

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Colin Cheetham a prisoner at HMP Wakefield on 1 May 2020

**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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## Summary

1. 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.
2. Our office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Colin Cheetham, who was 71 years old, died in prison from multiple organ failure on 1 May 2020, while a prisoner at HMP Wakefield. We offer our condolences to Mr Cheetham's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Cheetham received at Wakefield was of a good standard and equivalent to that which he could have expected to receive in the community. She made three recommendations but two have not been included in this report as they do not relate directly to Mr Cheetham's death.
5. We are concerned that Wakefield was unable to provide a piece of evidence requested by the PPO investigator because it could not be found.

## Recommendations

- The Head of Healthcare should ensure that timely end of life care planning is initiated.
- The Governor should ensure that prison documentation is stored securely and provided promptly when requested during a PPO investigation.

## Investigation Process

6. NHS England commissioned an independent clinical reviewer, to review Mr Cheetham's clinical care at HMP Wakefield. The clinical review is attached to this report as Annex 1.
7. The PPO investigator has investigated the non-clinical issues in Mr Cheetham's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. The PPO's family liaison officer, wrote to Mr Cheetham's next of kin, his wife, to explain the investigation. She did not have any specific questions for us to consider.
9. Mr Cheetham's wife received a copy of the initial report. She did not make any comments.
10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

## **Previous deaths at Wakefield**

11. Mr Cheetham was the 20th prisoner to die at Wakefield since May 2018. All the previous deaths were from natural causes apart from two that were self-inflicted. We have previously made recommendations about care planning for terminally ill prisoners.

## Key Events

12. On 29 June 2010, Mr Colin Cheetham was sentenced to life imprisonment for murder. He remained at HMP Wakefield, where he had been on remand since 5 October 2009, until his death.
13. Mr Cheetham had multiple long-term health conditions including type 2 diabetes (a condition that causes too much sugar in the blood which can lead to serious damage to several areas of the body), hypertension (high blood pressure), ischaemic heart disease (restricted blood supply to the heart due to blockages in the arteries), atrial fibrillation (AF, a heart condition which causes it to beat irregularly), sleep apnoea (potentially dangerous interruptions to breathing when asleep), lymphoedema (tissue swelling caused by a problem with the lymphatic system), chronic kidney disease (progressive loss of function of the kidneys) and recurrent cellulitis (a serious bacterial infection of the skin). He was also very overweight and had restricted mobility.
14. Mr Cheetham's conditions were regularly reviewed by healthcare staff at Wakefield. In 2018 and 2019, he was admitted to hospital on several occasions, for a range of conditions including urinary tract infections, cellulitis and pneumonia. After May 2018, Mr Cheetham was often too unwell to be located on a prison wing, and spent much of his time in the healthcare centre.
15. During 2020, Mr Cheetham more frequently refused appointments and medical interventions. He was assessed to have the mental capacity to make these decisions.
16. On 27 January, Mr Cheetham became very unwell, but he said that he preferred death to treatment, and could not be persuaded to go to hospital or move to a cell in the healthcare centre. He signed a disclaimer to say he was aware of the possible consequences of his decision.
17. On 5 February, to help with increasing shortness of breath he was offered a CPAP machine (a ventilator, mostly to help with breathing at night), but he refused to have one.
18. Mr Cheetham again refused to move to the healthcare centre on 26 February, after his volunteer carer raised concerns about his ability to cope on the wing. However, following further illness and a reoccurrence of his cellulitis, and then a fall on 5 March, he was moved to the healthcare centre, where he stayed until his death.
19. On 12 April, Mr Cheetham was ill enough for an ambulance to be called, but he refused to go to hospital. On 15 April, Mr Cheetham told a prison GP that he did not want to go back to hospital, and would prefer to die in prison. He was assessed to have the mental capacity to make this decision.
20. With his condition continuing to worsen, a multidisciplinary team (MDT) meeting was held on 24 April. It decided that as Mr Cheetham refused interventions or any active management of his symptoms, he should be put on an end of life pathway with palliative care (care with the focus on optimising the quality of life and reducing suffering). He was told that he could still change his mind about receiving hospital treatment.

21. Mr Cheetham did not change his mind. His symptoms were monitored and he was checked regularly through the nights. He died on 1 May.
22. There was no post-mortem examination as the coroner accepted the cause of death provided by the medical team involved in his care. The cause of death was given as multiple organ failure, caused by ischaemic heart disease, hypertension and type 2 diabetes. Underlying factors which contributed to these conditions, were morbid obesity (extreme overweight) and sleep apnoea.

## **Non-Clinical Findings**

### **Providing evidence to the PPO**

23. At the start of the investigation, the PPO investigator requested a copy of the wing observations book. Wakefield provided a copy but a page was missing. After several weeks of the PPO investigator chasing up the prison for the missing page, prison staff told him that the wing observations book could not be found. While we have no cause to believe the missing page was directly relevant to this case, it is unacceptable that the prison could not provide it and appeared to have failed to retain it in line with policy. We make the following recommendation:

**The Governor should ensure that prison documentation is stored securely and provided promptly when requested during a PPO investigation.**

### **Liaison with next of kin**

24. The investigation found that Mr Cheetham's next of kin, his wife, was not aware of the financial support available from the prison to help with funeral costs. If it had been discussed with her by Wakefield's family liaison officer, her understanding of the situation was not checked. However, after the PPO's investigator raised the matter with Wakefield, they promptly rectified the situation and said they would make the financial contribution in line with Prison Service instructions. We therefore make no recommendation.

**Louise Richards**  
**Assistant Ombudsman**

**October 2020**