

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Smith-Cox, a prisoner at HMP Wakefield, on 12 October 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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.

Mr Michael Smith-Cox died in hospital of sepsis caused by bronchopneumonia on 12 October 2015, while a prisoner at HMP Wakefield. He was 76 years old. I offer my condolences to those who knew him.

I am satisfied that Mr Smith-Cox received a high standard of care for his chronic health conditions at Wakefield. However, I am concerned that the use of restraints when Mr Smith-Cox went to hospital, was not justified by a fully considered risk assessment, which took into account his poor health and limited mobility. I have raised similar issues with the prison before.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

May 2016

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Summary

Events

1. Mr Michael Smith-Cox was sentenced to life imprisonment on 26 January 2005 and had been at HMP Wakefield since 17 August 2005. He had limited mobility and several chronic medical conditions, including diabetes. In 2013, a prison doctor considered that he was approaching the end of his life and healthcare staff developed care plans to manage his conditions. They reviewed him frequently and adjusted his medication as necessary. From March 2015, he was cared for in the prison's inpatient unit.
2. Healthcare staff monitored Mr Smith-Cox's blood glucose levels and encouraged him to control his diet by reducing his intake of sugary items, but he did not welcome or follow this advice. He also rejected help to stop smoking.
3. In September 2015, Mr Smith-Cox's health worsened. He found it difficult to move around and was very tired. On 15 September, healthcare staff found him unresponsive and treated him for low blood sugar level. On 30 September, a prison doctor diagnosed a possible chest infection and prescribed antibiotics.
4. Mr Smith-Cox's condition did not improve. On 3 October, he was admitted to hospital. He died on 12 October, from sepsis (a life-threatening condition triggered by an infection) and pneumonia.

Findings

5. Mr Smith-Cox had significant health problems. Healthcare staff appropriately admitted him to the prison's inpatient unit to stabilise his diabetes and monitor him. When his condition deteriorated, they assessed him promptly and sent him to hospital quickly. We are satisfied that Mr Smith-Cox received a high standard of care at Wakefield, equivalent to that he could have expected to receive in the community.
6. Mr Smith-Cox was restrained by an escort chain in hospital from 3 to 6 October and we are not satisfied that the prison fully took into account Mr Smith-Cox's medical condition and lack of mobility when assessing his risk. We make one recommendation.

Recommendation

- The Governor 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 Investigation Process

7. 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.
8. The investigator obtained copies of relevant extracts from Mr Smith-Cox's prison and medical records.
9. NHS England commissioned a clinical reviewer to review Mr Smith-Cox's clinical care at the prison.
10. We informed HM Coroner for West Yorkshire Eastern District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
11. We were unable to contact Mr Smith-Cox's family to inform them of the investigation and they had no contact with him.
12. The prison considered our initial report and recommendations, which they have accepted. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included at the end of the report.

Background Information

HMP Wakefield

13. 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, a segregation unit and a close supervision centre for exceptionally high-risk prisoners.
14. 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 in the healthcare unit.

HM Inspectorate of Prisons

15. 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.

Independent Monitoring Board

16. 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 because the prison had a large number of older prisoners. The IMB considered that health services were well managed and the quality of care was high.

Previous deaths at HMP Wakefield

17. Mr Smith-Cox was the eighth prisoner to die from natural causes at Wakefield since January 2014. We have raised the issue of the need for properly considered risk assessments to justify the use of restraints in a number of previous investigation reports.

Key Events

18. On 26 January 2005, Mr Michael Smith-Cox was sentenced to life imprisonment for sexual offences. He had been at HMP Wakefield since 17 August 2005. He had several chronic health conditions, including diabetes, high blood pressure, heart and lung problems, breathlessness and osteoarthritis in his shoulder. Prison GPs prescribed a large number of medications and he often went to hospital because of illness or injuries. Mr Smith-Cox refused help to stop smoking.
19. Healthcare staff implemented care plans to manage Mr Smith-Cox's conditions. They reviewed him frequently, primarily to try to stabilise his diabetes. From 2012, Mr Smith-Cox had a number of falls.
20. On 3 October 2013, a prison GP reviewed Mr Smith-Cox's records and considered that he should be managed under the "Gold Standard Framework" (a system for managing the care of patients approaching the end of life). The doctor did not record a specific reason, but the medical records show that he was frail and his health was deteriorating because of his age and severe diabetes. Healthcare staff began appropriate plans.
21. On 15 September 2014, the GP discussed with Mr Smith-Cox whether he wanted anyone to try to resuscitate him if his heart or breathing stopped. Mr Smith-Cox decided he did not want to be resuscitated and this was formally recorded in his medical record.
22. On 7 January 2015, a prison GP reviewed Mr Smith-Cox and noted that his sodium and blood glucose levels should be checked frequently. A nurse began a blood glucose care plan with weekly checks.
23. On 23 February, a diabetes specialist nurse reviewed Mr Smith-Cox, noted that he repeatedly had high blood glucose levels and recommended changes to his diabetes medication. On 22 March, Mr Smith-Cox was moved permanently to the healthcare centre's inpatient unit so that staff could monitor his blood glucose levels and diabetes more closely.
24. On 25 March, Mr Smith-Cox reported pain in his left elbow. A prison GP diagnosed cellulitis (an infection of the deeper layers of the skin and the underlying tissue) and prescribed antibiotics. On 1 April, a prison GP noted ongoing infection and two broken/ulcerated areas, with a risk that the infection might spread to underlying tissues. She continued the antibiotics and requested X-rays and swab tests. Nurses frequently cleaned and dressed Mr Smith-Cox's wound (which did not heal until 30 September).
25. In August, nurses found that Mr Smith-Cox had a large number of biscuits in his cell and discussed the importance of controlling his diabetes. Mr Smith-Cox was unhappy about this and wanted to leave the inpatient unit but was not medically fit. Mr Smith-Cox's blood glucose level had increased and nurses explained that his diabetes had to be controlled with a good diet and he needed to eat fewer biscuits and less chocolate. On 5 September, a nurse noted that Mr Smith-Cox would not engage with healthcare staff and did not want to stop smoking, but continued collecting his medications and meals.

