Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Rapson a prisoner at HMP Wakefield on 23 August 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*

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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 Rapson died on 23 August 2016 of an abdominal aortic aneurysm at HMP Wakefield. Mr Rapson was 66 years old. I offer my condolences to Mr Rapson's family and friends.

Mr Rapson's health care needs were difficult to manage as he often refused treatment for various ailments and, unfortunately, this meant the opportunity for him to be screened for an aortic aneurysm was missed. The night before he was found dead, he was seen by a nurse who took no clinical observations. Although it would not have made a difference for Mr Rapson, it is disappointing that, during the emergency response it was evident that staff did not know an emergency code blue should provoke an instant ambulance request. This is an issue I have raised with Wakefield in the past and do so again.

I am concerned that Mr Rapson's family found the distressing process of dealing with their loss compounded by what they felt to be unsympathetic treatment. Elements of the prison's family liaison could have been more effective and helpful.

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 **March 2017**

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Summary

Events

1. On 21 September 1995, Mr John Rapson was sentenced to nine years imprisonment for sexual offences and was sent to HMP Preston. He was already on a life licence for murder when he was convicted of these offences. On 1 December 1995, he was transferred to HMP Wakefield. Mr Rapson had a number of respiratory and circulatory complaints which staff tried to manage. He frequently refused treatment, including NHS screening for Abdominal Aortic Aneurysms. (AAA - a swelling in the main blood vessel that leads away from the heart, through the abdomen to the rest of the body, which can be fatal if not treated. Screening is offered to those 65 years old and over.)

2. On 22 August 2016, at 9.51pm, a nurse saw Mr Rapson in his cell. Mr Rapson complained of constipation, vomiting and feeling something in his back 'pop'. The nurse did not use any medical equipment or take any observations. He prescribed paracetamol and advised Mr Rapson to stay hydrated. Mr Rapson did not ring his cell bell again, and staff did not check him again that night.

3. On 23 August, at 5.45am an officer was doing the roll count when she noticed Mr Rapson lying on the floor of his cell. He did not respond when she shouted. She went into the cell, a nearby colleague heard her shouting, and also entered the cell. The senior officer radioed an emergency code.

4. A prison manager and a nurse attended immediately. The prison manager asked the control room to call an ambulance which they did straight away at 5.48am. The nurse and officers considered that Mr Rapson had already died because his limbs were stiff and he was a waxen colour, so they did not attempt to resuscitate him. Paramedics arrived, agreed resuscitation was futile and pronounced Mr Rapson dead at 6.10am.

Findings

5. Care in respect of Mr Rapson's long-term conditions and invitations for AAA screening was good. However, on 22 August, the nurse did not take an equipment bag with him when he went to assess Mr Rapson or take any clinical observations. He did not check on him again that night, nor did he ask wing staff to do so.

6. Staff in the control room did not call an ambulance immediately when a code blue was called, and a prison manager specifically asked them to do so. Neither the manager nor control room staff appeared to realise that control room staff should call an ambulance immediately when a code blue is broadcast.

7. The prison made every effort to inform Mr Rapson's family of his death in person. It is unfortunate that, because the family were away, they were informed of Mr Rapson's death by telephone, with some confusion created by asking HMP Haverigg to facilitate the initial contact. Family liaison lacked continuity and the family were not offered a prison visit. They also found it difficult to contact the prison family liaison officer and they felt interactions with the prison were sometimes insensitive.

Recommendations

- The Head of Healthcare should ensure that staff arrange to review prisoners they have visited during the night.
- The Head of Healthcare should ensure staff take an equipment bag with them when called out to see prisoners and take clinical observations, including an ECG where appropriate.
- The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and ensures the control room calls an ambulance immediately when an emergency code is used.
- The Governor should ensure that there is continuity when a family liaison officer is assigned, that they are easy to contact, make reasonable enquiries where families request information and are sensitive in their dealings with them.

The Investigation Process

8. 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. Two people made contact.

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

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

11. 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.

12. One of the Ombudsman's family liaison officers contacted Mr Rapson's sister, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She raised the following matters and others which have been addressed by separate correspondence.

