

**Investigation into the circumstances surrounding the  
death of a man at HMP Wakefield  
in February 2009**

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

**August 2009**

This is a report into the death of a man at HMP Wakefield on 1 February 2009. The post mortem showed that he died of cancer. He had been in custody since 1995.

I offer my sincere condolences to the man's family for their loss. One of my family liaison officers liaised with his family during the investigation process.

The investigation was led by my one of my investigators. I thank the Primary Care Trust for the appointment of the clinical reviewer. I am also grateful to the Governor and staff of HMP Wakefield, especially the liaison officer, whose assistance was greatly appreciated.

As with all deaths from natural causes, the findings of the clinical review play an essential part in my report. The clinical reviewer judges that the man received a good standard of care whilst at HMP Wakefield. He had regular mental health reviews, made a good recovery from his heart attack, and no cancer symptoms had been detected. I endorse the recommendation from the clinical review concerning the process for acting on abnormal blood tests.

Although I have made no formal recommendation on these matters, the Governor may wish I recognise the speed with which the staff responded to the emergency when the man was discovered in his cell, and the support offered by the prison's care team.

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

**August 2009**

## **CONTENTS**

Summary

The Investigation Process

HMP Wakefield

Key Findings

Issues

Recommendations

## SUMMARY

The man was married and had a stepdaughter. He was charged with murder 1995 and remanded to HMP Blakenhurst.

Whilst on remand the man was transferred to a clinic, (a forensic psychiatry specialist treatment centre) on 2 March 1995. He was found to be suffering from a psychotic disorder (a serious illness that affects the mind) with the potential for self harm. He was sentenced to life in prison at the Crown Court in November 1995. He was sent to HMP Shrewsbury and transferred to HMP Wakefield on 30 January 1996.

Throughout his time at Wakefield, the man was frequently seen by a consultant forensic psychiatrist. He regularly reviewed the man's mental health, prescribed medication, and recorded any concerns or changes that occurred.

The man complained of chest pain on 26 November 2002. He was sent to the emergency department of an outside hospital. The diagnosis was that he had suffered an inferior myocardial infarction (heart attack), and had ischaemic heart disease (reduced blood supply to the heart muscle).

On 19 March 2003, the man was reviewed at the cardiology department of the outside hospital. He had made a good recovery, his blood pressure was within normal range, and he had been advised to give up smoking.

The man remained in good health until 1 February 2009. At 7.20am, an officer conducted full roll check of the wing and saw the man lying on his bed seemingly asleep. At 8.50am, another officer unlocked B1 landing and noticed that he had not come out of his cell. The other officer and his colleague called out to the man but received no response and noticed that he was pale in colour. The other officer checked for a pulse but found none and noted that he was very cold to touch. When the nurses arrived, they assessed he had been dead for some time and agreed that cardiopulmonary resuscitation (CPR) was inappropriate. The paramedics confirmed his death at 9.08am.

The man's family were informed of his death later that morning and the prison's family liaison officers maintained contact with them in the following weeks. The prison offered to assist with the funeral costs.

The post mortem showed that the man had died from cancer.

The findings of the clinical review have strongly influenced this report. I judge that the man received good quality care whilst at Wakefield. I draw attention to the emergency response and the actions of the care team, and make one recommendation concerning blood tests.

## THE INVESTIGATION PROCESS

1. My investigator visited Wakefield and interviewed seven members of staff who knew the man. Notices were posted to staff and prisoners about the investigation, inviting contributions, but no one came forward. In addition, my investigator studied all relevant prison records relating to him. They included his main prison record, medical records and statements made by staff.
2. The local Primary Care Trust asked a medical practitioner to carry out a review of the man's clinical care. I am grateful to him for undertaking this review. My investigator discussed aspects of the man's treatment with both healthcare staff at Wakefield and with the clinical reviewer.
3. My investigator contacted HM Coroner to inform him of the nature and scope of my investigation and request a copy of the Post Mortem report. Upon completion, my report will be sent to the Coroner to assist his enquiries into the man's death.
4. One of my family liaison officers contacted the man's family during the investigation. His family raised the following issues that they wished to be considered by my investigator:
  - Why was the man not referred to the hospital for an x-ray in November 2008?
  - Why was he not receiving treatment for cancer?
  - What medication was he taking at the time of his death?
  - What were the circumstances in which the man was found?
  - Was there any evidence of bullying against him?
  - Why were his clothes returned unwashed?

My investigator has attempted to address the issues raised by the family within this report. I hope that it provides the family with a better understanding of the treatment given to the man prior to his death and the events of the morning of 1 February 2009.

