Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Haywood a prisoner at HMP Oakwood on 7 April 2016

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*

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 David Haywood died from a pulmonary embolism (blood clot), caused by pneumonia, at HMP Oakwood on 7 April 2016. He was 65 years old. I offer my condolences to Mr Haywood's family and friends.

While Mr Haywood received generally compassionate healthcare at Oakwood, the investigation identified a number of concerns. In particular, in March 2016, after a prison doctor asked for Mr Haywood to be sent to hospital for assessment, there was an inexplicable delay of almost 24 hours before this was arranged. A few days later, when his condition deteriorated, there was another excessive delay in sending him to hospital for treatment owing to a shortage of prison officers to escort him and healthcare staff did not actively follow this up with prison managers.

I also do not consider that the use of restraints when Mr Haywood went to hospital was always justified by an appropriately considered risk assessment and it is wholly unacceptable that he died while handcuffed to a prison officer. This was both inhumane and potentially distressing for the staff escorting him.

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 **October 2016**

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Summary

Events

1. On 13 January 2012, Mr David Haywood was convicted of sexual offences. He was subsequently sentenced to 12 years in prison. He had been at Oakwood since December 2014. However, between June and October 2015 he spent extended periods at HMP Birmingham, as he required 24-hour healthcare after hospital treatment and surgery.

2. Mr Haywood was an older prisoner with several chronic health problems. On his return to Oakwood, he was allocated a named nurse, who created care plans to manage his health conditions, and a multidisciplinary team reviewed him monthly. Mr Haywood's health gradually deteriorated. Healthcare staff frequently reviewed him, with advice from a Macmillan nurse, and he was also under the care of specialists. In January 2016, Mr Haywood had a heart attack. Hospital doctors fitted a stent and prescribed blood thinning medication, but he remained very ill.

3. In March 2016, Mr Haywood reported persistent weeping leg sores. Prison doctors diagnosed cellulitis and prescribed antibiotics but there was little improvement. On 31 March, a prison GP instructed healthcare staff to send him to hospital. Security staff did not make the arrangements for him to go to hospital until the next day. Doctors confirmed the diagnosis and discharged him on 6 April, with antibiotics.

4. On 6 April, a nurse was concerned about Mr Haywood's condition and decided to send him to hospital. Three hours later, the prison called an ambulance to take him to hospital. Officers used an escort chain (a long chain with a light handcuff at each end, one of which is attached to the prisoner and the other to an officer) to restrain him in hospital. At 4.00am on 7 April, an escort officer informed the prison that Mr Haywood was dying. Prison managers did not authorise removal of the escort chain and Mr Haywood died, restrained, on 7 April.

Findings

5. The delays in arranging for Mr Haywood to go to hospital on 31 March and 6 April were unacceptable. This was an area of concern raised by HM Inspectorate of Prisons, after an inspection of Oakwood in December 2014.

6. We are concerned that staff decided to restrain Mr Haywood when he was taken to hospital on 6 April. The decision to restrain him seemed to be based largely on his offences, not the risk he posed at the time. Subsequent risk assessments concluded that he should remain restrained, even after his admission to the end of life unit, when staff were already aware that he was dying. We are not satisfied that healthcare staff and prison managers took sufficient account of Mr Haywood's limited mobility, his very poor state of health and that he was nearing the end of his life, when assessing his risk. As a result, Mr Haywood died while restrained to an officer.

Recommendations

- The Director and Head of Healthcare should ensure that requests for prisoners to go to hospital are prioritised and that there is a clear and auditable process to ensure that appointments are arranged without delay.
- The Director 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 Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Oakwood informing them of the investigation and asking anyone with relevant information to contact her. One person responded.

8. The investigator obtained copies of relevant extracts from Mr Haywood's prison and medical records.

9. NHS England commissioned a clinical reviewer to review Mr Haywood's clinical care at the prison.

10. The investigator interviewed eight members of staff and one prisoner at HMP Oakwood on 10 May 2016. She and the clinical reviewer interviewed healthcare staff together.

11. We informed HM Coroner for South Staffordshire 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 Haywood's daughter, to explain the investigation. She had no questions or concerns for the investigation to consider and said that the prison family liaison officer had been excellent.

13. Mr Haywood's family received a copy of the initial report and indicated that they were satisfied with the findings.

14. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Oakwood

15. HMP Oakwood opened in 2012. It is near Wolverhampton and managed privately by G4S. Oakwood is one of the largest prisons in England and Wales, providing places for up to 1,605 Category C male prisoners.

