

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Dunlop a prisoner at HMP Wakefield on 22 October 2018

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 Dunlop died of lung cancer on 22 October 2018, at HMP Wakefield. He was 64 years old. I offer my condolences to Mr Dunlop's family and friends.

The standard of care Mr Dunlop received at HMP Wakefield overall, was equivalent to that which he could have expected to receive in the community.

However, the investigation found that Mr Dunlop's mental capacity to make decisions was not assessed during discussions about his resuscitation wishes.

I am concerned that the decisions to use restraints on Mr Dunlop when he was taken to hospital between July and August 2018 were clearly unjustified. It is disappointing to have to raise this matter with the prison again.

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

November 2019

Contents

Summary	1
The Investigation Process	3
Background Information	4
Findings	5

Summary

Events

1. Mr Dunlop was serving a 15-year sentence for sexual offences and had been at HMP Wakefield since 25 August 2016. He had a number of health conditions including spondylitis (a type of arthritis), osteoarthritis and nerve compression in his right forearm.
2. When he arrived at Wakefield, a nurse carried out Mr Dunlop's first night reception screen and arranged for his medication to be prescribed. There is no record that the nurse told Mr Dunlop about the smoking cessation service (Mr Dunlop smoked 50 cigarettes a day). A second reception screen was arranged for the next day, but there is no evidence that it was carried out.
3. In June 2017, Mr Dunlop asked healthcare staff to refer him to the smoking cessation service and he started a course of nicotine patches and lozenges.
4. In November 2017, Mr Dunlop was diagnosed with COPD (chronic obstructive pulmonary disease).
5. In March 2018, he was sent to hospital for a chest X-ray. This showed that Mr Dunlop might have a chest infection and the hospital advised that he be reviewed in eight weeks' time. However, in April, Mr Dunlop began coughing up blood. The X-ray results were abnormal but Mr Dunlop refused any further investigations. In July, he eventually consented to a CT scan and he was diagnosed with terminal lung cancer that had spread to his bones.
6. Mr Dunlop did not want to move to the healthcare unit despite several invitations to do so. After one session of radiotherapy, he declined any further hospital appointments. Mr Dunlop said he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect. Although his cognitive abilities were assessed, his capacity to make decisions was not.
7. On 15 October, Mr Dunlop was moved to the healthcare unit and on 21 October, he was moved to the palliative care suite.
8. At 10.42pm on 22 October, it was confirmed that Mr Dunlop had died.

Findings

9. The clinical reviewer concluded that the overall standard of care Mr Dunlop received at HMP Wakefield was equivalent to that which he could have expected to receive in the community. We agree. Staff appropriately monitored Mr Dunlop and made referrals for further investigations where necessary. His physical needs were addressed, and his preference to stay located on the wing for as long as possible was compassionately managed.
10. We are concerned that Mr Dunlop's mental capacity was not fully assessed even though he signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order.

11. We are also concerned that Mr Dunlop was restrained on the three occasions he went to hospital in July and August 2018. We do not consider it was appropriate or proportionate to use restraints, given that Mr Dunlop was in poor health with poor mobility, and despite nurses recording that it would cause problems getting in and out of the prison van and that he used a wheelchair.

Recommendations

- The Head of Healthcare should ensure that, where a prisoner is considering signing a DNACPR order, their mental capacity is considered and assessed, in accordance with NICE Guidelines, NG108.
- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Investigation Process

12. 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.
13. The investigator obtained copies of relevant extracts from Mr Dunlop's prison and medical records.
14. NHS England commissioned a clinical reviewer to review Mr Dunlop's clinical care at the prison.
15. We informed HM Coroner for West Yorkshire of the investigation. The coroner gave us the cause of death. A post-mortem was not carried out. We have sent the coroner a copy of this report.
16. The investigator wrote to Mr Dunlop's niece 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.
17. The investigation has assessed the main issues involved in Mr Dunlop'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.
18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out factual inaccuracies which have been amended. They submitted an action plan in response to our recommendations which has been annexed to this report.

