Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Richard Cullen, a prisoner at HMP Wakefield on 28 August 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Richard Cullen died of heart and lung disease at HMP Wakefield on 28 August 2015. He was 57 years old. I offer my condolences to Mr Cullen's family and friends.

Healthcare staff at Wakefield managed Mr Cullen's long-term health conditions effectively and there was no indication that he was acutely unwell at the time of his death, which was sudden and unexpected. I am satisfied that the care Mr Cullen received was equivalent to that he could have expected in the community. However, I am concerned that the member of staff who unlocked Mr Cullen's cell, on the afternoon he died, did not check on his welfare. This is an issue I have raised with the prison before and I know managers have now taken action to prevent a reoccurrence.

This version of my report, published on my website, has been amended to remove the names of the staff and prisoners involved in my investigation

Nigel Newcomen CBE
Prisons and Probation Ombudsman **March 2016**

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Summary

Events

1. On 8 November 2002, Mr Richard Cullen was sentenced to life imprisonment for murder. He had been at HMP Wakefield since March 2006.

2. Mr Cullen had a long history of heart and lung disease and had a heart attack in 2004. He was also a long-term smoker, who found it difficult to stop despite advice and support from staff. Healthcare staff at Wakefield created care plans for Mr Cullen's chronic health problems. They prescribed appropriate medication and reviewed him frequently. He was also under the care of cardiology and respiratory medicine specialists at Mid Yorkshire Hospitals Trust, who considered his condition stable.

3. On 28 August, wing staff locked prisoners in their cells at 11.30am. The officer who unlocked Mr Cullen's cell, at approximately 12.52pm, thought he was asleep and did not attempt to get a response from him. At around 3.10pm on 28 August, another prisoner discovered Mr Cullen unresponsive in his cell. He alerted staff who immediately used an emergency medical code to request help. Healthcare staff arrived at the cell within a minute. They attached a defibrillator and began cardiopulmonary resuscitation (CPR). Paramedics arrived at 3.23pm and continued CPR until 3.44pm, when they confirmed that Mr Cullen had died.

4. A post-mortem report concluded that Mr Cullen died from ischaemic heart disease (a disease of the blood vessels supplying the heart muscles with oxygen), coronary artery atheroma (chronic heart disease) and chronic obstructive pulmonary disease (the name for a collection of long-term progressive lung diseases, including chronic bronchitis and emphysema).

Findings

5. Healthcare staff managed Mr Cullen's long-term medical conditions in line with national guidelines. His medication, treatment and reviews were appropriate and timely. We agree with the clinical reviewer's conclusion that the care Mr Cullen received at HMP Wakefield was equivalent to that he could have expected in the community.

6. We are concerned that the officer who unlocked Mr Cullen after the lunchtime break did not adequately check his welfare, as stipulated in national and local instructions. However, we note that the Governor has since reissued a notice to staff, reminding them of the findings of some of our previous reports and the requirement to check prisoners' wellbeing when unlocking cells. Prison managers have also been advised to discuss this directly with staff. In view of the positive steps already taken by the prison to address this issue, we make no recommendation.

7. Mr Cullen had no next of kin listed in his records. The prison were unable to trace his family through the Probation Service, or his recorded telephone numbers. In similar circumstances in the future, the prison should seek the assistance of the police to locate a prisoner's family

The Investigation Process

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

9. The investigator visited Wakefield on 10 September 2015. He obtained copies of relevant extracts from Mr Cullen's prison and medical records and interviewed two prisoners.

10. NHS England commissioned a clinical reviewer to review Mr Cullen's clinical care at the prison.

11. We informed HM Coroner for West Yorkshire Eastern District of the investigation who gave us the results of the post-mortem examination. We have given the coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted Mr Cullen's brother, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He asked why the prison did not contact the family to inform them of Mr Cullen's death.

13. Mr Cullen's family received a copy of the initial report and indicated that they were satisfied with the findings. The prison also received a copy of the report and there were no factual inaccuracies.

Background Information

HMP Wakefield

14. 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.

15. 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 provides overnight and weekend care for prisoners with physical health problems. There is a dedicated palliative care suite situated in the healthcare unit.

HM Inspectorate of Prisons

16. The most recent inspection of HMP 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.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to April 2015, the IMB noted the importance of healthcare given the significant number of older prisoners. The Board considered that health services were well managed, the quality of care was high and they reported a significant reduction in prisoners' complaints about healthcare.

