Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Ferron a prisoner at HMP Wakefield on 28 February 2016

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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 David Ferron died in hospital of multi-organ failure, sepsis, pneumonia and cellulitis on 28 February 2016, while a prisoner at HMP Wakefield. He was 67 years old. I offer my condolences to Mr Ferron's family and friends.

For most of the time Mr Ferron was at Wakefield from 2011, healthcare staff managed Mr Ferron's chronic health conditions well and in line with national clinical guidelines. The clinical reviewer found that when Mr Ferron's condition began to decline in January 2016, there were some deficiencies in the standard of his care, which the healthcare provider at Wakefield, will need to address, although the clinical reviewer did not say that this affected the outcome.

Restraints were removed the day after Mr Ferron was admitted to hospital, but I am concerned that this, and other recent investigations into deaths at Wakefield, have found that managers at the prison are not applying the appropriate legal tests to justify the use of restraints when prisoners with poor health and limited mobility are taken to hospital.

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 **November 2016**

Contents

Summary

Events

1. Mr David Ferron had been at HMP Wakefield since 17 February 2011, shortly after he had been sentenced to ten years in prison. He had limited mobility and suffered from a number of chronic health problems, including heart disease, diabetes, high blood pressure and cellulitis. He also had recurrent leg sores.

2. Healthcare staff wrote care plans to manage his conditions, including daily leg dressings. They reviewed him frequently and adjusted his medication as necessary. From January 2016, Mr Ferron's leg sores deteriorated and, in February, he was moved to the prison's inpatient unit.

3. On 24 February, a doctor reviewed Mr Ferron, as his blood pressure was low. The doctor thought it unnecessary to send Mr Ferron to hospital and advised nurses to monitor his fluid intake, stop some medications and take blood tests the next day.

4. In the early hours of the next morning, Mr Ferron's blood sugar and blood pressure were low. Nurses gave him toast and a drink to try to raise this. A prison GP reviewed him at lunchtime and took a blood test. The result was abnormal, but the GP considered that this was to be expected. In the evening, Mr Ferron was weak and lethargic and his blood pressure and pulse were low. A nurse called the out of hours GP service and a prison doctor attended and examined Mr Ferron. He thought Mr Ferron might have sepsis and, and after consulting a hospital doctor, sent him to hospital immediately. Mr Ferron remained in hospital until he died on 28 February 2016.

Findings

5. The clinical reviewer considered that Mr Ferron's care was managed effectively for several years, but identified some areas from January 2016, where the standard of care should have been better, including that nurses did not routinely record observations about the condition of his leg sores. This made it difficult to track any changes for signs his condition was deteriorating. There was also a need for improved monitoring of clinical observations and fluid intake. Mr Ferron missed two routine hospital appointments in December 2015 and January 2016, for operational reasons, but these were rescheduled quickly. On the evening of 25 February, there were sufficient indications to admit Mr Ferron to hospital without waiting for an out of hours GP assessment. The clinical reviewer found a need for improvements in assessing and responding to prisoners with deteriorating health conditions, which the healthcare provider will need to address. The clinical reviewer did not say that these would have affected the outcome for Mr Ferron.

6. When Mr Ferron went to hospital on 25 February, a manager decided he should be restrained by an escort chain. While this was removed the next day, we are not satisfied from this and two other investigations into deaths at Wakefield within a week of Mr Ferron's, that managers are always applying the appropriate tests

to justify the use of restraints when prisoners with poor health and limited mobility are taken to hospital.

Recommendations

- The Head of Healthcare should ensure that clinical staff assess and manage prisoners with deteriorating chronic condition effectively to enable good standards of care, including that:
    - All treatment and care us is fully documented in prisoners' medical records to allow effective continuity of care.
    - Clinical staff use appropriate assessment and monitoring processes, in particular to monitor fluid balance and record vital signs.
    - Clinical staff have up to date training in using National Early Warning Scores and are aware of the triggers for escalation and when to refer to hospital promptly.

- The Governor should discuss the Graham judgment and its implications with all managers taking decisions about the use of restraints for prisoners taken to hospital and ensure that they fully understand the legal position, that assessments take into account the health of a prisoner, and are based on the actual risk the prisoner presents at the time.

The Investigation Process

7. 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.

8. The investigator obtained copies of relevant extracts from Mr Ferron's prison and medical records. She interviewed one member of staff by telephone on 25 April 2016.

