Investigation into the death of a man at HMP Wakefield in December 2010

Report by the Prisons and Probation Ombudsman for England and Wales

September 2011

This is the report into the death of the man at HMP Wakefield, on 11 December 2010. The man died of natural causes. Although the post mortem report has not yet been completed, I understand from the coroner that the likely cause of death was heart failure.

I offer my sincere condolences to the man's family and friends for their loss. One of my family liaison officers, told the man's daughter about the investigation to provide the family with the opportunity to raise any issues about the care which he received whilst he was in custody.

The investigation was carried out on my behalf by one of my investigators. I would like to thank the Governor and her staff, for their co-operation and in particular the Head of Litigation for his liaison during the course of our enquiries,

I am also grateful to Wakefield District NHS Primary Care Trust (PCT) for appointing the clinical reviewer to review the man's clinical care. As the man died from natural causes, the findings in the clinical review are essential to my own conclusions. The review shows that the standard of care which the man received was equitable to that which he could have expected in the community. The clinical reviewer's clinical review is the first annex to my report.

Like many Wakefield prisoners, the man had lived there for many years and in his case since 1995. Despite refusing to go on offending behaviour courses, he played an active part in prison life and many adaptations were made as he became more frail. I make six recommendations concerning healthcare staff awareness of PCT guidelines on clinical care, staff training in relation to recording information in the SystmOne electronic medical record and promotion of greater cohesion between prison staff and healthcare.

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

Nigel Newcomen
Prisons and Probation Ombudsman   September 2011

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SUMMARY

1. The man appeared at Chester Crown Court on 14 July 1994, when he was sentenced to life imprisonment and went to HMP Liverpool. On 6 September 1995, he was moved to HMP Wakefield. On arrival, he had a first reception health screen with a nurse and had no known medical conditions.

2. Over the next eight years, the man was diagnosed with a degenerative disease of the neck, causing him to suffer pain, numbness and increasingly limited movement. He developed other problems such as high blood pressure, swelling to his legs and, in October 2002, was diagnosed with ischaemic heart disease. The man received ongoing treatment for his conditions, was accommodated in an adapted room following a disability assessment and was encouraged to stop smoking.

3. In August 2010, the man developed a blister on his toe. The condition of his toes and legs deteriorated over a period of time, despite treatment, due to the lack of blood supply and his legs became ulcerated and infected. Consideration was given to referring him to outside hospital for possible amputation, however, he did not want to leave the prison. Whilst his condition did not become critical, the medical staff respected his decision and he was moved to the healthcare centre on 16 November, where he received daily treatment. Healthcare staff consulted with a tissue viability nurse (whose role is to give advice on keeping skin healthy and the management/prevention of ulcers) for specialist advice.

4. The man's condition stabilised after he was admitted to the healthcare centre, and the infected ulcers on his legs showed signs of improvement. Poor circulation had resulted in his toes turning black and it was likely that he would need amputation at some point in the future. On 11 December at 9.45am, he was found unresponsive in his room. Staff started emergency treatment and paramedics attended. However, he was pronounced dead at 10.34am.

5. A prison family liaison officer visited the man's daughter at home later that day to tell her of her father's death. The prison offered financial support towards the funeral costs.

6. I am satisfied that the care the man received at Wakefield was comparable to that which would be expected in the community. I make six recommendations, concerning healthcare staff awareness of PCT guidelines on clinical care, staff training on the use of recording information in the SystmOne electronic medical record and closer working between prison staff and healthcare.

THE INVESTIGATION PROCESS

7. The investigation was opened on 15 December 2010, when one of my investigators issued notices announcing the investigation to staff and prisoners. She met the Head of Litigation who was to act as the liaison officer for my investigation. My investigator also met the Deputy Governor, healthcare staff and the Chair of the Independent Monitoring Board (IMB). My investigator was provided with all documentation relating to the man. My investigator was shown C wing and the cell in the healthcare centre where the man died. No prisoners or staff came forward in response to the notices of my investigation.

8. My investigator visited HMP Wakefield again on 28 February and 7 March. During these visits she interviewed nine members of staff and one prisoner. Initial feedback from the investigation was provided, in writing, to the Governor on 21 March 2011.

9. Wakefield District NHS Primary Care Trust (PCT) asked the clinical reviewer to review the man's clinical care on their behalf and she was provided with all relevant documentation to assist this review. I thank the clinical reviewer for undertaking this review and for her timely report.

10. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and request a copy of the post mortem report. Upon completion, the investigation report will be sent to the Coroner to assist his enquiries into the man's death.

11. One of my family liaison officers contacted the man's daughter on 5 January 2011, to inform her about the investigation and to invite her to ask questions or raise concerns about the care of her father. She had no complaints and told my family liaison officer that any questions had already been answered by the prison family liaison officer. The man's daughter received a copy of my draft report as part of the consultation period and raised no further issues.

12. I received a letter from the Governor dated 11 April, in response to the initial feedback provided, whilst this investigation report was going through a robust validation process. It was pleasing to see that my concerns have already positively influenced decisions regarding future training and the recommendations made at the end of this report give direction for continued progressive change.