    - Had Mr Rapson been scanned for an AAA?
    - Was the response to his call for assistance on the night of 22 August adequate?
    - Family liaison was not always helpful or appropriate – it was insensitive and disjointed, and she felt that full support was not offered.

13. Mr Rapson's sister received a copy of the initial report. She pointed out some omissions. This report has been amended accordingly.

14. When we finalised our report, HMPPS had not provided details of any factual inaccuracies or an action plan addressing our recommendations. They have since provided both and we have made minor amendments to this report. A copy of their action plan is also attached.

Background Information

HMP Wakefield

15. 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 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. There is a dedicated palliative care suite in the healthcare unit.

HM Inspectorate of Prisons

17. 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

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 April 2016, the IMB reported that Wakefield provided an enormous amount of health and social care provision and, when visiting the different units, the Board continued to be impressed by the professionalism of the staff. While, they felt unfilled staff vacancies must eventually have an impact on patient care and outcomes, weekly visits to the healthcare departments demonstrated that the care and treatment of prisoners was of a very high quality.

Previous deaths at HMP Wakefield

19. Mr Rapson was the fourteenth prisoner to die from natural causes at Wakefield since January 2015. One prisoner has died from natural causes since. We have raised concerns about emergency response and family liaison before.

Key Events

20. On 21 September 1995, Mr John Rapson was sentenced to nine years imprisonment for sexual offences and was sent to HMP Preston. He was already on a life licence for murder when he was convicted of these offences. On 1 December 1995, he was transferred to HMP Wakefield.

21. Mr Rapson had a number of conditions including COPD (chronic obstructive pulmonary disease – lung disease) and, in 2009, had had a heart attack. He also had pernicious anaemia (a vitamin deficiency which affects red blood cell production in the stomach) and high blood pressure. He was on a number of medications to treat these conditions but often refused treatment and sometimes even to sign treatment refusal forms (although there are also a number of signed treatment refusal forms on file).

22. An Abdominal Aortic Aneurysms (AAA) is a swelling in the main blood vessel that leads away from the heart, through the abdomen to the rest of the body. AAAs can burst and lead to internal bleeding, which is usually fatal. If detected, they can be treated through monitoring or surgery. Screening is offered to those 65 years old and over. There is an undated form in Mr Rapson’s records offering him AAA screening printed on 30 April 2015 (Mr Rapson was 65 on 22 May 2015). It has the word 'declined' written across it, but there is no treatment refusal form signed by Mr Rapson. On 20 October 2015, it was noted that Mr Rapson had declined the opportunity of an AAA screening.

23. At 9.51pm on 22 August 2016, Mr Rapson pressed his cell bell. An officer attended and Mr Rapson told her he had vomited twice and his back hurt (he said he had felt something 'pop'). She called the healthcare department and a nurse attended immediately. He did not bring any equipment with him.

24. Mr Rapson told the nurse he had not opened his bowels for 1-2 days, had vomited some clear fluid that night, felt something in his back pop and was in increased pain afterwards. The nurse examined Mr Rapson but found no concerns. Mr Rapson told the nurse he had sciatica. He gave Mr Rapson some paracetamol for the pain and told him to keep hydrated.

25. At 5.45am on 23 August, the officer was doing her roll check (a count of all prisoners in their cells). When she got to Mr Rapson's cell, she saw he was on the floor of his cell. She shouted but he did not respond. A Senior Officer (SO) was nearby, heard the officer shouting and went into the cell with her. She immediately called an emergency code blue on her radio. An emergency code blue indicates a prisoner is unconscious, not breathing or is having breathing difficulties.

26. A Custodial Manager (CM) and a nurse responded to the code blue, and went into the cell. The CM asked the control room to call an ambulance, which they did at 5.49am. The nurse noted that Mr Rapson was waxen in colour and rigor mortis had set in. He and the officers agreed that resuscitation would be futile as there were clear signs of death. Paramedics arrived and pronounced Mr Rapson dead at 6.10am.

Contact with Mr Rapson's family

27. The prison appointed a family liaison officer on the morning of 23 August. At 7.55am (shortly after he came on duty) he collected the details of Mr Rapson's contacts, identified Mr Rapson had frequent contact with his sister, and noted a landline telephone number. A prison manager told the officer she had been in touch with HMP Haverigg and asked them to break the news in person to Mr Rapson's sister, as Haverigg was local to her and they would be able to attend more quickly.

