Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Trevor Lockwood, a prisoner at HMP Wormwood Scrubs, on 14 October 2021

A report by the Prisons and Probation Ombudsman

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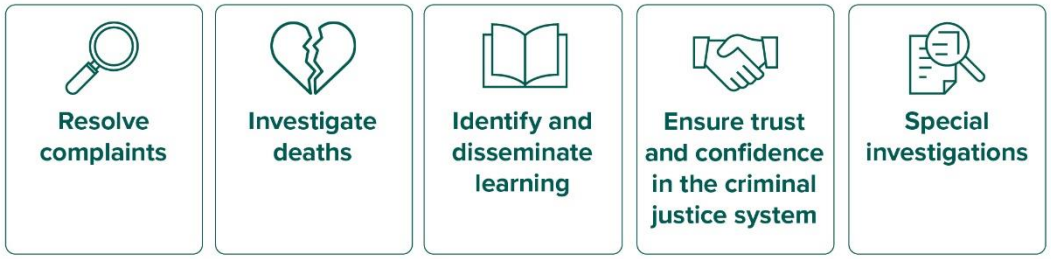
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Trevor Lockwood died from heart failure on 14 October 2021 at HMP Wormwood Scrubs. He was 78 years old. I offer my condolences to Mr Lockwood's family and friends.

Mr Lockwood had several health conditions, including heart problems, when he arrived at Wormwood Scrubs in May 2021. In June, a prison GP made a cardiology referral for him and the hospital scheduled an appointment for 29 July. However, Mr Lockwood was moved to HMP Frankland in error in mid-July and he was not returned to Wormwood Scrubs in time for his hospital appointment. I am concerned that not only was an elderly man in poor health sent on an unnecessary 500-mile round trip, but that he missed his cardiology appointment as a result.

The clinical reviewer concluded that the clinical care Mr Lockwood received at Wormwood Scrubs was equivalent to that which he could have expected to receive in the community. However, she found that Mr Lockwood did not have care plans for his long-term conditions as he should have done.

I am concerned that Mr Lockwood was restrained for a hospital appointment a week before his death. This was not proportionate given his advanced age and poor health. I am also concerned that the prison delayed making a payment towards Mr Lockwood's funeral, which resulted in the funeral having to be rescheduled. This added to Mr Lockwood's family's distress.

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

Sue McAllister CB
Prisons and Probation Ombudsman **August 2022**

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Summary

Events

1. On 28 May 2021, Mr Trevor Lockwood was sentenced to ten years imprisonment for sexual offences and was sent to HMP Wormwood Scrubs.

2. Mr Lockwood arrived at Wormwood Scrubs with several long-term health conditions, including a history of heart problems. He had poor mobility and used a wheelchair to get around.

3. In June, Mr Lockwood complained of chest pains. An electrocardiogram (ECG – a test to check the heart's rhythm) showed some abnormalities so a prison GP made a referral to the hospital's cardiology department. In early July, after Mr Lockwood had been given a cardiology appointment for 29 July, a prison GP noted that Mr Lockwood should not be transferred to another prison.

4. However, on 13 July, Mr Lockwood was transferred in error to HMP Frankland. He did not arrive back at Wormwood Scrubs until 30 July, so he missed his cardiology appointment. The GP made another referral, but Mr Lockwood was not seen by the cardiology department before he died.

5. In August, blood tests suggested that Mr Lockwood might have prostate cancer, and the prison referred him to hospital for tests. On 7 October Mr Lockwood attended hospital for a scan. He was escorted by two officers and restrained with an escort chain.

6. On the afternoon of 14 October, an officer unlocked Mr Lockwood's cell so that he could receive his medications. She found him unresponsive on his bed. Healthcare staff arrived very quickly and started CPR. However, when ambulance paramedics arrived, they said that Mr Lockwood had been dead for some time.

7. A post-mortem examination found that Mr Lockwood died from heart failure.

Findings

8. It was unacceptable that Mr Lockwood, an elderly man in poor health, was sent on an unnecessary 500-mile round trip to Frankland and back. We were told that an inexperienced member of staff had made an error. Although a GP at Wormwood Scrubs noted that Mr Lockwood should not be transferred, it appears that he did not use the official 'clinical hold' process (where prisoners are withheld from transfer for medical reasons).

9. The clinical reviewer found that the care Mr Lockwood received at Wormwood Scrubs was equivalent to that he could have expected to receive in the community. However, she found that staff had not put care plans in place for his long-term conditions. She also found a lack of end of life care planning.

10. Staff should have not attempted resuscitation given Mr Lockwood was dead when found.

11. We consider that the use of restraints on Mr Lockwood when he was taken to hospital on 7 October was not justified given his advanced age and poor health.

We found that the healthcare section of the risk assessment form was not completed accurately.

