Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Barry James a prisoner at HMP Wakefield on 2 June 2016

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141

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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Barry James died in hospital on 2 June of a perforated ulcer in his oesophagus while a prisoner at HMP Wakefield. Mr James was 64 years old. I offer my condolences to Mr James' family and friends.

We are not satisfied that Mr James received a standard of care at the prison equivalent to that he could have expected to receive in the community. Healthcare staff did not take adequate steps to address his nutritional needs and there was little evidence of any ongoing assessment or a robust plan to monitor him. There were occasions when he did not take or even collect his medication and there is no evidence that staff probed the reasons for this. When Mr James collapsed at the prison and was unresponsive, healthcare staff did not follow the expected procedures for medical emergencies.

It is disappointing that, despite Mr James' poor condition, staff used restraints for his last journey to hospital and managers did not complete a risk assessment before taking this decision. This is not the first time we have had to remind Wakefield of the legal position and the Prison Service guidance on restraints. When Mr James' condition deteriorated, prison staff could not easily locate the details of his next of kin so his family were not informed of his death until the following day.

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

Richard Pickering
Deputy Prisons and Probation Ombudsman **January 2017**

Contents

Summary 1
The Investigation Process 3
Background Information 4
Findings 8

Summary

Events

1. Mr Barry James was sentenced in 1993 to life imprisonment for sexual offences. He arrived at HMP Wakefield in June 2006 and a nurse noted he had a number of chronic medical conditions including a history of 'Barrett's Oesophagus' (inflammation and narrowing).

2. In March 2016, Mr James complained of chest pain and vomiting blood and the hospital admitted him as an inpatient. Hospital staff noted he had a stricture in his oesophagus and other issues which needed investigation but the stricture meant doctors could not explore the problems straight away.

3. The hospital admitted Mr James again on 7 April when, once again, he began vomiting blood. He was discharged with a diagnosis of severe oesophagitis (inflammation of the oesophagus lining which sometimes includes ulcers). He returned to the prison's healthcare centre's inpatient unit he was considered fit enough to return to his wing on 14 April. By 2 May, wing officers were concerned that Mr James was not eating. Healthcare staff admitted him again on 5 May and, the next day, a nurse assessed him for malnutrition. The assessment indicated he was at a medium risk of malnutrition and staff should observe him for three days to assess his nutritional requirements.

4. Mr James' weight increased and the healthcare unit discharged him back to the wing on 16 May. However, it seems there was little continued input into his nutritional care and his condition had deteriorated significantly by 30 May. He told nurses that he had difficulty swallowing but he had been drinking. On 31 May, officers found him unwell in his cell at 3.50pm and asked healthcare staff to examine him.

5. At 5.15pm, while healthcare support workers were helping him to dress so that he could again be admitted to the inpatient unit, he became unresponsive and they asked the emergency response nurse to attend. There are differing accounts of who asked for the ambulance - officers (when Mr James' first collapsed) or the emergency response nurse, but there is no evidence that anyone used an emergency code. The control room called for an ambulance at 5.19pm. Paramedics arrived and took Mr James to hospital at 6.02pm. Initially, staff used an escort chain to restrain him but managers authorised them to remove it the next day at 9.00am when Mr James' organs started to fail. He died at 2.30am on 2 June.

Findings

6. The clinical reviewer was concerned that staff did not manage Mr James' condition using structured plans, or appropriately monitor or review him – and also that some record keeping was poor. She also felt that staff missed signs of malnutrition and did not involve specialist services, such as dieticians in his management. Mr James missed collecting or taking his medication several times but staff did not explore the reasons for this and there is no evidence that staff explained the consequences to him.

7. Mr James collapsed in his cell on 31 May. Healthcare support workers who were assisting him at the time radioed for the emergency response nurse to assess him. There are conflicting accounts of who requested an ambulance and it is clear that no one used an emergency code, contrary to the prison's protocols.

8. Mr James was restrained using an escort chain when he was taken to hospital. Staff removed Mr James' restraints when his condition deteriorated, but there is no evidence that managers conducted a risk assessment before they decided to use an escort chain. We are therefore not satisfied that the use of restraints was justified.

9. When his condition deteriorated on 1 June, prison staff could not easily locate Mr James' next of kin details which delayed the family being informed of his death.