## HMP WAKEFIELD

5. HMP Wakefield is one of eight high-security prisons within the prison estate. Wakefield was originally built as a house of correction in 1594. It is now a main lifer centre. The average number of prisoners is approximately 700, including 100 category A and 10 high risk category A prisoners.
6. Wakefield has a separate healthcare block. There is an out-patient section and an in-patient facility with capacity to take 21 patients. Nursing care is available for 24 hours, seven days per week. A doctor is in the prison on Monday to Friday from 9.00am to 5.00pm. Outside these hours, care is provided via Local Care Direct (the local provider of out-of-hours primary health care). The in-patient facility contains a palliative care suite which allows staff to care for patients in advanced stages of serious illness.
7. The most recent report from HM Chief Inspector of Prisons concerns an unannounced inspection in April 2005. The Chief Inspector's report identified a lack of strong clinical leadership in healthcare. Her report also recommended resuscitation training at least annually, and that other relevant training should be made available to all (healthcare) staff.
8. Each prison in England and Wales has an Independent Monitoring Board (IMB) responsible for monitoring day-to-day life in the prison and ensuring that proper standards of care and decency are maintained. The last report published by the Wakefield IMB before the man's death (issued in April 2008) does not raise any issues which are relevant to this investigation.
9. This is the 14th death at Wakefield I have investigated since I took over responsibility for investigating all deaths in prison custody in 2004. In 2006, one of my reports recommended that a formalised case management approach to the care of prisoners with long term conditions be adopted, with a clearly identified person taking the lead in reviewing and co-ordinating that care. The Prison Service accepted this recommendation.
10. I recommended in another report that the Primary Care Trust should appoint a lead clinician to provide leadership and guidance on important clinical areas. Again, the Prison Service accepted my recommendation.

## KEY FINDINGS

11. The man was charged with murder in 1995 and was remanded to HMP Blakenhurst. Whilst on remand he transferred to a forensic psychiatry specialist treatment centre, in March 1995. He was found to be suffering from a psychotic disorder and likely to harm himself. In May 1995, the man was discharged from the treatment centre back to Blakenhurst following treatment. He was prescribed Trifluoperazine (medication for the treatment of psychotic disorders).
12. The man was sentenced to life in prison at the Crown Court in November 1995 and sent to HMP Shrewsbury. He transferred to HMP Wakefield on 30 January 1996. He continued with the medication until he was transferred back to the the treatment centre in July 1999. His medication was changed to Thioridazine (treatment for psychotic disorders). He returned to Wakefield in August 1999, as the treatment centre assessed that he no longer required their specialist care.
13. Prison staff encouraged the man to participate in offending behaviour programmes. Despite their attempts, he declined to participate in offending behaviour work or any educational programmes.
14. On 26 January 2001, the man was seen by a consultant forensic psychiatrist. He reviewed the man's medication as concerns had been raised in the medical profession about the safety of Thioridazine. The consultant forensic psychiatrist proposed that the man stop taking the drug for a period, with reviews and monitoring. The consultant forensic psychiatrist indicated that, if he relapsed, the man would be prescribed an alternative antipsychotic medication. On 4 February 2002, following several reviews, the consultant forensic psychiatrist prescribed Olanzapine (another medication for the treatment of psychotic disorders).
15. The man complained of chest pain on 26 November 2002 and was sent to the emergency department of an outside hospital. Following an initial period of assessment, he was admitted to the cardiology department for tests and observation. The diagnosis was that he had suffered a heart attack, and had reduced blood supply to the heart muscle. He remained in hospital until 3 December. He was prescribed Ramipril (treatment for blood pressure), Simvastatin (treatment for high cholesterol), and aspirin, and continued with the Olanzapine.
16. On 19 March 2003, the man was seen by a doctor at the cardiology department of the outside hospital. The doctor recorded that the man had made a good recovery and his blood pressure was within normal range. The doctor confirmed that the man was to remain on his current medication and had been advised to give up smoking.
17. During the period from March 2003 to end of 2007, the man had regular reviews with the consultant forensic psychiatrist and no concerns or changes were recorded.

