

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alexander Anderson, a prisoner at HMP Wakefield, on 11 November 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. 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 Alexander Anderson, who was 54 years old, died of lung cancer on 11 November 2019, while a prisoner at HMP Wakefield. We offer our condolences to Mr Anderson's family and friends.
4. The clinical reviewer concluded that the care Mr Anderson received at HMP Wakefield was equivalent to that which he could have expected to receive in the community. He has made six recommendations about clinical issues
5. We did not find any non-clinical issues of concern.

Recommendations

- **The Head of Healthcare should ensure that there are processes in place to ensure escorts for urgent investigations are prioritised. This will ensure patients have completion of investigations within the timescales outlined within national guidance.**
- **The Head of Healthcare should review the processes for arranging GP appointments and devise and implement a system to identify individuals who require an urgent appointment. This will ensure that there are no delays in patients accessing services and having further investigation/onward referral in a timely manner.**
- **The Head of Healthcare should ensure that all staff receive training in the correct techniques required to obtain valid samples. This will ensure there are no delays in patients accessing services and having further investigations/onward referral in a timely manner.**
- **The Head of Healthcare should ensure that the healthcare team discuss and document the use of an open-door policy when dealing with patients at the end of their lives. This will ensure that appropriate care and treatment can be given in a timely manner.**
- **The Head of Healthcare should ensure that personalised and specific care plans exist in relation to all patients who are at the end of their lives, including pain management and a personalised care plan which explicitly sets out the wants, needs and expectations in the event of deterioration at the end of life. This will direct health professionals in what individual care is required, and thereby avoid any confusion or ambiguity in delivering care.**

- **The Head of Healthcare should ensure that any patient who is identified at being at risk of falls has a multifactorial risk assessment and that a falls prevention care is implemented as outlined in NICE guidance 161 (falls in older people). This will ensure that measures are implemented to mitigate the risk of future falls.**

Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Anderson's clinical care at HMP Wakefield.
7. The PPO investigator has investigated the non-clinical issues in Mr Anderson'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 family liaison officer wrote to Mr Anderson's next of kin, his sister, to explain the investigation. She did not have any specific questions for us to consider.

Previous deaths at Wakefield

9. Mr Anderson was the 17th prisoner to die from natural causes at Wakefield since November 2017. There has been one further death from natural causes since.
10. There are no similarities between our findings in the investigation of Mr Anderson's death and the other deaths.

Key Events

11. On 16 June 2017, Mr Alexander Anderson was sentenced to 12 years in prison for sexual offences. He was sent to HMP Manchester.
12. Mr Anderson arrived into prison with a pre-existing diagnosis of chronic obstructive pulmonary disease, for which he was prescribed inhalers (COPD, an inflammatory condition of the lungs which restricts air flow). He was noted to be a smoker and was offered smoking cessation advice by healthcare staff. However, despite their repeated best efforts, he consistently declined. A care plan was devised to manage his COPD and he was regularly reviewed by healthcare staff.
13. On 15 February 2018, Mr Anderson transferred to HMP Wakefield. His diagnosis of COPD was noted, his care plans updated and his prescribed medications reviewed. Healthcare staff regularly reviewed Mr Anderson following his arrival at the prison
14. During a review by a prison GP in May 2019, Mr Anderson complained of increasing shoulder pain and a worsening of his COPD symptoms. The GP diagnosed him as having suspected lung cancer and made a two week wait referral to the oncology department at Leeds General Infirmary. In July, hospital staff confirmed Mr Anderson had lung cancer.
15. Hospital staff considered that due to his poor health, Mr Anderson was not suitable for surgical intervention. On 2 October, Mr Anderson was informed his condition was incurable and that palliative treatment was the only option open to him. He was told he had a matter of months to live. Mr Anderson told healthcare staff that he did not wish to be resuscitated in the event of a cardiopulmonary arrest and signed a DNACPR to that effect (a document that alerts staff to Mr Anderson's wishes not to be resuscitated).
16. On 6 October, Mr Anderson was moved to the prison's palliative care suite for pain management.
17. His condition continued to deteriorate and at 12.50am on 11 November 2019, Mr Anderson died. His death was confirmed by an out of hours GP at 3.26am.
18. The coroner gave Mr Anderson's cause of death as:
 - 1a) lung cancer

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