

**Investigation into the death of a man  
at HMP Wakefield in October 2004**

**Report by the Prisons and Probation Ombudsman for  
England and Wales**

**June 2005**

This is the report of an investigation into the death of a man, who died in October 2004 at HMP Wakefield. I offer my sincere condolences to the man's family for their loss. Some minor amendments have been made to this report to protect the identity of the man, his family and prison staff.

I wish to thank the Governor and his staff for their co-operation during this enquiry.

The man was 64 years old when he died and had been in poor health for a number of years. I am satisfied that he received the appropriate care and treatment during his time in custody.

There are no suspicious circumstances surrounding the man's death. He was a sick man who it seems took little personal care of his health. He had significant respiratory problems and had previously had two strokes.

I make no recommendations as the result of this investigation.

**Stephen Shaw CBE**  
**Prisons and Probation Ombudsman**  
**June 2005**

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## Summary

1. The subject of this report was a 64 year-old man, serving a life sentence for serious sexual offences against children. He had been at HMP Wakefield since early 1994. He suffered from a number of potentially life threatening conditions for which he had been receiving treatment for a number of years.
2. After his cell was unlocked at about 7.30 am on the day of his death, a fellow prisoner raised the alarm. Staff found the man lying on his bed. He was cold and there were signs of rigor mortis. Healthcare and paramedics were called, but they found no signs of life.
3. The clinical review details the man's long history of ill health and the fact that he did not always comply with treatment. He was obese and a heavy smoker.
4. The man's family did not wish to take part in this investigation and the report contains no recommendations.

## **Investigation methodology**

5. Upon notification of the man's death one of my senior investigators contacted HMP Wakefield and arranged to visit the prison. The investigation was opened and the official notice of investigation and notices for staff and prisoners were distributed around the establishment. The Governor made the man's core record, medical record and other documents available to my investigator.
6. My investigator took the opportunity to tour the prison and talk informally to a number of staff about the man. On a subsequent visit he also spoke with a prisoner who had asked to see him.
7. The Wakefield Primary Care Trust were contacted and agreed to carry out a clinical review of the man's care.
8. The man's next of kin were contacted but they did not wish to take part in my enquiry.
9. My investigator contacted Her Majesty's Coroner to inform him of my investigation.

## **HMP Wakefield**

10. Wakefield was originally built as a house of correction in 1594. The current prison was designated a dispersal prison in 1966. It remains part of the high security estate and holds prisoners convicted of serious offences, most of them sex offenders.
11. The length of sentences being served at Wakefield, and the nature of the offences for which they were imposed, also mean that Wakefield holds a significant proportion of elderly and infirm prisoners, some of whom may never leave prison custody.
12. The prison provides full-time, part-time and evening classes in education, workshops, training courses, a works department, kitchen, and farms and gardens. There are also offending behaviour courses, a sex offender treatment programme, cognitive self-change programme, enhanced thinking skills group, and a learning difficulties group. Drugs rehabilitation and alcohol education courses are available. A Listener scheme is in operation, whereby volunteer prisoners are trained by the Samaritans to provide support to other prisoner's who may be in distress.

## **The deceased**

13. The man was born in 1940. He was taken into care when he was four years old when his mother had an operation. He did not return home until he was 12. He then lived with his mother, step-father and two brothers.
14. He was first convicted of a criminal offence in 1957, an offence of dishonesty. He was sent to borstal. He was then in and out of prison throughout the rest of his life, mainly for offences of dishonesty and those related to motoring. His longest period out of prison was between 1985 and 1992.
15. He had a number of jobs: weaving, engineering, papermaking and gardening. He was married between 1977 and 1988.
16. In 1992, the man was convicted of five offences of indecent assault on young children. He was sentenced to three and a half years on each, to be served concurrently.
17. Whilst he was in custody for the above offences, a number of serious sexual offences committed against family members back in the mid-seventies came to light. In 1993, the man was sentenced to life imprisonment.
18. The man's last Parole Board Panel was in March 2003. He was not recommended for release on life licence, and had refused to attend the Panel in person. The Panel took the view that he was still too high a risk to children to recommend either his release or move to an open prison. He was due to have gone before the Parole Board again in March 2005.
19. The man was in poor health. He suffered from asthma, angina and had had two strokes. He was 64 years old when he died.

## **Events prior to the man's death**

20. The man first arrived at Wakefield in the spring of 1994 on transfer from another prison. He was not a well man and did little to improve his health. He was clinically obese and a heavy smoker. According to the clinical review, his compliance with medication left something to be desired.
21. He appears to have become institutionalised after spending so many years of his life in custody. He spent his time watching television, reading and modelling.
22. The man took part in, but did not complete the Sex Offender Treatment Programme. He made minimal progress and continued to hold distorted attitudes about children and sex.
23. In August 2001, he was admitted to hospital for four days with severe breathing problems. He was then an in-patient at hospital a further three times until January 2002 when he had a respiratory arrest. That occurred three days after admission and the clinical reviewer postulates that, if it had happened when not in hospital, the man would have died.
24. In May 2004, the man's breathing was further restricted when he contracted pneumonia. Mindful that changes on an x-ray may have indicated lung cancer, a bronchoscopy and a CT scan were arranged. Those were undertaken as an outpatient and the results were normal.
25. In October 2004, healthcare staff saw the man on C wing due to a worsening wheeze. He was given nebulised medication to good effect.

## **Discovery of the man's death**

26. Staff on C wing unlocked the cells around 7.30 am on the day he died. About 8.00 am, a prisoner alerted an Officer that he thought there was something wrong with the man as he could not wake him when he called. The officer went to cell C1-33 with another officer and saw the man lying on his bed. They tried to rouse him but they got no response. They found that he was cold and stiff to the touch.
27. Healthcare officers were called, as was an ambulance. The healthcare staff could detect no pulse and did not attempt cardio pulmonary resuscitation (CPR) as the man's chest was rigid. The paramedics arrived at 8.20 am and placed monitoring equipment on him but could detect no signs of life. He was officially certified dead at 8.55 am by the prison doctor.

## **Findings and conclusions**

28. The subject of this report was a very ill man who did little to help himself. He was institutionalised and not at risk of self harm. He had several potentially life threatening conditions for which he was always treated promptly and appropriately by the healthcare professionals within the prison and in the NHS hospitals he attended.

## **Recommendations**

29. I have no recommendations to make in relation to this case.