Recommendations

- The Head of Healthcare should ensure that healthcare staff develop, review and monitor management plans for prisoners with chronic medical conditions, in line with NICE guidelines and that records are fully completed.
- The Head of Healthcare should ensure staff know how to recognise the signs of malnutrition and involve specialist services where necessary.
- The Head of Healthcare should ensure staff explore why prisoners do not collect or take their medication, advise them of the potential consequences and record that they have done so.
- The Governor and the Head of Healthcare should ensure all staff are familiar with the medical emergency codes and use them appropriately.
- The Governor should ensure that managers understand the legal position and follow Prison Service guidance when authorising restraints for prisoners taken to hospital and that risk assessments are based on the actual risk the prisoner presents at the time.
- The Governor should ensure that next of kin records are up to date and stored centrally so that in an emergency staff can easily locate them.

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 James' prison and medical records.

12. NHS England commissioned a clinical reviewer to review Mr James' clinical care at the prison.

13. We informed HM Coroner for the County of 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. One of the Ombudsman's family liaison officers contacted Mr James' daughter, to explain the investigation. She did not raise any issues for the investigation to consider.

15. Mr James' family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

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

Background Information

HMP Wakefield

17. HMP Wakefield is one of eight high security prisons in England and Wales. It holds up to 750 men. There are four main residential wings, a healthcare centre, a segregation unit and a close supervision centre (a small therapeutic centre aiming to provide a supportive, safe, structured and consistent environment for some of the most challenging offenders).

18. Care UK took over all healthcare provision at Wakefield on 1 April 2016. Prior to this 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 for prisoners with physical health problems. There is a dedicated palliative care suite in the healthcare unit.

HM Inspectorate of Prisons

19. 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

20. 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 2016, the IMB noted the importance of healthcare because the prison had a large number of older prisoners which had continued to rise. The IMB considered that the quality of care and treatment was very high, although there were concerns about the number of staff vacancies in primary care.

Previous deaths at HMP Wakefield

21. Mr James was the twelfth prisoner to die from natural causes at Wakefield since April 2015. There have been three subsequent deaths. We have raised issues about restraints and family liaison before.

Key Events

22. On 29 June 1993, Mr Barry James was sentenced to life imprisonment with a tariff of 12 years for sexual offences and sent to HMP Brixton. Ashworth Secure Psychiatric Hospital admitted him in 1994 and Broadmoor in 2002. He was transferred to HMP Wakefield in June 2006.

23. Mr James had multiple medical conditions including asthma, diabetes, epilepsy and poor mobility. He also had a history of Barrett's Oesophagus (a chronic condition where acid and bile cause inflammation which can narrow the oesophagus). During the last 12 months of his life he had regular contact with Wakefield's healthcare team. He was at times difficult to manage, refusing to comply with medical instructions and his own self care.

24. On 9 March 2016, a healthcare worker saw Mr James who complained of chest pain and vomiting blood. The hospital admitted him and discharged him on 11 March with a diagnosis of urinary retention and a catheter in place. Mr James had not vomited again while in hospital but staff there noted that he had an oesophageal stricture and planned to examine his oesophagus in the near future.

25. On 7 April, a member of healthcare staff removed Mr James' catheter to see if he could manage without it. Mr James had also started to vomit blood again and had stopped taking his gastric medication for two weeks in protest that the hospital had postponed their plan to look at his oesophagus. They had delayed it because his oesophagus still had a stricture making investigation impossible. That evening, Mr James was admitted to hospital again after a prison GP thought that the vomiting of blood might be due to internal bleeding.

26. The hospital discharged Mr James on 11 April with a diagnosis of severe oesophagitis, antibiotics and instructions to give him a soft diet. Hospital staff had also re-catheterised him. He went straight to Wakefield's healthcare centre where staff cared for him until 14 April. Nurses felt he could manage on a residential wing. They planned to monitor his food intake and encouraged him to keep a food diary. On 19 April, the prison GP told nurses to inform him of any deterioration in Mr James' condition.

27. On 2 May, a wing officer asked a nurse to see Mr James in his cell as the officer was concerned Mr James had not been eating his meals. Mr James was unable to tell her when he had last eaten but said he had not drunk anything that day. The urine in his catheter was concentrated and he weighed just over eight stone (although this was probably a mistake given his recorded weight three days later was over nine). Although he agreed to be admitted to healthcare at the time, he changed his mind later in the day.

28. Healthcare staff visited Mr James over the next few days and found him in a confused and neglected state, in filthy conditions with uneaten food lying around. He agreed to be admitted to healthcare on 5 May.