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

10. 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.

11. One of the Ombudsman's family liaison officers and the investigator met Mr Ferron's family on 14 April, to discuss the investigation. His family gave them copies of Mr Ferron's diary entries and letters he had written to them. They had a number of concerns for the investigation to consider, including:

    - Whether there were appropriate care plans and information sharing about Mr Ferron's complex health issues.
    - They believed that healthcare staff did not consult Mr Ferron about his medication or dispense it consistently and that some medication had been confiscated. They asked whether it was appropriate for staff to dissolve pregabalin capsules in water and whether this was due to drug problems at Wakefield.
    - Inconsistent dressing of his leg wounds.
    - They believed that Mr Ferron's diabetic food pack had been withdrawn, and that staff had refused him a wheelchair and a carer.
    - They wanted to know why some of Mr Ferron's hospital appointments had been cancelled.
    - They asked whether he should have been admitted to hospital sooner.

12. Mr Ferron's family received a copy of the initial report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

13. Mr Ferron's family asked for their issues/questions to be shared with the clinical reviewer for comment. The investigator copied the family correspondence to the clinical reviewer. The clinical reviewer's response is attached to her clinical review report as annex 1a.

14. The initial report was shared with the Prison Service. The Prison Service pointed out a factual inaccuracy and this report has been amended accordingly. They said that the Modified Early Warning Score (MEWS) had been changed to the National Early Warning Score (NEWS). MEWS has been changed to NEWS. The action plan has been annexed to this report.

Background Information

HMP Wakefield

15. HMP Wakefield is one of eight high security prisons in England and Wales. It holds 750 men. There are four main residential wings, a healthcare centre, a segregation unit and a close supervision centre for exceptionally high-risk prisoners.

16. Spectrum CIC (Community Interest Company) provided primary healthcare at Wakefield, during normal working hours, at the time of Mr Ferron's death. Care UK took over on 1 April 2016. Humber NHS Foundation Trust (intermediate care) employs 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 2015, the IMB noted the importance of healthcare because the prison had a large number of older prisoners. The IMB considered that health services were well managed and the quality of care was high.

Previous deaths at HMP Wakefield

19. There have been 13 deaths from natural causes, at Wakefield, since the beginning of 2015, some of which are still being investigated. We have previously raised the issue of the need for properly considered risk assessments to justify the use of restraints.

Key Events

20. On 11 February 2011, Mr David Ferron was sentenced to ten years in prison, for sexual offences and sent to HMP Manchester. Mr Ferron had several complex medical conditions, including type 2 diabetes, discitis (an infection in the disc space between the spine), heart disease (four stents had been inserted in 2006, for blocked arteries), high blood pressure, depression, an enlarged prostate and chronic renal failure. He was obese and smoked. On 14 February, his community GP faxed information to the prison about his complex medical needs.

21. On 17 February, Mr Ferron transferred to HMP Wakefield. At an initial health screen, a nurse noted he was generally unwell, and needed a lot of medication to manage his condition. He wore a back brace and had limited mobility. A prison GP reviewed him and admitted him to the healthcare unit.

22. To help control some of the symptoms of Mr Ferron's diabetes, prison doctors prescribed pregabalin, which was appropriately administered in dissolved form, as pregabalin is often misused and traded in prisons. Healthcare staff held annual diabetes reviews and Mr Ferron attended diabetes clinics and screening between the annual reviews. He had a prisoner carer to help him with day-to-day living activities, such as keeping his cell clean.

23. Shortly after he arrived in prison, Mr Ferron developed oedema (the build up of excess fluids in the legs and ankles) and this condition persisted. He frequently saw nurses and doctors to monitor his conditions and change his leg dressings. He also attended diabetes, podiatry and ophthalmology clinics.

24. In February 2012, Mr Ferron said that, due to his limited mobility, he had difficulty walking the full length of the wing, queuing to receive his medication and going back to his cell. He was given access to a wheelchair, which was shared with other prisoners. In September 2012, Mr Ferron had a scan and saw a spinal consultant at hospital. The consultant found no neurological defects and discharged Mr Ferron.

