Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Thomas Wolens, a prisoner at HMP Wakefield, on 23 February 2021

A report by the Prisons and Probation Ombudsman

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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 Thomas Wolens died in hospital on 23 February 2021, from COVID-19 pneumonia, while a prisoner at HMP Wakefield. He was 67 years old. I offer my condolences to Mr Wolens' family and friends.

4. We cannot say where Mr Wolens contracted COVID-19. His symptoms began 14 days after his transfer from HMP Frankland to Wakefield, on the cusp of the accepted incubation period. He could therefore have been exposed to the virus at either of the prisons, or in transit.

5. The clinical reviewer concluded that Mr Wolens' clinical care at Wakefield was equivalent to that he could have expected to receive in the community. However, he made recommendations about the need for the frequency of blood tests for diabetics to be compliant with National Institute for Health and Care Excellence (NICE) guidelines, and about the prompt implementation of care plans.

6. We consider that Mr Wolens should have been formally notified of his clinical vulnerability to COVID-19 and the policy on shielding. Additionally, his next of kin should have been informed sooner of his diagnosis and that he had been taken to hospital.

7. We are concerned that Wakefield was unable to provide the risk assessment and other escort documents covering Mr Wolens final journey and stay in hospital. We were therefore unable to investigate the propriety of the escort arrangements.

Recommendations

- The Head of Healthcare at Frankland should ensure that blood tests for diabetic prisoners are conducted in line with National Institute for Health and Care Excellence (NICE) guidelines.

- The Head of Healthcare at Wakefield should ensure that care plans for long-term conditions are created promptly for newly-arrived prisoners.

- The Governor and Head of Healthcare at HMP Frankland should ensure that prisoners at risk of developing complications if they contract COVID-19 are managed in line with national guidance.

- The Governor should ensure that if a prisoner is suspected of contracting COVID-19, he is given the opportunity for someone to be notified.

- The Governor should ensure, in line with Prison Rule 22, that a prisoner's next of kin is informed promptly if he becomes seriously ill.

- The Governor should ensure that, in line with Prison Service Instruction 58/2010, all prison documents are stored securely and provided promptly for PPO investigations.

The Investigation Process

8. NHS England commissioned an independent clinical reviewer to review Mr Wolens' clinical care at HMP Wakefield.

9. The PPO investigator investigated the non-clinical issues, including aspects of the prison's response to COVID-19 and shielding prisoners; Mr Wolens' location; the security arrangements for his journey and admission to hospital; liaison with his family; and whether early release was considered.

10. The Ombudsman's family liaison officer wrote to Mr Wolens' next of kin, his niece, to explain the investigation. Mr Wolens' niece had no specific questions for the investigation to consider.

11. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies. They provided an action plan which is annexed to this report.

12. We sent a copy of our initial report to Mr Wolens' niece. She did not notify us of any factual inaccuracies.

Previous deaths at HMP Wakefield

13. Mr Wolens was the 25th prisoner at Wakefield to die since February 2019. Two of the previous deaths were self-inflicted and the remainder from natural causes. There have since been six deaths, one self-inflicted and five from natural causes, including two from COVID-19. We have made several previous recommendations about providing documents for PPO investigations.

COVID-19 (coronavirus)

14. COVID-19 is an infectious disease that affects the lungs and airways. It is mainly spread through droplets when an infected person coughs, sneezes, speaks or breathes heavily. On 11 March 2020, the World Health Organisation (WHO) declared COVID-19 a worldwide pandemic.

15. COVID-19 can make anyone seriously ill, but some people are at higher risk of severe illness and developing complications from the infection. People at high risk (clinically extremely vulnerable) include those who have had an organ transplant; have severe lung or kidney disease; or are having certain types of cancer or other treatment which significantly increases the risk of infection. Examples of those at moderate risk (clinically vulnerable) are people over 70; people under 70 with an underlying health condition, such as diabetes, or chronic respiratory, heart, liver or kidney disease; those with a weakened immune system; or who are very overweight. (These lists are not exhaustive.)

16. In response to the initial pandemic outbreak, HM Prison and Probation Service (HMPPS) introduced several measures to try and contain the outbreak - to be implemented at local level, depending on the needs of individual prisons. (An outbreak is defined as two or more prisoners, or staff, who are clinically suspected, or have tested positive for COVID-19 within 14 days.) A key strategy is 'compartmentalisation' to cohort and protect prisoners at high and moderate

risk; isolate those who are symptomatic; and separate newly-arrived prisoners from the main population. Other measures include social distancing and the use of personal protective equipment (PPE).