Background Information

HM Prison Wakefield

19. 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).
20. Care UK provides the healthcare provision 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

21. The last inspection at Wakefield was in June 2018. Inspectors noted that health services were good overall, but some parts of the healthcare environment required improvement. Primary care services were very good and had an appropriate emphasis on the care of patients with long-term conditions.

Independent Monitoring Board

22. 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 noted the difficulties and challenges presented by the change of healthcare provider. However, they also noted there had been noticeable improvements with the new team.
23. The IMB noted the new initiatives being put in place by the Head of Healthcare in an attempt to lessen the need to send prisoners to hospital. The Board noted that nurses would be trained to enable them to administer intravenous drugs and that a review would be carried out following every case in which an emergency ambulance was requested, to learn lessons and assess if any alternative treatments could be put in place.

Previous deaths at HMP Wakefield

24. Mr Dunlop was the 21st prisoner to die at HMP Wakefield since October 2015. All the deaths were from natural causes. There have been three deaths since Mr Dunlop's death, one from natural causes and two self-inflicted deaths. We have made a recommendation about restraints once before. In that case, the prisoner also used a wheelchair.

Findings

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

25. Mr Dunlop was serving a 15-year sentence for sexual offences and had been at HMP Wakefield since 25 August 2016. He had a number of medical conditions including spondylitis (a type of arthritis), osteoarthritis and nerve compression in his right forearm.
26. On 25 August 2016, a nurse carried out Mr Dunlop's reception screen. He recorded that Mr Dunlop had arthritis and took medication. His mental health was also assessed. Mr Dunlop was prescribed tramadol and paracetamol (for pain relief). Although the nurse noted that Mr Dunlop was a smoker who had smoked for over 50 years, there is no evidence that he told Mr Dunlop about the smoking cessation service.
27. An administrator arranged a second reception screen for the next day. There is no evidence that the reception screen took place.
28. On 7 June 2017, Mr Dunlop told a nurse that he wanted to stop smoking. She noted on his record that he was smoking 15 cigarettes a day and that she would ask a GP to prescribe Champix (a medication to stop smoking). In the meantime, she prescribed nicotine lozengers and patches.
29. On 27 June, a prison GP saw Mr Dunlop. Mr Dunlop said that he had been feeling low in mood. The GP considered that Mr Dunlop would not be an ideal candidate for Champix. He prescribed a low dose of trazadone (an anti-depressant). The prescription was changed to mirtazapine two weeks later after Mr Dunlop told the GP that he was having panic attacks.
30. From October 2017, Mr Dunlop complained of shortness of breath and in November 2017, he was diagnosed with COPD (Chronic Obstructive Pulmonary Disease, a group of lung conditions including bronchitis and emphysema). Mr Dunlop complained of chest pain and various tests were undertaken including an electrocardiogram (which measures heart activity and rhythms) and spirometry (which measures lung function). A consultant physician in respiratory diseases, who visited Wakefield weekly, prescribed inhalers.
31. Mr Dunlop's respiratory condition was up and down. Healthcare staff recorded that there were days when he felt quite well and other days where he was very short of breath. Mr Dunlop gave up cigarettes but started using a vaping device.
32. On 9 March 2018, the consultant diagnosed a chest infection and prescribed antibiotics. On 12 March, Mr Dunlop was sent to hospital for a chest X-ray. On 20 March, the results were sent to the prison and indicated that a dense region had been identified in his chest which might be an infection. It was recommended that he be re-examined in eight weeks' time.
33. During April, Mr Dunlop began to cough up blood. At first the amount was minimal but on 3 April, he told a prison GP that he had coughed up a blood clot. The GP referred him to Pinderfields Hospital because she was concerned that he might have tuberculosis.