Previous deaths at HMP Wakefield

18. Mr Cullen was the eighth prisoner to die from natural causes at Wakefield since the start of 2014. We have previously raised the issue of staff checking the wellbeing of prisoners when unlocking cells. The Governor has reissued instructions to staff in response to our recommendations.

Key Events

19. On 8 November 2002, Mr Richard Cullen was sentenced to life imprisonment for murder and taken to HMP Swansea. He was moved to HMP Wakefield on 7 March 2006.

20. Medical records indicate that Mr Cullen had a history of cardiovascular disease and that after a heart attack in December 2004, doctors had diagnosed ischaemic heart disease. Mr Cullen had also suffered from COPD for many years, although it is unclear when this was first diagnosed. Mr Cullen was a long-term smoker. Despite advice and support from prison healthcare staff and the use of nicotine replacement therapy, he found it difficult to stop smoking.

21. Healthcare staff at Wakefield managed Mr Cullen's long-term conditions within National Institute for Health and Care Excellence guidelines (NICE). They prescribed appropriate medication, monitored him frequently, and held annual reviews of his heart and lung diseases. Between 2010 and 2013, Mr Cullen was occasionally admitted to hospital as an inpatient, after experiencing chest pain and shortness of breath.

22. Mr Cullen was also under the care of cardiology and respiratory medicine consultants at Mid Yorkshire Hospitals Trust. A consultant in respiratory medicine, reviewed Mr Cullen's condition and medication annually and noted that he was clinically stable. His last respiratory review was in March 2015. His cardiology consultant reviewed him in May 2015.

23. On 2 July 2015, Dr A, a prison GP, revised Mr Cullen's medication after receiving a letter from his cardiology consultant about his most recent review. The doctor replaced furosemide with spironolactone (both used for fluid retention).

24. The next day, Nurse A introduced herself to Mr Cullen as his lead nurse under the Personalised Individual Nursing Care (PINC) project. (A specific pathway developed by the prison's primary healthcare provider to manage prisoners' long-term medical conditions and ensure they receive regular ongoing care.) The nurse completed care plans for Mr Cullen's heart disease and COPD and planned to see him monthly.

25. On 16 July, Nurse A conducted a full assessment of Mr Cullen's medical conditions and discussed his care plans. On 20 July, Nurse B carried out a further review, and concluded that his condition was stable. At Mr Cullen's last review with Nurse A, on 25 August, he raised no concerns and said he felt well.

Events of 28 August 2015

26. At 11.30am on 28 August, wing staff locked prisoners in their cells for the lunch period. When Officer A unlocked Mr Cullen at 12.52pm, he was lying on his bed and appeared to be sleeping. The officer did not attempt to rouse him.

27. At about 1.00pm, prisoner A, went into Mr Cullen's cell and left a magazine on his bed. The prisoner told the investigator that the curtain was drawn, and Mr Cullen was on his bed with a fleece jacket wrapped around him. He assumed

that he was sleeping. They did not speak, but the prisoner said this was not unusual.

28. Shortly after 3.10pm, another prisoner, prisoner B, looked in Mr Cullen's cell as he walked past. He said that they were good friends and he often went to see him in the afternoon after work. Mr Cullen appeared to be asleep, but his left leg was hanging over the side of his bed. He continued past the cell but returned, almost immediately, as he felt something was wrong. He went into the cell and spoke to Mr Cullen, but he did not reply. He shook him and he did not respond. He then opened the curtain. He immediately noticed that Mr Cullen's lips were purple, he had dribbled on his pillow and his lips and cheek appeared to have drooped.

29. Prisoner B ran to the cleaner's office on the wing, a very short distance away, where he knew officers usually took their breaks. He told Officer B and Officer C that something was wrong, as he could not wake Mr Cullen.

30. Officer B immediately contacted the control room, indicating a code blue emergency, while Officer C went with prisoner B to Mr Cullen's cell. (A code blue indicates circumstances such as when a person is unconscious or not breathing.) The control room called an ambulance immediately.

31. Officer C attempted to rouse Mr Cullen by shaking him and calling his name. Officer B arrived at the cell and did the same, but Mr Cullen did not respond. Three nurses arrived within a minute. They began CPR and attached a defibrillator to Mr Cullen's chest. At 3.12pm, the defibrillator advised 'no shock' and the nurses continued CPR, for a further four cycles.

32. Emergency paramedics arrived at 3.23pm and took over the CPR attempts. At 3.44pm, they confirmed that Mr Cullen had died.

