

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Brady a prisoner at HMP Wakefield on 1 May 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 Brady died on 1 May 2016 of pneumonia as a result of heart disease while a prisoner at HMP Wakefield. He was 67 years old. I offer my condolences to Mr Brady's family and friends.

I am satisfied that Mr Brady received a good standard of clinical care at Wakefield, equivalent to that he could have expected to receive in the community. Mr Brady was located in the palliative care suite while he recovered from a serious stroke and received constant care and supervision from healthcare staff. I am satisfied there is nothing that healthcare staff could have done to prevent Mr Brady's death.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

September 2016

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Summary

Events

1. In March 2005, Mr John Brady was sentenced to life imprisonment. He spent time at a number of prisons before being moved to HMP Wakefield in October 2007.
2. For the duration of Mr Brady's time at Wakefield, he suffered with hypertension (high blood pressure), bronchiectasis (a build-up of mucus in the lungs causing increased risk of infection), and several conditions associated with type 2 diabetes, including foot ulcers. Doctors prescribed Mr Brady several medications to treat his conditions although he often refused to take these.
3. Mr Brady required regular interventions from healthcare to ensure that he complied with advice on how to manage his foot ulcers and, in August 2015, he was moved to the prison's healthcare unit so that he could be monitored more closely.
4. On 11 February 2016, Mr Brady suffered a stroke and was taken to hospital. He remained in hospital for five weeks until he regained strength in the right side of his body, his speech improved and he was able to swallow.
5. On 17 March, Mr Brady returned from hospital to the palliative care suite at Wakefield. Nurses implemented care plans and supplied him with appropriate aids and equipment. Healthcare staff saw Mr Brady several times a day and closely monitored him.
6. A week after he returned to Wakefield, Mr Brady began to lose his appetite and had an erratic eating pattern. On 6 April, he refused to take any medication other than insulin and clopidogrel (an anti blood clotting medication). Prison nurses advised him of the risks of not taking his medication and added a nutritional thickening agent to his drinks.
7. On 30 April at approximately 10.00am, a nurse found Mr Brady unresponsive. He had a temperature, rapid heartbeat, low blood pressure, and low blood oxygen levels. The nurse sent Mr Brady to hospital by emergency ambulance.
8. Mr Brady remained in hospital where he deteriorated further. He died at 1.00am on 1 May.

Findings

9. We are satisfied that Mr Brady received a good standard of care at Wakefield, equivalent to that he could have expected to receive in the community. Mr Brady was recovering from a serious stroke, but his death was sudden and there was nothing healthcare staff at Wakefield could have done to prevent it. We make no recommendations.

The Investigation Process

10. 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.
11. The investigator obtained copies of relevant extracts from Mr Brady's prison and medical records.
12. NHS England commissioned a clinical reviewer to review Mr Brady's clinical care at the prison.
13. 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.
14. Mr Brady had not named any next of kin and had not made any telephone calls since arriving at Wakefield. Enquiries by both the prison and police were not able to trace any family.
15. The initial report was shared with the prison service. There were no factual inaccuracies. Mr Brady did not have any next of kin to share the report with.

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 situated 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 the importance of healthcare given the significant number of older prisoners. 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 Brady was the thirteenth prisoner to die from natural causes at Wakefield since June 2014. There are no similarities with the circumstances of the other deaths.

Key Events

21. On 17 March 2005, Mr John Brady was sentenced to life imprisonment for sexual offences and had been at HMP Wakefield since October 2007.
22. Mr Brady had a number of medical conditions; bronchiectasis (a build-up of mucus in the lungs causing increased risk of infection), type 2 diabetes and several conditions symptomatic of diabetes, including bilateral charcot (weak bones in the feet), diabetic neuropathy (nerve damage and loss of sensation in the feet), foot ulcers, and a toe amputation. Mr Brady also suffered with hypertension (high blood pressure). Nurses monitored his blood pressure regularly and doctors prescribed medication to improve blood flow.
23. Doctors prescribed Mr Brady with a number of medications to treat his other conditions including insulin for his diabetes, furosemide for heart failure, atorvastatin, clopidogrel and modafinil for stroke prevention and carbocisteine to reduce mucus levels in the lungs. However, Mr Brady regularly took a different amount of insulin to the prescribed dose and often refused his other medications. Healthcare staff explained to Mr Brady the risks associated with not taking his medications appropriately, particularly the risk of strokes. Clinicians were satisfied that Mr Brady had the mental capacity to make such decisions.
24. A majority of Mr Brady's appointments in healthcare and hospital were for the management of his diabetes, including his diabetic foot ulcers. Mr Brady did not follow the advice of clinicians and specialists with regard to his foot care. This resulted in regular infections in the wounds on his feet, and the development of new foot ulcers.
25. On 6 August 2015, Mr Brady was moved to the prison healthcare unit so that nurses could properly monitor his foot ulcers. Healthcare staff checked on Mr Brady several times a day and dressed his ulcers regularly. Mr Brady was able to move independently around his cell, though he used a wheelchair to travel to other parts of the prison. He did not need any assistance with daily living activities.
26. At 9.37pm on 11 February 2016, a nurse checked on Mr Brady and noted that he had right sided facial droop, weakness to his right side and was slurring his words. She monitored Mr Brady and asked for an ambulance. Paramedics attended and took Mr Brady to hospital.
27. Due to the risk of Mr Brady suffering a cardiac arrest, paramedics and healthcare staff advised that cuffs should not be applied to Mr Brady. The Governor authorised that restraints were not necessary. Mr Brady remained unrestrained for the duration of his hospital stay. Later that evening, the hospital told a nurse that Mr Brady had suffered a stroke.
28. The following day, a speech and language therapist assessed Mr Brady in hospital. She noted that he was able to open his eyes and understand commands, but unable to move his right arm, swallow or speak.
29. Mr Brady remained in hospital receiving occupational therapy to mobilise the right side of his body and improve his speech. Because he was unable to

swallow, he required a nasogastric tube (a tube from his nose to his stomach to receive food and liquids). The hospital would not discharge Mr Brady until he no longer required a nasogastric tube.

