Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Derek Hayward, a prisoner at HMP Wakefield, on 6 August 2023

A report by the Prisons and Probation Ombudsman

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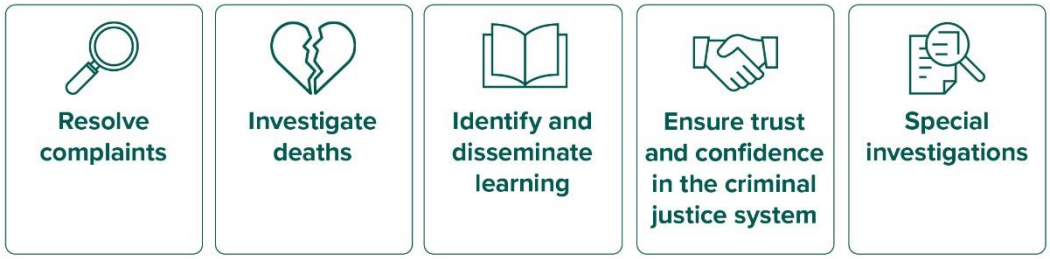
OUR VISION

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

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 Prisons 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 Derek Hayward died on 6 August 2023 from chronic obstructive pulmonary disease (COPD, a disease that restricts airflow and causes breathing problems) while a prisoner at HMP Wakefield. He was 84 years old. I offer my condolences to Mr Hayward's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Hayward received at Wakefield was of a good standard and was equivalent to that which he could have expected to receive in the community. The clinical reviewer made no recommendations.

5. There is no evidence that the use of restraints on Mr Hayward when he was taken to hospital on 9 July was justified given his age, ill health and poor mobility. The inappropriate use of restraints is an issue that we have raised with Wakefield on a number of occasions.

6. We also concluded that Mr Hayward's application for early release on compassionate grounds was not adequately or promptly progressed.

Recommendation

- The Operational Security Group Director for HMPPS should monitor compliance with policy on the use of restraints during hospital escorts (for inpatient admissions and outpatient appointments), including at HMP Wakefield, and discuss the findings with the Ombudsman.

- The Governor should ensure that the process for progressing and monitoring ERCG applications is reviewed so that applications are progressed in a timely manner and all the required information is provided.

The Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Hayward's clinical care at Wakefield.

8. The PPO investigator investigated the non-clinical issues relating to Mr Hayward's care.

9. The PPO family liaison officer wrote to Mr Hayward's next of kin, his son, to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond to our letter.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Wakefield

11. Mr Hayward was the twenty-seventh prisoner to die at Wakefield since August 2020. Of the previous deaths, twenty-three were from natural causes and three were self-inflicted.

12. We have previously made recommendations about the need for healthcare staff to ensure that they fully consider a prisoner's presenting health when completing the medical risk assessment. This is to ensure that restraints are not used unnecessarily on elderly and unwell men.

13. We were told that in February 2023, the Senior Management Team at Wakefield, including the Head of Healthcare, was briefed about the need to ensure that the use of restraints is proportionate and takes into account the prisoner's health at the time. Despite this action we have seen further examples of poor decisions being made and we are currently investigating cases where restraints feature as an issue.

14. In November 2023, the Ombudsman spoke to the Acting Governor to discuss the PPO's concerns and to consider what could be done to support them in this area.

15. Since then, Wakefield have told us that they have carried out further formal training in all aspects of escorting and cuffing arrangements and that bi-monthly training on the Graham judgement is being scheduled for all relevant staff.

Key Events

16. Mr Derek Hayward was sentenced to 14 years in prison and sent to HMP Forest Bank on 22 July 2021. He transferred to HMP Wakefield on 11 January 2022.

17. Before his arrival, Mr Hayward had been diagnosed with a number of medical conditions, including chronic obstructive pulmonary disease (COPD, a lung disease) and angina (chest pain caused by reduced blood flow to the heart).

18. During his reception screen at Wakefield, Mr Hayward was noted as being frail, a wheelchair user and underweight. He lived in the healthcare inpatient unit at Wakefield.

19. On 7 March 2022, Mr Hayward signed a DNACPR (do not attempt cardiopulmonary resuscitation) order which set out his consent not to be resuscitated if his heart or breathing stopped.

20. On 13 February 2023, a GP operating at Wakefield carried out a frailty review with Mr Hayward. He recorded that Mr Hayward appeared severely frail and had poor mobility.

21. On 6 March, a GP operating at Wakefield examined Mr Hayward during ward rounds. She diagnosed that Mr Hayward had an infective exacerbation of his COPD. She made an entry in the medical notes that she discussed sending him to hospital, but Mr Hayward had said that he felt like he was dying, and he wanted to remain in prison. She asked for a respiratory consultant at Wakefield to review Mr Hayward and to consider an application for early release on compassionate grounds (ERCG).

22. On 28 March, the respiratory consultant reviewed Mr Hayward, following concerns raised by healthcare staff that he had lost more weight. He recorded that Mr Hayward was very frail but in line with his wishes, he should not be admitted to hospital if his health deteriorated. He said that Mr Hayward's prognosis was poor, and he would arrange to complete the paperwork for a ERCG application. (He did not specify Mr Hayward's prognosis.)

23. On 30 March, the respiratory consultant made an entry in the medical records that he had completed the ERCG form.

24. On 31 March, the Prison Offender Manager (POM) and Community Offender Manager (COM) were asked to provide their reports for the ERCG application.

25. On 4 April, the POM submitted his report for the ERCG application.

26. On 18 April, the respiratory consultant reviewed Mr Hayward and told him that he was nearing the end of his life. He made an entry in the medical records stating, "Derek is not for hospital admission – this has been documented on SystmOne".