Key Events

17. Mr Thomas Wolens was remanded to prison in August 1987. He was convicted of murder and robbery on 22 January 1988 and sentenced to life imprisonment, with a minimum period to serve of 14 years.

18. After spending time at several prisons, Mr Wolens transferred from HMP Wakefield to HMP Frankland on 28 January 2020, to live on a dedicated wing for personality disorder treatment.

19. Mr Wolens had a history of heart failure, angina, type 2 diabetes and mental health problems. He also had a mild learning disability, which affected his ability to read and write. Healthcare staff noted he should be given information in easy-read format.

20. On 24 March 2020, during a medication review in anticipation of a potential prison lockdown, a prison GP noted that Mr Wolens was clinically vulnerable to complications from COVID-19.

21. Mr Wolens did not settle in the unit at Frankland and returned to Wakefield on 5 February 2021. He was immediately tested for COVID-19 and allocated to a single cell in the reverse cohorting unit, located in the healthcare inpatient centre. A further test was conducted on 9 February. Both test results returned as negative.

22. During the evening of 18 February, an officer monitoring Mr Wolens' telephone calls reported to the wing that he sounded low in mood. A wing officer checked Mr Wolens, who said that he was all right and had no problems. The officer noted that his mood and demeanour seemed good.

Transfer to hospital

23. Just after 5.30pm on 19 February, Mr Wolens fell in his cell. A healthcare assistant and a nurse took clinical observations and found that Mr Wolens' blood oxygen saturation level was very low. They then calculated a National Early Warning Score 2 (NEWS2 - an assessment to identify clinical deterioration). The total score was 7, which indicated high risk requiring emergency assessment by a critical care team. Mr Wolens was therefore sent to hospital by ambulance.

24. In the early hours of 20 February, Mr Wolens was admitted to the acute respiratory care unit. He tested positive for COVID-19 and was treated using a continuous positive airway pressure (CPAP) machine, as well as intravenous medication.

25. Healthcare staff contacted the hospital daily for updates on Mr Wolens' condition. On 21 February, the hospital told the prison that there had been a significant deterioration in Mr Wolens' condition, but a transfer to the intensive care unit would not be beneficial and his next of kin should be notified. The prison's family liaison officer then informed Mr Wolen's niece that he was in hospital and might die imminently. With consent, her contact details were shared with the hospital.

26. On 22 February, Mr Wolens said that he did not wish to be resuscitated if his heart or breathing stopped. End of life care was started and the prison informed

Mr Wolens' niece. The same day, the Governor authorised release on temporary licence and withdrew the prison escort officers.

27. Mr Wolens asked for the CPAP mask to be removed. Hospital staff complied with his wishes, as they were satisfied he had the mental capacity to make this decision. Mr Wolens died at 8.30pm on 23 February.

28. The prison arranged and paid for Mr Wolens' funeral, in line with national policy.

Cause of death

29. An inquest was held on 22 March, which concluded that Mr Wolens had died from COVID-19 pneumonia. He also had underlying atrial fibrillation, ischaemic heart disease and diabetes, which had contributed to, but did not cause his death.

Findings

Clinical Findings

30. The clinical reviewer concluded that Mr Wolens' clinical care at Wakefield was equivalent to that he could have expected to receive in the community. However, he found that the management of his diabetes at Frankland was not in line with national guidelines, as blood tests were not taken at the required intervals. He also found that no care plans were created for Mr Wolens' long-term conditions when he returned to Wakefield.

31. Full details of the clinical reviewer's findings are in the clinical review report. We reflect his recommendations in this report as they relate to the management of conditions which contributed to the cause of Mr Wolens' death. We recommend:

    The Head of Healthcare at Frankland should ensure that blood tests for diabetic prisoners are conducted in line with National Institute for Health and Care Excellence (NICE) guidelines.

    The Head of Healthcare at Wakefield should ensure that care plans for long-term conditions are created promptly for newly-arrived prisoners.

