

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Seaman, a prisoner at HMP Wakefield, on 29 May 2023

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



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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 HM Prison and Probation Service in ensuring the standard of care received by those within service remit is appropriate then our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.
3. Mr Paul Seaman died on 29 May 2023, of colon cancer which had spread to other parts of his body, at HMP Wakefield. He was 64 years old. He also had epilepsy which contributed to but did not cause his death. We offer our condolences to his family and friends.
4. The clinical reviewer concluded that the clinical care that Mr Seaman received at Wakefield was of a good standard and equivalent to that which he could have expected to receive in the community.
5. There was an order in place restricting Mr Seaman from contacting either of his two sons, as a result of which the prison family liaison officer opted not to contact them during Mr Seaman's illness. One of Mr Seaman's sons said that he was made aware at the funeral that his father had been ill with cancer for several months before he died, and that he would like to have been told of this earlier. There is no national guidance to advise prison family liaison officers what to do in these circumstances.

Recommendation

The Director General of Operations for HMPPS should update PSI 64/2011 to provide guidance on family liaison in the event of serious or terminal illness when there is a contact restriction in place.

The Investigation Process

6. On 30 May 2023, the PPO was informed of Mr Seaman's death.
7. NHS England commissioned an independent clinical reviewer to review Mr Seaman's clinical care at Wakefield.
8. The PPO investigator investigated the non-clinical issues relating to Mr Seaman's care.
9. The PPO family liaison officer wrote to Mr Seaman's son to explain the investigation and to ask if he had any matters he wanted us to consider. Mr Seaman's son said that he was told at Mr Seaman's funeral that Mr Seaman had been in the prison's healthcare unit with cancer for several months before he died and asked why he was not given this information sooner.
10. We shared the initial report with the Prison Service. There were no factual inaccuracies.
11. We shared the initial report with Mr Seaman's son. He did not respond.

Previous deaths at HMP Wakefield

12. In the three years before Mr Seaman's death, there were 21 deaths from natural causes (six of which were related to COVID-19), three self-inflicted deaths and an unascertained death at Wakefield. There has been one death from natural causes since Mr Seaman's death. There are no significant similarities between our findings in this investigation and those of the other deaths.

Key Events

13. On 8 June 2015, Mr Paul Seaman was remanded to HMP Holme House charged with sexual offences. On 25 June, he was transferred to HMP Durham. On 13 June 2016, Mr Seaman was sentenced to life in prison and, two days later, he was transferred to HMP Wakefield.
14. Mr Seaman had epilepsy, Type 2 diabetes, diabetic retinopathy (damage to the back of the eye caused by diabetes) and high blood pressure.
15. Healthcare staff at Wakefield created an epilepsy care plan, which they regularly reviewed. Mr Seaman controlled his epilepsy with medication.
16. On 1 October 2019, a GP at Wakefield noted that Mr Seaman was anaemic (a condition in which the number of red blood cells is lower than normal) and prescribed him iron tablets.
17. On 6 April 2022, a nurse reviewed Mr Seaman's blood test results which showed that his iron levels had dropped. She completed a fast-track referral (which requires patients with suspected cancer to be seen by a specialist within two weeks) for suspected upper gastrointestinal cancer.
18. Between 12 April and 8 August, Mr Seaman went to hospital for tests and treatment and spent a lengthy period in hospital, where hospital staff thought that he had spondylodiscitis (an infection of the vertebrae).
19. On 27 September, Wakefield appointed a Supervising Officer as the family liaison officer (FLO). Mr Seaman's next of kin was his son, and he also had another son, who was detained in another prison. The FLO identified that there were orders in place prohibiting Mr Seaman from contacting either of his sons.
20. On 1 October, Mr Seaman went to hospital for a colonoscopy (a fibre-optic examination of the large intestine). A hospital consultant found that Mr Seaman had colon cancer which had spread to other parts of his body. Hospital staff from the Colorectal and General Surgery Multidisciplinary Team decided that Mr Seaman's future management plan should be for best supportive care (treatment that is focused on managing symptoms) and not for palliative chemotherapy.
21. On 9 October, Mr Seaman asked the FLO to try to contact his sons. The FLO explained to Mr Seaman that there was a restraining order in place preventing contact between him and his sons.
22. On 7 December, a nurse completed an advance care plan (a structured discussion with prisoners about their wishes and thoughts for the future) as part of the Gold Standard Framework (a model that enables good practice to be available to all people nearing the end of their lives).
23. On 9 January 2023, Mr Seaman was added to the Dying Well in Custody patient group (which enables those involved in caring for individuals to manage this event with compassion).
24. On 7 February, Mr Seaman moved into the healthcare inpatient unit.

25. At 8.50pm on 29 May, a Healthcare Assistant went into Mr Seaman's cell and found that he had shallow breathing. She sat with Mr Seaman and, at 8.58pm, noted that there were no signs of life. A nurse asked for an ambulance to attend to verify that Mr Seaman had died. At 10.50pm, ambulance staff confirmed that Mr Seaman had died.
26. After Mr Seaman died, the FLO contacted the chaplain at HMP Whatton to inform him of Mr Seaman's death.
27. On 31 May, prison staff at Whatton told Mr Seaman's son that he had died. They delayed informing him until they had spoken to the psychology team and his prison offender manager to ensure that he was given appropriate support. There is no record that anyone at Wakefield told Mr Seaman's other son that he had died.
28. Mr Seaman's funeral took place on 12 July. Wakefield contributed to the costs in line with national guidelines. Mr Seaman's son attended the funeral.

Findings

Family liaison

29. Prison Service Instruction (PSI) 64/2011, on managing prisoner safety, instructs that when prisoners have a terminal illness, prisons must have in place procedures for engaging with their next of kin. Mr Seaman's son asked us why he was not told that his father was seriously ill in the prison's healthcare inpatient unit.
30. Mr Seaman told the FLO that he would like help contacting his sons, with whom he had a non-contact order. The FLO informed him of the contact restriction, and therefore took no further action.
31. This was a difficult situation for the FLO, and our view is that he could have chosen to contact Mr Seaman's family to determine whether they wished to be updated on his health. However, HMPPS guidance does not advise family liaison officers what to do when contact is prohibited between a terminally ill prisoner and their family. We consider that the guidance should be updated to provide instruction in these exceptional circumstances. We make the following recommendation:

The Director General of Operations for HMPPS should update PSI 64/2011 to provide guidance on family liaison in the event of serious or terminal illness when there is a contact restriction in place.

Clinical care

32. The clinical reviewer concluded that the clinical care Mr Seaman received at Wakefield was of a good standard and equivalent to that which he could expect to receive in the community.

Good practice

33. The clinical reviewer found that Mr Seaman's care was delivered in accordance with the Gold Standards Framework and the Dying Well in Custody Charter.

Head of Healthcare to note

34. There were no healthcare staff on duty at Wakefield who were trained to verify that Mr Seaman had died, and an ambulance paramedic was used to confirm death. This is not the best use of their resource.
35. The Deputy Head of Healthcare said that verification of death training is available to nurses should they wish to complete it. However, it is not mandatory, and nurses may choose whether they want to complete the training as an extension of their role. She said that they have two senior nurses who have both completed this training and are competent at verifying death.
36. The Head of Healthcare may wish to consider renewing the offer of verification of death training to suitable healthcare staff.

Inquest

37. The inquest, held on 13 June 2023, concluded that Mr Seaman died from natural causes.

Adrian Usher
Prisons and Probation Ombudsman

January 2024

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