30. On 14 March, Mr Brady was able to tolerate a small amount of soft diet and, two days later, a hospital doctor assessed Mr Brady as fit for discharge, though his communication was still poor and he was doubly incontinent. He required a hoist to get in and out of bed, and an air mattress. A nurse ensured that these requirements were in place for Mr Brady's return to Wakefield as well as instructing the prison kitchen to provide Mr Brady with a soft diet.
31. On 17 March, Mr Brady returned to Wakefield's palliative care suite and nurses implemented a care plan and gave him a buzzer to alert staff when he needed help. A nurse noted that Mr Brady was able to drink and feed himself but still required close monitoring.
32. Mr Brady settled well. He was proactive in his rehabilitative therapy and nurses noted on 20 March, he was able to help wash, dress and reposition himself in bed.
33. On 25 March, Mr Brady told a nurse that he did not feel hungry and, over the coming days, Mr Brady's food intake was erratic and he began to refuse his medication. Healthcare monitored his appetite and added a nutritional thickening agent to his drinks.
34. On 6 April, a nurse noted that Mr Brady refused to take any medication apart from insulin and clopidogrel. Healthcare staff regularly explained to Mr Brady the risks of not taking his medication and, on 12 April, a nurse noted that she would discuss this with a prison GP.
35. On 13 April, a prison GP assessed Mr Brady. There was no record that he discussed his refusal to take medication. During the appointment, the GP recommended the insertion of a catheter to reduce the pressure sores and infection from the prolonged use of incontinence pads, but Mr Brady declined. He noted that Mr Brady's condition was stable, but due to his significant medical history, that there was also a risk of sudden death. He noted that Mr Brady did not wish anyone to resuscitate him if his heart or breathing stopped. An order to this effect was put in place.
36. Healthcare staff saw Mr Brady several times a day, and on 29 April, nurses inserted a catheter at his request. However, later that day a nurse noted that it had become detached and the balloon remained in Mr Brady's bladder. She telephoned a urology specialist and they advised her that Mr Brady should attend hospital the following week. In the meantime, Mr Brady was given incontinence pads.
37. At 5.56am on 30 April, a nurse checked on Mr Brady and noted he was settled and sleeping. She recorded his blood sugar levels were stable.
38. At 8.55am, a nurse observed Mr Brady through the cell door window and noted that he was alert. However, just after 10.00am, a nurse went to administer Mr Brady's insulin but found him unresponsive with a high temperature, fast

heartbeat, low blood pressure, low blood oxygen and cyanosis (a bluish discoloration of the skin caused by lack of oxygen).

39. The nurse requested an emergency ambulance. Paramedics arrived at 10.19am and took Mr Brady to hospital. A senior manager authorised the escort without restraints, due to the seriousness of his condition, though instructed officers to apply an escort chain if Mr Brady improved.
40. Hospital doctors assessed Mr Brady and treated him with antibiotics. Later that day, hospital staff told an escorting officer that Mr Brady's condition had improved. At 3.30pm, the escorting officers applied 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) when Mr Brady moved wards.
41. At 8.00pm, Mr Brady's health suddenly deteriorated and he became semiconscious. Escorting officers removed the escort chain. Mr Brady's condition continued to deteriorate and he died at 1.00am on 1 May.

Contact with Brady's family

42. Mr Brady did not have a listed next of kin. On 12 February 2016, an officer contacted the probation service, the police and Mr Brady's solicitors in an effort to find out the name and contact details for a next of kin. However, no one was able to provide this. After Mr Brady died, the prison noted that he had not made any telephone calls since arriving at Wakefield. Staff made further enquiries with the police, public records office and Mr Brady's solicitors, but a next of kin could not be found.
43. Mr Brady's funeral was on 24 May 2016. The prison arranged and paid for this in line with national policy.
44. We are satisfied that the prison made concerted efforts to find Mr Brady's next of kin, sadly without success.

Support for prisoners and staff

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

Post-mortem report

47. The post-mortem concluded that Mr Brady died of pneumonia, a contributory factor was diabetes and heart disease.

Findings

Clinical care

48. Mr Brady received good care at Wakefield. Healthcare staff provided comprehensive medical attention in line with national guidelines to manage all his conditions including the serious conditions associated with his diabetes.
49. After his stroke and during his five-week hospital admission, prison healthcare staff maintained regular contact with the hospital. This ensured that they were well informed and able to provide the additional care Mr Brady needed when he was discharged.
50. He returned from hospital to the palliative care suite at Wakefield and healthcare staff provided everything he required to be as comfortable as possible. Clinicians monitored Mr Brady very closely, and there was a good balance between intervention and respect for his wishes. He often refused his medication. Nurses advised him of the likely consequences of this decision and clinicians were satisfied he had the mental capacity to make such a decision.
51. We agree with the clinical reviewer that Mr Brady received a standard of care in prison equivalent to that he could expect in the community.

Restraints, security and escorts

52. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility.
53. We are pleased to note that when Mr Brady went to hospital on 11 February and 30 April, he was not restrained because of the seriousness of his condition. On 30 April, when hospital staff said he had improved, officers applied an escort chain for a ward move. The escort chain remained in place for matter of hours and officers quickly removed it when Mr Brady deteriorated.
54. We are satisfied that managers at Wakefield appropriately considered Mr Brady's medical condition in determining the use of restraints and that their decisions were well judged.

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