16. Worcester Health and Care Trust provided the healthcare services until 31 March 2016. These include a daily GP clinic, some specialist services and out-of-hours GPs. From 1 April 2016, Care UK became the provider of healthcare services.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Oakwood was in December 2014. Inspectors reported that health services had improved considerably since the last inspection and, overall, were reasonably good. The range of services was appropriate and the management of prisoners with lifelong or complex health needs was very good, although staff shortages had led to a backlog of nurse reviews. Inspectors found that the healthcare rooms were well equipped and staff created appropriate care plans. However, there were often delays in arranging external hospital appointments because of the high demand and insufficient escort staff.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board made up of unpaid volunteers from the local community who help to help ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to March 2016, the IMB at Oakwood reported that, due to the uncertainty arising from the change of healthcare provider, there were a high number of vacancies and the use of agency staff had lowered continuity of care. The healthcare department worked with Macmillan nurses to provide end of life care, but there was no nurse cover during the night.

Previous deaths at HMP Oakwood

19. Mr Haywood was the second prisoner to die from natural causes at Oakwood. There were no significant similarities with the circumstances of the previous death.

Key Events

20. On 13 January 2012, Mr David Haywood was convicted of sexual offences. Two weeks later, he was sentenced to 12 years in prison. Mr Haywood spent time in several prisons, and was transferred from HMP Winchester to HMP Oakwood on 16 December 2014.

21. Mr Haywood had several complex medical problems, including type 2 diabetes, depression, an enlarged prostate and chronic obstructive pulmonary disease. (COPD - the name for a collection of progressive lung diseases, including chronic bronchitis and emphysema.) He had undergone surgery to remove his spleen and to have a hip replacement. Mr Haywood had limited mobility. He used a stick to move around the wing and a wheelchair to move from the wing to the healthcare centre. Doctors prescribed several medications for his medical conditions.

22. On 20 June 2015, Mr Haywood was admitted to hospital for assessment. Hospital doctors diagnosed a blockage in his stomach. He was discharged to HMP Birmingham on 3 August, as he remained unwell and needed 24-hour healthcare. On 17 September, Mr Haywood was readmitted to hospital for surgery to remove the obstruction.

23. On 4 October 2015, Mr Haywood was discharged from hospital and was returned to Oakwood. At his initial health screen, a nurse noted that he was pale, gaunt and generally unwell. His surgical wound was healing, and he was due to have a review with his consultant in six weeks. (Mr Haywood subsequently had several tests for further abdominal problems.)

24. Staff allocated Mr Haywood a cell in a unit for older prisoners, on the vulnerable prisoners' wing. On 10 October, a multidisciplinary team meeting, attended by healthcare staff and several prison managers, discussed his management and where he should be located. Mr Haywood wanted to remain on his wing, as he felt supported by staff and prisoners.

25. A senior nurse, Mr Haywood's lead nurse, created a care plan to monitor Mr Haywood's diabetes and allocated a carer to help collect his meals and clean his cell. She also arranged a soft diet and nutritional supplements.

26. On 12 October, a Macmillan palliative care specialist nurse reviewed Mr Haywood and recommended suitable diets and a weekly weight check. At a subsequent visit on 16 December, she noted he was pale and weak and reiterated her advice. Blood tests taken later that day, and repeated on 22 December, revealed abnormalities in his full blood count, liver, and kidney function, but this was attributed to his recent surgery. Mr Haywood told a prison GP that he felt much better.

2016

27. On 2 January 2016, Mr Haywood had a heart attack and was taken to hospital. Doctors inserted a stent to improve his blood flow and he returned to Oakwood on 4 January, with blood thinning medication. His consultant cardiologist said he

was stable apart from weight loss and low blood pressure. He recommended nutritional supplements and a prison GP prescribed them.

28. On 18 March, the lead nurse noted that Mr Haywood's left leg was very swollen and red. A locum GP diagnosed cellulitis and prescribed antibiotics. (Cellulitis is a bacterial infection of the deeper layers of the skin and underlying tissue.) The nurse noted that there was no evidence of sepsis (a widespread infection which reduces supply to the organs and can lead to multi organ failure). Staff monitored his leg over the next few days.

29. On the morning of 27 March, Mr Haywood told a healthcare assistant that his leg was worse, there was a discharge and he was in pain. In the afternoon, a nurse examined him and noted that his leg was still swollen and leaking fluid. However, Mr Haywood said there had been a slight improvement.

30. At a review the next day, the lead nurse noted there were several broken areas of skin, so she rang the out of hours doctor for advice. The doctor prescribed further antibiotics and nurses continued to monitor Mr Haywood.

31. On 31 March, a healthcare assistant saw that Mr Haywood's leg had deteriorated and the redness had spread to his inner thigh. She noticed that his right leg was also swollen, with redness and a rash, and requested a GP review. After examining him at 9.43am, a locum GP asked healthcare staff to send him to hospital for further treatment. At interview, he said that he had a discussion with Mr Haywood about admission to hospital to be placed on an intravenous drip. Mr Haywood was hesitant to go, as he was comfortable. He said that as his observations were stable, he had expected him to go to hospital within two hours.