26. On 14 September, a nurse found Mr Smith-Cox unresponsive due to hypoglycaemia (low glucose level in his bloodstream). He gave Mr Smith-Cox glucogel (a fast acting carbohydrate) and oxygen. Mr Smith-Cox slowly responded. Paramedics attended and were satisfied nurses could provide appropriate care.
27. Later in September, nurses noted that Mr Smith-Cox was finding it difficult to move around and was generally tired. They suspected he had a chest infection. On 25 September, a prison GP prescribed antibiotics. On 30 September, a prison GP reviewed Mr Smith-Cox and diagnosed a possible lower tract respiratory infection. She prescribed further antibiotics and nurses monitored him every four hours.
28. Mr Smith-Cox's mobility continued to decline and he complained of increasing hip pain. On 2 October, a prison GP reviewed him and asked healthcare staff to observe him over the weekend. The GP scheduled another appointment for 5 October and considered he should have X-rays if his condition did not improve.
29. On 3 October, a nurse noted that Mr Smith-Cox had severe hip pain and had a history of fractures. She suspected a further fracture. The nurse rang the out-of-hours doctor who reviewed Mr Smith-Cox's medical record and advised the nurse to send him to hospital. Two officers escorted him and used an escort chain to restrain him in hospital. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.)
30. Mr Smith-Cox was admitted to hospital, where doctors diagnosed a lower respiratory tract infection and treated him with antibiotics. His mobility remained poor and he was confused. Prison healthcare staff obtained updates on his condition and the hospital informed them that he was likely to die. On 6 October, prison healthcare staff recorded that Mr Smith-Cox might have suffered a stroke and a bleed on the brain. That day, a hospital doctor asked officers to remove the escort chain. A prison manager agreed this and restraints were not used again. Mr Smith-Cox died at the hospital in the early hours of 12 October.

Contact with Mr Smith-Cox's family

31. Prison staff were unable to contact any of Mr Smith-Cox's family when he had been admitted to hospital or when he died. Mr Smith-Cox had named his wife as his next of kin but he had received no family visits and had had no contact with any family members. The prison discovered from the police that his wife had died in March 2015 and they were unable to trace any of his other relatives. The Probation Service said that his family had severed all contact with Mr Smith-Cox.
32. The prison arranged and paid for Mr Smith-Cox's funeral, which was held on 7 December 2015.

Support for prisoners and staff

33. After Mr Smith-Cox's death a prison manager debriefed the escort officers. He offered his support and that of the staff care team.

34. The prison posted notices informing prisoners of Mr Smith-Cox's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Smith-Cox's death.

Post-mortem report

35. The post-mortem examination found that Mr Smith-Cox had died from sepsis caused by bronchopneumonia. Diabetes was a contributory factor.

Findings

Clinical care

36. Mr Smith-Cox had complex medical needs. Healthcare staff at Wakefield liaised effectively with the hospital about his care and implemented good, clear, holistic care plans, which were well communicated within the healthcare team and they discussed them with Mr Smith-Cox. The clinical reviewer considered that Mr Smith-Cox's primary care was consistent with national guidelines for managing diabetes. We are satisfied that Mr Smith-Cox's care and treatment at Wakefield was of a high standard, at least equivalent to that he could have expected to receive in the community.

Restraints, security and escorts

37. 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.
38. When Mr Smith-Cox was taken to hospital on 3 October, a nurse indicated that there were no medical objections to the use of restraints but Mr Smith-Cox had limited mobility, which restricted his ability to escape unaided. He had a suspected fracture to his hip/upper limb, which further impaired his mobility.
39. The security section noted Mr Smith-Cox's level of risk to the public was high due to the nature of his convictions and assessed him as a medium level of risk to hospital staff, escape potential, outside assistance and of hostage taking. A prison manager concluded that two officers should escort Mr Smith-Cox and use an escort chain. Mr Smith-Cox remained restrained until 6 October, when a doctor at the hospital asked officers to remove the chain.
40. The Prison Service has a responsibility to protect the public, but security must be balanced with humanity. It is difficult to understand how the prison concluded that restraints were necessary for an elderly and infirm man, with limited mobility and a suspected fracture of the hip, who was escorted by two prison officers. Too much weight was given to his original offences rather than his actual risk at the time. We repeat a recommendation we have made previously to Wakefield:

The Governor 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.

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