

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man on 4 September
2014, while in the custody of HMP Wakefield**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man from a blood infection on 4 September 2014, while a prisoner at HMP Wakefield. He was 63 years old. I offer my condolences to those who knew him.

The investigation was carried out by an investigator. A doctor reviewed the clinical care the man received at Wakefield. The prison cooperated fully with the investigation.

The man was sentenced to life in prison in 1985 and had been at Wakefield since 2011. He suffered from multiple chronic health problems. Healthcare staff frequently reviewed the man, and he was under the care of specialists throughout his time in prison.

As the man's health deteriorated, he suffered a number of serious infections and went to hospital for treatment. After hospital discharges, the man often lived as an inpatient in the prison's healthcare unit for treatment and support.

On 1 September 2014, the man was taken to hospital as an emergency, after he became acutely unwell. He was diagnosed with a blood infection and remained in hospital for treatment. The man's condition deteriorated significantly in hospital, and he died on 4 September.

I am satisfied that the man generally received a good standard of care for his chronic health conditions. However, I share the clinical reviewer's concerns about the co-prescribing of drugs, which left the man susceptible to serious infections. I do not consider that the use of restraints when the man went to hospital was justified by an appropriately considered risk assessment, a matter I have raised with Wakefield before. It was inhumane that the man died while handcuffed to a prison officer; it was also potentially traumatic for the staff involved.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

June 2015

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SUMMARY

1. In April 1985, the man received a life sentence. After spending time in a number of prisons and secure hospitals, the man transferred to HMP Wakefield in November 2011.
2. The man suffered from many chronic health problems, including rheumatoid arthritis, ischaemic heart disease, diabetes and obesity. He had a history of heart attacks, and had a defibrillator fitted to regulate his heartbeat.
3. The man's health gradually deteriorated while he was at Wakefield. Healthcare staff frequently reviewed him, and he was under the care of specialists. The man was often admitted to the prison's healthcare unit for closer monitoring and support. During 2013 and 2014, he suffered a number of serious infections for which he received treatment in hospital.
4. On 1 September 2014, the man was taken to Pinderfields Hospital, Wakefield, after he became acutely unwell. Doctors diagnosed him with a blood infection and he remained in hospital for treatment. The man's condition deteriorated significantly in hospital. He agreed that hospital staff should turn off his heart defibrillator, and should not resuscitate him if his heart or breathing stopped. The man died on 4 September.
5. The clinical reviewer concluded that the man received a good standard of care for his chronic diseases. However, he was concerned that doctors prescribed methotrexate and trimethoprim medication together, which left the man susceptible to serious infections. The clinical reviewer considered that healthcare staff at the prison need to have a better understanding of the potentially dangerous interaction of these drugs.
6. We are not satisfied that the prison fully took into account the man's medical condition when assessing his risk for hospital escorts. As a result, the man died while restrained to an officer. We make two recommendations.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Wakefield informing them of the investigation and inviting anyone with relevant information to contact him. One prisoner responded.
8. NHS England commissioned a doctor to review the man's clinical care in prison.
9. The investigator obtained copies of the man's medical records and relevant extracts from his prison record. The clinical reviewer interviewed a prison GP in November 2014, and the investigator interviewed prison staff in January 2015.
10. We informed HM Coroner for West Yorkshire (Eastern) of the investigation, who provided the post-mortem report on 6 January 2015. We were unable to conclude our investigation until we received the post-mortem report. We have sent the coroner a copy of this investigation report.
11. One of the Ombudsman's family liaison officers contacted the man's friend, his nominated next of kin, to explain the investigation. The man's friend did not have any specific issues for the investigation to consider.
12. The man's next of kin received a copy of the draft report and raised no issues that affected the factual accuracy of the report. The prison received a copy of the draft report, they raised no factual inaccuracies and their response to the recommendations has been added to the end of the report.

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, segregation unit and 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. Nottinghamshire Healthcare NHS Trust provides mental health services.

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. Pharmacy services and medicines management were very good, as were mental health services.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recent published report for the year to May 2013, the IMB noted that Wakefield provided a comprehensive healthcare service that met the needs of the population, despite underlying staffing problems.

Previous deaths at Wakefield

17. The man was the third prisoner to die from natural causes at Wakefield since the start of 2014. We have made recommendations about risk assessments for the use of restraints before and about the requirement to inform the next of kin in person, of a prisoner's death.