32. Prison staff did not arrange an ambulance until 7.49am on 1 April, almost 24 hours later. They told the investigator that the Orderly Officer did not know that Mr Haywood needed to go to hospital until that morning. Two officers escorted him, using an escort chain.

33. Hospital doctors confirmed the diagnosis of cellulitis and gave Mr Haywood intravenous antibiotics. They discharged him on 2 April, and he was returned to Oakwood. The discharge letter indicated that he had cellulitis in his right leg, which had not improved with antibiotics, and a fungal infection. Doctors discharged him with oral antibiotics, as Oakwood's healthcare department was not equipped to administer this intravenously.

34. On 6 April 2016, wing officers asked a nurse to examine Mr Haywood in his cell. He was unwell and had been hallucinating during the previous night. At 5.16pm, she noted that he looked grey and his leg was weeping. His blood sugar level was low and his pulse was raised. Mr Haywood said he had eaten and taken his medications, but he felt unwell. She checked him again at 7.04pm. Although his blood sugar level had slightly increased, he had started to vomit and she could not determine the cause. She decided to send him to hospital for further investigation. At interview she said that she did not call an emergency ambulance herself, as she knew there were staffing problems, but she had asked the night manager to arrange this as soon as possible. With hindsight, she regretted not calling an ambulance immediately.

35. The prison did not call an ambulance until three hours later, at 10.12pm. The paramedics arrived at the prison at 10.16pm and were with Mr Haywood at 10.25pm. The night manager said that the delay was due to him dealing with two other medical emergencies. Prison staff completed a security risk assessment. One of the clinical team leaders indicated in the medical section of the form that there was no objection to the use of restraints. The paramedics took Mr Haywood to hospital at 10.53pm, where he was admitted to the Acute Medical Unit. Doctors diagnosed cellulitis and an acute lower respiration infection. He was escorted by two prison officers, using an escort chain.

36. At around 4.00am on 7 April, one of the escort officers informed the night manager that the hospital was moving Mr Haywood to their end of life unit as he was going to die. At interview, the manager said he telephoned a senior manager at home to tell him about this. The senior manager asked him to keep him informed, but did not say anything about removing the restraints. The night manager said that he did not have the authority to approve the removal of restraints unless a doctor or nurse directly asked him to, or they needed to resuscitate him.

37. At 1.15pm, a prison manager carried out a management check at the hospital. He did not authorise the removal of the restraints. At 6.51pm, the escort staff told a senior manager that Mr Haywood had deteriorated. He was only expected to live for up to two hours and a nurse had asked for the handcuffs to be removed. She told the investigator that she had tried to consult other managers to arrange a risk assessment. Mr Haywood died at 7.00pm, while handcuffed to an officer.

Contact with Mr Haywood's family

38. A prison family liaison officer (FLO) was appointed. Mr Haywood had told staff that he had no contact with his family and he did not want anyone to know that he was in hospital. After his death, the FLO contacted the Probation Service, police and Mr Haywood's solicitor for information about his next of kin. However, after searching through Mr Haywood's property, prison staff found an address in Devon for his daughter. The local police informed her of Mr Haywood's death.

39. The FLO spoke to Mr Haywood's daughter on 10 April to offer condolences and support. She then arranged Mr Haywood's funeral, which was held on 3 May. The prison contributed to the costs, in line with national policy. Mr Haywood's daughter told us that the FLO had supported her well.

Support for prisoners and staff

40. After Mr Haywood's death, a prison manager debriefed the escort staff. She offered her support and that of the staff care team.

41. The prison posted notices informing prisoners of Mr Haywood's death, and offering support. Staff reviewed all prisoners considered to be at risk of suicide and self-harm, in case they had been adversely affected by Mr Haywood's death.

Cause of death

42. The Coroner confirmed that the cause of Mr Haywood's death was a pulmonary embolism (blood clot), caused by pneumonia. Mr Haywood also had chronic obstructive pulmonary disease (lung disease), diabetes and heart failure in the background. The Coroner said it was possible that Mr Haywood's limited mobility, arising from his leg ulcers, had made him more susceptible to a chest infection.

Findings

Clinical care

43. Mr Haywood arrived at Oakwood with several chronic medical conditions and a named nurse was allocated to oversee his clinical management. Within a few days of his return to Oakwood in October 2015, the nurse completed an initial older persons' healthscreen and placed him on the complex case list.