28. Two officers from Haverigg went to Mr Rapson's sister's house to break the news of his death. No one was in, and a neighbour told them that they were away for nine weeks. They obtained a number for Mr Rapson's sister's husband, and reported all this to HMP Wakefield at 1.00pm. A prison manager and a different family liaison officer at HMP Wakefield decided with the duty governor that it was appropriate to telephone Mr Rapson's sister to inform her of his death.

29. However, before this could happen, one of the Haverigg officers spoke to Mr Rapson's sister using the number she had for her husband. She asked Mr Rapson's sister to contact Wakefield. On being asked why she had called, the officer informed Mr Rapson's sister of her brother's death on her insistence.

30. Mr Rapson's sister requested that the Haverigg officer who had called her continue as the liaison officer, and said that she did not want contact with HMP Wakefield. However, Mr Rapson's sister changed her mind and, on 24 August, contacted the second FLO at Wakefield who told her she would contact Mr Rapson's sister with any important information. Mr Rapson's sister reported that the second Wakefield FLO was 'off-hand' to her.

31. On 1 September, the Haverigg officer contacted another member of the Safer Custody Team in Wakefield. Mr Rapson's sister had been in touch, the day before, to complain because the coroner's officer had told her that the second FLO at Wakefield was now the family liaison officer and no one from Wakefield had told her this.

32. The original Wakefield FLO then contacted Mr Rapson's sister on 2 September, gave her information about the funeral and explained what the next steps were. On 5 September, Mr Rapson's sister called the original Wakefield FLO to tell him the funeral had been arranged for 13 September. He was surprised as he thought he should be arranging the funeral. They discussed some other matters and Mr Rapson's sister confirmed she was happy for items in Mr Rapson's cell to be donated or destroyed, apart from some letters the police had taken.

33. Mr Rapson's funeral was on 13 September and the original Wakefield FLO and the prison Governor attended. Wakefield paid for the funeral in line with national policy.

Support for prisoners and staff

34. After Mr Rapson's death, a CM 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.

35. The prison posted notices informing other prisoners of Mr Rapson'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 Rapson's death.

Cause of death

36. The Coroner concluded that the cause of death was a haemorrhage caused by a ruptured abdominal atheromatous aortic aneurysm.

Findings

Clinical care

37. The clinical reviewer concluded that the care Mr Rapson received for his long-term conditions and for most aspects of his AAA was equivalent to that he could have expected to receive in the community. At times, however, Mr Rapson chose not to attend planned doctors' appointments in Wakefield and external hospital appointments. Records show that staff discussed the importance of attending and the consequences of not doing so with Mr Rapson. Staff recorded that they attempted to understand his reasons for refusing appointments, but that he often would not discuss them or said things such as 'I don't care' or 'I'm playing snooker'. It is unfortunate that had he attended his AAA screening in October 2015, the aneurysm might have been discovered and treatment started.

38. The clinical reviewer concluded that staff should have checked on Mr Rapson again after a nurse attended to him on the evening 22 August. A nurse did not feel that Mr Rapson's presentation was significantly concerning to request that wing staff carry out checks. The Head of Healthcare held a 'Significant Incident Meeting' on 30 August 2016, and the nurse explained that he found Mr Rapson's symptoms in line with his history of sciatica, and this is why he was not concerned. Since the meeting, the Head of Healthcare has asked staff to take clinical observations of prisoners who have vomited or feel generally unwell. She has also asked them to take equipment bags, preferably including an electrocardiogram machine (ECG – to test the electrical activity of the heart) with them to all night call outs. Discussions are also being held regarding the feasibility of prison staff conducting safety checks on prisoners who have been reviewed during the night.

39. We are concerned that the nurse did not take a medical equipment bag with him to the cell, and did take any clinical observations. Mr Rapson did not ring his cell bell on any further occasions during the night but we agree with the clinical reviewer that healthcare staff should have reviewed him later.

    The Head of Healthcare should ensure that staff arrange to review prisoners they have visited during the night.