KEY EVENTS

18. In April 1985, the man received a mandatory life sentence for murder and sexual offences. After spending time in a number of high security prisons, the man transferred to Broadmoor secure psychiatric hospital in December 2005. He was discharged to HMP Long Lartin in May 2011. In November 2011, he transferred to HMP Wakefield.
19. During his sentence, the man had developed a number of chronic health problems, including rheumatoid arthritis, ischaemic heart disease, hypertension, diabetes and obesity. He took many drugs to treat his conditions, including methotrexate to control and relieve the symptoms of arthritis. He suffered heart attacks, and gave up smoking in 1999 because of his heart problems. The man had a defibrillator fitted to regulate his heartbeat. He had frequent specialist reviews for his chronic illnesses.
20. At his initial health screen at Wakefield, a nurse noted the man's health problems. The nurse referred him to a cardiologist (heart specialist) because of his heart disease, and a prison doctor prescribed the man's regular medication. The man remained under the care of cardiologists, and other specialists, for the rest of his life.
21. The man initially lived as an inpatient in the healthcare unit at Wakefield. Staff noted that he sometimes found it difficult to get about because of his obesity, heart problems and arthritis, and found some daily activities difficult.
22. In December, the man moved to D Wing, a standard residential unit. Over the following months, healthcare staff reviewed the man frequently, and adjusted his medication and treatment as required. He also attended outpatient clinics to review and manage his chronic diseases.
23. In November 2012, the man was admitted to the healthcare unit after a number of falls. Healthcare staff noted that he was finding it increasingly difficult to get around and care for himself. Although he returned to D Wing, the man was often admitted to the healthcare unit when his health deteriorated. He preferred to stay on the wing and was reluctant to move. When he was admitted to the healthcare unit, staff clearly explained the reasons, and he usually accepted that it was necessary.
24. On 20 March 2013, a prison GP diagnosed the man with a suspected chest infection and prescribed the antibiotic trimethoprim (used to treat bacterial infections). The man's condition continued to deteriorate over the following days. On 25 March, the GP reviewed the man again, and noted that he was sick, with very low blood pressure. The GP sent the man to hospital, where doctors diagnosed septicaemia (a blood infection).
25. The man discharged himself from hospital, against medical advice, the next day. He first went to his wing, but later moved to the healthcare unit so that healthcare staff could monitor him. Blood test results in April were abnormal, although repeat tests in May showed that the man's blood count had returned to a safer level.

26. Over the following months, healthcare staff at the prison and hospital specialists continued to see the man frequently. In August 2013, a consultant noted that the man had a limited exercise tolerance of 100 yards. As his health deteriorated, the prison made adjustments to help the man. He moved to a cell with grab rails, and sometimes used a stick or wheelchair to help him get about. Another prisoner helped the man with his daily tasks.
27. At the beginning of 2014, the man suffered two urinary tract infections and went to hospital. Healthcare staff treated the man's infection with antibiotics when he returned to the prison.
28. The man was admitted to hospital again in March 2014, after experiencing chest pain and fluctuating blood pressure. A consultant diagnosed angina, and anaemia (iron deficiency) related to the man's arthritis. The consultant noted in error that the man should not be resuscitated if his breathing or heart stopped. The man told healthcare staff at Wakefield that he wanted to be resuscitated.
29. On 4 May, nurses reviewed the man as he was short of breath and incontinent. They suspected that he had a urinary infection, and admitted him to the healthcare unit. A nurse practitioner prescribed the man trimethoprim to treat his infection.
30. The man returned to his wing on 6 May, but his health gradually deteriorated. On 16 May, a prison GP reviewed the man. He was confused and struggling to breathe, and his clinical observations were poor. The GP sent the man to hospital, where he received treatment for septicaemia.
31. The man returned to the prison three days later. After a period in the healthcare unit until his condition stabilised, staff agreed that he could return to his wing. The prison put plans in place to closely monitor the man's health, including weekly GP reviews.
32. On 22 June, the man's health deteriorated and he became acutely unwell. After a review by two prison GP's, the man was admitted to hospital. He was treated for a urinary infection and discharged to prison five days later. However, he returned to hospital with a similar infection on 5 July.
33. When the man returned to the prison on 9 July, he refused to engage with his treatment and did not take his regular medication or eat regularly, despite staff encouragement. A prison GP reviewed him on 16 July and recorded that he had low blood pressure and blood sugar levels. Healthcare staff started to review the man more frequently, and encouraged him to engage with his health care.
34. On the morning of 22 July, the man was admitted to hospital after experiencing strong chest pains. A consultant diagnosed ventricular tachycardia (a rapid heartbeat), and fitted the man with a new heart defibrillator. The consultant told the man that he had serious heart problems, which would become progressively harder to treat.

