Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Michael Downs, a prisoner at HMP Wakefield in April 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*

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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.

This is the investigation report into the death of Michael Downs, who died of bronchopneumonia and heart disease, while a prisoner at HMP Wakefield, on 12 April 2015. I offer my condolences to his family and friends.

I am satisfied that Mr Downs received a good standard of care at Wakefield for his chronic health conditions and there is nothing the prison could have done to prevent his death. However, I am concerned that the prison did not inform Mr Downs' family promptly of his admission to hospital on 10 April, when he was seriously ill. This meant they were unable to see him before he became unconscious. Escort officers gave Mr Downs commendable care during his final admission to hospital, but I am not satisfied that the use of restraints until shortly before his death, was justified by a fully considered risk assessment. I also do not consider that the presence of three officers was necessary when he was on life support. This did not allow his family sufficient privacy with him before he died.

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 **November 2015**

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Summary

Events

1. Mr Downs was serving a life sentence at HMP Wakefield. He had a number of chronic health conditions including angina, peripheral vascular disease, osteoarthritis and chronic obstructive pulmonary disease (COPD - the name for a collection of lung diseases including chronic bronchitis and emphysema). His conditions were managed by medication. Healthcare staff reviewed him regularly.

2. Shortly before 5.00am on 31 March 2015, Mr Downs fell in his cell. A nurse took his clinical observations including blood pressure, pulse rate and oxygen levels, which were outside the normal range. After giving him medication, using a nebuliser to help him breathe and improve his oxygen levels, Mr Downs appeared to settle and she took no further action. At around 7.45am, Mr Downs had further breathing difficulties. A nurse administered oxygen and requested an ambulance. Mr Downs was admitted to hospital and doctors treated him for a chest infection.

3. In hospital, doctors treated Mr Downs with antibiotics and he returned to the prison at 7.20pm on 9 April. At 4.30am the next day, his condition deteriorated. He was taken to hospital as an emergency and diagnosed with severe pneumonia. At 9.25am on 12 April, Mr Downs had a cardiac arrest. Hospital staff resuscitated him and placed him on life support. Until that point, Mr Downs had been restrained by an escort chain.

4. At 11.45am, the prison's family liaison officer informed Mr Downs' son of his father's serious condition. His family went to the hospital. Doctors removed life support and Mr Downs died later that day.

Findings

5. The clinical reviewer noted that the nurse, who attended to Mr Downs early on 31 March, should have considered more active medical intervention in the light of his clinical observations. However, this would not have affected the outcome for Mr Downs and overall, she was satisfied that Mr Downs received a good standard of care at Wakefield, equivalent to that he could have expected to receive in the community.

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6. We are concerned that the prison did not inform Mr Downs' family that he had been re-admitted to hospital on 10 April, until after he had had a cardiac arrest on 12 April and was unconscious in intensive care.

7. We do not consider that the use of restraints when Mr Downs was in hospital at the end of his life was properly justified. However, we commend the care that escorting officers gave Mr Downs during his final admission to hospital, although the presence of three prison staff in his final hours was excessive and allowed his family no private time with him.

Recommendations

- The Head of Healthcare should ensure that healthcare staff take appropriate action when clinical observations are outside the normal range and might indicate a deterioration in a prisoner's condition.
- 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.
- The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible so that they are able to visit them in hospital without unnecessary delay.
- The Governor should ensure that unless there are overriding security concerns, escorts should allow the family of dying prisoners some private time with them.

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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 her. No one responded.

9. The investigator obtained copies of relevant extracts from Mr Downs' prison and medical records. She interviewed four members of staff at Wakefield on 15 May and three members of staff by telephone in June.

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

11. We informed HM Coroner for Wakefield of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted Mr Downs' son to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He asked why he was not told sooner of Mr Downs' admission to hospital on 10 April and why there were three officers at Mr Downs' bedside which affected the family's privacy.

13. The Prison Service received a copy of the initial report; they did not raise any factual inaccuracies and provided an action plan which is annexed to this report.

14. Mr Downs' family received a copy of the initial report. They did not raise any issues, or comment on the factual accuracy of the report.

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Background Information

HMP Wakefield

15. HMP Wakefield is one of eight high security prisons in England and Wales. It holds up to 750 men. There are four main residential wings, a healthcare centre, segregation unit and close supervision centre for exceptionally high-risk prisoners.

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 provides overnight and weekend care for prisoners with physical health problems. Nottinghamshire Healthcare NHS Trust provides mental health services. HMP [Prison]

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.