25. Between July 2014 and March 2015, prison GPs referred Mr Ferron to consultants at the Diabetic Medicine, Vascular and Dermatology departments at hospital, who diagnosed that Mr Ferron's oedema and leg ulcers were due to venous insufficiency (insufficient blood supply to the heart from the legs) due to heart failure. After reviewing Mr Ferron, the consultants discharged him from their care in March 2015.

26. In consultation with specialist vascular nurses, prison nurses drew up care plans to manage and dress Mr Ferron's chronic leg wounds. He had a named nurse to oversee his care and wore compression stockings on both legs. He sometimes complained that the stockings were too tight, and nurses gave him further advice on when to wear them. They also advised him to elevate his legs and watch for lost circulation. Mr Ferron suffered from recurrent cellulitis in his legs and was prescribed antibiotics to treat this.

27. On 23 April 2015, Mr Ferron complained of chest pain. A nurse completed an ECG (a test to measure the heart's rhythm). The result was normal. Another nurse reviewed Mr Ferron and said his left leg appeared red and hot. She

prescribed antibiotics and nurses continued to see him every few days to dress his wounds.

28. On 31 July, a prison GP reviewed Mr Ferron and arranged a chest X-ray. Another GP reviewed the X-ray result on 4 August and found no significant changes since 2012, but there were signs of a mild cardiomegaly (enlarged heart). He booked an appointment to discuss this with Mr Ferron but he did not attend.

29. On 7 September, a prison GP told Mr Ferron about the X-ray results. Mr Ferron said he had been short of breath and had a cough for the past two weeks. She checked his pulse and it was normal. She noted he had a longstanding oedema and his blood pressure was raised at 138/78mmHg. She prescribed antibiotics and scheduled a review in three weeks, which she conducted. Mr Ferron said he felt much better and was no longer short of breath. She examined his chest and found nothing abnormal.

30. On 20 November, a prison GP examined Mr Ferron's legs and noted the leg ulcer was infected and the oedema had increased. He prescribed antibiotics and told Mr Ferron to raise his legs, use a muscle pump and increase his fluids. On 25 November, a nurse noted an improvement.

31. Mr Ferron was unable to attend a hospital appointment for spinal problems, scheduled for 8 December 2015, as the vehicle for disabled prisoners had been used earlier that day and had not returned in time for Mr Ferron's appointment. However, he attended a rearranged appointment on 14 December.

32. At a diabetes review on 22 December, Mr Ferron told a nurse that recently he had felt tired and often fell asleep during the day. She noted that his feet were swollen and arranged a blood test for 31 December.

33. On 26 December, a nurse changed Mr Ferron's dressing and noted that his leg was weeping. On 29 December, a nurse noted scattered skin breaks on his right shin and larger breaks on his left shin. She completed a Doppler test (an ultrasound to measure the blood flow through arteries and veins) and the results were normal. Blood tests taken on 31 December were within normal limits. A nurse found that his left shin was macerated (a common wound care problem where the skin is softened and breaking down).

January 2016

34. While dressing Mr Ferron's leg on 3 January 2016, a nurse noticed his left leg was swollen and inflamed, with excessive leakage and a strong smell. She took a swab of the wound and arranged a GP review.

35. On 4 January, a prison GP diagnosed an infection and prescribed antibiotics. A nurse noted that if there was no improvement after Mr Ferron's course of antibiotics, he should be referred to the tissue viability or vascular team. His leg wound deteriorated and, on 10 January, prison staff gave him his own wheelchair to get around, due to the extent of his leg dressings. She noted that the doctor should review him on 11 January, but the next GP review did not take place until 19 January.

36. On 11 January, Mr Ferron told a specialist diabetes nurse that as he often fell asleep in the evenings, he missed taking his metformin medication and eating his evening meal. The nurse checked his blood sugar level and noted it was high. Mr Ferron said he would try to take the metformin in the evening with food to see if this lowered his sugar level. (Mr Ferron's family thought that his diabetic food pack might have been withdrawn, but there was no evidence of this.) The nurse scheduled the next diabetic review for three months later.

37. On 12 January, a nurse completed Mr Ferron's annual cardiovascular and hypertension disease management review. She found nothing abnormal. On Friday 13 January, the prison rearranged an ophthalmic appointment for 22 January, as they kept alternate Fridays free for transfers, so only urgent hospital appointments were facilitated.

