

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr William Treadwell, a prisoner at HMP Wakefield, on 4 July 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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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. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr William Treadwell, who was 81 years old, died of an acute ischaemic stroke on 4 July 2019, while a prisoner at HMP Wakefield. We offer our condolences to Mr Treadwell's family and friends.
4. The clinical reviewer concluded that the care Mr Treadwell received at HMP Wakefield was equivalent to that which he could have expected to receive in the community. She has made one recommendation about a clinical issue.
5. We did not find any non-clinical issues of concern.

Recommendations

- **The Head of Healthcare should ensure that falls assessments are completed on those known, or suspected, to be at risk of falls.**

Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Treadwell's clinical care at HMP Wakefield.
7. The PPO has investigated the non-clinical issues in Mr Treadwell's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at Wakefield

9. There have been 16 deaths from natural causes at HMP Wakefield in the last two years. There has been one further death from natural causes since Mr Treadwell's death. There are no similarities between our findings in the investigation of Mr Treadwell's death and the other deaths.

Key Events

10. On 30 May 2002, Mr Treadwell was sentenced to life imprisonment for sexual offences. He was sent to HMP Wakefield. Mr Treadwell arrived in prison with a number of pre-existing medical conditions, including high blood pressure, type 2 diabetes and a history of strokes, for which he received regular reviews and appropriate treatment.
11. On 2 July 2019, prison staff found Mr Treadwell slumped in a chair in his cell. His face appeared to have dropped on one side and he was unresponsive. He was taken to Pinderfields Hospital, Wakefield, for review. Mr Treadwell was not restrained.
12. Hospital staff concluded that Mr Treadwell had had a serious stroke. They gave him a course of antibiotics and placed him on oxygen therapy.
13. Hospital staff told the prison officers accompanying Mr Treadwell, that his prognosis was poor and that he was not expected to recover. Hospital staff signed a do not attempt cardiopulmonary resuscitation (DNACPR) form on Mr Treadwell's behalf and started palliative care.
14. Later that evening, hospital staff withdrew Mr Treadwell's oxygen therapy. His condition continued to deteriorate, and at 8.00am on 4 July, Mr Treadwell died. A hospital doctor confirmed his death at 8.30am.
15. A post-mortem examination gave Mr Treadwell's cause of death as:
 - 1a) an acute ischaemic stroke,
 - 1b) type 2 diabetes, hypertension, cerebrovascular disease (a group of disorders that affect the blood supply to the brain) and ischaemic heart disease.

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