34. On 11 April, the consultant reviewed Mr Dunlop's X-ray results. He recorded that they looked abnormal and asked to see Mr Dunlop. Mr Dunlop was at work so the consultant made a referral for him to have a CT scan and bronchoscopy (which examines the airways).
35. On 13 April, the consultant saw Mr Dunlop and explained the procedures he needed to undertake which included having his bloods taken. Mr Dunlop refused to have any blood tests because he said he had a needle phobia. The consultant told him to have another X-ray and to have a think about having the blood tests. The consultant recorded that all three recommended procedures (CT scan, bronchoscopy and bloods tests) needed intravenous access, which Mr Dunlop would not agree to.
36. On 17 April, Mr Dunlop's X-ray results showed no changes to the mass that had been identified. A CT scan was needed to evaluate the situation further.
37. On 27 April, the consultant explained the X-ray results to Mr Dunlop and the importance of having a CT scan, bronchoscopy and blood tests, but again, Mr Dunlop refused. He agreed to have another chest X-ray instead in eight weeks' time.
38. By May, Mr Dunlop was experiencing pain under his arm. On 11 May, a nurse explained that the pain might be because of the abnormality in his chest. He prescribed co-codamol (a medication for pain relief).
39. On 12 June, Mr Dunlop had a chest X-ray. The results showed no change to the mass, but one of Mr Dunlop's ribs had deteriorated indicating that any cancer present might have spread to his bones.
40. On 22 June, the consultant discussed the results with Mr Dunlop. He explained that he probably had cancer and suggested he consider moving to the healthcare unit so that his pain could be better controlled. Mr Dunlop said he would think about it. On the same day, the consultant referred him for a CT scan 'without contrast' (which gives a better picture) but it required him to have an injection.
41. The consultant prescribed morphine sulphate and oramorph to better manage Mr Dunlop's pain, particularly through the night. The consultant also spoke to a senior officer on Mr Dunlop's wing to make him aware of the situation.
42. On 5 July, Mr Dunlop had a CT scan at Dewsbury and District Hospital. He was escorted by two officers and was restrained using double cuffs on his way to hospital. (Double cuffing is when the prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs.) This was reduced to single cuffs with an escort chain when they arrived at the hospital. The scan was conducted while Mr Dunlop was still wearing an escort chain. He was double cuffed again straight after his scan.
43. On 18 July, the consultant saw Mr Dunlop and explained the results of the scan. The results confirmed that Mr Dunlop had lung cancer which had spread to his bones, and that the condition was terminal.
44. The clinical reviewer concluded that the care Mr Dunlop received in terms of his diagnosis was equivalent to that which he could have expected to receive in the

community. We agree. Healthcare staff appropriately investigated Mr Dunlop's symptoms, made timely referrals to secondary care providers (despite his resistance to most investigatory procedures) and discussed his diagnosis with him.

Mr Dunlop's clinical care

45. On 20 July 2018, the consultant made a referral to a palliative care specialist nurse and on 23 July, a palliative care nurse visited Mr Dunlop to introduce herself.
46. A nurse had already arranged for Mr Dunlop to have a soft diet and arrangements had been made for him to be taken to the healthcare unit in a wheelchair when needed (as he still refused to move there permanently). A pressure relieving cushion and a mattress topper were obtained.
47. On 26 July, Mr Dunlop had an appointment with his oncologist at St James's Hospital. He was escorted by two officers and was restrained using an escort chain. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.) The oncologist explained to Mr Dunlop that he needed treatment to help control his pain and offered him a single session of radiotherapy. Mr Dunlop agreed to have radiotherapy and signed the consent forms.
48. On 27 July, Mr Dunlop said he did not want anyone to resuscitate him if his heart or breathing stopped and signed DNACPR order (which means that, in the event of cardiac or respiratory arrest, no attempt at resuscitation will be made). Although in February 2018, Mr Dunlop had undergone a mini mental state examination which tests cognitive functioning, his capacity to make decisions was not examined.
49. Staff regularly assessed Mr Dunlop to ensure his pain was being managed and that anti-sickness drugs were regularly administered.
50. On 9 August, an MRI (Magnetic Resonance Imaging) scan was cancelled because Mr Dunlop said he was too unwell.
51. On 13 August, Mr Dunlop had radiotherapy at St James's Hospital. He was escorted by two officers and was restrained using an escort chain.
52. On 15 August, a note was made in his medical records at the request of the Head of Safer Custody, that it should be made clear on all prison escort records that Mr Dunlop was a palliative care patient as this would aid the prison's decision-making on cuffing arrangements.
53. On 17 August, Mr Dunlop told a nurse that he did not want any more hospital appointments.
54. On 7 September, Mr Dunlop agreed to move to the healthcare unit and staff noted he had developed some pressure sores, which they treated. The next day, Mr Dunlop insisted on moving back to the residential wing and his pain management regime was amended to compensate for the fact that he could not access oramorph on the wing.