12. Wormwood Scrubs failed to make a payment to the funeral directors on time which resulted in the funeral being rescheduled.

Recommendations

- The Governor should review the circumstances that led to Mr Lockwood being transferred in error to HMP Frankland and address any training needs identified.
- The Head of Healthcare should ensure that staff know when and how to apply clinical hold to prisoners who have outstanding hospital appointments.
- The Head of Healthcare should ensure that staff:
    - put care plans in place for all prisoners with long-term conditions; and
    - hold end of life discussions and care planning at an early stage for prisoners with complex and deteriorating conditions.
- The Head of Healthcare should ensure that staff fully understand the circumstances in which resuscitation is inappropriate, in accordance with European Resuscitation Council Guidelines.
- The Governor and Head of Healthcare should ensure that:
    - healthcare staff complete the medical information section of the escort risk assessment form accurately; and
    - all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.
- The Governor should review the circumstances that led to the delay in payment and postponement of the funeral and ensure that the Business Hub makes funeral payments promptly in future.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Wormwood Scrubs informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

14. The investigator obtained copies of the relevant extracts from Mr Lockwood's medical and prison records.

15. NHS England commissioned an independent clinical reviewer to review Mr Lockwood's clinical care at HMP Wormwood Scrubs.

16. We informed HM Coroner for London West of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

17. The Ombudsman's family liaison officer contacted Mr Lockwood's wife to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She had some questions which are covered in this report and the clinical review.

18. The initial report was shared with Mr Lockwood's wife. In response, she said that she found reading the report to be a very traumatic and stressful experience. She raised some issues which did not impact on the accuracy of the initial report and which have been addressed in separate correspondence.

19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found no factual inaccuracies.

Background Information

HMP Wormwood Scrubs

20. HMP Wormwood Scrubs is a local prison in West London holding over 1,000 men. The prison holds men on remand from West London courts or prisoners serving short sentences or coming to the end of long sentences. Practice Plus Group provides physical health services, and Barnet, Enfield and Haringey Mental Health Trust provide mental health services.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Wormwood Scrubs was in June 2021. Inspectors said that the prison was continuing to improve and was safer, cleaner, and better organised than it had been in the past. They said that staff turnover continued to be a problem and that a large proportion of them were inexperienced and training had fallen behind because of the COVID-19 pandemic.

22. Inspectors found that healthcare was led by a strong management team and partnership working between healthcare and the prison was good. They said that the management of long-term health conditions had improved, that prisoners could see a doctor or nurse promptly, and that fewer hospital appointments were being cancelled.

23. However, inspectors said that although there was improved use of care plans, there was a need for them to be more personalised for prisoners with long-term health conditions. Inspectors were also concerned that there was poor identification of prisoners with disabilities and that there was little in the equality and diversity action plan to take account of older prisoners and those with disabilities.

Independent Monitoring Board

24. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to May 2021, the IMB reported that there had been an improvement in safety, but that the COVID-19 pandemic had put a strain on services including healthcare. They said that the quality and quantity of food was a persistent cause of complaints from prisoners.

Previous deaths at HMP Wormwood Scrubs

25. Mr Lockwood was the sixth prisoner to die at Wormwood Scrubs since October 2019. One of the previous deaths was from natural causes and four were self-inflicted. We have previously made recommendations about inappropriate resuscitation attempts and use of restraints.

Key Events

26. On 28 May 2021, Mr Trevor Lockwood was sentenced to 10 years imprisonment for sexual offences and was sent to HMP Wormwood Scrubs.

27. Mr Lockwood had a history of heart problems. He had previously had a heart bypass operation (to reroute blood around failing arteries to improve the blood flow and oxygen supply to the heart) following three heart attacks. He had also had a stroke (the term for when the blood supply is cut off to part of the brain) and had hypertension (high blood pressure) and diabetes (the inability of the body to regulate sugar in the blood). He had had several hip operations and used a wheelchair to get around.

28. Before being sent to Wormwood Scrubs, Mr Lockwood had been given a hospital appointment for his heart condition, but he was unable to attend because of his imprisonment.

29. On 11 June, Mr Lockwood said that he had been having chest pains for four days. An electrocardiogram (ECG - a test that checks the rhythm and electrical activity of the heart) showed some abnormalities. A prison GP made a referral to the hospital's cardiology department.

30. Mr Lockwood was given medication (metformin) to treat his diabetes. However, he refused to take it as he said he preferred to control his diabetes through his diet. Staff stopped the medication on 19 June.

31. On 2 July, Mr Lockwood complained of chest pain and was taken to hospital. He was diagnosed with pneumonia and returned to prison the following day.

32. Mr Lockwood had asked to move to a prison further north in the country to be closer to his wife. However, on 6 July, a prison GP noted that Mr Lockwood should not be transferred to another prison because of his outstanding hospital appointment (scheduled for 29 July).

