Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Stephenson a prisoner at HMP Wakefield on 3 March 2016

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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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.

Mr Michael Stephenson died in hospital from pneumonia, on 3 March 2016, while a prisoner at HMP Wakefield. He was 62 years old. I offer my condolences to Mr Stephenson's family and friends.

Mr Stephenson had long-term health conditions and risk factors associated with heart disease. He was often an uncooperative patient, but healthcare staff at the prison managed his chronic conditions as well as they could and reviewed him frequently. I am satisfied that the care Mr Stephenson received was equivalent to that he could have expected in the community.

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 **September 2016**

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Summary

Events

1. On 6 April 1994, Mr Michael Stephenson was sentenced to life imprisonment for sex offences. He had been at HMP Wakefield since 7 July 1994.

2. Mr Stephenson had a number of cardiovascular risk factors, including hypertension (high blood pressure), high cholesterol and obesity. He was a long-term smoker and found it difficult to stop, despite advice and support from staff. He was prescribed appropriate medication and reviewed frequently, but he often refused to take his medication and attend healthcare appointments.

3. At 10.45am on 2 March 2016, Mr Stephenson said he was short of breath and felt generally unwell. A nurse arranged an urgent GP review and an ECG test to monitor his heart. At approximately 11.00am, a prison doctor examined Mr Stephenson and arranged an ambulance to take him to hospital. Mr Stephenson initially refused to leave the prison, but later agreed after staff encouraged him to go.

4. In the early hours of 3 March, Mr Stephenson's condition deteriorated and doctors decided they needed to induce a coma. Mr Stephenson initially refused treatment, but, at 7.40am, he agreed. At 8.58am, he suffered a cardiac arrest. Hospital staff attempted to resuscitate him but he did not recover. At 9.26am, a doctor recorded that Mr Stephenson had died.

Findings

5. Mr Stephenson frequently refused treatment for his conditions and often did not attend healthcare appointments. This made it difficult to manage his health conditions effectively. Despite his lack of cooperation, the clinical reviewer concluded that healthcare staff managed his conditions in line with national guidelines and prescribed appropriate medication.

6. Officers restrained Mr Stephenson with an escort chain when he went to hospital on 2 March. While a review of the need for restraints shortly after Mr Stephenson was admitted to hospital would have been preferable, we recognise that restraints were removed as soon as hospital staff requested this.

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 him. No one responded.

8. The investigator visited Wakefield on 10 March 2016. He obtained copies of relevant extracts from Mr Stephenson's prison and medical records.

9. The investigator interviewed one member of staff at Wakefield on 13 April.

10. NHS England commissioned a clinical reviewer to review Mr Stephenson'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 sent the coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted Mr Stephenson's sons to explain the investigation. They had no specific concerns for the investigation to consider.

13. Mr Stephenson's family received a copy of the initial report. They did not make any comments.

14. The initial report was shared with the Prison Service. The Prison service pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

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, a segregation unit and a close supervision centre for exceptionally high-risk prisoners.

16. At the time of Mr Stephenson's death, Spectrum CIC (Community Interest Company) provided primary healthcare services during normal working hours and Humber NHS Foundation Trust (intermediate care) employed the nurses in the inpatient unit, which provides overnight and weekend care. Care UK took over all healthcare provision at Wakefield on 1 April 2016. There is a dedicated palliative care suite in the healthcare unit.

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.

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 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

19. Mr Stephenson was the ninth prisoner to die from natural causes at Wakefield since April 2015. There were no significant similarities with other investigations, although we have previously identified the need for better risk assessments to justify the use of restraints for elderly or infirm prisoners taken to hospital.

Key Events

20. On 6 April 1994, Mr Michael Stephenson was sentenced to life imprisonment for sexual offences. He had been at HMP Wakefield since 7 July 1994.

21. Mr Stephenson had a number of cardiovascular risk factors, including high blood pressure, obesity and high cholesterol for which he was prescribed medication. He was a long-term smoker and found it difficult to stop, despite advice and support from prison healthcare staff and nicotine replacement therapy. Healthcare staff monitored his medical conditions frequently, but he did not always take his medication or attend his scheduled appointments.

22. On 7 August 2014, Mr Stephenson reported shortness of breath and chest pain. His observations were normal and a nurse advised him to notify wing staff if the pain continued. The next morning, he had an ECG (an electrocardiogram test to monitor the electrical rhythms of the heart). The ECG showed some abnormalities, but they were not recent. A prison GP arranged a blood test and, on 13 August, referred Mr Stephenson to a cardiology (heart) specialist.

23. On 19 November, a consultant cardiologist reviewed Mr Stephenson at hospital. Mr Stephenson said he felt well and had none of the symptoms the consultant asked about. The consultant recommended an echocardiogram (an ultrasound scan of the heart), but Mr Stephenson later refused to go to hospital for this. A nurse was due to conduct a follow up review at the prison's cardiology clinic, but Mr Stephenson did not attend his first two appointments. On 23 December, she referred him back to the prison GP.

24. On 8 January 2015, a prison GP spoke to Mr Stephenson about not attending the cardiac clinic and warned him of the risks of not taking his medication. He noted that Mr Stephenson appeared unconcerned about the increased risks, but agreed to take amlodipine (to reduce blood pressure) and nothing else.

25. On 5 February, a nurse reviewed Mr Stephenson and noted he had not been taking his blood pressure medication and had refused to take statins (to reduce cholesterol). She reminded him of the importance of taking his medication and advised him about maintaining a healthy lifestyle and that he should stop smoking to reduce his risk of cardiovascular disease.