35. Healthcare staff at Wakefield took the man's clinical observations every day, after he returned from hospital. They noted that he had started to comply with his medication regime again. Although the man asked to return to his wing, a multidisciplinary team decided that he should remain in the healthcare unit until his health had improved sufficiently.
36. On 23 August, nurses recorded that the man was sick and incontinent. Over the following days, his health fluctuated and staff closely monitored his condition. On 27 August, a prison GP reviewed the man. He diagnosed a possible urinary tract infection, and prescribed trimethoprim.
37. On 28 August, the GP reviewed the results of blood tests, which were normal. At a review the next day, he noted that the man was responding appropriately to his medication, and had acceptable medical observations. The GP planned to repeat blood tests the following week.
38. The man's condition continued to fluctuate. His mobility was poor and he was incontinent. On 1 September, a prison GP reviewed the man after a nurse noted that he was confused, breathless and incontinent. The GP immediately sent the man to Pinderfields Hospital by emergency ambulance. Three prison officers escorted the man, and restrained him with an escort chain. (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.)
39. Hospital staff diagnosed the man with neutropenic sepsis (an infection caused by a lack of white blood cells), and pancytopenia (a shortage of all types of blood cells). He received treatment with antibiotics and a blood transfusion. However, the man's condition deteriorated significantly and he agreed with doctors at the hospital that to attempt resuscitation if his heart or breathing stopped would no longer be appropriate.
40. The man's condition continued to deteriorate, and he was immobile and often drowsy. On 3 September, his condition improved slightly, and he agreed to turn off his heart defibrillator after a discussion with the consultant and a friend, who was his nominated next of kin.
41. On 4 September, hospital staff told prison officers that the man had a poor prognosis. He was confused, struggling to speak and bed-bound. During the afternoon, prison managers reviewed the man's security arrangements. After consulting the specialists, who did not think that the man's death was imminent, they decided that the man should remain handcuffed.
42. At around 7.00pm, prison officers thought that the man appeared to have stopped breathing. A senior officer (SO) called for nurses to attend, who checked the man for signs of life. The nurses told the SO that the man had died. The man then removed the handcuff and chain. A hospital doctor attended later and certified the man's death.
43. At around 8.30pm, a prison manager went to the hospital to debrief the prison officers on duty and offer them support.

44. Prison managers asked a SO to act as the prison's family liaison officer. At around 9.00pm, he telephoned the man's friend, his nominated next of kin, to inform him of his death. The SO and another prison family liaison officer, an officer, visited the man's friend the next day.
45. The SO continued contact with the man's next of kin after his death. In line with national guidance, the prison contributed to the funeral costs.
46. Notices were issued to prisoners and staff at Wakefield, informing them of the man's death and offering support to those who might have been affected. The escort officers who were with the man when he died said that they had received appropriate support.

Post-mortem

47. After a post-mortem examination, the Coroner gave the cause of death as 1a) neutropenic sepsis, due to 1b) drug-induced pancytopenia, due to 1c) rheumatoid arthritis.

ISSUES

Clinical care

48. When the man arrived at Wakefield, he already had significant health problems and suffered from multiple chronic diseases. The clinical reviewer concluded that management of these diseases was generally equivalent or better than the man could have expected to receive in the community. Healthcare staff reviewed the man frequently, and there was evidence of multidisciplinary and specialist input into his care.
49. Although satisfied with the general health care provided at Wakefield, the clinical review was concerned about the management of several infections in the months before the man died. The man's multiple health problems, particularly his rheumatoid arthritis, heart failure and diabetes, left him more vulnerable to infection. However, the clinical reviewer considered that prescribing the antibiotics methotrexate and trimethoprim together, significantly contributed to the man's susceptibility to serious infections.
50. The clinical reviewer noted that the man took methotrexate to control his rheumatoid arthritis for many years before his death. A potential side effect of this drug is a shortage of all types of blood cells. Staff monitored the man frequently through blood tests (in line with national guidelines), which revealed no concerns.
51. However, the clinical reviewer stated that co-prescribing methotrexate and trimethoprim can increase suppression of bone marrow (which produces blood cells), and significantly increases the risk of infection. He concluded that taking methotrexate and trimethoprim together reduced the man's ability to produce white blood cells, and increased his susceptibility to the serious infections he suffered in March 2013, May 2014 and August 2014.
52. The clinical reviewer found that healthcare staff at Wakefield missed opportunities to note the potentially dangerous interaction of the two drugs. The prison's electronic SystemOne medical record automatically alerts staff when they co-prescribe methotrexate and trimethoprim, but this warning was either dismissed or ignored. A prison GP told the clinical reviewer that he decided to prescribe the man trimethoprim in August 2014, as he thought a short course of the drug would not be harmful. The clinical reviewer also found that on previous occasions, the pharmacy had noted the potential interaction of the drugs when issuing prescriptions, but had not sufficiently highlighted this to healthcare staff.
53. Although there is guidance about the potentially dangerous interaction between the drugs, it appears that this was not widely understood. Five different clinicians at Wakefield prescribed the man trimethoprim in addition to methotrexate. On the three occasions that the man completed his course of trimethoprim, he suffered severe infections and was admitted to hospital. On the third occasion, the infection was fatal.
54. The healthcare provider at Wakefield, Spectrum CIC, informed us that they have investigated the matter at a local level through a root cause analysis. The clinical reviewer considered that all clinicians should be fully aware of