Management of Mr Wolens' risk of infection from COVID-19

32. Shortly after confirmation of the COVID-19 pandemic, a prison GP at Frankland incidentally noted that Mr Wolens was clinically vulnerable to complications from COVID-19. As with another recent investigation at Frankland, there is nothing to indicate that the risks and possibility of shielding were discussed with him – although he would have benefitted from a degree of protection from the restrictions and limited contact when the prison went into lockdown. (The national guidance on shielding has since changed.) This omission did not adversely affect Mr Wolens, but it is important that prisons adhere to national policies on managing risk during the ongoing pandemic. We repeat a previous recommendation:

    The Governor and Head of Healthcare at HMP Frankland should ensure that prisoners at risk of developing complications if they contract COVID-19 are managed in line with national guidance.

33. When he returned to Wakefield, Mr Wolens was isolated for 14 days, in line with national policy and tests for COVID-19 during this period were negative.

34. While there is no evidence that information on COVID-19 was given to Mr Wolens in easy-read format, he had fortnightly mental health meetings, attended by the learning disability nurse, in which they spoke about a number of things, including Mr Wolens' concerns about COVID-19. It was noted that he appeared to have a reasonable understanding of the implications of the virus and the measures necessary to comply with infection control.

35. Mr Wolens had agreed to receive the COVID-19 vaccine but he died before receiving it.

36. When Mr Wolens became unwell, staff were mindful that he was on blood thinning medication and took immediate steps to send him to hospital for further assessment.

37. We cannot say when or where Mr Wolens contracted COVID-19. The incubation period after exposure to the virus is thought to be up to 14 days. As he became unwell on the 14th day after his return to Wakefield, he could have been exposed either at Frankland, Wakefield, or during the journey between the prisons.

Contacting Mr Wolens' next of kin

38. Prison Rule 22 states that prisons should inform the next of kin immediately if a prisoner becomes seriously ill. In March 2020, this obligation was reinforced in national Prison Service guidance on family liaison and communicating with prisoners' families during the pandemic. The guidance also states that if a prisoner is suspected of having contracted COVID-19 (a formal diagnosis is not required), they should be given the opportunity to have someone informed.

39. On the advice of clinicians, the prison contacted Mr Wolens' niece two days into his admission to hospital, after a marked deterioration in Mr Wolens condition. We consider that the prison should have attempted to inform her the previous day, when Mr Wolens was diagnosed with COVID-19. At the very least, she should have been told soon after he moved to the acute respiratory care unit when it was clear that he was very poorly. We recommend:

The Governor should ensure that if a prisoner is suspected of contracting COVID-19, he is given the opportunity for someone to be notified.

The Governor should ensure, in line with Prison Rule 22, that a prisoner's next of kin is informed promptly if he becomes seriously ill.

Provision of risk assessment and escort documents

40. When prisoners travel outside of the prison, a risk assessment is conducted to determine the nature and level of any security arrangements, including any restraints. The level of restraints used should be necessary in the circumstances and based on a risk assessment which considers the risk of escape and the risk to the public, and which also takes account of factors such as the prisoner's health and mobility.

41. Prison Service Instruction (PSI) 58/2010 has a mandatory instruction that staff must comply with PPO requests for information and assistance. The investigator asked several times for copies of the risk assessment, Person Escort Record and escort logs covering Mr Wolens' journey and admission to hospital, but they were not provided.

42. The prison initially said Mr Wolens had no escort documents after 2018. When challenged as to the likelihood of him being allowed out of prison without a risk assessment and other documents and the lack of concern about missing security paperwork, they agreed to check again. There was no response to subsequent reminders and a request for an explanation for this report. Therefore, we do not know whether Mr Wolens was restrained and, if so, whether the level of restraint was proportionate to his medical condition and circumstances. Additionally, we

were unable to assess whether he was appropriately managed by escort staff during his journey to hospital and throughout his admission.

43. We have raised with Wakefield several times the issue of providing documents for PPO investigations. The prison has previously told us in response that delays had occurred from time to time due to functional heads not having oversight, but that this had now changed and there was a single point of contact for all deaths in custody who would copy requests to functional heads. As we have experienced problems again in this investigation, we repeat our previous recommendation:

The Governor should ensure that, in line with Prison Service Instruction 58/2010, all prison documents are stored securely and provided promptly for PPO investigations.

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Prisons and Probation Ombudsman **March 2022**

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