26. On 16 July, a nurse examined him and noted that he had not been taking his medication. She explained the risks of heart disease and gave him 28 amlodipine tablets, as he agreed to start taking them again.

27. On 29 September, a prison GP saw Mr Stephenson, who had reported a recurrent headache, and noticed that he had not requested a repeat prescription of amlodipine. Mr Stephenson admitted that he had not been taking it as prescribed, so the GP changed his medication to be collected daily to help improve his compliance. Over the next four months, healthcare staff arranged a GP review and two blood test appointments, but he did not attend. The reasons were not recorded and there was no record of compliance with his medication or that his blood pressure was checked during this time.

28. On 8 February 2016, a nurse examined Mr Stephenson after he reported worsening lower back pain over the previous two weeks. She noted that he did not have any other symptoms and contacted a prison GP to request a prescription for ibuprofen and paracetamol (painkillers). The GP advised her to check his blood pressure before giving him ibuprofen because his last reading had been very high (170/110). There was no record that this was done. The nurse arranged a physiotherapy appointment on 22 February. Mr Stephenson did not attend and the reason was not recorded.

29. Around 10.40am on 2 March, Mr Stephenson went to the prison's healthcare unit and told a nurse that he felt generally unwell and had been short of breath for the previous four weeks. She noted that his breathing was loud. His oxygen saturation level was 84% (the normal range is 98-100%), so she gave him oxygen through a mask and it rose to 97%. She requested an emergency GP assessment and arranged an ECG.

30. At approximately 11.00am, a prison GP examined Mr Stephenson and recommended an urgent admission to hospital, as the ECG had indicated a heart attack. At 11.02am, a nurse requested an ambulance. Initially, Mr Stephenson refused to go to hospital, even though the GP told him that his condition was potentially life-threatening. Paramedics arrived at 11.19am. Mr Stephenson continued to refuse to go hospital but the paramedics persuaded him and they left the prison at 11.44am. Two prison officers escorted him, using an escort chain. (An escort chain is a long chain with a handcuff at each end, one of which is attached to a prison officer.)

31. Mr Stephenson's condition deteriorated in hospital and staff could not maintain his oxygen levels. At 2.50am on 3 March, he was admitted to the Acute Assessment Unit and nurses asked officers to remove the restraints, which a prison manager agreed five minutes later. At 5.20am, doctors told Mr Stephenson that they needed to induce a coma to treat pneumonia. At first he refused treatment, but at 7.40am, he changed his mind. At 8.58am, he suffered a cardiac arrest. Hospital staff unsuccessfully attempted resuscitation him and at 9.26am, a doctor recorded that Mr Stephenson had died.

Contact with Mr Stephenson's family

32. At 7.50am on 3 March, the prison appointed an officer as their family liaison officer and asked him to inform Mr Stephenson's next of kin of his declining health but had difficulty finding a contact number. The officer contacted Mr Stephenson's probation officer to get more information, but Mr Stephenson died before this was received.

33. Over the next five days, the officer continued to try and identify Mr Stephenson's next of kin and he located three of his sons and they were informed of their father's death. They had not been in contact with their father for some years and the prison arranged and paid for the funeral, in line with national policy.

34. On 11 April, the chaplaincy held a memorial service for prisoners and staff.

Support for prisoners and staff

35. After Mr Stephenson’s death a prison manager debriefed the escort officers and offered them his support and that of the staff care team.

36. The prison posted notices informing other prisoners of Mr Stephenson’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 Stephenson’s death.

Post-mortem report

37. The post-mortem examination found that Mr Stephenson had died from pneumonia. Heart disease was a contributory factor.

Findings

Clinical care

38. Mr Stephenson had long-term health conditions and risk factors associated with heart disease, including high blood pressure, high cholesterol, diabetes, being overweight and he smoked. Healthcare staff managed his conditions well and gave him advice to try to help him stop smoking, lower his blood pressure and reduce his risk of cardiovascular disease. The clinical reviewer concluded that healthcare staff prescribed appropriate medication and referred Mr Stephenson to specialist hospital services when required.

39. Mr Stephenson's blood pressure was rarely controlled to the target levels (140/90 or below) in National Institute for Health and Care Excellence (NICE) guidelines. The clinical reviewer noted that healthcare staff monitored his blood pressure in accordance with these guidelines and attempted to take additional blood pressure readings when they had the opportunity. Sometimes they noted his blood pressure was high, but did not record any action taken in response to this. However, this was difficult to manage because of his poor compliance. Mr Stephenson's blood pressure was not monitored in the six months leading up to his death, largely because he did not attend appointments to review his conditions.

40. The clinical reviewer made several recommendations for improving the delivery of healthcare at Wakefield, which the Head of Healthcare will need to address. As they were not directly related to the cause of Mr Stephenson's death, we do not repeat them in this report.

41. We are satisfied that Mr Stephenson received a good standard of care at Wakefield, equivalent to that he could have expected to receive in the community.

Restraints, security and escorts

42. When prisoners have to travel outside prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility. Decisions should be kept under review as circumstances change.

43. When Mr Stephenson was taken to hospital on 2 March, a manager decided that he should be restrained by an escort chain. There was no full risk assessment to indicate how his condition affected his risk at the time, but there was no medical objection to the use of restraints. While it would have been preferable to have reviewed Mr Stephenson's risk once he had got to hospital and his health deteriorated, we recognise that restraints were removed promptly 15 hours after his admission, as soon as he was admitted to the hospital's Acute Assessment Unit. We therefore make no recommendation.

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