

**Prisons &
Probation**

Ombudsman
Independent Investigations

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

**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 John Blackman died in hospital from pneumonia and respiratory failure on 3 March 2016, while a prisoner at HMP Wakefield. He was 69 years old. I offer my condolences to Mr Blackman's family and friends.

Mr Blackman had a number of long-term health conditions, including chronic obstructive pulmonary disease. He was often uncooperative with his treatment and ignored advice, but healthcare staff at the prison managed his chronic illnesses as well as they could. I am satisfied that Mr Blackman received a good standard of healthcare at Wakefield, equivalent to that he could have expected to receive in the community. Although I consider that Mr Blackman was incorrectly restrained when he was first taken to hospital in February 2016, this was quickly rectified and no restraints were used in the final weeks of his life.

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

July 2016

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Summary

Events

1. In June 1996, Mr John Blackman was sentenced to life imprisonment for sexual offences. He had been at HMP Wakefield since July 2000.
2. Mr Blackman suffered from several chronic health conditions including asthma, diabetes, chronic kidney disease and chronic obstructive pulmonary disease. Healthcare staff monitored these conditions frequently, prescribed medication, and arranged for him to attend hospital appointments when necessary.
3. Mr Blackman did not always act on the advice healthcare staff gave him. He declined various treatment options and refused to be admitted to the prison's inpatient unit, despite his deteriorating health. This made it difficult to monitor and manage his conditions effectively. Prison and healthcare staff eventually moved him to the inpatient unit, against his wishes, for his own safety.
4. On 6 February 2016, Mr Blackman had breathing problems and was admitted to hospital as an emergency. In hospital, he was treated for end stage renal and respiratory failure. Despite an initial improvement, Mr Blackman's condition declined and he received palliative care. He died in hospital on 3 March.

Findings

5. The clinical reviewer found that Mr Blackman's care was equivalent to that he could have expected to receive in the community and we are satisfied that he received appropriate care at Wakefield.
6. Mr Blackman was restrained for brief periods when he was first admitted to hospital on 6 February and we do not consider that managers applied the appropriate tests. Managers need to update their understanding of the legal position for using restraints, but we make no formal recommendation, as the position was quickly rectified. On 10 February, a manager took an appropriate and humane decision not to restrain Mr Blackman in hospital and he was not restrained again for the remaining weeks of his life.

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 Blackman's prison and medical records.
9. The investigator interviewed three members of staff at Wakefield on 13 April.
10. NHS England commissioned a clinical reviewer to review Mr Blackman'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 Blackman's brother to explain the investigation. He had no specific matters for the investigation to consider.
13. Mr Blackman's family was informed the initial report was available, but did not wish to receive a copy or make any comment.
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 Blackman'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 for prisoners with physical health problems. 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 Blackman was the eighth prisoner to die from natural causes at Wakefield since April 2015. We have raised the issue of the need for properly considered risk assessments to justify the use of restraints in previous investigation reports.