29. On 6 May, a nurse opened a 'maintaining weight and general health care plan'. The care plan included three interventions – to check Mr James' weight, complete a Malnutrition Universal Screening Tool (MUST) and encourage Mr James to eat an adequate diet and take nutritional supplements. She had

weighed Mr James the day before and he was nine stone and one pound and his body mass index (BMI) 17.8. A healthy BMI is 18.5 and anything lower is considered underweight.

30. Mr James missed a gastroscopy appointment on 9 May because he refused to fast for the required 6 hours before the procedure. The hospital made a new appointment for 6 June.

31. On 10 May, a nurse completed the MUST. The MUST is a five step screening tool which aims to identify adults at risk of malnutrition or obesity and includes management guidelines which staff can use to develop care plans. She weighed Mr James again (he was ten stone and one pound), and noted he had put on a considerable amount of weight in just a few days. His MUST score was 'one' – scores range from zero to two and denote the level of risk of malnutrition. A risk of one indicates that an individual is at medium risk and staff should observe their dietary intake for three days. If their intake is inadequate, goals should be set to improve and increase overall nutritional intake and staff should monitor the individual and review care plans regularly.

32. By 16 May, Mr James' weight had increased to ten stone four pounds and his BMI was 20.2, although no one had recorded his actual weight 'goal' in the medical record. He seemed much better so staff discharged him from the healthcare unit.

33. On 25 May, Mr James did not attend the hatch for his medication and no one documented or appeared to explore the reasons why. (There are other instances of this and on some occasions he clearly refused to attend when he was reminded to do so.)

34. On 30 May a nurse visited Mr James in his cell as wing officers were again concerned he was not eating. There were plates of food in his room and Mr James also told her that he had not been eating due to problems swallowing but he had been drinking. He was alert and fully able to communicate so she agreed someone would check on him the next day. She then made a further request for a soft diet.

35. On 31 May, at approximately 3.50pm, two officers went to Mr James' cell to carry out a routine cell search. Mr James was naked on his bed and there was blood and phlegm in a bowl on the floor. Mr James mumbled at the officers and waved them away. The officers told the wing manager and a senior officer of their concern that Mr James was not very well and one of them called the Matron.

36. At approximately 5.15pm, healthcare support workers went to prepare Mr James for admission to healthcare. As they were dressing him he became unresponsive. One of them radioed for the emergency response nurse to attend but did not use a medical emergency code. According to an officer, at this point an ambulance was requested but it is not clear who did this.

37. The emergency response nurse went straight to Mr James' cell with emergency equipment, including a defibrillator. Another nurse also attended. When she got to Mr James' cell, the emergency response nurse saw that he was cyanosed,

unresponsive and cold. She also asked for an ambulance. Staff in the control room called for an ambulance at 5.19pm.

38. In the meantime, healthcare staff moved Mr James onto the landing so they had more space to treat him. Mr James resisted attempts to help him, lashing out and pulling off an oxygen mask. Paramedics arrived at the scene at 5.43pm and when his condition improved took him to hospital at 6.20pm. Escort staff used an escort chain which was removed at 9.00am the next day.

39. Mr James continued to deteriorate, suffered a collapsed lung and a hospital doctor pronounced him dead at 2.30am on 2 June 2016.

Contact with James' family

40. Mr James did not have a named next of kin on his prison record. After extensive searches, the police informed Mr James' daughter of his death on 3 June.

41. The prison's family liaison role was taken over by one officer and subsequently another officer. Once Mr James' daughter had been informed of his death they offered the family support with arrangements and other practical matters. Mr James's funeral was on 16 August and the Governor and a prison manager attended. The prison contributed to the costs, in line with national policy.

Support for prisoners and staff

42. After Mr James' death, the duty governor debriefed the escort staff at the hospital to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

43. The prison posted notices informing other prisoners of Mr James' death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case Mr James' death had adversely affected them.

Post-mortem report

44. The coroner provided a copy of the post-mortem report. Mr James died of 1) perforated oesophageal ulcer and 2) acute pyelonephritis.

Findings

Mr James' clinical care

45. The clinical reviewer noted that the healthcare team at Wakefield tried to engage with Mr James and encourage him to manage his various health needs, but he was often resistant to this. However, she felt that the team neglected some aspects of his care and that overall the care he received was not of a standard he could have expected in the community.