HMP WAKEFIELD

13. HMP Wakefield is a high security prison of which there are only eight in England and Wales. It is located between the city centre and a residential district, housing in excess of 750 prisoners of Category A, B, and high security remand. There are four residential wings, A, B, C, and D, of which B wing houses remand prisoners in a separate unit. Prisoners are also located in the healthcare centre, the segregation unit and closed supervision centre both located on F Wing. Outside agency services are provided by a number of agencies, such as healthcare from the local PCT. The prison is attended by prison visitors (independent volunteers recruited by prison establishments on behalf of the Prison Service, who visit prisons in order to offer friendship to prisoners) and the Independent Monitoring Board (IMB).

Independent Monitoring Board

14. Each prison has an Independent Monitoring Board (IMB) whose members are appointed by the Secretary of State for Justice from members of the community. Their role is to satisfy themselves that the prisoners are treated humanely and justly and that there are adequate programmes for preparing prisoners for release. The IMB report directly to the Secretary of State for Justice if they have any concerns. They also submit annual reports about how the prison has met the standards and requirements placed on it. Members of the IMB have access to every prisoner, every part of the prison and every prison record.

15. In their annual report for the period 1 May 2009 to April 2010, the IMB made the following comments:

> ”The ageing population of Wakefield does raise our concerns regarding available accommodation and purposeful activity not just for the ageing but for the prisoners of limited abilities. Simple activities we feel should be more available for the prisoners of limited ability.”

In respect to the provision of the healthcare centre:

> ”The Primary Care Centre has now been in operation for a full year and is providing a comprehensive first-contact service throughout the time that cells are unlocked. Medication is dispensed three times each day with up to 100 prescriptions being filled at each morning session. Seasonal immunisations are administered when appropriate. A GP is available from 8 o’clock in the morning until 6 p.m., with an average of 30 prisoners on call-up each day for the treatment of acute conditions. The Unit also provides a number of regular clinics for the management of chronic illnesses and the detoxification of drug misusers.
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> ”The in-patient unit contains 15 beds and is normally working to full capacity with a mixture of elderly, infirm, chronic illnesses, and psychiatric cases … overall the Health Care Unit provides a comprehensive service that meets the needs of the prison population.”

HM Inspectorate of Prisons

16. HM Chief Inspector of Prisons last conducted a full announced inspection of the prison in December 2008. The then Chief Inspector noted that since the last full inspection in 2003:

> "Wakefield has improved considerably over the last five years and it is pleasing that in general the improvement has been sustained. There is still work to be done on aspects of safety, staff-prisoner relationships and activities, but the principal issue to be tackled is how to motivate and engage serious sexual offenders, so that their risk is reduced and they can progress through the prison system."

Performance rating

17. Prisons in England and Wales are assessed for performance by the National Offender Management Service (NOMS). For public prisons, NOMS use a combination of the Prison Performance Assessment Tool (PPAT, which looks at 33 indicators) and the public prison weighted scorecard (which looks at a set of 44 indicators). Each establishment is then given a rating between one and four; 4 = Exceptional performance, 3 = Good performance, 2 = Requiring development, 1 = Serious concerns. For the last three performance reports, HMP Wakefield has been given a rating of 3.

Risk assessments

18. On each occasion when a prisoner is escorted outside the prison to hospital, a risk assessment considers the risk to the public, potential for escape and likelihood of outside assistance. The assessment informs the decision about the number of escorting officers and the type of restraint to be used (single cuffs or two metre long escort (closet) chain with a cuff at either end). It also determines the circumstances and the authority required for the restraints to be removed. The risk assessment is reviewed by prison managers each day that a prisoner is in hospital and amended where necessary.

Categorisation

19. Prisoners are risk assessed when they come into prison and given a category based on their offence and the risk that they pose to the public should they escape. There are four levels of category: A, B, C and D, with category A prisoners being the most dangerous. A category B prisoner is one for whom the highest security conditions are not necessary but for whom escape must be made very difficult. Prison Service Order (PSO) 0900, gives guidance on appropriate assessment.

Incentives and Earned Privileges (IEP) Scheme

20. The Incentives and Earned Privileges, or IEP scheme was introduced in 1996 to encourage and reward good behaviour in prisons. Governors have devolved responsibility to draw up their own schemes however the scheme

must operate on at least three tiers: Basic, Standard and Enhanced. Prisoners move between levels according to their behaviour and performance. The key earnable privileges/incentives are: extra and improved visits, eligibility to earn higher rates of pay, access to in-cell television, opportunity to wear own clothes, more private cash to spend and time out of cell for association.

Listeners

21. Listeners support prisoners who may be at risk of suicide and/or self-harm. They are trained, selected and supported by Samaritans to offer confidential emotional support, 24 hours a day, to fellow prisoners in distress.

22. The Listeners scheme is confidential and any prisoner can ask to speak to a Listener at any time of the day or night. Prisoners can access a Listener by approaching them in person or asking a member of staff to make arrangements for a Listener to speak to them. During the hours when prisoners are locked in their cells, anyone wishing to speak to a Listener can make the request from the staff on duty.

Previous deaths in custody at Wakefield

23. The man's death was one of 28 to have occurred at Wakefield since April 2004 when the office began investigating all deaths in prison custody in England and Wales. 19 of the previous deaths were due to natural causes, the remainder self-inflicted. There are no similarities between any previous deaths and that of the man.