55. Staff monitored Mr Dunlop's pressure sores and they began to improve. Staff frequently documented their concerns about their ability to care for Mr Dunlop effectively while he remained on the residential wing.
56. On 15 October, Mr Dunlop agreed to move to the healthcare unit again, for 'respite care'. His condition rapidly deteriorated and his cell was left unlocked so that healthcare staff could administer appropriate care when required.
57. On 21 October, Mr Dunlop was moved to the palliative care suite in the healthcare unit. On 22 October, his morphine was administered via a syringe driver (an intravenous method which ensures a continual dose).
58. Mr Dunlop gradually became unresponsive and at 10.42pm, a prison GP confirmed that Mr Dunlop had died.
59. The clinical reviewer concluded that the clinical care Mr Dunlop received was equivalent to that which he could have expected to receive in the community. We agree.
60. Despite his refusal to transfer to the healthcare unit, staff appropriately monitored Mr Dunlop and responded to any deterioration in his condition.
61. We are concerned, however, that contrary to NICE Guidance NG108 (which covers all aspects of assessing mental capacity), Mr Dunlop signed a DNACPR order without being assessed to ensure that he had the mental capacity to make that decision. We therefore make the following recommendation:

The Head of Healthcare should ensure that, where a prisoner is considering signing a DNACPR order, their mental capacity is considered and assessed, in accordance with NICE Guidelines, NG108.

Mr Dunlop's location

62. Mr Dunlop was mostly nursed on a residential wing because that was what he wanted. Healthcare staff and prison staff did what they could to manage him appropriately even though this was challenging. Staff frequently engaged with Mr Dunlop to discuss his decision to stay on the wing and to gently encourage him to at least visit the healthcare unit for respite care. Mr Dunlop was eventually moved to the healthcare unit (on 15 October), and then to the palliative care suite (on 21 October).
63. We are satisfied that staff made good efforts in trying to convince Mr Dunlop to move to a more suitable location and they eventually succeeded.

Restraints, security and escorts

64. 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.
65. On 5 July 2018, Mr Dunlop had an appointment for a CT scan. His consultant had already concluded that it was likely he had cancer and prescribed morphine sulphate and oramorph. The medical risk assessment was conducted by a nurse and did not express any objections to restraints being used, and said that his medical condition did not impede his ability to escape unaided. However, she also said that Mr Dunlop used a wheelchair for distances and that Mr Dunlop might struggle to get into the prison van if he was double cuffed because of his limited mobility.
 66. The security assessment, completed by an escort collator, recorded that Mr Dunlop presented no risk to prison staff, was unlikely to receive outside assistance but presented a medium risk to hospital staff, of hostage taking and of escaping under his own steam. His risk to the public was assessed as high. A prison manager authorised the escorting and restraint decision. Mr Dunlop was escorted to hospital by two officers. He was double cuffed on his way to hospital which was reduced to single cuffs with an escort chain when they arrived at the hospital. The scan was conducted while Mr Dunlop was still wearing an escort chain and he was double cuffed straight after his scan.
 67. On 26 July, the medical assessment was completed by a nurse. She did not object to restraints being used and said that Mr Dunlop's medical condition did not impede his ability to escape unaided. She also noted that he used a wheelchair. The security assessment, completed by the escort collator, reflected the previous assessment. A prison manager noted that healthcare had identified Mr Dunlop as having impaired mobility/being disabled and concluded that an escort chain only was appropriate. Two officers accompanied him to his hospital appointment.
 68. On 13 August, Mr Dunlop was escorted to hospital by two officers and was restrained using an escort chain. By this time, Mr Dunlop had very poor mobility and he used a wheelchair. There were no objections to restraints recorded in the medical section of the escort risk assessment, but it said that Mr Dunlop was a wheelchair user. Again, Mr Dunlop was assessed as a high risk of harm to the public, and a medium risk of escape, with a focus on his motivations to escape rather than means to do so. A note on the Person Escort Record by an officer said that when Mr Dunlop returned to the prison he was in obvious pain.
 69. We are concerned that the manager who authorised the use of double cuffs for Mr Dunlop's hospital transfer on 5 July 2018, failed to take into account his medical condition and lack of mobility. A nurse noted on the risk assessment form that Mr Dunlop had limited mobility and may struggle to get into a van if double cuffed, but there is no evidence that the authorising manager took this into account when deciding on the level of restraint to be used. We consider that the use of double cuffs on Mr Dunlop was clearly disproportionate to the risks he posed.

