

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Thomas Fisher at HMP Wakefield on 21 February 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 Thomas Fisher died on 21 February 2016 of a bleed in the digestive tract while a prisoner at HMP Wakefield. He was 70 years old. I offer my condolences to Mr Fisher's family and friends.

Mr Fisher was a frail man who suffered with chronic obstructive pulmonary disease and had an abdominal aortic aneurism, both of which prison healthcare managed well. I am satisfied that Mr Fisher's care in prison was equivalent to that he could have expected to receive in the community and there is nothing healthcare staff could have done to predict or prevent his death which was sudden and unconnected with his chronic conditions.

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 23 August 2010, Mr Thomas Fisher was sentenced to 16 years in prison for sexual offences and was sent to HMP Hull. He moved to HMP Wakefield on 1 March 2012.
2. When he arrived at Wakefield, a nurse noted Mr Fisher was a long-term heavy cigarette smoker and he declined any help to stop smoking. He had an abdominal aortic aneurism (a swelling of the main blood vessel that leads away from the heart, down through the abdomen to the rest of the body), and long-standing back pain from an old injury.
3. In April 2012, Mr Fisher was diagnosed with chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema), which was managed with medication and reviewed annually by a visiting respiratory consultant.
4. Mr Fisher's aortic aneurism was reviewed in October 2014 during a routine NHS screening. Healthcare staff saw Mr Fisher frequently over the next 16 months to monitor and treat his conditions.
5. In the ten days leading up to his death, Mr Fisher reported bouts of indigestion, acute abdominal pain, and constipation. Healthcare staff reviewed him and prescribed gaviscon (to treat heartburn and indigestion) and senna (a laxative). He was referred for a GP appointment on 26 February 2016.
6. At 5.18am on 21 February, an officer found Mr Fisher slumped, unresponsive on the floor of his cell. The officer asked for assistance from a senior officer, and they entered Mr Fisher's cell. The senior officer noted Mr Fisher was cold to touch and had no signs of life and called for healthcare assistance at 5.25am. A nurse arrived and found that Mr Fisher was very cold to the touch with rigor mortis in his lower limbs and no pulse. The nurse and senior officer agreed that resuscitation was not appropriate. A paramedic attended and declared Mr Fisher dead at 6.00am.

Findings

7. We are satisfied that Mr Fisher received a good standard of health care at Wakefield, equivalent to that he could have expected to receive in the community. Mr Fisher's death was sudden and there was nothing healthcare staff at Wakefield could have done to prevent it.
8. While it did not affect the outcome for Mr Fisher, the officer who found Mr Fisher unresponsive did not call an emergency code which would have triggered and immediate request for an ambulance. In other circumstances such a delay could be crucial.

Recommendation

- The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including using the appropriate emergency code to effectively communicate the nature of a medical emergency and ensure an emergency ambulance is called immediately.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Wakefield informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
10. The investigator visited Wakefield on 1 March 2016. She obtained copies of relevant extracts from Mr Fisher's prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr Fisher's clinical care at the prison.
12. We informed HM Coroner for West Yorkshire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted Mr Fisher's sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Fisher's sister asked for details of the medications that Mr Fisher was receiving, and whether Mr Fisher was diagnosed with lung cancer.
14. Mr Fisher's sister received a copy of the initial report and indicated that she was satisfied with the findings.
15. The initial report was shared with Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Wakefield

16. 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.
17. Spectrum CIC (Community Interest Company) provides primary healthcare services during normal working hours. Humber NHS Foundation Trust (intermediate care) employs the nurses in the inpatient unit, which provides overnight and weekend care for prisoners with physical health problems. There is a dedicated palliative care suite in the healthcare unit.

HM Inspectorate of Prisons

18. The most recent inspection of HMP 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

19. 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 there were a significant number of older prisoners being looked after by healthcare. The Board considered that health services were well managed, the quality of care was high and they reported a significant reduction in prisoners' complaints about healthcare.

Previous deaths at HMP Wakefield

20. Mr Fisher was the tenth prisoner to die from natural causes at Wakefield since the start of 2014. There are no similarities with previous deaths.