27. On 21 April, healthcare and prison staff met to discuss Mr Hayward's ERCG application. An entry in the medical records states that paperwork had been submitted. It was also documented that an officer from the Offender Management

Unit (OMU) would contact the adult social care team about a place for Mr Hayward in a nursing home.

28. On 11 May, a nurse made an entry in the medical records. She said that there had been a meeting to discuss the ERCG application and that an assessment referral had been sent to Thameside (the local authority).

29. On 16 May, OMU asked the respiratory consultant to assess Mr Hayward and to provide them with an up-to-date condition report.

30. On 17 May, a nurse met Mr Hayward to complete consent forms to allow probation to try and find him a place in a nursing home.

31. On 25 May, Mr Hayward gave his consent to the nurse to share his health information with other agencies in relation to the ERCG application.

32. On 13 June, the nurse made an entry in the medical records. She stated that nurses and social workers would be visiting Mr Hayward on 16 June to carry out a care needs assessment.

33. On 3 July, the COM submitted her report for the ERCG application.

34. At approximately 1am on 9 July, a nurse responded when Mr Hayward pressed his emergency alarm. He reported pain in his chest. She carried out an electrocardiogram (ECG, a test to check the heart's rhythm and electrical activity) which concluded that there were "new changes and irregular". The results were shared with the prison's remote clinical service, Telemeds, who recommended that Mr Hayward should have a follow-up hospital appointment.

35. Before Mr Hayward left the prison, a nurse completed the medical risk assessment. She indicated that she did not object to the use of restraints, and she did not consider that his medical condition restricted his ability to escape. However, she indicated that his mobility was impaired and that he used a wheelchair.

36. A Custodial Manager, the night orderly officer, recorded on the PER that Mr Hayward should be restrained using an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer).

37. At approximately 8.20am, Mr Hayward discharged himself from hospital and he returned to Wakefield at 9.45am.

38. On 28 July, Wakefield's Governor submitted his report for the ERCG application, and the application was subsequently sent to the Public Protection Casework Section (PPCS) of HM Prison and Probation Service (HMPPS).

39. On 28 July, the PPCS emailed Wakefield about the application. They asked for the doctor's report to be completed, a report from the consultant, the POM report to be updated and three other documents.

40. On 2 and 3 August, Wakefield provided the PPCS with some of the outstanding information.

41. At approximately 5.52pm on 6 August, a nurse made an entry in the medical records to say that Mr Hayward was deteriorating rapidly.

42. At approximately 7.15pm, a nurse checked Mr Hayward and recorded that he was responding to voice and breathing. Around 45 minutes later, a healthcare assistant checked Mr Hayward again and could not find a pulse.

43. At 8.10pm, the prison called for an ambulance which arrived at 8.30pm. The attending paramedics confirmed that Mr Hayward had died.

44. The prison appointed a family liaison officer. Mr Hayward had listed his son as the next of kin but there were no contact details recorded. At approximately 1.25pm on 8 August, the family liaison officer made contact with Mr Hayward's son.

Post-mortem report

45. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor established that Mr Hayward's cause of death was COPD (a disease that restricts airflow and causes breathing problems). Old age and ischaemic heart disease (decreased blood flow and oxygen to the heart) were listed as contributory factors.

Inquest into Mr Hayward's death

46. The inquest into Mr Hayward's death was held on 15 August 2023 and a verdict of natural causes was recorded.

47. The coroner concluded that Mr Hayward's death was due to COPD and that old age and ischaemic heart disease were contributory factors.

Non-Clinical Findings

Admission to hospital

Restraints, security and escorts

48. 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.

49. 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 he has a serious medical condition. It said that medical opinion about a prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

50. On 9 July, Mr Hayward was sent to hospital because of chest pain and an irregular ECG. At this time, Mr Hayward, who was 84 years old, had been diagnosed as being very frail (he weighed less than seven stone) and was in the final months of his life. He also used a wheelchair.

51. We are therefore concerned that the nurse concluded that his health did not affect his ability to escape and her decision not to object to the use of restraints.

52. We have investigated a number of deaths at Wakefield in recent months, where the use of restraints has been identified as a concern and we have made recommendations to the Governor and Head of Healthcare. We therefore make the following recommendation:

    The Operational Security Group Director for HMPPS should monitor compliance with policy on the use of restraints during hospital escorts (for inpatient admissions and outpatient appointments), including at HMP Wakefield, and discuss the findings with the Ombudsman.

Compassionate release

53. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months, can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release are set out in the Early Release on Compassionate Grounds Policy Framework. Among the criteria is that the risk of reoffending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison and release would benefit the prisoner and his family.

54. Wakefield provided the investigator with a copy of their process for dealing with ERCG applications. This stipulates that applications should be submitted to PPCS within 10 weeks of the application being triggered.

55. On the 31 March 2023, the prison began the ERCG application process. The prison submitted the application to PPCS on 28 July, which was 17 weeks after the application was started. The application sent to PPCS was incomplete and some of the documentation was also out of date. This caused a further delay.

56. It is imperative, given the short life expectancy of the prisoner, that applications are progressed as quickly as possible. We therefore make the following recommendation:

The Governor should ensure that the process for progressing and monitoring ERCG applications is reviewed so that applications are progressed in a timely manner and all the required information is provided.

Head of Healthcare to note

57. On 28 March, the respiratory consultant recorded in Mr Hayward's medical records that he was not to be admitted to hospital. He made a further entry on 18 April to say that Mr Hayward was not for hospital admission and that this had been recorded in the SystmOne medical records. Despite this, Mr Hayward was sent to hospital on 9 July.

58. The Head of Healthcare advised the investigator that while it had been recorded on a number of occasions that Mr Hayward should not be admitted, the alert which notifies staff of this was not created until 11 July.

Adrian Usher
Ombudsman **January 2024**

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