44. Mr Haywood was reviewed at monthly multidisciplinary meetings and the clinical reviewer considered the meetings worked well. Nevertheless, she identified gaps in the management and review of his long-term diseases. She noted that Mr Haywood's care plan did not reflect up to date assessments and his diabetes and COPD were not monitored, in spite of the increased risk of infection. Between 21-27 March, there were no clinical entries to indicate there had been any assessments of Mr Haywood's worsening cellulitis, and he only saw a GP on 31 March.

45. The clinical reviewer was also concerned that, when Mr Haywood was discharged from hospital, on 2 October, his medication was changed to oral antibiotics, as Oakwood could not administer them intravenously. She considered that this aspect of his care was not equivalent to that he could have expected in the community. However, this decision to change his medication and discharge him was taken by the hospital and is therefore outside our remit. The clinical reviewer has made a number of recommendations that the head of healthcare will need to address.

46. We agree with the clinical reviewer's conclusion that, in spite of the weaknesses identified, Mr Haywood received compassionate care. Healthcare staff tried, in very difficult circumstances, to ensure Mr Haywood was as comfortable as possible.

Transfer to hospital

47. On 31 March, a prison GP asked healthcare staff to send Mr Haywood to hospital and expected him to go within two hours. However, prison staff did not make the arrangements until 24 hours later, and there is no evidence that healthcare staff checked the reasons for the delay, or attempted to expedite the process. Although prison staff said that they were not aware of the request until the morning of 1 April, the escort risk assessment for the journey was completed on 31 March. This suggests that healthcare staff had passed on the prison GP's request the same day.

48. On 6 April, a nurse decided to send Mr Haywood to hospital. She asked the night manager to arrange this, as she knew there was a shortage of escort staff owing to other emergencies that evening. There is no evidence that staff clinically prioritised the various emergencies and the prison did not call an ambulance for Mr Haywood until three hours later. We are concerned about the considerable and unacceptable delays in arranging for Mr Haywood to be taken to hospital. We note that HM Inspectorate of Prisons raised a similar issue after an inspection in December 2014. We make the following recommendation:

The Director and Head of Healthcare should ensure that requests for prisoners to go to hospital are prioritised; and that there is a clear and auditable process to ensure that appointments are arranged without delay.

Restraints, security and escorts

49. 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.

50. 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.

51. Oakwood has a local security strategy and operating procedure, based on Prison Service Instruction (PSI) 33/2015, about the external movement of prisoners. This says that restraints must be removed if a healthcare professional seeks their removal because of an immediate risk to the prisoner's health. It goes on to say that, restraints should also be removed, unless there is a risk of escape, if a healthcare professional asks for examination or treatment. If there is a risk of escape, or staff have any doubts they should contact the Duty Director, who will decide whether to remove or retain the restraints.

52. Mr Haywood had been in poor health for many months. He had limited mobility, using a walking stick to move around his cell and a wheelchair to get to the healthcare centre. The risk assessment for his hospital admission on 1 April 2016 concluded that Mr Haywood was a low risk of escape, hostage taking and to hospital staff, but based on his offences, a medium risk to the public. The medical section of the risk assessment noted he was fully mobile (which was incorrect) and did not give any information about his current medical condition. Two officers accompanied him, using an escort chain to restrain him.

53. Mr Haywood was acutely unwell when he went to hospital as an emergency on 6 April. Prison security staff assessed him as a low risk of escape, hostage taking and to hospital staff, and a high risk to the public, again based on his offences. The medical section of the risk assessment noted some of Mr Haywood's existing medical conditions and that he was mobile, but indicated that there were no medical objections to the use of restraints. Two prison officers acted as escorts and prison managers decided they should use an escort chain.

54. In the early hours of 7 April, one of the escort officers informed the prison that Mr Haywood was dying. In spite of this, no one considered removing the restraints, and a management check at 1.15pm indicated that they should remain in place. Managers at the prison later reviewed the risk assessment and authorised the continued use of the escort chain. At 6.51pm, escort staff told a prison manager that Mr Haywood was unlikely to survive much longer and a nurse had asked for

the removal of his restraints, but she did not give immediate approval. Instead, she decided to request a further risk assessment. Mr Haywood died nine minutes later.

55. Public protection is critical, but security measures must be proportionate to a prisoner's individual circumstances. We are very concerned that Mr Haywood died while handcuffed to a prison officer. This was both inhumane treatment of Mr Haywood and potentially traumatic for the escort staff. It seems that the decision to restrain him was based on the nature of his offences, rather than his actual risk at the time and prison managers did not appropriately consider how his condition affected his risk, in line with the court judgment. An objective assessment would have identified that Mr Haywood was not a risk of escape, particularly after his admission to the end of life unit, where doctors expected him to die imminently.

56. 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 Director 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.

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