Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Antoni Imiela a prisoner at HMP Wakefield on 8 March 2018

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 Antoni Imiela died on 8 March 2018 of cardiomyopathy (disease of the heart muscle) at HMP Wakefield. He was 63 years old. I offer my condolences to Mr Imiela's family and friends.

The investigation found that Mr Imiela received a good standard of clinical care at the prison, equivalent to that which he could have expected to receive in the community.

I am concerned that when Mr Imiela was found unconscious on his cell floor, staff failed to call a medical emergency code. This meant there was a short delay in calling an ambulance. While the delay did not affect the outcome for Mr Imiela, it is important that staff follow the correct medical emergency procedures.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **October 2018**

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Summary

Events

1. Mr Antoni Imiela was serving a life sentence for sexual offences and had been at HMP Wakefield since February 2012. He was obese, had high blood pressure and was assessed as being at risk of developing cardiovascular disease. He had also been diagnosed with hepatitis C (a virus that can infect and damage the liver) in 2008 for which he declined treatment until September 2016.

2. In December 2017, tests showed that Mr Imiela had symptoms of heart disease. On 2 March 2018, the results of an electrocardiogram (ECG - a test that checks the heart's rhythm) indicated that Mr Imiela had severe heart failure. A prison GP made a referral to a cardiologist (heart specialist).

3. On 7 March, a cardiologist examined Mr Imiela. He arranged further investigations and prescribed Mr Imiela medication for heart disease.

4. At approximately 9.53am on 8 March, an officer found Mr Imiela unconscious on the floor of his cell. He called for assistance and shortly afterwards another officer arrived, who radioed a code blue (which indicates that a prisoner is unconscious or not breathing). The control room immediately called an ambulance.

5. Paramedics arrived at 10.15am and took control of Mr Imiela's care. At 10.55am, the ambulance took Mr Imiela to hospital. His condition continued to deteriorate and he died at 11.25am.

6. The post-mortem examination showed that Mr Imiela died from cirrhotic cardiomyopathy (disease of the heart muscle found in patients with liver cirrhosis (scarring of the liver)).

Findings

7. The clinical reviewer concluded that Mr Imiela received a good standard of clinical care at Wakefield. Prison GPs monitored his risk of developing cardiovascular disease, prescribed appropriate medication and referred him to a specialist when his condition deteriorated.

8. The officer who found Mr Imiela unconscious in his cell did not radio a medical emergency code as he should have done, which caused a short delay in calling an ambulance. While we are satisfied that the delay in calling an ambulance did not affect the outcome for Mr Imiela, it is important that staff use the correct medical emergency procedures to ensure that healthcare staff are alerted and an ambulance is called immediately.

Recommendations

- The Governor should ensure that all prison staff understand their responsibilities during medical emergencies. Staff should use an emergency code immediately when there are serious concerns about the health of a prisoner, so that there is no delay in calling an ambulance.

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 obtained copies of relevant extracts from Mr Imiela's prison and medical records. Our investigation was suspended between 9 April and 9 July 2018 while we awaited the cause of death.

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

12. We informed HM Coroner for West Yorkshire Eastern District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

13. The investigator wrote to Mr Imiela's son to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond to our letter.

14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Wakefield

15. HMP Wakefield is a high security prison and holds up to 750 men. There are four main residential wings, a healthcare centre, a segregation unit and a close supervision centre (a small unit aiming to provide a supportive, safe, structured and consistent environment for some of the most challenging offenders).

16. 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, which provides overnight and weekend care for prisoners with physical health problems.

HM Inspectorate of Prisons

17. 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

18. 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 30 April 2017, the IMB reported that they were confident that the general level of medical care given in the prison was very satisfactory. However, the ageing nature of its population meant that one of the greatest challenges facing HMP Wakefield was providing appropriate care and living conditions for its elderly prisoners, and in particular for the increasing number of prisoners over the age of 55. Both physical and social care assessments were required, but had not yet been undertaken for each prisoner. This process had been started by the healthcare services and would also require continued funding and support from the local authority.

Previous deaths at HMP Wakefield

19. Mr Imiela was the 19th prisoner at Wakefield to die since March 2015. All were from natural causes. There have been two natural causes deaths since. Our investigation into one of those deaths found that staff did not use a medical emergency code as they should have done.