Key Events

20. On 28 June 1996, Mr John Blackman was sentenced to life imprisonment for sex offences, with a minimum time to serve of 14 years. He had been at HMP Wakefield since 13 July 2000.
21. Mr Blackman suffered from several long-term health conditions, including asthma, diabetes, chronic kidney disease and chronic obstructive pulmonary disease (COPD – the name for a collection of chronic lung diseases such as chronic bronchitis and emphysema). He had previously smoked. As his conditions deteriorated, his mobility declined and it became more difficult to treat him effectively on a residential wing. Healthcare and prison staff spoke to him frequently about moving to the prison's inpatient unit. However, he preferred to stay on the wing, supported by other prisoners, who acted as his carers. Healthcare staff created care plans, reviewed him regularly and prescribed appropriate medication, including long-term oxygen therapy, day and night. However, he did not use his inhaler continuously, as prescribed.
22. At the beginning of January 2015, Mr Blackman had a minor stroke, which left him with weakness on the right side of his body, but refused to go to hospital or be admitted to the inpatient unit. Healthcare staff reviewed him frequently, often several times a day. On 20 January 2015, a nurse from the healthcare outreach team assessed Mr Blackman. He noted that he had limited mobility, needed a wheelchair to mobilise and was short of breath while attending to his personal hygiene. He suggested a personalised care plan, but Mr Blackman did not want to cooperate with this.
23. On 23 January, a nurse attended a Gold Standards Framework meeting (GSF – a systematic, evidence-based approach to support and palliative care) to discuss Mr Blackman's case. She noted that, although he remained adamant that he did not want healthcare input, the healthcare outreach team would continue to monitor him.
24. On 18 March, a nurse noted that Mr Blackman's oxygen saturation level was 86% (the normal range is 98-100%). She gave him medication through a nebuliser and asked the lead nurse for a second opinion. After assessing Mr Blackman with the inpatient manager, the lead nurse arranged an urgent GP review. A GP examined him later the same day and prescribed prednisolone (a steroid) and amoxicillin (an antibiotic) to treat shortness of breath and a productive cough. Mr Blackman's health declined, but he refused to be admitted to the prison's inpatient unit or to hospital and signed a disclaimer confirming his decision. Healthcare staff monitored him frequently until his condition improved.
25. On 15 May, a nurse noted that Mr Blackman continued to do well with the support of the primary care team and outreach nurses. Healthcare staff reviewed his conditions frequently and his prison carers gave him additional support with daily tasks. Prison and healthcare staff continued to encourage Mr Blackman to move to the inpatient unit, but he refused to leave his friends on the wing.
26. On 1 December, Mr Blackman's COPD symptoms worsened. He was short of breath, but again refused admission to the inpatient unit. The GP prescribed a short course of prednisolone and amoxicillin. On 2 December, a record of a

decision not to attempt resuscitation in the event of a cardiac or respiratory arrest was entered on Mr Blackman's medical record, but it is not clear who completed the entry in the record or whether it was discussed with Mr Blackman.

27. On 8 January 2016, healthcare and prison staff held a multidisciplinary meeting to discuss Mr Blackman's care and his insistence that he wanted to stay on the wing. The meeting agreed that, in spite of his persistent refusal, it would be better and safer for him to move to the inpatient unit. Prison staff discussed whether they could move him by force, but healthcare staff warned that the trauma could prove damaging, or even fatal.
28. On 27 January, a nurse noted that Mr Blackman had fallen over numerous times within 48 hours and could not use his personal alarm. He had not been using his oxygen concentrator or taking his prescribed medication as directed. She considered it was no longer safe for him to remain on the wing and discussed this with the inpatient manager and a prison manager. Mr Blackman was taken to a hospital outpatient appointment that day and when he got back, staff took him directly to the prison's inpatient unit. Initially, he refused all treatment, but later agreed to take his medication and resume oxygen therapy.
29. At 1.42am on 3 February, a nurse noted that Mr Blackman was very confused, with a raised temperature and a low oxygen saturation level (88% on oxygen). She telephoned the out of hours GP, who advised her to call an ambulance. Mr Blackman was taken to hospital, escorted by two prison officers who used an escort chain to restrain him. (An escort chain is a long chain with a handcuff at each end, one of which is attached to a prison officer and the other to the prisoner.) Hospital staff treated him for severe COPD and discharged him two days later. A nurse fully reviewed his needs when he returned to the inpatient unit.
30. Three days later, on 6 February, Mr Blackman was admitted to hospital again as an emergency. Two prison officers escorted him and used an escort chain, which was not used after 10 February. Hospital staff admitted Mr Blackman to the hospital's High Dependency Unit and treated him with oxygen therapy and antibiotics. Initially, his condition stabilised, but then declined ten days later. The hospital treated him for end stage renal and respiratory failure. Prison healthcare staff kept in daily touch with the hospital for updates on his condition.
31. On 26 February, a hospital consultant informed the prison that Mr Blackman's health had deteriorated and they had started end of life care. On 1 March, a specialist palliative care nurse assessed him and suggested medications to manage his pain and keep him peaceful. On 3 March, at 5.58am, Mr Blackman died.