KEY EVENTS

24. The man, prior to coming into custody lived in the Chester area. He was retired, having had a career in the army, but not having worked for a long period of time due to ill health. The man did have a significant offending history and this was not his first custodial sentence. Following his arrest, he spent his time on remand at HMP Liverpool. He was sentenced to life in prison at Chester Crown Court, when with a minimum tariff of ten years and he was moved to HMP Wakefield where he remained until he died.

25. On arrival at HMP Liverpool on 29 October 1994, the man should have had an initial health screen but there are no records available. The first entry dated 17 July 1995, simply states 'seen on B1'. There is reference to an injury the same year on 24 August, when he sustained a broken nose following an assault.

26. After he was sentenced, the man was assessed as a category B prisoner and transferred to Wakefield on 6 September 1995. He underwent a health assessment upon reception when he declared no known medical conditions, that he was physically and mentally in good health, but disclosed historical heavy drinking. The man was a smoker. His blood pressure was recorded as 140/80.

27. During his time in custody, the man worked in the charity workshop and acted as an elderly and disability representative for his peers. After his tariff had expired, he was refused for parole on a number of occasions. He appealed against his parole refusal but to no avail. He remained as standard on the IEP scheme as he did not complete specific offending behaviour work. The man did not wish to address the issues linked to his sexual offending and would not complete any programmes run by the prison, although he always complied with the regime and was polite to staff.

28. In January 1996, the man first reported that he experienced numbness in his hands. The following year in April 1997, he was prescribed diclofenac (for joint pain) and it was observed that he had some swelling in his ankles. The man was monitored for several months. On 20 June, he complained of continuing numbness in his hands and fingers, as well as experiencing weakness in his legs. His blood pressure was recorded as 150/90 and he was prescribed simvastatin (for reducing cholesterol) and referred to a neurologist by the prison doctor A.

29. Over the next few months, the man's symptoms increased. He experienced continued numbness in his arms, hands, fingers and a tingling sensation in his abdomen. The man went to his neurological appointment on 6 November 1997 at Pinderfields Hospital, and was diagnosed with cervical spondylosis with myelopathy by the doctor (a deterioration of the neck and spine causing a disturbance of the spinal cord resulting in pain, numbness and pins and needles in the limbs). He was prescribed paracetamol and advised that he might need an operation.

30. On 19 January 1998, the man was admitted to Leeds General Infirmary. He underwent surgery for anterior cervical discectomy. (This is a procedure used to treat problems of a prolapsed disc, which causes nerve pain in the arms. A cage joins two discs together to prevent movement and the associated pain.) The man returned to Wakefield on 23 January. During the few months following surgery, he continued to experience pain in his neck, and 'jumping' in his legs. He was regularly reviewed by healthcare staff and he was prescribed medication, paracetamol, diclofenac (for pain relief) and baclofen (a muscle relaxant used to control spasms), to help alleviate the symptoms.

31. However, over the following years, the man's symptoms did not improve and he experienced increasing discomfort. He was taken to outside hospital for specialist appointments to review his condition and his was medication regularly reviewed.

32. In January 2001, the man was diagnosed with high blood pressure. In addition to diclofenac and baclofen, he was prescribed bendrofluazide (used to reduce fluid in the body for those suffering with high blood pressure) and atenolol (to treat high blood pressure) his observations were taken daily. The medication had little positive impact and his blood pressure remained high. The man was reviewed on 10 September 2001. His blood pressure was recorded as 170/92, weight 90kg and again he was advised to stop smoking. Following a review of his medication in January 2002, he was prescribed baclofen, bendrofluazide, diclofenac, amlodipine (to treat high blood pressure and increase blood circulation), quinine sulphate (to treat night time cramps) and paracetamol.

33. The man was diagnosed with Dupuytren's disease of the left palm (a condition where the tissue of the palm contracts, making extending the fingers difficult) on 10 June 2002.

34. On 3 October, the man was taken to Pinderfields General Hospital accident and emergency department as he had chest pains. Following a risk assessment, he was assessed as needing to be cuffed at all times. However, the use of an escort chain was authorised. He was admitted to the coronary care unit and subsequently diagnosed with ischaemic heart disease (caused when the coronary arteries (which supply the heart muscle with blood and oxygen).

35. The man returned to Wakefield a week later on 10 October and he was prescribed quinine, meloxicam (a non-steroid anti-inflammatory for relieving pain and inflammation in joints), pravastatin (to lower cholesterol), aspirin (to lower the risk of blood clots in the heart), bisoprolol rampril (to treat high blood pressure in those with heart disease), amlodipine and a glyceryl trinitrate (GTN) spray (to widen the arteries to encourage oxygen to the heart muscle). He spent the night in healthcare and returned to his wing on 11 October.

36. In the following years, the man continued to experience chest pains which necessitated the use of his GTN spray, he was reviewed by specialists at outside hospital and his mobility deteriorated. By July 2005, he was using a

walking stick to assist with his mobility and in June 2006, he was assessed for a wheelchair and placed on the disability register. The man signed an agreement that an identification card could be placed outside of his cell (alerting others to his mobility issues and the need for additional help), to ensure that he was assisted in an emergency.