Independent Monitoring Board

18. 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 their latest annual report, for the year to April 2014, the IMB reported that Wakefield had a significant number of older prisoners, and this brought its own problems and challenges for the provision of healthcare. There was a monthly healthcare forum, which included representatives from each wing who acted as a representative for any queries.

Previous deaths at HMP [Prison]

19. Mr Downs was the fifth prisoner to die from natural causes at Wakefield since the start of 2014. We have previously identified the need for the prison to inform families quickly when a seriously ill prisoner is admitted to hospital and that the use of restraints for seriously ill prisoners should be fully justified.

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Key Events

20. On 10 July 1989, Mr Downs was sentenced to life imprisonment for two murders. Mr Downs had a number of chronic conditions including COPD. Healthcare staff managed Mr Downs' conditions with medication and regular reviews. Mr Downs had spent time at a number of prisons during his sentence but had been at Wakefield for some years.

21. At 4.51am on 31 March 2015, Officer A responded to a cell bell from a cell next to Mr Downs. Mr Downs had fallen and had alerted his neighbour. The officer found Mr Downs on the floor and radioed the night manager and healthcare staff for help.

22. Nurse A responded and she and prison staff helped Mr Downs back to bed. The nurse recorded his clinical observations, which were outside the normal range. His pulse rate was 130bpm, respiratory rate 22bpm, blood oxygen saturation was 89%, temperature 35.8c and his blood pressure was 123/94. She gave Mr Downs his nebuliser (which administers medication in the form of a mist inhaled into the lungs) to improve his oxygen saturation levels. The nurse ensured he was settled and able to use his cell bell if necessary. She made a note in the handover book for a nurse to check him later that morning.

23. At around 7.45am, Officer B responded to Mr Downs' cell bell. Mr Downs was sitting in his chair. He was short of breath but able to speak. Nurse B attended and noted Mr Downs had a wheeze in both lungs and creps (crackling noise heard when breathing). He appeared to be confused. The nurse gave him oxygen and his nebuliser, and requested an ambulance.

24. Ambulance staff took Mr Downs to Pinderfields Hospital, Wakefield. Doctors diagnosed infective COPD and a chest X-ray and blood tests confirmed this. Mr Downs also had a drop in blood pressure and raised CK (creatine kinase) levels, which can indicate a heart attack or heart disease. Doctors treated Mr Downs with intravenous fluids and antibiotics.

25. On 2 April, Nurse C and a prison manager, A, visited Mr Downs in hospital. The nurse Bullock recorded that Mr Downs was unwell, having intermittent bouts of confusion and was waiting for a CT scan. He was able to speak only in short sentences due to extreme breathlessness and was receiving oxygen through a nasal tube. She noted that his mobility was poor and he needed help from a member of staff to walk and could manage only short distances.

26. On 7 April, Nurse D visited Mr Downs. A respiratory registrar told her that Mr Downs still required oxygen and oral antibiotics as he had developed pneumonia but hoped that after another day of treatment, Mr Downs would be able to be discharged back to the prison.

27. At 7.20pm on 9 April, Mr Downs returned to the inpatient healthcare unit at the prison. The hospital had diagnosed an exacerbation of his COPD. Nurse E noted that Mr Downs' colour was poor and he was anxious and gasping for breath. She helped him into a chair and advised him not to move without help from staff, as his mobility was poor.

28. At 4.30am on 10 April, Nurse E noted that Mr Downs' condition had deteriorated. His breathing was laboured and erratic and he appeared more confused. His oxygen levels were low, he had been incontinent, had oedema (fluid retention) and clubbing to both feet (which can indicate insufficient oxygen). The nurse gave him a salbutamol nebuliser but there was no improvement. She considered Mr Downs was at high risk of respiratory failure and requested an ambulance. Paramedics took Mr Downs to Pinderfields Hospital and he was admitted for treatment.

29. Later that morning, Nurse C went to see Mr Downs at the hospital. He appeared very confused and disorientated and his treatment included intravenous antibiotics for pneumonia and oxygen. A chest X-ray showed no change and doctors prescribed Mr Downs oramorph (strong pain relief) for agitation and pain.

30. On 11 April, the manager asked Nurse A to check that Mr Downs was receiving appropriate care at the hospital, as the officers who were escorting him had said that they had to help feed Mr Downs and assist him with his personal care. Nurse A found Mr Downs was agitated and talking to himself. He was not using the nasal cannula as required. A doctor told her that Mr Downs had severe pneumonia with secondary delirium and that a head CT scan had shown nothing abnormal. Nurse A was satisfied that his care was appropriate.