Key Events

20. On 7 December 2002, Mr Antoni Imiela was remanded to custody for sexual offences and sent to HMP Wakefield. On 4 March 2004, he was sentenced to life in prison. On 31 May 2011, Mr Imiela was moved to HMP Belmarsh before being returned to Wakefield on 27 February 2012.

21. A nurse completed Mr Imiela's reception health screen when he arrived at Wakefield and noted that in 2008 he tested positive for the hepatitis C virus (an infectious disease which primarily affects the liver), but had refused treatment. (Mr Imiela continued to decline treatment for hepatitis C until September 2016, when he received treatment which was effective.) He also had arthritis in both knees and had stopped smoking in 2004.

22. Mr Imiela was obese (108kgs) and prison GPs advised him about healthy eating and exercise. In August 2014, Mr Imiela had a cardiovascular risk assessment (QRISK2- a prediction algorithm used to predict a patient's risk of developing cardiovascular disease). A nurse recorded Mr Imiela's risk as 11.43% (a score of 10% or more indicates a need for intervention to lower the risk) and made a referral to the weight loss clinic. The weight loss clinic gave Mr Imiela advice about healthy eating.

23. On 23 January 2015, a prison GP examined Mr Imiela, who complained of shortness of breath, chest tightness and swollen ankles. The GP recorded Mr Imiela's blood pressure as 159/99 (raised) and his QRISK2 score as 20.87%. The results of an electrocardiogram (ECG - a test to check the heart's rhythm) were normal. He arranged a full set of blood tests which revealed a slightly raised cholesterol level and elevated liver enzymes (caused by inflamed or injured liver cells).

24. On 23 February, a nurse recorded Mr Imiela's QRISK2 score as 13.51% and his blood pressure as 140/90 (normal). There was no evidence that healthcare staff recorded Mr Imiela's blood pressure again until October.

25. On 2 October, a prison GP examined Mr Imiela, who complained of difficulty when urinating. Mr Imiela had a urine test with normal results. The GP recorded Mr Imiela's blood pressure as 150/91 (high) and prescribed him ramipril (to treat high blood pressure). He arranged for nurses to record Mr Imiela's blood pressure weekly. He saw Mr Imiela on 17 November and noted that his blood pressure had improved.

26. Prisons GPs continued to prescribe Mr Imiela ramipril during 2016 and his blood pressure remained slightly raised. Mr Imiela continued to attend the gym and told nurses he followed a healthy diet. His weight remained at 108kgs.

27. On 4 January 2017, a prison GP reviewed Mr Imiela's blood pressure and medication. She recorded Mr Imiela's blood pressure as 154/99 (high) and increased his ramipril dosage. Mr Imiela's blood pressure remained high and he declined continuous blood pressure monitoring.

28. On 8 February, Mr Imiela complained of a dry cough. A prison GP noted that this can be a side effect of ramipril and changed Mr Imiela's blood pressure medication to losartan.

29. Mr Imiela's cough did not improve and on 11 April, a prison GP made a referral for a chest X-ray. The GP noted that Mr Imiela snored excessively and often woke with a dry mouth. On 18 May, he noted that the results of the chest X-ray were normal and diagnosed Mr Imiela with obstructive sleep apnoea (a condition where the walls of the throat relax and narrow during sleep, interrupting normal breathing. Poorly controlled sleep apnoea may increase the risk of developing high blood pressure and having a stroke or heart attack). Mr Imiela declined to wear a continuous positive airway pressure machine (CPAP- this prevents the airway closing by delivering a continuous supply of compressed air through a mask) at night to reduce his symptoms.

30. On 21 September, a prison GP saw Mr Imiela to discuss his continued symptoms of breathlessness. He recorded Mr Imiela's weight as 115kgs and noted that he had noisy breathing at night and fatigue during the day. He made a referral to a respiratory specialist from the hospital.

31. On 1 November, the respiratory specialist examined Mr Imiela in prison and arranged an overnight oximetry test to record his sleep, breathing pattern, oxygen levels and heart rate. On 13 December, he told Mr Imiela he had sleep apnoea.

32. On 28 December, a prison GP admitted Mr Imiela to the prison's inpatients unit for observation. Investigations indicated that Mr Imiela had fluid in his lungs and swelling in both legs. The GP prescribed a diuretic. The results of a B-type natriuretic peptide test (a test which measures the level of proteins in the blood) indicated that Mr Imiela had symptoms of heart failure.