37. The man became an elderly and disability prisoner representative on C wing in April 2008. During interview, Officer A commented that the man was proactive in this role and contributed when he attended meetings to represent his peer group and their needs within the establishment.

38. The man continued to be monitored regularly by healthcare and outside specialists. In October 2008, his medication had been reviewed and was listed as: bisoprolol, aspirin, amlodipine, ramipril, quinine, pravastatin, and in addition, codeine (for pain relief), co-codamol (for pain relief), hydrocortisone (reduces inflammation of infected skin). He was also briefly prescribed for flucloxacillin for red and inflamed cellulitis (a skin infection) on his leg, which responded well. Over the following year, he was encouraged to reduce smoking, strengthen his legs to aid his mobility and to manage his anxiety about his age-related illnesses. In February 2009, he was prescribed fluoxetine (a low dose anti-depressant) to help stabilise his mood which was affecting his sleep.

39. The level of support provided to the man increased. On 18 November 2009, the first prison doctor wrote to the disability officer highlighting that in the community he would be receiving home help. Following the letter, he was assigned a specific peer carer to facilitate collection of meals and cleaning his cell.

40. At the beginning of 2010, the man was reviewed by a second prison doctor. His medication is recorded as previously, and in addition he was prescribed doxazosin (for the treatment of high blood pressure), furosemide (to help reduce excess fluid to combat swelling in legs), and pregabalin (for the relief of nerve pain). The man continued to experience limited mobility, reported chest discomfort and was often anxious about his degenerative illness. He continued to be monitored and, whilst he did not stop altogether, he reduced smoking significantly.

41. That same year, the man sought legal representations with regards to his continued B categorisation and allocation at Wakefield citing his age and poor health as indicators of reduced risk. His requests were not upheld by the prison and no further action was taken.

42. In April, following a review of his care plan and disability needs, the man was assigned a full time peer carer to assist him in collecting his meals and cleaning his cell. My investigator interviewed the man's nominated full-time carer, who confirmed that he was well supported in this role by prison staff. An adapted cell for prisoners with disabilities was identified in July but initially the man was reluctant to move. Eventually, he moved to the adapted room which improved his access to the showers and he soon settled in. The man's

disability plan was regularly reviewed and he was provided with additional aids to assist him. During my investigator's visit on 15 December, she observed handrails in his room to enable him to use the toilet more easily, a walking frame and lengths of material to help him close the windows.

43. On 2 August, the man was assessed by a physiotherapist as he was experiencing continued pain and weakness in his lower left leg and ankle. As physiotherapy was not helping, he was referred back to the doctor. He saw a third prison doctor on 25 August and was referred for an MRI scan (magnetic resonance imaging, used to diagnose skin and bone conditions) and codeine and paracetamol were prescribed to relieve his pain.

44. Two days later, the man was seen by Nurse A as he had a blister on his left toe. A dressing was applied to prevent rubbing and he was referred to a fourth prison doctor having reported that his ankles were swelling.

45. On 9 September, the man was assessed by the fourth prison doctor who noted that the toes on his left foot were red and infected and there was an abscess of the skin. Amoxicillin and flucloxacillin (antibiotics) were prescribed for seven days. Four days later, the man was seen by the second prison doctor who noted that the man had

> "… quite marked ischaemia [insufficient blood flow] of his right forefoot. Indeed the line of reduced circulation starts on the lower third of calf."

The doctor diagnosed peripheral vascular disease (a disease of the arteries, the blood vessels that carry blood from the heart to the rest of the body. The arteries become narrowed, restricting blood flow to the muscles in the limbs. Peripheral arterial disease usually affects the legs and can cause pain which comes on when walking). He was prescribed nitrazepam (a treatment for those unable to sleep) and pregabalin were prescribed. The man was again encouraged to stop smoking.

46. Nurse A saw the man on 23 September, when he reported that the new medication was affecting his sleep pattern. He was told that he had an appointment with the second prison doctor on 4 October but that he should alert them if his symptoms persisted. The man did not report to have his dressings changed on 24 September as he was too tired.

47. The man was reviewed by a fifth prison doctor on 28 September, when he was given another prescription of flucloxacillin and amoxicillin for cellulitis of the toe. On 4 October, he was assessed by the doctor who observed that the man's toe retained "some sign of viability" (meaning that the tissue was capable of living). The following day the doctor noted that the toe had improved in colour and used a Doppler test (to measure the blood supply to the legs). The doctor confirmed during interview that there was no detectable reading from this procedure. The man was advised to keep his legs raised and was provided with extra pillows and the prescription of antibiotics was repeated.

48. On 7 October, the man attended an appointment with the smoking cessation advisor and was prescribed varenicline (for supporting those wishing to stop smoking).

49. A week later, Nurse B examined the man's legs. She recorded that they were swollen and there was a small blister to his lower left leg, which had been oozing puss. The man's leg dressing was renewed. The toe on his left foot remained ischaemic. He declined to attend the smoking cessation programme during this week, choosing to stay in bed.

50. The man went to Pinderfields Hospital on 19 October for an MRI scan. The medical report following the scan concluded that there were severe degenerative changes in the spinal discs, but no significant cord compression.