33. However, on 13 July, Mr Lockwood was transferred to HMP Frankland. He arrived there on 14 July, after an overnight stay at HMP Lincoln.

34. Frankland began the process to refer Mr Lockwood to a local hospital cardiology department. However, Frankland is a high security prison (for Category A and B prisoners), and Mr Lockwood's lower security category (Category C) meant it was an unsuitable location for him. He was sent back to Wormwood Scrubs via HMP Peterborough, where he spent three nights. He arrived back at Wormwood Scrubs on 30 July.

35. Mr Lockwood missed his cardiology appointment while he was away from Wormwood Scrubs. A prison GP resubmitted a referral to the hospital on 31 July, but a new appointment had not been arranged by the hospital before Mr Lockwood died.

36. On 31 August, a prison GP told Mr Lockwood that blood tests showed that he might have prostate cancer. The GP made a hospital referral, and when the hospital delayed arranging an appointment, prison healthcare staff chased it up.

37. On 7 October, Mr Lockwood went to hospital for a virtual colonoscopy (a non-invasive scan of his bowels) as part of the investigation into suspected cancer. Two prison officers accompanied him, and he was restrained using an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner's wrist and the other to an officer's wrist). Investigations were still ongoing at the time of Mr Lockwood's death.

Events of 14 October

38. On the morning of 14 October, an officer visited Mr Lockwood to check that there were adequate measures in place to evacuate him in the event of an emergency. Mr Lockwood told the officer that he needed repairs to his wheelchair and toilet and would like his cell cleaned. The officer said that Mr Lockwood was polite, and there was no mention of any distress or health problems. Mr Lockwood's clinical notes make no mention of him raising any issues when he collected his medications earlier in the morning. Mr Lockwood was last seen at around 11.30am, and nothing unusual was noted.

39. At around 3.30pm, an officer unlocked Mr Lockwood's cell so that he could get his medications. She found him unresponsive on his bed. Healthcare staff were close by and so quickly attended Mr Lockwood and began resuscitation attempts. Ambulance staff were also with Mr Lockwood in less than ten minutes after the officer found him. They assessed that Mr Lockwood was already dead, as he had the beginnings of rigor mortis (stiffness of the limbs that normally sets in around two to six hours after death). Mr Lockwood was declared dead at 3.50pm.

Contact with Mr Lockwood's family

40. The prison arranged for a family liaison officer from a prison local to Mr Lockwood's next of kin, his wife, to visit her on the evening that he died. They also appointed a family liaison officer (FLO) for Wormwood Scrubs, and he phoned Mr Lockwood's wife the next day. He provided guidance about the prison's contribution to the funeral and responded to queries on several issues, including missing property that had been lost during Mr Lockwood's transfer back to Wormwood Scrubs in July.

41. Although Wormwood Scrubs told Mr Lockwood's wife that they would contribute to the funeral costs in line with national guidance and were aware of the date of the funeral, they failed to release payment in time and the funeral was cancelled and had to be rescheduled.

Support for prisoners and staff

42. After Mr Lockwood's death, the Head of Safety carried out a hot debrief for the healthcare and wing staff who had been present. Those requiring follow up support were seen by the Care Team. Prison staff visited all the vulnerable prisoners on the wing to offer support.

43. The prison posted notices to staff and prisoners informing them of Mr Lockwood's death, and offering support.

Post-mortem report

44. A post-mortem examination found that Mr Lockwood died from congestive cardiac failure (the heart's failure to pump blood around the body properly), caused by biventricular cardiac hypertrophy (a thickening of the walls of the lower chambers of the heart) and ischaemic heart disease (a restriction in the blood supply to the heart due to blockages in the arteries), which in turn was caused by hypertension (high blood pressure) and type 2 diabetes. Metastatic malignant neoplasm of the prostate (cancer which has spread from the prostate to other parts of the body) was given as an underlying issue which contributed to but did not cause the death.

Findings

Transfer of Mr Lockwood to HMP Frankland

45. On 6 July, a prison GP at Wormwood Scrubs noted that Mr Lockwood should not be transferred to another prison because of his outstanding hospital appointment on 29 July. Despite this, Mr Lockwood was moved to Frankland on 13 July. Once there, staff realised that there had been a mistake as Mr Lockwood was a Category C prisoner and sent him back. However, he did not get back to Wormwood Scrubs until 30 July, by which time he had missed his hospital appointment.

46. Wormwood Scrubs told the investigator that the transfer was made in error by an inexperienced member of staff. They said they thought this was in response to Mr Lockwood's request to move further north to be nearer to his wife, although Frankland was even further away from his wife's home (in the midlands) than Wormwood Scrubs.