Key Events

21. On 23 August 2010, Mr Fisher was sentenced to 16 years in prison for sexual offences and was sent to HMP Hull. He moved to HMP Wakefield on 1 March 2012.
22. At his reception healthcare screen at Wakefield, Mr Fisher told a nurse that doctors had diagnosed him with an abdominal aortic aneurism in 2009. The nurse noted that Mr Fisher was a long-term and heavy cigarette smoker and made an appointment for him to see a GP.
23. A prison GP examined Mr Fisher on 23 March and arranged blood tests, a chest X-ray and an electrocardiogram (ECG).
24. On 30 April, a prison GP noted that the results of the recent blood sample and ECG were consistent with chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema).
25. On 8 May, Mr Fisher's chest X-ray result identified a shadow on his lung. A prison GP made an urgent referral under the NHS pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks. However, Mr Fisher refused to attend any appointments at the hospital, despite advice. He told prison healthcare staff that, if he had lung cancer, he did not want to receive treatment. Healthcare staff were satisfied that Mr Fisher had the mental capacity to refuse treatment. However, Mr Fisher did agree to have X-rays taken within prison healthcare.
26. By November, after several X-rays, prison doctors were satisfied that the shadow on Mr Fisher's lung was likely caused by his COPD and there was no evidence of lung cancer. Healthcare staff frequently advised him to stop smoking, but he refused. Clinicians managed his COPD with salbutamol, salmeterol and tiotropium bromide inhalers (which open airways and aid breathing) and regular respiratory assessments.
27. Healthcare staff saw Mr Fisher frequently over the next 23 months to review and treat his conditions. In addition to the management of his COPD, doctors prescribed Mr Fisher with co-codamol for his long-standing back pain, and nutritional drinks to help with weight gain.
28. On 10 October 2014, Mr Fisher had a routine abdominal aneurism screen (as part of an NHS check for all males over 65). A specialist vascular nurse advised Mr Fisher to make lifestyle changes. Healthcare staff continued to review Mr Fisher frequently.
29. Between 22 April and 6 October 2015, there were three occasions when Mr Fisher suffered with vomiting and indigestion. Healthcare nurses saw Mr Fisher in his cell, where they gave him medical advice and gaviscon (to treat heartburn and indigestion). Over the next four months, there was nothing significant in the records.

30. On 6 February 2016, a nurse gave Mr Fisher gaviscon after he complained of heartburn and indigestion.
31. On 11 February, a nurse examined Mr Fisher after he complained of abdominal pain that felt like indigestion. She gave him gaviscon.
32. On 16 February, wing officers called healthcare because Mr Fisher complained of severe abdominal pain. A nurse examined him in his cell and Mr Fisher told her that he had been constipated for two days so she gave him senna (a natural laxative).
33. On 18 February, a nurse examined Mr Fisher and told him to take two senna tablets at night for up to three nights. She also advised Mr Fisher to tell healthcare if he did not have a bowel movement within three days and made an appointment for the GP on 26 February.

21 February 2016

34. At 5.18am on 21 February, an officer conducted morning checks on Mr Fisher's wing. He turned on the night light in Mr Fisher's cell and saw that he was slumped on the floor. He called to Mr Fisher but he did not respond. He then turned on the main light and could see that Mr Fisher looked pale and was not responding to his name.
35. The officer called a Senior Officer (SO) and they unlocked Mr Fisher's cell together at 5.19am. When the SO examined Mr Fisher, he could not find a pulse or any signs of life and Mr Fisher's body was cold to the touch.
36. At 5.25am, the SO contacted the control room and requested healthcare staff. The control room called an ambulance.
37. At 5.32am, a nurse arrived and assessed Mr Fisher. Mr Fisher was in a partially reclined position on the floor between the sink and the bed. He was very cold to the touch, rigor mortis was present in his lower limbs and there were no signs of life. A nurse and a SO agreed that Mr Fisher had been dead for some time and that resuscitation would not be appropriate.
38. At 5.55am, a paramedic responder arrived. He considered Mr Fisher had been dead for several hours and declared his death at 6.00am.

Contact with Mr Fisher's family

39. Mr Fisher had nominated both his wife and sister as his next of kin. After his death, the prison appointed an officer as the family liaison officer. At 10.00am, she and a senior manager visited Mr Fisher's wife and informed her that he had died. They then visited Mr Fisher's sister to deliver the same news. They offered their condolences and support to both.
40. Mr Fisher's funeral was on 8 March 2016. The prison contributed to the costs, in line with national policy.

Support for prisoners and staff

41. After Mr Fisher's death, a senior manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
42. The prison posted notices informing staff and prisoners of Mr Fisher's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Fisher's death.

Post-mortem report

43. A post-mortem report concluded that Mr Fisher died from a gastrointestinal haemorrhage (bleeding in the digestive tract) and duodenal ulcer (ulcer in the small intestine).

Findings

Clinical care

44. The clinical reviewer considered that Mr Fisher suffered with mild symptoms associated with a duodenal ulcer, which were relieved with the appropriate medication. Mr Fisher was not compliant with many aspects of his health; however, the prison's healthcare team remained proactive and monitored Mr Fisher's health regularly.
45. The clinical reviewer considered that Mr Fisher's care was equivalent to that he could have expected to receive in the community. We are satisfied that the prison's healthcare team had a well-coordinated approach to Mr Fisher's care. His death was sudden and unexpected and there was nothing that healthcare staff at Wakefield could have done to prevent it.

Emergency response

46. Prison Service Instruction (PSI) 03/2013 'Medical Emergency Response Codes', contains a mandatory instruction that prison staff should use a code blue (or code one) for any emergency where a prisoner is unresponsive, has symptoms including chest pain and difficulty in breathing and that they should not delay summoning emergency assistance.
47. When the officer saw Mr Fisher collapsed on the floor of his cell and unresponsive, he did not call an emergency code. It took another seven minutes before the SO called for healthcare assistance. It was clear that Mr Fisher had been dead for some time, so the delay in calling an emergency code did not affect the outcome, but in other circumstances a seven minute delay could be crucial. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including using the appropriate emergency code to effectively communicate the nature of a medical emergency and ensure an emergency ambulance is called immediately.

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