

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ernest Wright, a prisoner at HMP Wakefield, on 4 September 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. 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 Ernest Wright, who was 79 years old, died of heart failure and pneumonia on 4 September 2020, at HMP Wakefield. We offer our condolences to Mr Wright's family and friends.
4. The clinical reviewer concluded that Mr Wright received a good standard of care, equivalent to that he could have expected to receive in the community. However, she made two recommendations, one of which we have included in our report.
5. We are concerned that an application for compassionate release was never considered, even though Mr Wright was on an end of life pathway.

Recommendations

- The Head of Healthcare should ensure that patients with palliative care needs are invited to multidisciplinary team meetings about their care.
- The Governor and Head of Healthcare should ensure that, when a prisoner is placed on an end of life pathway, staff consider starting an application for release on compassionate grounds.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer, to review Mr Wright's clinical care at HMP Wakefield.
7. The PPO investigator has investigated the non-clinical issues in Mr Wright's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. One of our family liaison officers wrote to Mr Wright's next of kin, his nephew, to explain the investigation and to ask if he had any matters they wanted the investigation to consider. He did not raise any issues.
9. Mr Wright's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.
10. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Previous deaths at HMP Wakefield

11. Mr Wright was the 20th prisoner to die at Wakefield since September 2018. Of the previous deaths, 17 were from natural causes and two were self-inflicted. We have previously made recommendations about inviting palliative care patients to multidisciplinary meetings about their care and about delays in making compassionate release applications.

Key Events

12. In May 2009, Mr Ernest Wright was recalled to custody for murder. He was sent to HMP Wakefield.
13. Mr Wright had several long-term health conditions, for which he received appropriate medication.
14. In 2019, Mr Wright's health began to deteriorate. He was seen regularly by the healthcare staff at Wakefield, but often refused to go to hospital for any further investigations, because he said that it was too much hassle. He said he was happy to be seen by the prison GP. On several occasions Mr Wright did agree to a referral, but when the appointment day came, he refused to go to hospital.
15. In October, a multidisciplinary team meeting was held to discuss Mr Wright's ongoing refusal to attend hospital appointments. On the same day, a nurse spoke to Mr Wright to talk to him about his care needs. Mr Wright said that he would not attend any appointments made for him because he could not be bothered with the hassle.
16. On 25 October, healthcare staff discussed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) with Mr Wright, who agreed that if he stopped breathing he did not want to be resuscitated.
17. Over the next six months, Mr Wright was seen by healthcare staff daily. Mr Wright continued to refuse to go to hospital for any investigations.
18. On 21 May 2020, Mr Wright had a fall in his cell, he was seen by a nurse practitioner, who said that he needed to go to hospital. Mr Wright was escorted to hospital by two officers, using the single cuffing method (when the prisoner's wrist is attached to a prison officer's wrist by a set of handcuffs). The hospital doctor said that Mr Wright had broken his hip and needed an operation.
19. On 23 May, Mr Wright had an operation on his hip. The operation went well but while in hospital Mr Wright caught pneumonia. He was given intravenous antibiotics. On 2 June, while he was in hospital, it was noted that Mr Wright was refusing his antibiotics. It was agreed that he would return to Wakefield for ongoing care.
20. On 2 June, a multidisciplinary meeting was held and it was agreed that Mr Wright did not have any specialist palliative care needs. It was also acknowledged that Mr Wright was refusing any medical interventions, declining any investigations and there was no confirmed diagnosis of cancer.
21. On 17 July, another multidisciplinary meeting was held. The gold standards indicator was changed from amber to red. A red rating indicates that the patient is in the last days of their life. An end of life care plan was created to support Mr Wright.
22. Over the next two months, Mr Wright's health gradually deteriorated. On 4 September, Mr Wright died in his sleep. The post-mortem report concluded that Mr Wright died from congestive heart failure and pneumonia.

Non-Clinical Findings

Compassionate release

23. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months, can permanently be released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000. The criteria include that the risk of reoffending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section of Her Majesty's Prison and Probation Service.
24. In July 2020, Mr Wright's health began to deteriorate significantly and he was placed on an end of life pathway. It was clear that healthcare staff knew that Mr Wright did not have long left to live. We are concerned that prison staff did not consider starting an application for release on compassionate grounds. We have previously made recommendations to Wakefield about the timeliness of compassionate release applications. We make the following recommendation:

The Governor and Head of Healthcare should ensure that, when a prisoner is placed on an end of life pathway, staff consider starting an application for release on compassionate grounds.

Louise Richards
Assistant Ombudsman

January 2021

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