31. At 9.25am on 12 April, Mr Downs had a cardiac arrest and the escort officer removed the restraints they had been using until then. Hospital staff resuscitated him and attached him to a life support machine. Doctors moved him to the intensive care unit and said his condition was critical. After discussion with Mr Downs' family, doctors removed the life support. Mr Downs died that evening.

Contact with Downs family

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32. After Mr Down's cardiac arrest, the prison appointed Supervising Officer (SO) A as the family liaison officer. The SO initially had some difficulty finding an up to date telephone number for Mr Downs' son, but eventually got his number from prison telephone records.

33. At 11.45am, SO A telephoned Mr Downs' son to let him know he was in a critical condition in intensive care. The SO arranged for Mr Downs' family to visit him in hospital and met them at the hospital at 3.25pm. Doctors discussed withdrawing life support with Mr Downs' family. They did not want to be present when life support was removed and, as the SO was going off duty, she agreed that another member of staff, SO B, would telephone them when he died. SO B informed Mr Downs' son at 6.12pm, very shortly after Mr Down had died.

34. Mr Downs' funeral was on 14 May and the prison contributed to the costs in line with national policy.

Support for prisoners and staff

35. The duty governor, debriefed the staff involved with Mr Downs' care to give them the opportunity to discuss any issues arising and to offer support.

36. The prison posted notices informing other prisoners of Mr Downs' death, and offering support. The chaplaincy held a memorial service for Mr Downs on 16 June.

Post-mortem report

37. A post-mortem report concluded that Mr Downs died of bronchopneumonia, ischemic heart disease, and chronic obstructive pulmonary disease.

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Findings

Clinical care

38. The clinical reviewer was satisfied that, overall, healthcare staff managed Mr Downs' complex health needs effectively and he received a high standard of care at the prison. Clinicians followed established national guidance for the treatment of chronic obstructive pulmonary disease and ensured they managed his condition and any exacerbations in line with National Institute for Health and Clinical Excellence (NICE) guidelines. Nurses were caring and compassionate and this was particularly evident as his condition deteriorated. We are satisfied that Mr Downs received care equivalent to that he could have expected to receive in the community.

39. Although it would not have altered the outcome for Mr Downs, the clinical reviewer considered that an opportunity for earlier medical intervention might have been missed when Nurse A recorded Mr Downs' observations, just before 5.00am on 31 March, and noted that they were outside the normal range. Nurse A told us that she considered Mr Downs' oxygen saturation levels were normal for a COPD patient, and she was satisfied that Mr Downs condition had settled after using his nebuliser. However, the clinical reviewer considered that the combined observations were indicative of deterioration in Mr Downs' health and should have prompted further action.
We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff take appropriate action when clinical observations are outside the normal

Restraints, security and escorts

40. When prisoners have to travel outside prison, such as to a hospital, staff make a risk assessment to determine the nature and level of any security arrangements, including any restraints.

41. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. 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 takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape

when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment 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.

42. On 31 March, Mr Downs was taken to hospital as he was short of breath and confused. A supervising officer and two officers escorted him. He was assessed as a high risk to the public, a medium risk to hospital staff and a medium risk of escape. Healthcare staff assessed his mobility as impaired but did not object to the use of restraints. There was no further detail on Mr Downs' condition or whether it impacted on his risk of escape. Mr Downs was restrained with an escort chain and handcuffs. (An escort chain is a long chain with handcuffs each end, one attached to an officer and the other to the prisoner.)

43. At 6.20pm that evening, Mr Downs asked officers to remove the restraints. Officers kept them on and noted that he became agitated and aggressive. At 7.40am the next day, prison manager, A, authorised that the restraints should be reduced to just an escort chain to allow treatment. Mr Downs remained on an escort chain until he returned to the prison on 9 April.

44. On 10 April, Mr Downs went to hospital as a medical emergency, at this time he was seriously ill with laboured breathing, low oxygen levels and confusion. A supervising officer and two officers escorted him and used an escort chain. Healthcare staff noted that Mr Downs used a wheelchair and had reduced mobility. They did not object to restraints but stated that an escort chain should be used to allow for treatment. There was no information on whether his condition impacted on his risk of escape. On 12 April, Mr Downs had a cardiac arrest and officers removed the escort chain so that hospital staff could treat him. The restraints were not reapplied.

