Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Martin Cogan a prisoner at HMP Wakefield on 12 February 2019

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 Martin Cogan died of ischemic heart disease caused by coronary artery atheroma (a build-up of plaque in the arteries around the heart) on 12 February 2019 at HMP Wakefield. He also had a longstanding traumatic brain injury which did not cause but contributed to his death. He was 54 years old. I offer my condolences to his family and friends.

We found that the clinical care that Mr Cogan received at HMP Wakefield was equivalent to that which he could have expected to receive in the community. His heart condition had not been diagnosed and when he was found unresponsive, an appropriate emergency code was called and timely resuscitation attempts were made. We make no recommendations.

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 **October 2019**

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Summary

Events

1. Mr Martin Cogan had been in prison since 2003, serving a life sentence for murder. He was sent to HMP Wakefield in 2004.

2. Before he went to prison, Mr Cogan had had a road traffic accident and sustained a head injury which left him with epilepsy and regular seizures. He was prescribed medication which he did not take consistently.

3. Mr Cogan was not known to have a cardiovascular disease and did not have any physical symptoms to indicate a heart condition such as chest pains.

4. At 8.30am on 12 February, officers found Mr Cogan unresponsive and called a medical emergency code blue. Healthcare and prison staff tried to resuscitate Mr Cogan until paramedics arrived and took over.

5. At 9.14am, paramedics pronounced that Mr Cogan had died.

Findings

6. Mr Cogan received a good standard of care at Wakefield, equivalent to that which he could have expected to receive in the community.

7. Mr Cogan died of ischaemic heart disease, caused by coronary artery atheroma (a build-up of plaque in the arteries around the heart). We are satisfied that Mr Cogan was not known to have a heart condition or any symptoms, and that his death could not have been prevented.

8. We found that Mr Cogan received appropriate healthcare for his seizures and epilepsy.

9. We found that the emergency response from healthcare and prison staff was timely and appropriate.

10. We make no recommendations.

The Investigation Process

11. 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.

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

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

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

15. The Ombudsman's family liaison officer, contacted Mr Cogan's mother to explain the investigation. She did not have any specific matters that she wanted us to consider.

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

Background Information

HMP Wakefield

17. HMP Wakefield is a high security prison which 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 prisoners).

18. Care UK provides healthcare services at Wakefield. They provide primary healthcare services during normal working hours and overnight and weekend care 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 last inspection at Wakefield was in June 2018. Inspectors noted that health services were good overall but that some parts of the healthcare environment needed improvement. They noted that 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 30 April 2018, the IMB noted that the year 2017 to 2018 was the first complete year in which Care UK had provided healthcare at the prison.

21. The IMB noted that the healthcare environment has been much more settled and that the teams had tried to build on improving the qualitative aspects of care for each prisoner.

Previous deaths at HMP Wakefield

22. Mr Cogan was the eleventh prisoner to die at HMP Wakefield since February 2017, and he was the tenth to die from natural causes. There have been six deaths since Mr Cogan died, all from natural causes.

Key Events

23. On 22 May 2003, Mr Martin Cogan was sentenced to life in prison for murder and sent to HMP Nottingham.

24. On 6 October 2004, Mr Cogan was transferred to HMP Wakefield.

25. Mr Cogan had an initial and secondary health screen at which his medical issues were noted. These included a blood clot on the brain after a road traffic accident in 1981 which led to epilepsy and seizures, a drug overdose in 1988 and depression and self-harm in 1992. He was prescribed medication to treat his epilepsy and was under the care of a consultant neurologist until April 2018.

26. Mr Cogan did not take his epilepsy medication, as prescribed, and had regular blood tests to monitor his compliance with his medication. The results of Mr Cogan's regular blood tests were within normal limits and did not indicate that he had other physical health conditions. Medical records show that Mr Cogan did not always attend planned appointments.

27. The mental health team reviewed Mr Cogan on numerous occasions as he did not comply with his medication but assessments showed that there were no mental health concerns that affected his decision-making.

28. At 8.05am on 12 February, an officer unlocked Mr Cogan's cell door. He said that he did not see anything unusual and carried on unlocking other cells.

29. At 8.30am, two officers were locking the cells of prisoners who remained on Mr Cogan's landing. An officer pushed open Mr Cogan's door to confirm that he was inside and asked if he was ok. He said that Mr Cogan was lying on his bed, face down, and did not respond.

30. Both officers went into Mr Cogan's cell. An officer checked for a pulse in Mr Cogan's neck but could not find one and they thought that he was dead.

31. At 8.32am, an officer radioed a medical emergency code blue and the other officer called a Custodial Manager (CM) to help them.

32. Both officers moved Mr Cogan on to the floor and the CM arrived at the cell.

33. A nurse went to Mr Cogan's cell with emergency equipment as soon as she heard the code blue. A second nurse followed. The officers and the CM tried to resuscitate Mr Cogan while the nurses used a defibrillator to give an electric shock to Mr Cogan's heart, which advised no shock. The nurses administered adrenaline.

34. At 8.52am, paramedics arrived but their resuscitation attempts were unsuccessful and they pronounced Mr Cogan dead at 9.14am.

Contact with Mr Cogan's family

35. Mr Cogan's next of kin was his mother, who lived approximately 60 miles from the prison.

36. At 9.00am on 12 February 2019, an officer was allocated as the family liaison officer (FLO). That afternoon, the FLO and an officer visited Mr Cogan's mother and told her that Mr Cogan had died. They offered their condolences and support.

37. Mr Cogan's funeral took place on 12 March 2019. Wakefield paid for the funeral, in line with national instructions.

Support for prisoners and staff

38. After Mr Cogan's death, the duty governor debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

39. The prison posted notices informing other prisoners of Mr Cogan'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 Cogan's death.

Post-mortem report

40. The post-mortem concluded that Mr Cogan died of ischaemic heart disease, caused by coronary artery atheroma (a build-up of plaque in the arteries around the heart).

Findings

Clinical care

41. The clinical reviewer, concluded that the care that Mr Cogan received at Wakefield was of a good standard and was equivalent to the care that he would have expected to receive in the community.

42. She found that Mr Cogan was not known to have cardiovascular disease and did not have any physical symptoms to indicate a heart condition such as chest pains. She was satisfied that healthcare staff could not have completed preventative care as Mr Cogan did not attend planned appointments.

43. The clinical reviewer identified that healthcare staff tried to talk to Mr Cogan about taking his medication, as prescribed, but he did not comply. She found that healthcare staff appropriately and regularly referred him to mental health services to ensure that his decision-making was not impaired by his mental health issues, and that he had mental capacity.

Emergency response

44. When Mr Cogan was found unresponsive in his cell, prison staff appropriately called a code blue in line with Prison Service Instruction (PSI) 03/2013.

45. Healthcare and prison staff promptly and appropriately tried to resuscitate Mr Cogan. We agree with the clinical reviewer that healthcare staff were responsive and acted appropriately in their emergency response. We make no recommendations.

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