33. On 3 January, Mr Imiela agreed to start CPAP therapy and he returned to the wing on 8 January. On 23 January, the results of a chest X-ray showed a pleural effusion (excess fluid) around Mr Imiela's right lung. A prison GP made an urgent referral to a respiratory specialist under the NHS pathway that requires patients with suspected cancer to be seen by a specialist within two weeks.

34. On 31 January, the respiratory specialist examined Mr Imiela and noted that test results showed he had heart failure. He made a referral for an urgent CT scan. This took place on 21 February and showed abnormalities in Mr Imiela's right lung. He arranged a repeat CT scan in six weeks.

35. On 2 March, Mr Imiela had an ECG. The results indicated severe heart failure and the respiratory specialist made a referral to a cardiologist (heart specialist).

36. On 7 March, the cardiologist examined Mr Imiela in prison. He noted that Mr Imiela would need an MRI scan in the next few months and encouraged him to use his CPAP machine. He prescribed bisoprolol for heart disease.

Events of 8 March

37. At approximately 9.53am, an officer found Mr Imiela collapsed and unconscious on his cell floor. He radioed for assistance from healthcare and prison staff. At 9.55am, another officer attended and radioed an emergency code blue (which indicates a prisoner has breathing difficulties or is unconscious). The control room immediately called an ambulance. An officer and a governor arrived and started cardiopulmonary resuscitation (CPR).

38. At 9.57am, three nurses arrived and continued with CPR and advanced lifesaving procedures. The paramedics arrived at 10.15am and took over Mr Imiela's care. At 10.55pm, Mr Imiela was taken from Wakefield to hospital. Two officers accompanied Mr Imiela and did not use restraints. His condition continued to deteriorate and he died at 11.25am.

Contact with Mr Imiela's family

39. An officer acted as the prison's family liaison officer (FLO). When he arrived at Wakefield in February 2012, Mr Imiela refused to provide next of kin details. Investigations found that Mr Imiela had contact with his son and the police provided his address.

40. Due to potential media interest in Mr Imiela's case and because Mr Imiela's son lived a considerable distance from the prison, the FLO was concerned that Mr Imiela's son would find out about his death before a prison FLO could visit him.

41. The FLO asked the local police to inform him of Mr Imiela's death. At 4.30pm, a police officer visited Mr Imiela's son and told him Mr Imiela had died. The police officer also passed on the FLO's contact details.

42. At 1pm on 9 March, the FLO spoke to Mr Imiela's son on the telephone and offered condolences and support. She remained in contact with Mr Imiela's son until Mr Imiela's funeral on 14 April. The prison contributed to the costs in line with national instructions.

Support for prisoners and staff

43. After Mr Imiela's death, a prison 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.

44. The prison posted notices informing other prisoners of Mr Imiela's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Imiela's death.

Post-mortem report

45. The post mortem found that Mr Imiela died from cirrhotic cardiomyopathy, disease of the heart muscle found in patients with liver cirrhosis (scarring of the liver).

Findings

Clinical care

46. Prison GPs completed a cardiovascular risk assessment for Mr Imiela and encouraged him to change his diet and to exercise regularly to reduce his risk of developing cardiovascular disease.

47. When Mr Imiela reported breathlessness, prison GPs undertook appropriate tests and referred him to hospital specialists when necessary. When tests showed that Mr Imiela had severe heart failure, prison GPs referred him to a cardiologist, whose care he was under when he died.

48. The clinical reviewer considered that Mr Imiela received a good standard of care at Wakefield which was equivalent to that which he could have expected to receive in the community.

Emergency response

49. Prison Service Instruction (PSI) 03/2013 on medical emergency response codes requires that a code blue is called if a prisoner has breathing difficulties or is unconscious so that an ambulance is called immediately. When the officer found Mr Imiela collapsed and unconscious in his cell, he radioed for assistance and called the custodial manager but should also have called a medical emergency code blue. We would have expected the officer to use the appropriate emergency code to ensure that the control room immediately called an ambulance.

50. The clinical reviewer commented that the short delay in calling an ambulance did not affect the outcome for Mr Imiela. However, in all medical emergencies it is imperative that the correct procedures are followed. We make the following recommendation:

    The Governor should ensure that all prison staff understand their responsibilities during medical emergencies. Staff should use an emergency code immediately when there are serious concerns about the health of a prisoner, so that there is no delay in calling an ambulance.

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