Contact with Mr Blackman's family

32. On 7 February, the prison appointed an officer as their family liaison officer. She telephoned Mr Blackman's brother to let him know he was very ill in hospital. She arranged a family visit for 10 February. On 26 February, she telephoned his brother to tell him that Mr Blackman's condition had deteriorated further and hospital staff had stopped all active treatment. She gave him a contact number for the hospital and agreed that she would call him if there were any further developments.
33. At 6.54am, on 3 March, the officer telephoned Mr Blackman's brother to tell him that Mr Blackman had died and offered her condolences and support. She kept in frequent contact with Mr Blackman's family and, on 8 April, she and a prison manager, attended Mr Blackman's funeral. The prison contributed to the costs of the funeral, in line with national policy.
34. On 11 April, the prison held a memorial service for prisoners and staff.

Support for prisoners and staff

35. After Mr Blackman's death, a manager debriefed the escort officers and offered his support and that of the staff care team.
36. The prison posted notices informing other prisoners of Mr Blackman's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm prevention in case they had been adversely affected by Mr Blackman's death.

Post-mortem report

37. The post-mortem examination found that Mr Blackman had died from pneumonia and respiratory failure caused by chronic obstructive pulmonary disease (COPD). He also had aortic valve stenosis (a narrowing of the aortic valve in the heart), ischaemic heart disease (narrowed or blocked blood vessels) and chronic renal failure (kidney failure), but these did not cause his death.

Findings

Clinical care

38. Mr Blackman suffered from several complex chronic conditions. Healthcare staff reviewed him frequently, prescribed appropriate medication and planned his care using the Gold Standards Framework. The clinical reviewer considered that healthcare staff monitored his COPD in line with National Institute for Health and Care Excellence (NICE) guidelines and produced a care plan that took account of his decision to remain on a residential wing. She noted that there was a high standard of record keeping, which showed that healthcare and prison staff worked well to adapt his care to meet his needs and preferences. We are satisfied that the eventual decision to move him to the inpatient unit was appropriate.
39. There was no record that healthcare staff had discussed with Mr Blackman the decision not to attempt resuscitation, which was recorded in December 2015. The clinical reviewer has made a recommendation about this, which the Head of Healthcare will need to address but this did not directly affect Mr Blackman's death, and we do not repeat it in this report.
40. Overall, we are satisfied that Mr Blackman received appropriate care and treatment at Wakefield, which the clinical reviewer considered was equivalent to that he could have expected to receive in the community.

Restraints, security and escorts

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. When Mr Blackman was first taken to hospital on 6 February, a prison manager signed an emergency risk assessment indicating there were no medical objections to the use of restraints. A subsequent risk assessment noted he was a medium risk of escape. The prison manager told the investigator that an escort chain was considered the minimum level of restraint for a wheelchair user.
43. On the morning of 7 February, a prison manager reviewed his risk assessment and decided that restraints should be removed. These were replaced on the evening of 9 February, when another prison manager was told that his condition had improved, although he did not see Mr Blackman at the time. The next morning, he reviewed his decision at the hospital and restraints were removed and not used again. He told the investigator that, once he saw Mr Blackman, he

was satisfied that there was no need for him to be restrained for the remainder of his time in hospital.

44. From the evidence available, we do not consider that it is likely that Mr Blackman was a medium risk of escape as the initial risk assessments suggested. He was a wheelchair user whose mobility was further impaired by severe breathing difficulties, and was escorted by two prison officers. It is evident that some of the managers did not fully follow the requirements of the 2007 High Court judgment and need to revise their understanding of the guidance. However, we recognise that Mr Blackman was restrained for only brief periods after his initial admission. On 10 February, a prison manager made an appropriate and humane decision to remove the restraints, which were not used again for the remaining three weeks of Mr Blackmans life. We therefore make no formal recommendation.

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