Contact with Mr Cullen's family

33. There were no next of kin details in Mr Cullen's prison record. When he arrived at Wakefield, he had nominated his partner, but asked for her details to be removed soon afterwards. When asked, he repeatedly refused to nominate anyone else, and records show that staff last asked him in February 2013. Mr Cullen received no visits in prison and made no phone calls.

34. Mr Cullen had three phone numbers recorded on the prison telephone system, but had never called them. After his death a senior manager, rang the numbers, but none related to his family. The prison contacted the Probation Service but they had no details of family contacts. The senior manager said that they did not consider contacting the police as they had no names or other information to help identify possible relatives.

35. On 2 September, Mr Cullen's brother telephoned to inform the prison that he was Mr Cullen's next of kin and left his contact details. Officer D contacted him the next day. She explained their attempts to find Mr Cullen's next of kin and offered support. The officer and the senior manager kept in touch with Mr Cullen's brother, who visited Wakefield, spoke to some of his friends and attended a memorial service. In line with Prison Service guidance, the prison contributed to the costs of Mr Cullen's funeral, which was held on 14 September 2015.

Support for prisoners and staff

36. After Mr Cullen's death, another senior manager debriefed prison staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. Officer B confirmed she spoke to the prisoner who found Mr Cullen unresponsive in his cell to offer support. The senior manager requested they speak to him again and confirm he is ok.

37. Healthcare staff did not attend the debrief, but the Head of Operations, offered the nurses involved in the resuscitation attempts appropriate support.

38. The prison posted notices informing other prisoners of Mr Cullen's death, and offering support. Staff reviewed all prisoners considered to be at risk of suicide and self-harm, in case they had been adversely affected by Mr Cullen's death.

Post-mortem report

39. A post-mortem report concluded that Mr Cullen died from ischaemic heart disease, coronary artery atheroma (chronic heart disease) and chronic obstructive pulmonary disease.

Findings

Clinical care

40. Mr Cullen had suffered from chronic heart and lung disease for many years. His medical records indicate that healthcare staff managed his long-term conditions effectively, in consultation with cardiology and respiratory medicine specialists. They created care plans, prescribed appropriate medication and reviewed him frequently. When Mr Cullen's symptoms of chest pain and shortness of breath worsened, staff sent him to hospital promptly for further investigations and treatment.

41. We agree with the clinical reviewer that Mr Cullen received a good standard of care, equivalent to that which he could have expected in the community.

Unlocking cells

42. Prison officers are expected to check on a prisoner's wellbeing when unlocking cells. The Prison Officer Entry Level Training (POELT) manual states:

> "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response, you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead."

43. Prison Service Instruction 75/2011 states:

> "…there need to be clearly understood systems in place for staff to assure themselves of the well being of prisoners during or shortly after unlock… Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process."

44. We are concerned that Officer A did not attempt to obtain a response from Mr Cullen, or adequately check his welfare when he unlocked his cell at 12.52pm on 28 August. This led to another prisoner finding him. The clinical reviewer suggested that as Mr Cullen's body was still warm when healthcare staff arrived at 3.10pm, it was likely that he had not been dead for long. We cannot know if the outcome would have been different had the officer roused him when he unlocked his cell. However, this could make a difference in the future.

45. In response to previous advice and recommendations from this office, the Governor of Wakefield issued a notice to staff (33/2015) in February 2015. This drew attention to PSI 10/2011 and reminding staff of, "the requirement that when a cell door is unlocked, officers must satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention". In December 2015, the Governor issued a further notice, again referring to our findings and reiterating staffs' responsibilities when unlocking prisoners. Another senior manager, also wrote to other managers advising them to speak to staff directly about this. As Wakefield has proactively addressed this issue since Mr

Cullen's death, we do not make a recommendation. However, the prison should note that PSI 75/2011 has replaced PSI 10/2011 and the Governor might wish to amend the notice to staff to reflect this.

Liaison with Mr Cullen's family

46. Mr Cullen's family learned of his death through media reports and questioned why the prison had not informed them personally.

47. Mr Cullen had not nominated anyone as next of kin and during his imprisonment, he had made no telephone calls or received social visits. After his death, a prison manager unsuccessfully attempted to trace his family through the Probation Service and by ringing unused telephone numbers stored in the prisoner telephone system. He explained that he did not think it was worth contacting the police, as he could provide no names or other personal details. We consider this was reasonable in the circumstances but believe that the police can often be of considerable help in cases like this and encourage the prison to contact them if similar problems arise in the future.

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