18. The man was reviewed by a prison doctor, on 8 April 2008. The prison doctor recorded that his blood pressure was 150/96 and prescribed Amlodipine (to angina and blood pressure) instead of Ramipril, whilst all the other medication remained the same. Three weeks later, the prison doctor saw the man again and recorded his blood pressure as 138/86 with a pulse of 62. The normal range for blood pressure is 100/70 to 140/90, although this does vary throughout the day depending on the individual's activities. A blood pressure reading of greater than 140/90 is classed as high and a reading of 90/60 or below is classed as low.
19. Over the next few months, the man continued to go to his mental health appointments, and had regular reviews of his blood pressure. There no changes were made to his medication, and both conditions seemed stable.
20. On 3 November, a second prison doctor recorded the man's blood pressure as 160/76 with a pulse of 70. He increased the dose of Amlodipine as the man's blood pressure was raised. Ten days later, he was seen by the consultant forensic psychiatrist who again recorded that there were no concerns or changes.
21. The second prison doctor next saw the man on 26 January 2009. His blood pressure was recorded as 112/54 with a pulse of 66. The man said that he was not experiencing any chest or joint pain and the doctor recorded that he was not short of breath. Blood samples were requested by the doctor as part of a routine health review.
22. The next day, a nurse took the blood samples as requested. Later that same evening, the wing staff were concerned about the man and called for healthcare assistance. A healthcare officer saw him in his cell at 6.11pm. He told the healthcare officer that he was feeling weak but was eating and drinking normally and had no problems sleeping. The healthcare officer recorded his blood pressure as 104/67 with a pulse of 75. He told the nurse that he was taking his medication as prescribed. The healthcare officer advised the man to see healthcare the next morning (28 January). Despite being urged by staff to go healthcare, he refused to go.
23. Five days later on 1 February, an officer conducted a routine roll check of the wing at 7.20am and saw the man in his single cell, lying in his bed with his head on the pillow, under the covers and seemingly asleep in a natural sleeping position. At 8.50am, another officer unlocked the cells. After a few minutes he noticed that the man had not come out of cell and returned, accompanied by his colleague. The other officer called to the man but got no response and noticed that he was pale in colour. He checked for a pulse but could not find one and found that the man was very cold to touch. The officer's colleague collected the senior officer (SO) who arrived at 8.54am. She immediately called a Code Blue (the prison emergency code for a person who is not breathing). The SO also checked for a pulse and breathing but was unable to find any.
24. Within minutes, two nurses reached the man's cell bringing the emergency equipment. They assessed him and thought he might have been dead for quite

some time as his pupils were fixed and dilated, he was mottled in colour, and his chest was hard indicating that rigor mortis had set in. Both nurses agreed that cardiopulmonary resuscitation (CPR) was inappropriate. The paramedics arrived at 9.08am and pronounced that life was extinct. A doctor confirmed the man's death at 9.15am.

25. A hot debrief for all staff involved was conducted by senior management later that morning in conjunction with the care team. Following that meeting, the other officer was allowed to go home and contact was maintained by the care team.
26. The man's family were contacted in accordance with the instructions set out in Prison Service Order (PSO) 2710, "Follow up to deaths in custody". The prison's family liaison officer maintained contact with his family in the weeks following his death. This included ensuring that all his monies and belongings were returned. The prison also offered to assist with funeral costs.
27. Following contact with my own family liaison officer, the man's family wished to know if there was any evidence of bullying against him. There were no records of any reported incidents of bullying against him. At interview, the officer's colleague said that the man was "a gentleman". He added that he, "spoke nice, he spoke with respect and he got respect back".
28. As noted earlier, the family also asked why the man's clothes were returned unwashed. This is a sensitive matter, as some bereaved families may be equally upset if clothes are in fact laundered before their return. Good practice would be for the prison's family liaison officer to first check the family's preference, and I am disappointed if this did not happen on this occasion. The Governor will wish to ensure that this is covered in the prison's contingency plans for a death in custody.

## ISSUES

### Clinical care

29. The clinical reviewer has concluded that the man received a good standard of care from both the primary care and mental health teams whilst at Wakefield. His report says that there were numerous regular proactive reviews that were well documented.
30. The review highlights the process for acting on abnormal blood test results. The results of the blood tests on 27 January 2009 were not passed urgently to medical staff. The man's blood tests did show a raised alkaline phosphatase, which rose progressively from 2005. (I understand this abnormality is very likely related to the cancer that was discovered at post mortem.) The clinical reviewer says it was reasonable to repeat the test results and observe the trend for a period of time, bearing in mind that there could be many possible explanations for test abnormalities. However, after several months' observation such results should have been examined more critically. However, even if the cancer had been discovered and treated earlier, it would not necessarily have affected the outcome.
31. The clinical reviewer makes the following recommendation which I endorse:

**The Head of Healthcare should review the process for acting on abnormal blood tests to ensure that results are promptly received and doctors can make timely, documented clinical decisions.**

### Emergency response

32. I find that the staff who responded to the man's emergency assistance acted with great speed and professionalism. The clinical reviewer comments that the decisions that the man had died and not to attempt resuscitation were appropriate, and I agree. The Governor may wish to recognise the professionalism displayed by the staff who realised that he had not come out of his cell and provided swift emergency assistance.

### Care and support for staff

33. All the staff interviewed by my investigator wished to place on record their thanks for the support made available following the man's death. The care team provided both work and off duty contact details so that staff were able to speak to someone whenever they wished. This particularly applied to the support given to the other officer. Again, the Governor may wish to recognise the work of the care team.

## **RECOMMENDATION**

The Head of Healthcare should review the process for acting on abnormal blood tests to ensure that results are promptly received and doctors can make timely, documented clinical decisions.

*Fully accepted and process put in place.*

1.