70. Mr Dunlop was restrained with an escort chain for his two subsequent hospital visits on 26 July and 13 August. On both occasions, healthcare staff had recommended the use of an escort chain because Mr Dunlop had limited mobility and they noted he might need to use a wheelchair. There is evidence that the authorising managers took this into account when deciding to restrain Mr Dunlop with an escort chain. However, we do not consider that the decision to restrain Mr Dunlop was proportionate to the risks Mr Dunlop posed, over and above the control already available through the two escorting officers, given that his health was clearly deteriorating and he had poor mobility.
71. In our report on the death of a prisoner at Wakefield in June 2016, we recommended that the Governor ensure all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.
72. The prison accepted our recommendation and submitted an action plan in January 2017 setting out the steps they would take to implement it. This included reintroducing an algorithm to enable healthcare staff to better evidence their recommendations on restraints and prisoners' current medical conditions. The algorithm was to be routinely attached to the PER.
73. Although all three risk assessments for Mr Dunlop had an algorithm attached, the first authorising manager failed to take this into account when deciding to double cuff Mr Dunlop on 5 July, and although the other two authorising managers did take the algorithms into account, they still made unjustified decisions to restrain Mr Dunlop on 26 July and 13 August. We therefore repeat our previous recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Liaison with Mr Dunlop's family

74. On 23 July, the prison appointed a family liaison officer (FLO). She discussed practical support with Mr Dunlop in terms of his location and any aids, and who he wanted to name as his next of kin. Mr Dunlop said he would like to name his daughter as his next of kin but he did not have any contact details for her.
75. The FLO sought help from the probation service and the police in locating Mr Dunlop's daughter but they were only able to trace an address from 2015, where she no longer lived. The police were unable to offer any further assistance. There were details of a family member on Mr Dunlop's file, but as she was a victim of Mr Dunlop's offences, the FLO was cautious about approaching her.
76. The FLO therefore sought the assistance of the police and the probation service again. Eventually, the police provided details of a potential address, but before the FLO could confirm the address, Mr Dunlop had died. The police provided an alternative address and the FLO visited the family the next day.

77. The FLO attended the address, but was informed that before she arrived the police had already delivered the news of Mr Dunlop's death by telephone. The FLO offered advice and support. The family told the FLO that they might be able to contact Mr Dunlop's estranged daughter, via social media, and would pass on the FLO's details. The FLO recorded that Mr Dunlop's daughter did not contact her.
78. Mr Dunlop's funeral was held on 27 November 2018. The prison contributed to the funeral costs in line with national policy.

Compassionate release

79. 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.
80. On 20 July 2018, Mr Dunlop's consultant initiated an application for compassionate release. The Deputy Governor did not support release on the grounds there was no current assessment of Mr Dunlop's risk to children and there was no appropriate care plan detailing how he would be looked after in the community. He considered that his needs could be met in custody, given that they had a palliative care suite at the prison.
81. We are satisfied that the prison appropriately considered compassionate release.

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