

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Walter Howes a prisoner at HMP Wakefield on 4 May 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 Walter Howes died of respiratory failure caused by aspiration pneumonia in hospital on 4 May 2019 while a prisoner at HMP Wakefield. Mr Howes also had chronic asthma and ischaemic heart disease which did not cause but contributed to his death. He was 85 years old. I offer my condolences to those who knew Mr Howes.

I agree with the clinical reviewer that the standard of healthcare that Mr Howes received at Wakefield was equivalent to that which he could have expected to receive in the community.

However, I am concerned that despite Mr Howes' very poor health and mobility, he was restrained by an escort chain on his way to hospital on several occasions. I draw this issue to the attention of the Executive Director for the High Security and Long-Term Estate.

I am also concerned that prison staff prevented hospital nurses from carrying out post-death care for Mr Howes until the police arrived.

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**

**June 2020**

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# Summary

## Events

1. On 4 May 2001, Mr Walter Howes was sentenced to life in prison for murder and wounding, with intent to cause grievous bodily harm. On 28 June 2009, he was transferred to HMP Wakefield.
2. Mr Howes had several long-term conditions. He had a history of angina, chronic asthma, arthritis in his left shoulder, ischaemic heart disease, anaemia, hypothyroidism,) hypercholesterolaemia (high cholesterol levels), emphysema (a lung condition which causes shortness of breath), an enlarged prostate and he had previously had a heart attack.
3. Mr Howes frequently saw healthcare staff to monitor and treat his medical conditions. He was a wheelchair user and relied on help from prisoners to collect his meals. He had many hospital appointments.
4. From January 2019, Mr Howes was often breathless and had problems swallowing. As a result, prison staff arranged for him to go to hospital on a number of occasions and when hospital staff had stabilised his condition, he returned to Wakefield. For each journey, two officers escorted him and used handcuffs for the journey.
5. On 29 April, healthcare staff found him unwell and breathless and treated him for low oxygen saturation levels. An ambulance was called and paramedics took him to hospital. Two officers escorted him and used handcuffs for the journey.
6. Mr Howes' condition did not improve and he remained in hospital. He deteriorated further and on 4 May, he died from respiratory failure caused by aspiration pneumonia. He also had chronic asthma and ischaemic heart disease which contributed to his death.

## Findings

7. The clinical reviewer concluded that the standard of care Mr Howes received at the prison was equivalent to that which he could have expected to receive in the community. Healthcare staff produced detailed care plans and managed Mr Howes' conditions in consultation with specialists. Towards the end of his life, staff provided constant medical and social care.
8. We are not persuaded that prison staff took into account that Mr Howes was seriously ill and a minimal security risk when they restrained him for hospital journeys.
9. Prison staff prevented hospital nurses from completing last offices for Mr Howes after he died and instructed them to wait until police arrived. We do not consider that this decision was justified.

## Recommendation

- The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, 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 Executive Director for the High Security and Long-Term Estate should assure himself that meaningful action is taken to ensure that this happens.
- The Governor should remind staff that the PPO should be provided with any material they request, in line with PSI 58/2010.
- The Governor should ensure that in cases where there are no security considerations or the possibility that a crime may have been committed, hospital nurses are allowed to complete the last offices for a deceased prisoner.

## The Investigation Process

10. 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.
11. The investigator obtained copies of relevant extracts from Mr Howes' prison and medical records.
12. NHS England commissioned an independent clinical reviewer to review Mr Howes' clinical care at the prison.
13. We informed HM Coroner for West Yorkshire Eastern of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
14. We were unable to contact Mr Howes' family, who had had no contact with him, to inform them of the investigation.
15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS clarified the events regarding the escort risk assessment process and this report has been amended accordingly.

# Background Information

## HMP Wakefield

16. 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 which aims to provide a supportive, safe, structured and consistent environment for some of the most challenging offenders).
17. Care UK have provided all healthcare provision at Wakefield since 1 April 2016. 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

18. The most recent inspection of HMP Wakefield was in June 2018. Inspectors found that clinical governance had improved since the last inspection and prisoner consultation at a monthly patient forum influenced service improvement. They noted that access to healthcare services was good and staffing levels were reasonable to support primary care, although there had been some delays with social care assessments.