51. The following day, the second prison doctor reviewed the man's medication. It remained the same, and in addition he was prescribed escitalopram (for the treatment of depression). Two days later, the man attended a smoking cessation appointment.

52. Nurse A cleaned and redressed the man's leg on 25 October, which remained red and swollen. The following day he was assessed by the second prison doctor who noted that the man's legs remained swollen due to excess fluid, and there was pus on his left toe nail. Metronidazole (an antibiotic for infected skin ulcers), flucloxacillin and phenoxymethylpenicillin (an antibiotic to treat bacterial infections) were prescribed. Three days later, Nurse A renewed the dressings, cleaned the wounds with saline and saw that there were two ulcerated areas on the man's left leg, in addition to his infected toe. The same day the man also attended the smoking cessation group, although it appeared from his carbon monoxide reading that he had not cut down.

53. On 31 October, Nurse A re-examined the man's legs and noted several small ulcerated areas on his left leg, leaking a fluid that contained blood as a result of the infection. His legs were cleaned and new dressings applied. The next day, the man was assessed by a physiotherapist. The man reported that he was unable to sleep in his bed due to increasing pain in his left leg.

54. The man's went to the dressing clinic on 3 November, as he had removed the dressings which were causing discomfort. The weeping blistered areas were sprayed with betadine (an antiseptic for the treatment of infected leg ulcers) and the man was given advice about cleaning his legs and general hygiene to remove dead skin cells and reduce the risk of infection. Nurse C agreed that betadine spray would be administered every other day. Later the same day, he underwent a mobility screening in his cell. The man reported that he slept in his chair rather than his bed and was helped from a nominated peer carer. He was clear that he did not want to move from his wing. He was granted temporary day care unlock which means that prisoners who are not fit to work due to their medical condition can associate with other prisoners during the day.

55. Five days later, the second prison doctor reviewed the man as staff reported that his legs remained swollen and the ulcers were not healing. The doctor stopped the medication to reduce the swelling, as the man's blood pressure had reduced. The next day the man again reported to the doctor, as he had pain in his legs due to the ulcers. He was prescribed tramadol (used to relieve severe pain).

56. Over the next few days, the man's dressings were changed regularly. Nurse A recorded that his legs were ulcerated and leaking oedematous fluid (clear fluid retained by the skin). On 15 November, Nurse A asked the second prison doctor to reassess the man's legs as they were especially red. The following day Nurse D also discussed the man's deterioration with prison doctor B and the possibility of admitting him to the healthcare centre due to the increased level of nursing care which he required.

57. The man was admitted to healthcare on 16 November. By this time, both of his lower legs were swollen, red and leaking fluid. He was prescribed antibiotics, nitrazepam (to help him sleep) and pravastatin as well as being encouraged to sleep in bed with his legs raised. The Nurse Manager was to contact the tissue viability nurse for advice on dressings.

58. On 18 November, the Nurse Manager discussed the man's leg ulcers with the tissue viability nurse, who advised removal of the dead cells from the infected areas and honey dressings (an antibiotic treatment for infected wounds). The man's legs were cleaned and soaked with potassium permanganate (an antiseptic solution which helps to sooth leg ulcers and promote drying), they were less swollen and no longer weeping. The Nurse Manager asked the second prison doctor to re-evaluate the man as he had a temperature and complained that his legs felt tight.

59. Later the same day, the second prison doctor assessed the man's legs which had vastly improved in terms of swelling, although he was in more pain. The doctor noted defined demarcation lines and that the man's toes were almost black. Morphine sulphate (to relieve severe pain) was prescribed at night time. During interview, the second prison doctor explained that he and the man discussed the possibility of surgery. The doctor told my investigator that the man reiterated that he did not want to go to outside hospital, although this was not explicitly recorded on the electronic medical record. The doctor went on to explain that operating at this stage could increase the man's risk. The plan was to manage the infection as the greater the improvement, the more likely that surgery would have a successful outcome.

60. During the night of 18 November, the man slept in bed. The following night he declined to get into bed and slept in his chair all night. On 20 November, the man's legs were soaked in potassium permanganate and his legs redressed. The Nurse Manager noted that there was some swelling to the top of his left foot, and a smell was coming from the ulcers. The man was again told to sleep in bed with his legs raised.

61. Over the next few days the man had his legs regularly checked and he was assisted with his hygiene. On 23 November, the second prison doctor recorded that the quinine and pravastatin had run out as the prescription had been lost, although this was rectified. The same day, the Nurse Manager cleaned and redressed the man's legs with honey dressings. The area around his foot was covered in dry and dead skin caused by infection and smelled. The man also told her that he was having spasms in his thighs. She asked for another Doppler test (used to measure the blood supply to the legs) and for a review by the doctor.

62. The next day, Nurse Manager changed the dressings. The man complained of pain in his left lower leg that it smelt and was cold to the touch. Nurse Manager advised the second prison doctor and again asked for a Doppler test. Later that day, the doctor assessed the man. The swelling had reduced but a second demarcation line was forming on the middle of his foot. A Doppler test was performed and a pulse was detectable halfway down the calf before it was lost. The doctor recorded that there was no infection and the wounds were clean. The man again said that he did not wish to go into hospital. The doctor thought that leg surgery was not at this stage an emergency, but the situation might change over a short period. Naftidrofuryl (used for helping blood circulation) and isosorbide (to relax the blood vessels to help the heart to work more efficiently) were prescribed.

