

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Warren Wilkinson a prisoner at HMP Leeds on 14 March 2019

A report by the Prisons and Probation Ombudsman

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 Warren Wilkinson died in a hospice on 14 March 2019 of sepsis, caused by cancer, while a prisoner at HMP Leeds. He was 27 years old. I offer my condolences to Mr Wilkinson's family and friends.

Mr Wilkinson was diagnosed with cancer on 14 December 2017. He did not respond well to treatment and slowly deteriorated. He spent his last few weeks of life in a hospice surrounded by his friends and family.

I am satisfied that the standard of care Mr Wilkinson received at Leeds was equivalent to that which he could have expected to receive in the community.

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

Sue McAllister CB
Prisons and Probation Ombudsman

August 2019

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Summary

Events

1. On 26 December 2016, Mr Warren Wilkinson was remanded in custody at HMP Leeds for offences including burglary, criminal damage, driving while disqualified, resisting arrest, damaging property and breaching an antisocial behaviour order. He was later sentenced to six years and four months imprisonment. On 27 April 2017, he was moved to HMP Lindholme.
2. On 12 July, Mr Wilkinson went to see a prison nurse as he was concerned that he had a small lump in his right armpit. The nurse noted that she thought it was a fatty lump and told Mr Wilkinson to tell healthcare staff if there were any changes.
3. On 25 September, Mr Wilkinson was seen by a prison GP, who noted that he had large lumps under his left and right armpits and three lumps along his jawline. The GP referred him for an urgent hospital appointment under the suspected cancer pathway.
4. On 14 November 2017, Mr Wilkinson was told that he had malignant lymphoma (a type of cancer). On 15 December, he was moved back to Leeds where a palliative care suite was available. The next day, he started chemotherapy treatment.
5. Mr Wilkinson did not respond well to his treatment and on 14 August 2018, it was decided that no further treatment would be appropriate. Mr Wilkinson was told his condition was terminal.
6. On 28 February 2019, Mr Wilkinson was taken to a hospice for end of life care. His condition deteriorated rapidly and he died in the hospice on 14 March.

Findings

7. Mr Wilkinson's health gradually deteriorated following his diagnosis. His health needs and risks were assessed and reviewed when necessary, and in a timely manner. The clinical reviewer concluded that the healthcare Mr Wilkinson received at Leeds was of a high standard and equivalent to that which he could have expected to receive in the community.
8. We make no recommendations.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Leeds 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 Wilkinson's prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr Wilkinson's clinical care at the prison.
12. We informed HM Coroner for West Yorkshire of the investigation. We have sent the coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted Mr Wilkinson's mother, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.
14. The investigation has assessed the main issues involved in Mr Wilkinson's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.
15. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HM Leeds

16. HMP Leeds is a local prison which can hold a maximum of 1,218 prisoners who are on remand, convicted or sentenced. The prison serves the courts of West Yorkshire. Care UK provides health services, including mental health services. The prison has 24-hour primary healthcare cover.
17. In August 2018, Leeds was selected to be part of the “10 Prisons Project”, which seeks to improve safety, security and decency in the prisons involved. The project is focusing on reducing violence, improving living conditions, preventing drugs from entering the prison and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Leeds was in November 2017. Inspectors found that leadership and oversight were well established with strong clinical governance in place, demonstrating accountability for practice. They noted that access to most clinics was reasonable and there were routine waits of about two weeks to see a GP. Inspectors found that medical leadership was clear and effective, and that the management of long-term conditions was impressive. They noted that two experienced nurses provided effective assessment and oversight of patients with identified conditions, that complex care arrangements were good and there was effective liaison with community specialist services. Inspectors found that patients had good access to planned external hospital appointments, that there were few cancellations, and a GP clinically prioritised any proposed modifications.

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 annual report for the year ending December 2018, the IMB reported that the majority of healthcare complaints related to medication; prisoners told the IMB that the delivery of drug medication to them did not always follow the drug administration guidelines. The Board was also concerned that prisoners were not attending their healthcare appointments and the ‘did not attend’ figure was unacceptably high.

Previous deaths at HMP Leeds

20. Mr Wilkinson was the 15th prisoner to die at HMP Leeds since March 2017. Of the previous deaths, five were from natural causes and nine were self-inflicted. There have been three deaths since Mr Wilkinson’s death, one of which was from natural causes. There were no similarities between the circumstance of Mr Wilkinson’s death and the previous deaths at Leeds.