38. On 14 January, when a nurse changed Mr Ferron's leg dressings, she noted a wound swab should be taken within five days, but this was not done until 12 February. The results were satisfactory. Mr Ferron's left leg improved but he then developed round itchy lesions over his body. A prison GP prescribed an anti-fungal cream. On 29 January, Mr Ferron began a programme to help him stop smoking.

39. On 1 February, a nurse noted Mr Ferron had cellulitis and prescribed antibiotics. That day, Mr Ferron wrote to his family and said his left leg was getting worse and he had an open wound from his knee down to his ankle. He said his skin would not heal, it constantly leaked, burnt and stung, and there was an odour when nurses removed the dressing.

40. On 10 February, a nurse noted that Mr Ferron's wound was still very wet and leaking. On 17 February, his leg was red and hot to touch, with marked cellulitis, so staff admitted him as to the prison's healthcare unit as an inpatient. A prison GP assessed him and noted that, although his temperature was slightly raised at 37.3°C, his clinical observations did not suggest sepsis. She prescribed stronger antibiotics and asked nurses to check his clinical observations regularly and send him to hospital if his condition worsened. Later that day, a nurse recorded that Mr Ferron was unwell but was not a cause for concern. In the evening, staff noted that Mr Ferron had no concerns and was able to move confidently from the bed to the chair in his cell.

41. On 22 February, a prison GP noted that Mr Ferron's cellulitis had improved after the course of antibiotics and it was planned that he would go back to his wing. However, on 24 February, he told another GP that he felt lethargic and had a rash on his arms. She kept him in the inpatient unit.

42. That evening, a nurse found that Mr Ferron's blood pressure was low and thought he might need to go to hospital. She could not contact the prison GP, so consulted a respiratory medicine specialist at the hospital, who was in the prison at that time. He examined Mr Ferron and noted he was taking a lot of cardiac and blood pressure medication and believed that this, and poor fluid intake, might account for his low blood pressure. He thought it was not necessary to send him to hospital at that stage. He encouraged Mr Ferron to increase his fluid intake and advised the nurse to stop some of his medications temporarily and take blood tests the next day.

43. On 25 February, a nurse examined Mr Ferron, as he felt unwell. She gave him toast to increase his blood sugar level and a hot drink to try to raise his blood pressure. At lunchtime, a prison GP reviewed Mr Ferron's cellulitis and blood pressure and arranged a blood test. He noted the results were "abnormal, but expected", so did not consider that further action was necessary. Nurses continued to check Mr Ferron's clinical observations. In the afternoon, a nurse gave him a drink to increase his glucose levels and he ate a meal.

44. Just after 8.00pm, a nurse took Mr Ferron's observations. He felt unwell and his blood pressure and pulse were low (78/51 and 55). He was pale, lethargic and weak. The nurse rang the out of hours doctor, who said Mr Ferron needed a physical assessment by a GP. At around 10.45pm, a doctor went to the prison, examined Mr Ferron, noted his history of low blood pressure, cellulitis and renal failure and suspected he might have sepsis. The doctor telephoned a doctor at the hospital, who advised him to send Mr Ferron to hospital as an emergency. Two officers escorted him, using an escort chain to restrain him.

45. In hospital, doctors diagnosed pneumonia and sepsis. The next day, a hospital doctor asked officers to remove the escort chain. A prison manager agreed this and restraints were not used again. Mr Ferron remained in hospital and died in the early hours of 28 February.

Contact with Mr Ferron's family

46. At 10.30am on 26 February, the prison appointed a family liaison officer. An hour later, she informed Mr Ferron's family that he was seriously ill in hospital. She then went to the hospital and gave them more information about Mr Ferron's condition. Mr Ferron's family were able to stay with him and were with him when he died.

47. After Mr Ferron's death, a prison manager went to the hospital to meet his family and offered condolences.

48. The family liaison officer telephoned Mr Ferron's family shortly afterwards and offered her condolences and support. She remained in contact with them until after Mr Ferron's funeral, which was held on 4 April. The prison contributed to the costs, in line with national policy.

Support for prisoners and staff

49. While the prison manager was at the hospital, he debriefed the escort staff and offered his support and that of the staff care team.

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

Post-mortem report

51. A post-mortem examination concluded that Mr Ferron died from multiple organ failure, sepsis (a whole body response to an infection, which can lead to sudden death and cannot be predicted), pneumonia and cellulitis due to hypertensive and ischaemic heart disease (high blood pressure and reduced blood supply to the heart) with type 2 diabetes mellitus, obesity and pulmonary emphysema.