47. Not all of Mr Lockwood's property transferred with him from Peterborough to Wormwood Scrubs, and he was still trying to get it returned to him at the time of his death. His telephone calls reveal that this was a cause of distress to him. Although not linked to his death, the disruption for an elderly prisoner and the loss of his property were further unfortunate consequences of the unnecessary moves. We recommend:

    The Governor should review the circumstances that led to Mr Lockwood being transferred in error to HMP Frankland and address any training needs identified.

48. While a prison GP noted on 6 July that Mr Lockwood should not be transferred to another prison pending his cardiology appointment on 29 July, it appears that the GP did not use the official clinical hold process (where prisoners are withheld from transfer for medical reasons). We recommend:

    The Head of Healthcare should ensure that staff know when and how to apply clinical hold to prisoners who have outstanding hospital appointments.

Clinical care

49. The clinical reviewer considered that overall, the clinical care Mr Lockwood received at Wormwood Scrubs was of a standard that was equivalent to that he could have expected to receive in the community. However, she identified some learning points.

Long term condition care *plans*

50. The clinical reviewer said that although Mr Lockwood was regularly reviewed at weekly meetings, no care plans were created for his long-term conditions. She also noted that there had been no discussion with Mr Lockwood about his end of life wishes including whether he wanted to be resuscitated if his heart or breathing stopped, which would have been appropriate given his age and health. We recommend:

The Head of Healthcare should ensure that staff:

- **put care plans in place for prisoners with long-term conditions; and**
- **hold end of life discussions and care planning at an early stage for those with complex and deteriorating conditions.**

Resuscitation

51. Healthcare staff arrived very quickly after Mr Lockwood was discovered and they started CPR. Notes made later in the day by two nurses say that Mr Lockwood was cold to the touch and that his jaw was stiff so that it could not be opened to insert an airway to provide oxygen. They wrote that CPR was applied for up to three minutes and stopped before the ambulance paramedics arrived. The ambulance records say that CPR was still taking place when the paramedics arrived but was stopped once it was established by them that Mr Lockwood had rigor mortis. Whichever account is correct, it is clear that CPR was started on Mr Lockwood even though he had been dead for some time.

52. In September 2016, Professor Sir Bruce Keogh, the National Medical Director at NHS England, wrote to Heads of Healthcare for prisons introducing new guidance to support staff on when not to perform cardiopulmonary resuscitation. This guidance was designed to address the issue of inappropriate resuscitation following a sudden death in a prison and was in line with the European Resuscitation Council Guidelines 2015 which state, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile".

53. The clinical reviewer discussed the appropriateness of the resuscitation attempt with the Head of Healthcare, who agreed to carry out a reflective case study session with staff. We recommend:

    The Head of Healthcare should ensure that healthcare staff fully understand the circumstances in which resuscitation is inappropriate, in accordance with European Resuscitation Council Guidelines.

Use of restraints on 7 October

54. 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.

55. 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.

56. Mr Lockwood went to hospital on 7 October for a planned procedure. In preparation for this on 30 September, a nurse completed the medical information section of the

risk assessment form. He indicated on the form that Mr Lockwood's medical condition did not restrict his ability to escape unaided and that he did not suffer from impaired mobility. This was incorrect, as Mr Lockwood was an elderly, frail man who used a wheelchair.

57. The duty governor on 7 October authorised the use of an escort chain and wrote on the risk assessment form that an escort chain was being used because of mobility issues. However, she must have found out this information separately, as it was not included in the medical information section of the form. We consider that the use of restraints on Mr Lockwood was not proportionate to the risk he posed given his advanced age and failing health. We recommend:

The Governor and Head of Healthcare should ensure that:

- **healthcare staff complete the medical information section of the escort risk assessment form accurately; and**
- **all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.**

Family liaison and funeral arrangements

58. Initial communications between the prison FLO and Mr Lockwood's wife following his death were good. However, the prison's handling of its payment towards the funeral costs was very poor.

59. The funeral was arranged for 16 November, and the funeral directors asked for payment by 3 November. However, the prison had still not paid by 9 November. Despite assurances from the prison that they would pay the invoice before the funeral was due to take place, they did not do so, and the funeral was postponed. The prison finally made the payment on 23 November and the funeral took place on 8 December.

60. In her letter to the Ombudsman, Mr Lockwood's wife said that sorting out the funeral had been very stressful for the family and she found it difficult to understand how there could not be an established procedure following a death in custody. In response to the investigator's queries, Wormwood Scrubs said that personnel changes and inexperience within the Business Hub with processing payments was the cause of the delays. We consider that the delays and subsequent postponement of the funeral would have added to the distress of Mr Lockwood's family at an already difficult time. The prison must ensure that this does not happen again. We recommend:

The Governor should review the circumstances that led to the delay in payment and postponement of the funeral and ensure that the Business Hub makes funeral payments promptly in future.

Inquest

61. The inquest into Mr Lockwood's death concluded on the 17 October 2023. The coroner confirmed that Mr Lockwood died of natural causes.

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