## 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 latest annual report for the year to 30 April 2018, the IMB noted that the integration of separate nursing teams after the change of healthcare provider remained positive. It also noted that there had been a significant shift towards nursing staff working more collaboratively with hospital staff as a way of providing better and more integrated care for prisoners.

## Previous deaths at HMP Wakefield

20. Mr Howes was the seventeenth prisoner to die from natural causes at Wakefield since May 2017. There has been one self-inflicted death since. We have made recommendations to Wakefield about the need for properly considered risk assessments to justify the use of restraints in a number of previous investigation reports.

## Key Events

21. Mr Walter Howes was serving a life sentence for murder and wounding with intent to cause grievous bodily harm. He had been at HMP Wakefield since 28 June 2009. Mr Howes had had poor health for several years and had a history of angina, chronic asthma, arthritis in his left shoulder, ischaemic heart disease, anaemia, hypothyroidism, hypercholesterolaemia (high cholesterol levels), emphysema (a lung condition which causes shortness of breath), an enlarged prostate and he had previously had a heart attack. He was a wheelchair user and prisoners helped him to collect his meals.
22. Mr Howes frequently saw healthcare staff to monitor and treat his medical conditions. Prison GPs prescribed appropriate medications and he often went to hospital because of illness.
23. In 2015, specialist nurses were appointed to help Mr Howes manage his asthma and heart conditions. They scheduled appointments for him to see a consultant respiratory physician every six months. They also checked his lung function annually and checked that he used his inhalers correctly. They also scheduled regular reviews with the hospital consultant cardiologist.
24. After a review in July 2017, hospital consultants noted that Mr Howes was gradually deteriorating, that his condition was primarily respiratory in origin and that he should continue taking his heart failure medication.
25. On 11 April 2018, Mr Howes told his respiratory physician that he was breathless. He complained about leg cramps from taking furosemide (for heart failure). The respiratory physician told him to continue taking the medication.

### 2019

26. On 30 January 2019, Mr Howes complained of breathing difficulties. Nurses arranged for him to go to hospital. Two officers escorted and handcuffed him. He returned to the prison that day.
27. On 9 February, Mr Howes told a nurse that he had problems swallowing. She noted that his feet were swollen and completed a GP referral. However, the next day, Mr Howes' condition deteriorated. Nurses consulted the out-of-hours GP who said that Mr Howes should go to hospital. Before they left the prison, staff completed a security risk assessment and a prison manager, decided that Mr Howes should be restrained using an escort chain and accompanied by two officers. While in hospital, managers authorised the removal of the restraints on 10 February. After treatment, Mr Howes returned to Wakefield on 12 February.
28. On 27 February, a prison GP reviewed Mr Howes. She noted that his eating and drinking had improved and he took a nutritional supplement.
29. On 9 and 19 March, Mr Howes went to hospital for tests. Each time, two prison officers escorted him and handcuffed him using an escort chain.
30. On 29 April, Mr Howes complained of feeling unwell. Wing staff arranged for him to be reviewed in the healthcare unit. A nurse checked his observations which were all in the normal range. She calculated his National Early Warning Score

(NEWS – a tool used to detect and respond to clinical deterioration) which meant that he needed further monitoring but remained at very low risk of needing intensive care. She referred him to the prison GP. The prison GP noted that Mr Howes had a blueish discolouration and that his oxygen saturation levels were 88% (low). The prison GP arranged for his transfer to a hospital. Two staff escorted him, unrestrained.

31. On 30 April, a senior nurse and a prison GP from Wakefield visited Mr Howes in hospital and spoke to the hospital nurses. Mr Howes received intravenous fluids and antibiotics. He was unable to respond verbally and could only respond by opening his eyes. They received updates from hospital nurses by telephone.
32. Mr Howes continued to deteriorate and became unresponsive. He died in hospital at 1.20am on 4 May.

### **Contact with Mr Howes' family**

33. On 10 February 2019, as Mr Howes was ill and in hospital, an officer tried to locate contact detail for Mr Howes' next of kin but found that he had no contact with his family.
34. On 30 April, when Mr Howes was in hospital, a hospital GP said that as he was very ill, prison staff should contact his family. Wakefield immediately appointed a prison manager as the family liaison officer (FLO). He checked Mr Howes' records but found that his family had severed all contact with him. The prison arranged and paid for Mr Howes' funeral in line with national instructions.