Findings

The diagnosis of Mr Wilkinson's terminal illness and informing him of his condition

21. On 26 December 2016, Mr Warren Wilkinson was remanded in custody at HMP Leeds for various offences including burglary, criminal damage, driving while disqualified, resisting arrest, damaging property and breach of an antisocial behaviour order.
22. On 27 April 2017, Mr Wilkinson was moved to HMP Lindholme.
23. On 12 July, a nurse saw Mr Wilkinson because he was complaining of a small lump in his right armpit. She noted that it was not tender to touch and was moveable. She thought it was a fatty lump and advised Mr Wilkinson to tell healthcare if there were any changes.
24. On 25 September, a nurse saw Mr Wilkinson and noted that he had large lumps under his left and right arm pits and three lumps along his jawline. He discussed this with an advanced nurse practitioner, and it was agreed that Mr Wilkinson needed an urgent blood profile, assessment and a fast track referral to the hospital.
25. On 2 October, a prison GP noted that he suspected Mr Wilkinson had malignant lymphoma (a type of cancer that develops in the lymphatic system and spreads throughout the body). He referred him to a haematology (blood) consultant at the Doncaster Royal Infirmary using the suspected cancer pathway referral (for an appointment in two weeks). Mr Wilkinson attended an appointment on 6 October, and on 14 November, a hospital consultant diagnosed lymphoma cancer.

Mr Wilkinson's clinical care

26. On 15 December, Mr Wilkinson was moved back to Leeds where a palliative care suite was available.
27. On 16 December, Mr Wilkinson started chemotherapy treatment for high grade T-cell lymphoma (a rare and aggressive form of cancer that can be found in the blood, lymph nodes, skin or multiple areas of the body) which initially put him into remission. However, within a few months he relapsed.
28. Over the next nine months, Mr Wilkinson received treatment to try to control the cancer and treat the symptoms. He had a peripherally inserted central catheter (PICC) line fitted (a thin long soft tube that is inserted into a vein in the arm and can be used for long term medication such as chemotherapy) to administer his chemotherapy treatment and regularly attended the hospital for check-ups. Mr Wilkinson did not respond well to any of the treatments and his health slowly deteriorated.
29. On 14 August 2018, Mr Wilkinson was discussed at a multidisciplinary team meeting with a palliative consultant. It was decided that no further treatment would be appropriate as there was only a very small chance that it would help and it would be too intense for Mr Wilkinson to tolerate. After the meeting, a

prison GP saw Mr Wilkinson and told him that his condition was terminal. Mr Wilkinson was upset but understood. Prison staff made a mental health referral due to his emotional state.

30. Mr Wilkinson's health continued to deteriorate. On 28 January 2019, after a multidisciplinary meeting, it was agreed that a do not attempt resuscitation (DNAR) order should be put in place. Mr Wilkinson agreed that he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect.
31. On 28 February, Mr Wilkinson was taken to a hospice in Halifax for end of life care, where on 14 March he died. His cause of death was sepsis (a serious complication of an infection), which had been caused by T-cell lymphoma.
32. The clinical reviewer noted that appropriate care plans were evident in Mr Wilkinson's record and were in line with the National Institute for Health and Care Excellence (NICE). All care plans were reviewed six monthly. Mr Wilkinson was frequently not compliant with planned care, reviews and hospital appointments. He was also often non-compliant with his medication and supplementary drinks.
33. The clinical reviewer was satisfied that Mr Wilkinson's clinical care at Leeds was equivalent to that he could have expected to receive in the community.

Mr Wilkinson's location

34. On 15 December 2017, Mr Wilkinson was transferred to HMP Leeds where a palliative care suite was available.
35. While Mr Wilkinson was in HMP Leeds he did not always want to be located in the healthcare unit, and told prison staff that he would rather be on the wing sharing a cell with his friend. However, when his health was particularly bad he did go to the palliative care suite for some respite. His friend was allowed to go there with him for support. This was good practice and meant that his friend could offer emotional and psychological support as Mr Wilkinson was approaching the end of his life. On 28 February, he was transferred to a hospice for end of life care.
36. We consider Mr Wilkinson's location was appropriate.

Liaison with Mr Wilkinson's family

37. On 4 March 2019, when Mr Wilkinson's condition deteriorated and he was transferred to a hospice, the prison appointed a family liaison officer (FLO). He contacted Mr Wilkinson's mother to tell her that Mr Wilkinson was now in a hospice. (Mr Wilkinson had not wanted her contacted earlier.)
38. The FLO offered ongoing support to Ms Wilkinson at the hospice and after Mr Wilkinson's death. Mr Wilkinson's funeral was held on 8 April, and the prison contributed to the costs in line with national guidelines.

Compassionate release

39. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.
40. In December 2018, the prison applied for Mr Wilkinson's early release on compassionate grounds due to his medical condition. On 5 February 2019, the Public Protection Casework Section (within HM Prison and Probation Service) refused the application because they considered the risk of Mr Wilkinson reoffending was too high. The prison resubmitted the application on 26 February, when Mr Wilkinson's condition deteriorated further. On 7 March, the application was again refused, as the risk of Mr Wilkinson reoffending remained too high.
41. We consider that the prison appropriately considered compassionate release.

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