

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr David Zold, a prisoner at HMP Wakefield, on 25 March 2023**

**A report by the Prisons and Probation Ombudsman**

## 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



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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. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.
3. Mr David Zold died of leukaemia on 25 March 2023 at HMP Wakefield. He was 72 years old. We offer our condolences to Mr Zold's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Zold received at Wakefield was equivalent to that which he could have expected to receive in the community. She found that while Mr Zold's behaviour was challenging at times, he was managed with compassion and care by confident, competent staff. She made no recommendations.
5. When Mr Zold was taken to hospital on 27 February and 14 March, staff applied restraints (an escort chain). We found that healthcare staff had failed to complete the escort risk assessment accurately which meant that the manager who authorised restraints was not fully aware of the state of Mr Zold's health and mobility. The use of restraints on Mr Zold was not proportionate given his age, ill health and poor mobility. The inappropriate use of restraints is an issue we have raised with Wakefield before.

## Recommendations

- The Governor should provide the Ombudsman with the detail of whatever refreshed, auditable process he has embedded for quality assuring the completion of escort risk assessments to the required standard.

## The Investigation Process

6. HMPPS notified us of Mr Zold's death on 25 March 2023.
7. NHS England commissioned an independent clinical reviewer to review Mr Zold's clinical care at HMP Wakefield.
8. The PPO investigator investigated the non-clinical issues relating to Mr Zold's care.
9. The PPO family liaison officer wrote to Mr Zold's next of kin, his cousin, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.
10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found no factual inaccuracies.

## Previous deaths at HMP Wakefield

11. Mr Zold was the 27th prisoner to die at Wakefield since March 2020. Of the previous deaths, 23 were from natural causes and three were self-inflicted.
12. We have previously made recommendations about the need for healthcare staff to complete the medical section of the escort risk assessment fully and accurately, and to ensure that restraints are not used unnecessarily on elderly and unwell men being taken to hospital. We were told that in February 2023, the Senior Management Team at Wakefield, including the Head of Healthcare, were briefed about the need to ensure that the use of restraints on men being transferred to hospital must be proportionate and take their current health into account.

## Key Events

13. On 16 November 2009, Mr David Zold was sentenced to life imprisonment for sexual offences. On 1 April 2010, he was moved to HMP Wakefield.
14. Mr Zold was diagnosed with type 2 diabetes in 2009. He was frequently non-compliant with medical advice and often refused to attend hospital. As a result, his diabetes was poorly controlled.
15. In September 2022, when Mr Zold became unwell, he initially refused to attend hospital but eventually agreed. In hospital he was diagnosed with severe heart failure (the heart's inability to pump blood around the body properly), and ischaemic heart disease (a restriction in the blood supply to the heart due to blockages in the arteries). While in hospital, doctors also advised Mr Zold that because of circulation problems caused by his diabetes, he should have one of his toes amputated. However, Mr Zold refused to agree to an amputation. Due to his heart disease and foot problems, he had very poor mobility and used a wheelchair to get around.
16. Over the next few months, there were several occasions when Mr Zold was very unwell and was advised by healthcare staff at Wakefield that he needed to go to hospital, but he refused. Healthcare staff assessed that Mr Zold had the mental capacity to make these decisions, and he signed disclaimers to acknowledge that he was rejecting medical advice.
17. On 26 February 2023, officers took Mr Zold to see healthcare staff as he was very short of breath and had vomited a few times after eating. A nurse spoke to Mr Zold about the seriousness of his heart failure and poor health, but he refused to go to hospital.
18. Healthcare staff checked on Mr Zold that evening and the next morning. They also took blood samples. They were subsequently told that Mr Zold's blood test results were abnormal and that he needed a blood transfusion. On the afternoon of 27 February, a nurse examined Mr Zold in his wheelchair. He said that he had not eaten in four days as he had vomited when he tried and that he was unable to breathe properly when lying down and had to sit up to sleep.
19. Mr Zold agreed to go to hospital. Two officers escorted him and applied 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). Mr Zold remained in hospital for several days. Hospital doctors diagnosed Mr Zold with leukaemia (a cancer of the blood).
20. Mr Zold declined any treatment for his cancer and asked to go back to prison. On 2 March, he returned to Wakefield.
21. During the evening of 13 March, Mr Zold had a fall in his cell and then another one shortly after midnight. Healthcare staff assessed him and found him to have low blood pressure and low blood sugar levels (related to his diabetes). Mr Zold was very unwell, and he was taken to hospital. Two officers escorted him and applied an escort chain. Hospital doctors noted the rapid progression of his leukaemia and said that he did not have long to live. Mr Zold said that he wanted to end his life in prison, and he returned to Wakefield on 17 March.

22. On 24 March, Mr Zold became critically unwell. He died at Wakefield on 25 March.

### **Post-mortem report**

23. The post-mortem report concluded that Mr Zold died from acute myeloid leukaemia (a cancer of the white blood cells that progresses quickly). Ischaemic heart disease (a restriction in the blood supply to the heart due to blockages in the arteries) was also listed as an illness that contributed to the death but did not cause it.

### **Inquest**

24. The inquest held on 15 May 2023, concluded that Mr Zold died from natural causes.

## Non-Clinical Findings

### Restraints, security and escorts

25. 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. A judgment in the High Court in 2007, known as the Graham Judgement, 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. It said 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.
26. Mr Zold was very ill when he was taken to hospital on 27 February and 14 March 2023. Although it was not known that he had leukaemia on the first of these occasions, he already had severe heart failure which made him breathless. He was unable to walk more than 30 yards and used a wheelchair to get around the prison. Despite this, staff restrained him using an escort chain on both occasions.
27. A senior nurse completed the healthcare section of the escort risk assessment for Mr Zold's transfer to hospital on 27 February. She said on the form that Mr Zold's medical condition did not restrict his ability to escape unaided. This was clearly inaccurate. She also left blank the section that asks if the prisoner suffers from impaired mobility.
28. The member of staff who completed the healthcare section of the escort risk assessment for the transfer on 14 March, did not add their details so we do not know who completed it (possibly the nurse who completed the PER that day). Again, it noted that Mr Zold's medical condition did not restrict his ability to escape unaided and the section asking whether the prisoner has impaired mobility was left blank.
29. As the healthcare sections of the escort risk assessments were not completed accurately, the authorising manager was not fully aware of Mr Zold's health and poor mobility. We consider that the use of restraints on Mr Zold was not proportionate to the risk he posed, given he was a 72-year old wheelchair user in poor health.
30. The inappropriate use of restraints on prisoners being taken to hospital is an issue we have raised with Wakefield before. We recommend:

**The Governor should provide the Ombudsman with the detail of whatever refreshed, auditable process he has embedded for quality assuring the completion of escort risk assessments to the required standard.**

**Adrian Usher  
Prisons and Probation Ombudsman**

**November 2023**

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