    The Head of Healthcare should ensure staff take an equipment bag with them when called out to see prisoners and take clinical observations, including an ECG where appropriate.

The emergency response

40. Prison Service Instruction (PSI) 03/2013 requires prisons to have a medical emergency response code protocol, which should ensure that an ambulance is called automatically in a life-threatening medical emergency. The PSI explicitly states that when a medical emergency is called over the radio network, an ambulance must be called immediately and local procedures should ensure this. The PSI notes that it is better to act with caution and request an ambulance that can be cancelled later if it is not needed.

41. When the officer saw that Mr Rapson had collapsed on the floor of his cell, she and the SO immediately entered and the SO called a code blue. They quickly established that it would be pointless to attempt cardio pulmonary resuscitation. When the CM arrived, he immediately requested that staff in the control room call for an ambulance. In fact, staff in the control room should have done this as soon as they heard the 'code blue'. They should not have waited to be specifically told to do so.

42. The prison's Medical Emergency Response Protocol was reissued in February 2015. It clearly states that, where a code blue (also referred to as a code one) or a code red (also referred to as a code two) has been broadcast, staff in the control room should automatically call for an ambulance. The fact that staff in the control room did not call the ambulance immediately and that the CM phoned them specifically to request one, indicates that staff were not aware of the protocol.

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and ensures the control room calls an ambulance immediately when an emergency code is used.

Family liaison

43. We expect prisons to make every effort to break the news of a prisoner’s death to the next of kin face to face. The original Wakefield FLO quickly identified Mr Rapson’s sister as the next of kin and an address and landline number for her. As she lived some distance from the prison, a manager appropriately requested that nearby HMP Haverigg provide someone to break the news face to face.

44. When the Haverigg officers arrived at the address they found out Mr Rapson’s sister was travelling for nine weeks, but found a mobile phone number for her husband. One of the officers used this to speak to Mr Rapson’s sister, first to ask her to call Wakefield, but subsequently to break the news of Mr Rapson’s death. Wakefield had planned to do this. We feel that in the circumstances these actions were appropriate.

45. Mr Rapson’s sister said that when she changed her mind about contact with Wakefield, and contacted the second FLO at Wakefield on 24 August, she was rude to her. She said that the officer said ‘I thought you did not want to be involved’ and did not provide any useful information. One of the Haverigg officers had told her that she would be offered a visit to the prison to see Mr Rapson’s cell and that the prison would discuss funeral arrangements and costs with her. Mr Rapson’s sister said that the officer in Wakefield did not do any of this.

46. The investigator asked the second Wakefield FLO about this incident. She said that she was not rude to Mr Rapson’s sister and that one of the Haverigg officers had told her she had informed Mr Rapson’s sister about the funeral costs. She did not offer a prison visit at that time as she expected the original Wakefield FLO would do this later. Wakefield has not sent the completed family liaison log to the PPO despite it being requested, and there is no evidence that Mr Rapson’s sister was offered a visit to the prison, which should have happened.

47. Mr Rapson's sister said that the Original Wakefield FLO did not seem to know what was in her brother's cell or what the police had taken. She found out subsequently that they had removed some letters. Although we would not expect the officer to know the specifics of Mr Rapson's cell contents off hand, we have not seen any evidence to suggest he tried to find out.

48. Mr Rapson's sister had to call the switchboard every time she wanted to contact the original Wakefield FLO because his duties meant he was not readily contactable. We appreciate that this must have been frustrating.

49. Mr Rapson's sister has told us that a member of staff passed documents to her at his funeral which were stamped 'HMP Wakefield'. She found this insensitive and upsetting.

50. We feel that the initial contact with Mr Rapson's sister was appropriate if a little confused, and that the prison did try to provide reasonable family liaison overall. However, we expect a visit to the prison to be offered. We also expect there to be a record of the contents of the cell. Mr Rapson's sister did not always know who her liaison officer was, understandably felt misinformed, and did not realise that the prison would help her organise the funeral.

The Governor should ensure that there is continuity when a FLO is assigned, that the FLO is easy to contact, makes reasonable enquiries where families request information and is sensitive in their dealings with them.

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