the potential implications of co-prescribing of methotrexate and trimethoprim. We repeat the clinical reviewer's recommendation:

The Head of Healthcare should ensure that all prescribing clinicians and pharmacists are made aware of the potentially serious interaction between trimethoprim and methotrexate, and that in particular trimethoprim should not be co-prescribed to anyone on regular methotrexate at any time, even in short courses.

Use of restraints

55. 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.
56. A judgment in the High Court in 2007, made it clear that prison staff need to distinguish between the 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 judgement indicated that prison staff must take into account medical opinion about the prisoner's ability to escape and keep this under review as circumstances change.
57. The man attended many hospital appointments while in prison, both as an outpatient and inpatient. We have reviewed the risk assessments for a number these visits in 2014.
58. As the man's health deteriorated, he went to hospital more frequently, often with serious infections. Prison security staff noted that the man was a high risk to the public on the basis of his index offences 30 years earlier, and a medium risk of escape. Prison managers always directed the use of restraints, noting that officers should use an escort chain to restrain the man because of his poor health. One senior officer and two prison officers usually accompanied the man to hospital.
59. Healthcare staff gave no medical objections to the use of restraints in their input to the risk assessment. They noted the man's limited mobility, but did not comment on how or whether the man's medical condition or lack of mobility impacted on his risk of escape, as required by the 2007 High Court judgement.
60. When the man went to hospital for the final time on 1 September 2014, three prison officers accompanied him and used an escort chain to restrain him. Over the next three days, the man received treatment for a serious infection and his condition deteriorated significantly. Prison managers reviewed the man regularly. On the morning of 4 September, officers noted that the man was disorientated and had difficulty breathing during the night. A SO told us that, when he came on duty that morning, the man was immobile, confused and bed-bound. He said that the man's received medication through a drip, and his condition remained the same during the day.

61. Later that afternoon, the duty governor visited the hospital to review the man. The duty governor and the SO discussed whether it would be appropriate to remove the escort chain because of the man's deteriorating health, which limited his risk of escape. Hospital staff examined the man, and told the duty governor that he was not close to death.
62. The duty governor telephoned the prison and discussed the man's condition with the Deputy Governor. As the man was a Category A prisoner, the Deputy Governor reviewed security arrangements with a representative of the Head of High Security Prisons. After reviewing the information available, the representative of the Head of High Security Prisons and the Deputy Governor agreed that the man would remain restrained with the escort chain. They directed officers to review the man frequently, and to contact prison managers if his prognosis changed so that they could review the decision. The man was restrained until around 7.00pm, when officers noticed that he had stopped breathing. The SO removed the escort chain after nurses told him that the man had died.
63. We are very concerned that the man died while handcuffed to a prison officer. This was both inhumane and potentially traumatic for the staff involved who were troubled by the decision. It does not appear that managers from Wakefield or the High Security prisons group applied the High Court judgment appropriately when making decisions about restraints. The SO and the duty governor noted that the man's risk of escape had reduced as a result of his condition. We consider that an objective assessment would have identified that the man was not a risk of escape on the morning of 4 September (and very likely before that). However, Prison Service managers based their decision to keep the man restrained on his prognosis and the imminence of his death, rather than his current risk of escape, as the judgment requires.
64. The man had been unwell with reduced mobility for many months, and was acutely unwell when he went to hospital on 1 September. The risk assessment for his admission did not adequately take into account his actual condition at the time, or the impact of this on his risk of escape. The managers who reviewed the man on 4 September also failed to sufficiently take this into account.
65. The Prison Service has a responsibility to protect the public, but security must be balanced with humanity and measures must be proportionate to a prisoner's individual circumstances. We have made previous recommendations to Wakefield about the inappropriate use of restraints. We consider that there is a need for those involved in making decisions at all levels of the Prison Service, including the Deputy Director of High Security Prisons in category A cases, to ensure that a prisoner's health and mobility are fully taken into account in risk assessments for hospital escorts, and that staff follow the 2007 High Court judgment.
66. Ultimately, it is prison managers' responsibility to ensure that the process is managed properly, but Heads of Healthcare also need to ensure that healthcare staff understand their responsibilities and have appropriate