63. The next day, the second prison doctor asked for the man to be screened for MRSA as it was likely that he would undergo amputation due to the reduction of blood supply in his lower legs. Over the next few days, the dressings to the man's leg ulcers and toes were changed and he slept well. On 28 November, Nurse Manager recorded that the man was more mobile and the smell appeared to come from the honey dressings, as opposed to the ulcers.

64. The second prison doctor assessed the man on 29 November, and diagnosed "critical lower limb ischaemia". The man's pain was more controlled and, despite the tissue on the tips of his toes having died, they "appeared pinker". Oromorph (to relieve severe pain) was prescribed to be taken before his dressings were changed to help manage the pain and it was agreed that they did not have to be changed daily. The man continued to sleep in his chair and the Nurse Manager recorded that on 30 November there was no smell from his wounds.

65. Over the next couple of days, the man was encouraged to be as mobile as possible, his legs were checked regularly and it appeared that his wound was healing.

66. On 4 December, Nurse E discovered the man sitting on the floor between the toilet and his bed at 4.00am. He had slipped returning to his bed, after using the toilet. He was not hurt, but was advised to use a urine bottle during the night. Later the same day, his dressing was changed and there was a reduction in leakage from his wound. This progress continued over the next few days. Although the man was encouraged to sleep in bed with his legs

raised, he continued to largely stay in his wheelchair. On 6 December, metronidazole (an antibiotic for the treatment of leg ulcers) was prescribed.

67. Two days later, on 8 December, the second prison doctor reassessed the man. He ordered that the potassium permanganate leg soaks continued and he should be given morphine sulphate for pain prior to this procedure. The man's legs were less swollen but the blackness of his toes had increased. He continued to receive daily care. The second prison doctor confirmed in interview that the man's legs "showed remarkable improvement, so his death was against the improvement in his leg and the reason why he was in healthcare".

Events of 11 December

68. Nurse F recorded that on the morning of 11 December at 4.00am, the man had slipped from his wheelchair and needed assistance, with the aid of a hoist, to return to bed but he was not hurt.

69. At 9.15am, Nurse G went into the man's room and advised him to collect his medication from the treatment room, which he agreed to do. Nurse H asked Nurse G to take the man's medication to him half an hour later at approximately 9.45am as he had still not collected it. Nurse G went into the man's room and he was lying in bed on his side. He did not respond when asked to sit up. Nurse G shook his shoulder, which was warm to the touch but got no response. Nurse G checked for a pulse, rolled the man onto his back and summoned assistance. During interview, Nurse G explained that realising that "something's not right here…I shouted for Nurse H to bring the emergency bag down and we need an ambulance".

70. Nurse H arrived straight away with the emergency bag. Nurse H also checked for a pulse, but could not find one. The nurses started cardio pulmonary resuscitation (CPR). My investigator confirmed, having visited the room, that the bed the man was lying on had a solid metal base, which is suitable for undertaking CPR.

Response to the emergency

71. An external defibrillator (a portable electronic device that diagnoses heart rhythms after cardiac arrest) was attached to the man's chest by Nurse H. The nurse told my investigator that it advised not to administer an electric shock to stimulate his heart, but to continue CPR, which Nurse G did. Officer B and Officer C arrived to assist. Officer B had asked for an ambulance via the control room at 10.00am. Officer C gave oxygen and Officer B took over chest compressions.

72. At 10.14am the paramedics arrived at the healthcare centre, and took over from prison staff. The man was pronounced dead at 10.34am.

73. Officer D was identified as the prison's family liaison officer and, along with her colleague the reverend visited the man's daughter, the nominated next of kin at 4.30pm to break the news of her father's death. Financial assistance was offered on behalf of the Prison Service as per the guidance in PSO 2710, "Follow up to death in custody".

ISSUES

Clinical care

74. The clinical reviewer was commissioned by Wakefield District PCT to review the medical care that the man received while he was in custody. Her clinical review looks at the care and treatment he received at Wakefield and measures whether it was appropriate and comparable to that which is available in the community. The clinical reviewer and I are satisfied that the care the man received was comparable. The clinical reviewer makes four recommendations, which I endorse and have reflected in my own consideration of the issues.

75. The man entered custody in 1994, with no known medical conditions, although in the following years his physical health deteriorated. He was diagnosed with cervical spondylosis in 1997, which caused him pain and restricted his mobility. He was assessed for wheelchair use in 2006 and from 2009 was appointed a peer carer to assist him in his daily activities.

76. In 2001, the man was diagnosed with high blood pressure. In 2002, he suffered a heart attack and was diagnosed with ischaemic heart disease. Due to the nature of his circulatory problems and his increasing lack of mobility, he suffered with swollen legs and developed ulcers that became infected. The man's condition was discussed with a tissue viability nurse, although it was apparent during interview that healthcare staff generally were unaware of the clinical policy for managing prisoners with leg ulcers and how to access current PCT guidance. Given the ageing population at Wakefield, I am surprised that staff are not regularly using the most up to date guidance, and make the following recommendation:

    The head of healthcare should ensure that all healthcare staff can access the PCT policies on managing prisoners with leg ulcers (and other clinical policies) and remind them of the need to follow the appropriate clinical guidelines.