45. The duty governor said that as a category A prisoner, Mr Downs was considered a high risk to the public. While his mobility was impaired, he was still able to walk to some extent and therefore the manager considered he posed a risk to others. He said Mr Downs' behaviour was unpredictable and he was sometimes aggressive and confused because of his condition. He said that a supervising manager went to the hospital each day to assess Mr Downs' condition and to ensure that the use of restraints was still appropriate.

46. Public protection is fundamental, but 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. While we accept that

Mr Downs' level of risk was reviewed regularly, we do not consider that the risk assessments fully took into account Mr Downs's condition, or whether it impacted on his risk of escape, as required by the 2007 High Court judgment. We have raised this matter with Wakefield before and the prison undertook to make changes. 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.

47. We note that during Mr Downs' last admission to hospital, the escort officers sensitively supported Mr Downs and because of a shortage of hospital staff, attended to his personal care, including feeding him and changing his soiled bed linen. This level of care was commendable.

Liaison with Mr Downs' family

48. When Mr Downs was admitted to hospital on 31 March, he was allowed to contact his family a number of times using a prison mobile phone carried by escort officers. However, when he was taken to hospital again on 10 April, seriously ill with pneumonia, there is no record that he used the phone to call his family. Staff described him as very confused and disorientated and it is therefore unlikely that he would have been able to ask staff to contact his family on his behalf. No one from the prison informed his family that he had been admitted to hospital with pneumonia on 10 April and it was not until he was unconscious and in intensive care on 12 April, that SO A contacted Mr Downs' son.

49. Nurse C told us the prison's policy dictates that the next of kin are contacted only when the prisoner has been in hospital for more than five days, unless their condition is life threatening. She said that Mr Downs' condition had been stable up until the morning of his death and deteriorated very quickly.

50. Prison Rule 22 requires that when a prisoner becomes seriously ill, the governor should "at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed". This is

reflected in Prison Service Instruction (PSI) 64/2011, which requires prisons to contact the next of kin of prisoners who are seriously ill.

51. We consider Wakefield should have informed Mr Downs' son immediately when he was taken to hospital again on 10 April. Mr Downs' health had deteriorated significantly and he had been admitted as an emergency. He suffered from COPD and had been diagnosed with severe pneumonia. Had the prison informed Mr Downs' family sooner, this would have allowed them the opportunity to visit him while he was still conscious. We make the following recommendation:

The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible so that they are able to visit them in hospital without unnecessary delay.

52. Mr Downs' family were unhappy about the lack of privacy they had when visiting him in his last hours. Two of the escorting staff had left the bedside to allow some privacy, but remained in the room. At this time Mr Downs' was unconscious. We consider the presence of three escort staff at the end of Mr Downs' life was excessive and did not allow his family private time with him before his death. We make the following recommendation:

The Governor should ensure that unless there are overriding security concerns, escorts should allow the family of dying prisoners some private time with them.

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No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that healthcare staff take appropriate action when clinical observations are outside the normal range and might indicate deterioration in a prisoner's condition.	Accepted	Humber NHS Foundation Trust will ensure that all staff are trained in the use of the National Early Warning Score (NEWS). The Head of Healthcare will monitor all individual care plans to ensure that staff have taken and documented the actions required when clinical observations are outside the normal range.	Humber NHS Foundation Trust Target date for completion: 03 February 2016	
2	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 Governor and Head of Healthcare will remind all staff involved in the risk assessment process of the legal position and instruct them that assessments must fully take into account the health of a prisoner and be based on the actual risk that the prisoner presents at the time. The local risk assessment document at HMP Wakefield will be amended to reflect the requirements contained in the standard risk assessment form	Governor and Head of Healthcare Target date for completion: 30 September 2015	

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No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
			within the National Security Framework. Management checks will continue to review the condition of the prisoner to establish if there has been a deterioration in the health of a prisoner and this will be reflected in the commentary on the risk assessment form All future risk assessments will evidence the actual risk posed at the time of escort and all risk assessments carried out will be monitored via external and internal audit processes.		
3	The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible so that they are able to visit them in hospital without unnecessary delay.	Accepted	The Head of Healthcare and clinical services lead have been reminded to contact the Duty Governor at the earliest opportunity whenever a prisoner becomes seriously or terminally ill. Duty Governors have been instructed that in such circumstances they must make arrangements to contact the next of kin as soon as	Governor Completed 27 April 2015	

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No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
			possible.		
4	The Governor should ensure that unless there are overriding security concerns, escorts should allow the family of dying prisoners some private time with them.	Accepted	Staff will be provided with guidance on the need to balance security with decency when making decisions about contact between dying prisoners and their families.	Governor Target date for completion: 30 September 2015	