input into the risk assessment process. We make the following recommendation:

The Deputy Director of Custody for High Security Prisons 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.

Next of kin contact

67. A SO telephoned the man's friend, his nominated next of kin, at around 9.00pm on 4 September to inform him of his death. The SO and another family liaison officer went to see the man's friend at his home the next day to offer condolences and support.
68. Prison Service instructions require that prisons should, where possible, inform the next of kin in person, when a prisoner dies. The SO told us that he discussed the contact with a duty governor. They decided that it would be appropriate to telephone the man's friend to break the news of his death, as he was not a direct relative, had very infrequent contact with the man, and was already aware of his condition. While we consider it would have been preferable to have agreed with the man's next of kin in advance, how they would notify him of his death, we accept that this was a judgement call by the prison and the telephone call was followed up by a personal visit the next day.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that all prescribing clinicians and pharmacists are made aware of the potentially serious interaction between trimethoprim and methotrexate, and that in particular trimethoprim should not be co-prescribed to anyone on regular methotrexate at any time, even in short courses.
2. The Deputy Director of Custody for High Security Prisons 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.

ACTION PLAN: The man – HMP Wakefield

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible
1	<p>The Head of Healthcare should ensure that all prescribing clinicians and pharmacists are made aware of the potentially serious interaction between trimethoprim and methotrexate, and that in particular trimethoprim should not be co-prescribed to anyone on regular methotrexate at any time, even in short courses.</p>		<p>An alert notice has been sent out to all prescribers, partners and other services within Spectrum. A Root Cause Analysis (RCA) has been completed and an action plan developed. Progress on the action plan will be monitored, and the following recommendations have been made:</p> <ul style="list-style-type: none"> • Develop procedures for the management of out of hours prescribing and supply procedure. • Training to be given to appropriate staff on SystemOne interaction star alert system, pharmacy manager interaction alerts, summary of product characteristic (online information) for high risk drugs and refresher on British National Formulary 1. • Develop standard operating procedure for clinical checking by the pharmacist and any resultant formal communication with the prescriber. • Develop a high risk drugs information folder to be available at each secure environment site available to all prescribers and clinicians. • To present learning from the RCA to a non-medical prescribing forum, an appropriate professional 	<p>June 2015</p> <p>Head of Healthcare</p>

			<p>forum, GP clinical meeting and at one-to-one clinical GP supervision sessions with the lead GP.</p> <ul style="list-style-type: none"> • Develop guidance regarding the required frequency of blood tests for patients prescribed methotrexate. 	
2	<p>The Deputy Director of Custody for High Security Prisons 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.</p>		<p>Risk assessments for prisoners taken to outside hospital will be carried out at HMP Wakefield in line with the <i>Graham</i> judgement.</p> <p>The Deputy Director of Custody (DDC) for High Security will ensure that Governors at establishment level work together with relevant clinicians to ensure that the use of restraints during escorts to hospital are appropriately risk assessed. The escort level and any application of restraints will be proportionate to the assessed security risks and justified. These will take into account the prisoner's individual circumstances/current condition, the risk of escape and the risk to the public, nursing staff and escorting staff presented by the prisoner at the time.</p> <p>Where this is in relation to a category A prisoner, authority will be sought from the DDC if levels of restraints below the agreed National Security Framework levels are considered to be appropriate. All authorising officers (on behalf of the DDC) will ensure that when considering approval for reduction of restraints they take into account the health of the prisoner and the actual risk the prisoner presents at the time as part of their decision process. During out of hours or emergency situations, the reduction or removal of restraints will be considered as per Prison Service Instruction 09/2013 provisions.</p>	<p>April 2015</p> <p>Deputy Director of Custody</p>