Relationship between officers and healthcare professionals

77. My investigator interviewed officers who helped to attempt to resuscitate the man. During these interviews, it became obvious to both my investigator and the clinical reviewer that the officer's role in the healthcare centre remained very distinct to healthcare professionals. There was little evidence that officers are required to participate in morning staff briefings when patients are discussed even though they work in healthcare. Some told my investigator

that they were unaware of some of the more specific needs of those prisoners located in the healthcare centre. I recognise that some information is difficult for a healthcare professional to share with staff who are not clinically qualified and that medical confidentiality must be respected. Nevertheless I have seen good multi-disciplinary work in other prison healthcare centres and commend this to the Governor and healthcare manager.

78. I am satisfied that there is no link to the care or treatment which the man received which would have affected the outcome and I do not criticise the individual officers. I appreciate that an officer's role differs to that of healthcare professionals, but suggest that effective information sharing of would be beneficial to promote a more cohesive environment.

The Governor should work with the head of healthcare to ensure that uniformed and healthcare staff work together to meet the specific needs of the prisoners who are inpatients.

Chronic disease management

79. During interview with the Disability Liaison Officer, it was apparent that there was a proactive and well-informed team of staff to support those prisoners with disabilities and/or chronic disease. I am pleased to reflect that the dedication of staff, such as the Disability Liaison Officer, in this area undoubtedly ensured that the man was able to reside with his friends on C wing for as long as possible, whilst maintaining a reasonable standard of living.

80. I judge that the use of peer support/carers for prisoners with significant mobility issues was good practice. During interview, the man's carer explained that the role is assigned to assist with collecting meals, laundry, cleaning of the cell and general duties that can help the individual. Because it is a specific position in which prisoners are employed, I am sure that the prison makes appropriate safeguards to protect those who are vulnerable.

Support for carers

81. A notice to prisoners was issued the same day by the Governor, announcing the man's death and support via the Listeners or Samaritans was available. The man's carer found out about his death via this notice and said in interview in response to finding out in this manner:

> "[I was] downhearted for the simple reason we're all inmates in here but we're still human. And the way this prison acts as if to say 'he's just another inmate, let him get on with it', which is to my opinion is wrong."

This is a sad statement from a prisoner who clearly took a pride in his work as a carer and I know that the prison will consider his views carefully and respectfully. I believe that prisoners who support men like the man should be

treated with respect and told personally about a death rather than being told together with the rest of the prison population.

The Governor should ensure that any prisoner acting in the role of a carer for someone who has died is told the news personally.

82. There was a memorial service at Wakefield for the man on the day of his funeral, which his daughter attended. I hope that this was a comfort to her and reassured her that her father was a well respected member of the community. His friends were also there, and his carer and another prisoner wrote a short tribute which was read at the service. I am pleased to learn that the man was remembered in this way and the prisoners reflected during my investigation that it helped with their healing process of losing a friend. The nature of the prison population at Wakefield means that they live together in close proximity, often for many years, and a memorial such as this is a dignified and respectful tribute to the support which they well have given each other over that time.

Staff Support

83. Later on the morning of the man's death, a hot debrief was held in the healthcare centre with all staff involved attending. Support was immediately made available to them via the care team. During interview, all staff said that they were contacted by a member of the care team and were aware that, if they chose to, they could contact them at any point for ongoing support.

Record keeping

84. During the man's time as an inpatient in the healthcare centre, he was reviewed daily and received appropriate care. The second prison doctor confirmed during interview that he had regular discussions with the man about the condition of his legs, even before he was admitted to the healthcare centre. The doctor ensured that he fully understood the implications of any decision not to be transferred to outside hospital and adapted his treatment, to which the man's leg ulcers responded well. This dialogue was first recorded on 24 November. I am pleased that the man's wish to remain at Wakefield was respected. However, healthcare staff could have more clearly demonstrated how they exercised their duty of care, as well as their decision-making process, with more frequent record keeping.

The head of healthcare should ensure that entries are made on the electronic recording system, outlining all the decisions regarding clinical care, on every occasion, by all members of the healthcare staff.

85. Healthcare staff at Wakefield use the SystmOne electronic medical recording system. I am concerned, having reviewed the SystmOne medical records for the man, that there are entries recorded which are 'automated'. This means that text was added to his clinical record, which gives a misleading record of contact and treatment. In this case, frequent reference to a care plan was

generated by the system, but the man had no care plan at the time of those entries.

86. The man did not have a formalised care plan until 12 November, just prior to his admittance to the healthcare centre. My investigator interviewed a member of staff from the healthcare team about the system, and subsequently observed the computer system in use. From further discussion with staff, my investigator was concerned that staff were not aware of the automatic text entries they were generating, as opposed to the deliberate entry of misleading information. The electronic system rightly records each time a patients clinical notes are accessed by a member of staff. However, in this case automated text entries pertaining to treatment, and review of care plans were also generated, which had not taken place. The accuracy of an individual's medical record is central to the effective delivery of clinical care. I appreciate that SystmOne is widely used within prison healthcare settings and Wakefield staff do not control its design. However, they should be aware of its limitations and how the use of automatic text entries could be misleading.