46. Although a 'MUST' was completed and Mr James' weight increased once he was discharged back to the wing on 16 May, there was a distinct lack of follow-up care. We note and have raised with the prison concerns around the reliability of the recording of Mr James' weight. These concerns have been addressed separately. No care plans or management plans were implemented specifically to address the outcome of the 'MUST' screening. The single care plan in place at the time of Mr James' death had not been completed for 21 days before he went into hospital. Where an individual is considered to be at risk of malnutrition, NICE guidelines recommend the person is screened weekly and the use of other types of nutrition considered. Healthcare staff did not screen him weekly although he was prescribed nutritional supplements.

47. However, there is little evidence that staff encouraged Mr James to take the nutritional supplements prescribed and although a soft diet was arranged, he often did not collect it or officers found the food rotting in his cell. Officers mostly alerted healthcare staff to these incidents. Healthcare staff had given Mr James a food diary but no one reviewed it, discussed it with him or referred him to a dietician. The clinical reviewer also feels that signs of malnutrition were missed and, if staff had noticed, specialist services such as a dietician could have been involved in his care.

48. Mr James was not in possession of his own medication and he did not always collect or take it. Instances of this are documented on 30 March, 5 May, 6 May and 25 May but there is no evidence that healthcare staff addressed this or considered whether he had problems actually swallowing the medication. We make the following recommendations:

    The Head of Healthcare should ensure that healthcare staff develop, review and monitor management plans for prisoners with chronic medical conditions, in line with NICE guidelines and that records are fully completed.

    The Head of Healthcare should ensure staff know how to recognise the signs of malnutrition and involve specialist services where necessary.

    The Head of Healthcare should ensure staff explore the reasons why a prisoner has repeatedly failed to collect or take their medication, advise them of the potential consequences and record that they have done so.

Emergency response

49. On 31 May, when Mr James became unresponsive, the healthcare support worker said she radioed for the emergency response nurse but we note she did not use a code. The prison has in place an emergency protocol which says that staff should use a code one or a code blue where the issue is, broadly, a breathing problem. On hearing the code, healthcare staff should attend the scene with appropriate equipment and staff in the control room should immediately call an ambulance. 'Code 2' is used for situations where there is, generally, excessive bleeding.

50. The emergency response nurse said that when she arrived she also requested an ambulance. There is no evidence that she used a code either. We feel the healthcare support workers should have used a code at the point Mr James became unresponsive. We make the following recommendation:

The Governor and the Head of Healthcare should ensure all staff are familiar with the medical emergency codes and use them appropriately.

Restraints

51. 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.

52. Mr James was taken to hospital as an emergency on 31 May and restrained by an escort chain. An escort chain is a long chain with handcuffs at either end, one attached to an officer and the other to the prisoner. However, the prison were unable to provide a risk assessment for that journey. On the morning of 1 June, hospital staff told the escort officers that Mr James' organs were failing and an officer informed the duty governor. A risk assessment was completed, which assessed Mr James as a high risk to the public, medium risk to hospital staff and escape and a low risk of receiving outside assistance. However, the duty governor noted that due to Mr James' deteriorating health it was not appropriate to use cuffs so he authorised removal of the restraints and they were removed at 9.00am that morning.

53. While we are pleased that the escort officer reported the decline in Mr James' condition and prison staff quickly took the decision to remove restraints, had healthcare and prison staff fully assessed his risk at the time he was taken to hospital, he might not have been restrained at all. We make the following recommendation:

The Governor should ensure that managers understand the legal position and follow Prison Service guidance when authorising restraints for prisoners taken to hospital and that risk assessments are based on the actual risk the prisoner presents at the time.

Contact with Mr James' family

54. On 1 June, when it became obvious Mr James might not recover from his illness, an officer extensively checked his prison records and contacted the Probation Service for help tracing his family but they could not find any details. Prison records were re-checked and details of family members, including his wife and a daughter, listed as his next of kin, were found but were incomplete.

55. Mr James died in the early hours of 2 June. On 3 June, after resolving conflicting information about family issues, the police confirmed they had visited Mr James' next of kin and delivered the news of his death.

56. While we are pleased that efforts to trace Mr James' family started as soon as the prison realised how ill he was and we are satisfied that, in the circumstances, it was appropriate that the police broke the news, it is clear that the next of kin records were not up to date and information was not centrally stored. Prison staff and the police therefore spent a lot of time trying to locate his family.

The Governor should ensure that next of kin records are up to date and stored centrally so that in an emergency staff can easily locate them.

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