Findings

Clinical Care

52. The clinical reviewer found that the management of Mr Ferron's chronic long-term medical conditions at Wakefield was generally satisfactory. Healthcare staff managed his diabetes thoroughly and well, in accordance with National Institute for Health and Care Excellence (NICE) guidelines. They carried out screenings and preventative assessments, referred him to appropriate specialists, implemented thorough care plans and cared for the wounds caused by his oedema and leg ulcers to a high standard. The clinical reviewer considered that, until the end of December 2015, Mr Ferron's care was of a good standard and equivalent to that he could have expected in the community.

53. After 3 January 2016, the clinical reviewer considered that there were some weaknesses in managing Mr Ferron's deteriorating condition. She did not say that these would have affected the outcome for Mr Ferron, but his care at this stage was not equivalent to community care. There was a delay of eight days in Mr Ferron seeing a GP after a nurse referred him on 11 January. A wound swab, which should have been taken shortly after 14 January, was not completed until almost one month later on 12 February. Staff did not compare swab results for cellulitis to track the spread of infection and often did not record observations about his leg wounds or cellulitis, which made it difficult for the staff involved in his care to note any improvement or deterioration.

54. Mr Ferron often fell asleep and missed taking his evening dose of metformin, an essential drug to help control his diabetes. There is no record that staff reminded him to take it. There were sometimes delays in taking his clinical observations and taking blood tests. Healthcare staff used NEWS (National Early Warning Score) to score vital signs to help detect deterioration in a patient's severity of illness, which is good practice. However, scores were not always consistently recorded or acted on.

55. Mr Ferron missed two external health appointments at the end of December and in January. While this was not ideal, we are satisfied that these were quickly rearranged, not urgent and not detrimental to his care.

56. When Mr Ferron was admitted to the inpatient unit on 17 February, the clinical reviewer considered that there was a missed opportunity to take a blood test, which might have indicated a deterioration in his kidney disease. Finally, although the clinical reviewer considered that it did not affect the outcome, Mr Ferron should have been referred to hospital urgently on the evening of 25 February, when tests showed acute renal failure, and there was no need to consult an out of hours doctor before doing so. We make the following recommendation:

The Head of Healthcare should ensure that clinical staff assess and manage prisoners with deteriorating chronic condition effectively to enable good standards of care, including that:

- **All treatment and care us is fully documented in prisoners' medical records to allow effective continuity of care.**

- **Clinical staff use appropriate assessment and monitoring processes, in particular to monitor fluid balance and record vital signs.**
- **Clinical staff have up to date training in using National Early Warning Scores and are aware of the triggers for escalation and when to refer to hospital promptly.**

Restraints, security and escorts

57. 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, the Graham judgment, 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.

58. A prison manager told the investigator that, when Mr Ferron went to hospital on 25 February, staff did not complete an escort risk assessment as he had left as an emergency. The Person Escort Record noted that two officers should escort Mr Ferron and use an escort chain to restrain him.

59. No one reviewed the use of restraints when Mr Ferron was admitted to hospital and he remained restrained by an escort chain until the next day, when a hospital doctor asked officers to remove the chain.

60. While we accept that restraints were removed relatively quickly, they were not removed until a doctor requested this. There is no evidence that prison managers assessed his risk before this, in line with the Graham judgment and subsequent Prison Service guidance. Mr Ferron was one of three prisoners from Wakefield to die in hospital within a week of each other. We recognised in each of the other cases that restraints were removed promptly after a review, and therefore did not make a formal recommendation, although there was little evidence they were justified initially. However, the three cases together, demonstrate that managers at Wakefield have a lack of understanding of the tests that managers should apply when deciding whether the use of restraints is justified, when seriously ill prisoners are taken to hospital. One manager indicated that an escort chain was the minimum level of restraint that would be used for a prisoner dependent on a wheelchair. While the Prison Service has a fundamental responsibility to protect the public, security must be balanced with humanity and legally justified. We make the following recommendation:

    The Governor should discuss the Graham judgment and its implications with all managers taking decisions about the use of restraints for prisoners taken to hospital and ensure that they fully understand the legal position, that assessments take into account the health of a prisoner, and are based on the actual risk the prisoner presents at the time.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141