### **Support for prisoners and staff**

35. After Mr Howes' death, the duty governor debriefed the escorting staff to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
36. The prison posted notices informing other prisoners of Mr Howes' 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 Howes' death.

### **Cause of death**

37. The Coroner noted that Mr Howes had died from respiratory failure caused by aspiration pneumonia. He had chronic asthma and ischaemic heart disease which did not cause but contributed to his death.

# Findings

## Clinical care

38. We agree with the clinical reviewer that Mr Howes' care and treatment in prison was equivalent to that which he could have expected to receive in the community. Healthcare staff liaised effectively with the hospital about his care and there were good, clear holistic care plans, which were well communicated to healthcare staff and discussed with Mr Howes. Staff looked after Mr Howes well and maintained his dignity throughout his decline. We are satisfied that he received good support and treatment from prison healthcare staff throughout his illness.

## Restraints, security and escorts

39. 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 (including the risk to the public) and the prisoner's risk when he has a serious medical condition. The judgment indicated that medical opinion about a prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.
40. Healthcare staff, who completed the medical section of the risk assessment when Mr Howes attended hospital from January 2018 onwards, did not object to the use of restraints but stated that Mr Howes had impaired mobility. There are many entries throughout his records where he is described as breathless and a wheelchair user. Despite this, a number of managers authorised that Mr Howes should be restrained by an escort chain and escorted by two escort officers.
41. When Mr Howes was admitted to hospital in February 2019, a prison manager described Mr Howes as looking frail and noted that he could not walk unaided. The duty manager authorised the removal of the restraints on the basis of Mr Howes' age and infirmity later that day.
42. When Mr Howes was urgently transferred to hospital on 30 April, his risk assessment concluded that his risk to the public was high, his risk to hospital staff and escape potential was medium (yet noted that there was no intelligence to suggest a risk to hospital staff or escape risk). His risk of hostage taking and likelihood of external assistance were low. The medical section of the risk assessment recorded that there were no medical objections to the use of restraints. However, it stated that no restraints should be used and that he was wheelchair bound. The form also detailed two historic convictions from 1951 (for theft) and 1988 (sexual offences against his next of kin). A prison manager authorised the use of an escort chain.
43. It was good to see that the Person Escort Record noted that there was a discussion between medical staff and the duty governor before Mr Howes went

to hospital by ambulance for the final time. As a result, approval was given for Mr Howes not to be restrained.

44. Mr Howes was an elderly Category B prisoner, who had been in poor health and poor mobility for several years, and had frequently been taken to hospital for appointments and admission. We are very concerned that staff considered that that it was appropriate to use an escort chain for Mr Howes. It is difficult to see how staff assessed that such a seriously ill and elderly man had the ability to escape unaided from two escort officers.
45. We are also concerned that when we emailed the Head of Safer Prisons and Equalities for a copy of any local risk assessments and to ask the manager with responsibility for the use of restraints process to explain how the local policy applied to elderly prisoners, we never received a response.
46. After seeing the initial report, the Head of the Safer prisons and Equalities said that the email had been passed to the security manager for a response. However, due to an administrative oversight a response regarding the use of restraints had not been sent to us.
47. The Prison Service has a responsibility to protect the public, but security must be balanced with humanity and measures must be proportionate to a prisoner's individual circumstances. We are not satisfied that managers appropriately considered Mr Howes' condition during at least the last year of his life and how it affected his risk. We have previously made recommendations about the use of restraints and it is disappointing that, despite the prison's assurances that they had taken action to improve the process, we have to repeat the following recommendation:

**The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, 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.**

48. We also draw it to the attention of the Prison Group Director and make the following recommendation:

**The Executive Director for the High Security and Long-Term Estate should assure himself that meaningful action is taken to ensure that this happens.**

49. We also recommend:

**The Governor should remind staff that the PPO should be provided with any material they request, in line with PSI 58/2010.**

### **Decency after death**

50. Shortly after a death has been confirmed, nurses complete a process called "last offices" to demonstrate respect to the deceased as well as to comply with health, safety and legal requirements. Records show that the duty governor decided that hospital nurses could not perform last offices for Mr Howes until police

attended. The circumstances of Mr Howes' death were not suspicious and we cannot see how this decision was justified. We recommend that:

**The Governor should ensure that in cases where there are no security considerations or the possibility that a crime may have been committed, hospital nurses are allowed to complete the last offices for a deceased prisoner.**

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