

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Edward Adams, a prisoner at HMP Wakefield, on 31 December 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 Edward Adams died on 31 December 2019 of lung cancer at HMP Wakefield. He was 81 years old. I offer my condolences to Mr Adams' family and friends.
4. The clinical reviewer concluded that the clinical care Mr Adams received at Wakefield was equivalent to that which he could have expected to receive in the community. She made no recommendations.
5. We found that the decision to restrain Mr Adams when he was taken to hospital was not clearly justified given his advanced age and poor mobility.

## Recommendation

- **The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that risk assessments show clear justification for the use of restraints.**

## The Investigation Process

6. NHS England commissioned an independent clinical reviewer, to review Mr Adams' clinical care at Wakefield.
7. The PPO investigator has investigated non-clinical issues, including Mr Adams' 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 Adams' next of kin to explain the investigation. He did not respond to our letter.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.
10. The initial report was also shared with the Coroner as part of the consultation process. The Coroner's Officer provided further information about events when Mr Adams was ill in his cell before he moved to the prison's palliative care suite. We have amended our report to acknowledge and take account of the additional information.
11. As a result of additional information, the investigator interviewed three members of prison staff.

### Previous deaths at HMP Wakefield

12. Mr Adams was the 18<sup>th</sup> prisoner to die at Wakefield since December 2017. Of these deaths, 15 were from natural causes and three were self-inflicted deaths. We have previously made recommendations about the need to show clear justification for the use of restraints.

## Key Events

13. Mr Edward Adams was serving time in prison for sexual offences and had been at HMP Wakefield since 27 May 2015.
14. In February 2018, Mr Adams complained of shortness of breath. Healthcare staff arranged for him to have a CT scan at a hospital in Yorkshire. Prison staff sent him to hospital, restrained and escorted by two officers. The scan results indicated that Mr Adams had cancer.
15. When healthcare staff scheduled further hospital appointments, Mr Adams declined to attend because he said that he felt humiliated when handcuffed in public.
16. On 28 November 2018, an application for Mr Adams' early release on compassionate grounds was submitted to the Public Protection Casework Section (PPCS) of Her Majesty's Prison and Probation Service (HMPPS). The application was refused because although he was very ill, he was not physically incapacitated and was not assessed as having a life expectancy of three months or less.
17. On 15 July 2019, Mr Adams needed to attend hospital for an urgent scan for long term oxygen therapy. He only agreed to attend the appointment after it was decided that his escort officers would use an escort chain (an escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer).
18. The scan results showed that Mr Adams had disseminated malignancy (where the cancer has spread to other areas). In discussion with Mr Adams, hospital specialists and prison staff, it was agreed that he was not suitable for chemotherapy. Mr Adams also said that he did not want any further treatment and it was decided that he would receive palliative care only.
19. Mr Adams' physical condition continued to deteriorate. Another application for his early release on compassionate grounds was submitted, but it was refused again on 10 December 2019.
20. On 13 December, Mr Adams moved to the prison's palliative care suite.
21. On 31 December, it was confirmed that Mr Adams had died.

### Cause of death

22. There was no post-mortem examination as the coroner accepted the cause of death provided by the hospital doctor. The doctor gave Mr Adams' cause of death as terminal lung cancer.

## Non-Clinical Findings

### Restraints, security and escorts

23. 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.
24. 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 (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.
25. The investigator reviewed Mr Adams' escort risk assessments from July 2019. Prison staff completed an escort risk assessment before his hospital appointments. Mr Adams had been diagnosed with cancer, was elderly and his health had deteriorated. Records showed that he struggled to get out of bed, used stairs with difficulty, found it difficult to move around the wing and was easily tired. His hospital cardio respiratory consultant had requested that a note be added to his medical record saying that due to his frailty and breathlessness, prison staff should only use an escort chain if necessary. Mr Adams' 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 he was a risk to hospital staff or an escape risk) and his risk of hostage taking and likelihood of external assistance were low.
26. When a nurse completed the medical section, she noted that Mr Adams had impaired mobility. She did not object to the use of restraints. She also completed an algorithm for the use of handcuffs to and from the hospital and noted that as an alternative to double handcuffs (double cuffing is when the prisoner's hands are handcuffed in front of them and one wrist is attached to a prison officer by an additional set of handcuffs), an escort chain was appropriate for the journey.
27. A prison manager authorised two officers to escort Mr Adams to hospital by taxi. Mr Adams was restrained using an escort chain for the journey and his hospital appointment.
28. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances. Mr Adams was an elderly, category B prisoner, who had poor mobility for several years and had been diagnosed with cancer. These factors do not appear to have been taken into consideration when the risk assessment was completed. 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. There is no evidence to justify the reason why staff had no objection to the use of restraints. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that risk assessments show clear justification for the use of restraints.**

**Comments received after the initial report**

29. The Coroner's Officer provided copies of two notes which were found in Mr Adam's possessions and were seized by the police. The letters outlined Mr Adam's feelings about his care in October and November 2019. Mr Adams complained that Prison Officers had denied him access to pain relief during the night. However, we did not find any evidence to substantiate his complaint.

**Lisa Burrell  
Assistant Ombudsman**

**October 2020**

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