The head of healthcare should review the use of automated text entries on SystmOne to ensure that the records accurately reflect the treatment that prisoners receive.

87. My investigator was told by staff that they were not confident about accessing care plans on SystmOne. Adding to this frustration, staff had some difficulty printing a comprehensible copy of a prisoner's care plan for reference.

The Head of Healthcare should ensure staff have adequate training and are confident about using the SystmOne recording system.

CONCLUSION

88. I judge that the man received appropriate medical treatment at Wakefield. He received individualised care and support which allowed him to remain in the prison rather than, against his wishes, going to hospital. After years of treatment for several chronic conditions, and years in prison, he became a frail elderly man who, on 11 December, died unexpectedly.

89. Despite the many positive findings in this investigation, I have drawn attention to several procedural issues in this report. The standard of care that the man received whilst at Wakefield ensured that his multiple conditions were satisfactorily managed. I do not think that his care was likely to have been further improved by admission to outside hospital and I am pleased that staff observed his wish to remain at Wakefield.

90. I believe that the man and his family and friends were generally treated with dignity and respect during the time he was at Wakefield. Following his death, the prison appropriately followed the guidance given in PSO 2710, “follow up to death in custody”.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that all nursing staff are aware of the need to follow clinical guidelines and have easy access to the PCT policies on the management of leg ulcers (and other clinical policies).

   Accepted - *All Primary Care Nurses access policies under Spectrum, the healthcare provider within the prison. Clinical guidelines / policies are available to staff. Any prisoners that are moved to healthcare for more complex care do so under the guidance of GPs working within primary care and should have a suitable care plan that can be adhered to. Due to the prison having different healthcare providers operating within HMP Wakefield work is being undertaken at the joint Clinical Governance meetings to create shared policies where relevant.*

   Completed 27.07.11 - Policies are available on the Spectrum website for all staff. Due to the organisation being in its infancy this is a continued development but all staff have access in one form or another. Staff within the inpatients facility also use these guidelines in order to maintain consistency.

2. The Governor should work with the head of healthcare to ensure that uniformed and healthcare staff work together to meet the specific needs of the prisoners who are inpatients.

   Partially accepted - *All staff detailed to work in the in-patients area of the HCC are required to attend the both the morning and afternoon briefings; this includes nurses, HCOs and pure Discipline staff, even those cross detailed on an ad hoc basis.*

   The current status of prisoners are discussed at these briefings; however, it is not possible to discuss their conditions in detail with due regard to the individual expertise of staff attending and on the associated grounds of medical confidentiality.

   The structure and content of these briefings will be reviewed to ensure that all staff have appropriate knowledge of each prisoner's condition and ongoing treatment, with due regard to their role and expertise.

   Completed 27.07.11 - All unified staff detailed to work in the healthcare centre attend briefings and are kept fully informed in developments for those offenders who reside on healthcare.

3. The Governor should ensure that any prisoner acting in the role of a carer for someone who has died is told the news personally.

   Accepted - *Where a prisoner is known to have a close relationship with the deceased, they will be advised in person of their death and provided with appropriate support.*

Prisoners may be employed as helpers (rather than carers) to prisoners and in such circumstances they would fallen within this scope.

Completed 07.09.11 - Where a prisoner is known to have a close relationship with the deceased, they will be advised in person of their death and provided with appropriate support.

4. The Head of Healthcare should ensure that entries are made on the electronic recording system, outlining all decisions regarding medical care, on every occasion, by all members of the healthcare staff. This would ensure that any informed decision to decline medical treatment is transparent to those with access to the records.

   Partially Accepted - *A record keeping programme is in place at HMP Wakefield covering all healthcare staff. The training session focuses on previous recommendations and highlights the need to ensure that accurate and timely entries are made onto SystmOne. The sessions also gives training on entering all decision making onto SystmOne including refusal of hospital treatment. Regular SystmOne training is also offered to staff within the establishment. The next audit Record Keeping Audit is scheduled to take place in September 2011.*

   Completed 27.07.11 - Training sessions are conducted regularly within healthcare for all SystmOne users. Any declines by offenders for medical care are entered onto the system and offenders are made aware that this will be done. Documented reasons from offenders are noted onto the system for those refusing treatment. This will be monitored regularly by the SystmOne Trainer.

5. The head of healthcare should review the use of automated text entries on SystmOne to ensure that the records accurately reflect the treatment that prisoners receive.

   Not accepted - *Auto-mated" entries are accuracy and performance measures and as such it is not appropriate to stop them. We will investigate the use of auto-entries in this case and the effect it had upon care plans. Any learning points to be shared with the staff through the SystmOne staff training days.*

6. The Head of Healthcare should ensure staff have adequate training and are confident in utilising the SystmOne recording system.

   Accepted - *All healthcare staff are able to access SystmOne training within the establishment and this operates on a monthly basis along with regular record maintenance.*

   Completed 27.07.11 - SystmOne training support continues to be offered within the prison for all healthcare staff.