stage of his life and should remain in the healthcare centre at Wakefield for palliative care (to relieve symptoms and pain). The hospital cancelled all further dialysis sessions and the doctor implemented an order that he should not be resuscitated. He did not discuss this with him, as he was confused at the time and he did not want to cause him any undue distress.

50. Healthcare staff spoke to a palliative care specialist on 11 July, who advised which medications to prescribe. She was concerned that there was an order not to resuscitate the man, which had not been discussed with him. A doctor reviewed him that afternoon. He said he was happy to continue being cared for by the nursing team at Wakefield and was aware that he was very unwell. The doctor discussed the order not to resuscitate with him and he said he did not want resuscitation to be attempted. The doctor explained that they could review this at any time. He said he did not want his family informed of his condition. Security staff agreed that his door could be left open at all times to enable unrestricted nursing care.

51. The man found it difficult to swallow and healthcare staff administered his medications intravenously through his abdomen. His condition continued to

deteriorate, but he remained comfortable. Nurses checked him every half an hour throughout the day and night. At 1.35am, a nurse saw that he was no longer breathing. Paramedics attended and confirmed death at 2.01am.

52. The man had had no contact with any family members during his time in prison and despite the efforts of the prison, Coroner and this office no family were traced after his death. In line with national guidelines, the prison arranged and paid for his funeral, which was held on 28 July.

Support for staff

53. A Governor's notice informed staff of the man's death. A senior manager debriefed the healthcare staff and the care team offered them support.

Cause of death

54. The post-mortem report showed the man's cause of death as bronchopneumonia and extensive tissue infections, end stage renal failure and peripheral vascular disease, and diabetic neuropathy.

55. After the draft report was issued, the Coroner made us aware of additional toxicology results. Blood samples taken during the post-mortem showed the level of paracetamol and fentanyl to be above the therapeutic range. An additional cause of death was added as 'administration of multiple analgesic drugs'. The clinical reviewer said that although the drugs were above the therapeutic range, this would not necessarily have indicated negligent care and the results did not cause him significant concern. All opiate based analgesia has the potential to depress respiration. The prescribing clinician would consider this fact balanced with the need to ensure adequate pain control. As the patient's condition deteriorates there is always the potential for this to influence breathing, however in palliative care the overriding aim is symptom management.

ISSUES

Clinical care

56. The man suffered from complex medical conditions, made worse by many years of poor engagement with healthcare staff and not taking his prescribed medication for diabetes which resulted in serious complications. There is clear evidence that staff at Wakefield attempted to help him to manage his diabetes, such as encouraging him to take his medication and explaining the risks to his health if he did not. He began to take his medication more regularly in August 2013, but by this time his health had significantly declined.

57. The clinical reviewer found that healthcare staff made appropriate attempts to engage with the man and emphasised the importance of good diabetes control. When his condition deteriorated and renal and cardiovascular problems occurred, doctors referred him appropriately to secondary services. The clinical reviewer concluded that the care he received at Wakefield was of a high standard and equivalent to that he might have expected to receive in the community. The clinical review identified some areas of good practice in his management, including comprehensive record keeping which demonstrated responsive and holistic care. He identified some areas for improvement in healthcare procedures, which the Head of Healthcare will need to address, but overall we are satisfied that he received a good standard of care at the prison.

Escort risk assessments

58. 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.

59. 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 the 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 and kept under review as circumstances change. It found 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.

60. The man was an exceptional high risk prisoner, which meant he was considered one of the most dangerous prisoners in the high security estate. He had a history of attacks on prison staff. When he went to hospital, a senior manager and four officers accompanied him.

61. The risk assessments for hospital escorts show that staff considered the man a high risk to the public and of hostage taking; a medium risk to hospital staff and of escape; and a general risk to prison staff due to previous offences. The healthcare input into the risk assessment was by a list of standard questions in

which yes/no was indicated. This indicated no medical objections to the use of restraints and that his medical condition did not impact on his risk of escape. There was no other medical information about how his condition impacted on his risk of escape, even when he had his leg amputated.

62. Staff restrained the man with an escort chain, and replaced this with a standard cuff for medical interventions and interaction with hospital staff. The escort chain remained in place during dialysis treatment, but was removed for tests such as MRI scans and surgery, but reapplied straight after. While it is possible that restraints were appropriate for initial hospital admissions, there was insufficient healthcare input into the risk assessments. The same risk assessment remained in place throughout his hospital stays. Senior managers reviewed the risk assessment but it was never amended.

63. Public protection is fundamental and the man had been assessed as an exceptionally high risk prisoner. However, security measures must be proportionate to a prisoner's individual circumstances which must be fully considered, taken into account and balanced against the security risks. He was in very poor health and, from June, he was confined to bed. He had had one leg amputated. It is difficult to see how he would have had the ability or opportunity to escape or reoffend in his condition, particularly with his intensive level of escort. We are particularly concerned that he was restrained for dialysis treatment, which is not consistent with the 2007 High Court judgement about the use of restraints when prisoners are having life saving treatment.

64. We have raised the issue of the need to ensure appropriate risk assessment with Wakefield before. In response, the prison undertook an action plan to ensure there was relevant input from clinicians to the risk assessment and the proportionate use of restraints. The man may have been an exceptionally high risk prisoner, but towards the end of his life he was also seriously incapacitated and it appears there is a continuing need to for managers at the prison to ensure that decisions about risk assessments are based on all the available evidence about how a prisoner's health and mobility at the time impact on their risk of escape, rather than previous assessments of their risk when they were healthy. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

RECOMMENDATION

1. The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner 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 of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.	Accepted	The Head of Security and Head of Healthcare will continue to work together with relevant Clinicians to ensure that the use of restraints during escorts to hospital is appropriately risk assessed on an individual case by case basis and the prisoner's medical condition is considered as part of the risk assessment process. The escort level and any application of restraints will be proportionate to the assessed security risks and justified. These will take into account the prisoner's individual circumstances, the risks of escape and the risks to the public, nursing staff and escorting staff presented by each prisoner. Where this is in relation to a Cat A prisoner, authority will be sought from the DDC for High Security if levels of restraints below agreed NSF levels are considered to be appropriate. During out of hours or emergency situations, the reduction or removal of restraints will be considered as per PSI 09/2013 provisions.	Complete & ongoing Head of Security and Head of Healthcare