Investigation into the circumstances surrounding the death of a prisoner on 19 April 2005 at HMP Wakefield

Report by the Prisons and Probation Ombudsman for England and Wales

September 2005

This is the report of an investigation into the circumstances of the death of a prisoner on 19 April 2005 at HMP Wakefield.

One of my investigating officers conducted the investigation. West Yorkshire Primary Care Trust carried out the clinical review.

My colleagues and I would like to extend our condolences to the prisoner's family for their loss. I would like to thank Wakefield who ensured that all relevant information was available to my investigator.

I endorse the three recommendations made by the clinical review.

Stephen Shaw CBE
Prisons and Probation Ombudsman

September 2005

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Summary

The prisoner died on 19 April 2005 at the age of 73, while in custody at Wakefield. He had been sentenced to life imprisonment for sexual offences against children. He was to serve a minimum sentence of nine years.

Prison staff discovered the prisoner in his cell, following the afternoon movement of prisoners to workshops and education. Immediate assistance was called for, but staff were unable to save him.

A clinical review was carried out on behalf of the Wakefield West Primary Care Trust.

The prisoner's death was not connected to the fact that he was in prison or to the level of care that he received there. The prisoner died in his cell of natural causes as a result of: -

- Haemopericardium
- Ruptured myocardial infarction
- Occlusive coronary artery atheroma (blocked arteries)

This report endorses the three recommendations made by the clinical review, and identifies one example of best practice.

Investigation Methodology

All the indications were that this was a death from natural causes.

When someone dies in prison from an apparently natural cause, I judge that the public interest may be served simply by a clinical review carried out by an independent healthcare professional, rather than by my conducting a full investigation. My approach in cases of apparent natural cause death, therefore, has been to conduct an initial review to determine if a full investigation is justified. In this prisoner's case, my investigator decided that the circumstances did not require a full investigation. He did so after a review of the available documentation.

My investigator was given access to all the prisoner's prison records, including his medical records, and was given copies of everything that was required. The documents were well presented, with an index, which was a considerable help to the investigation.

Notices to staff and prisoners were sent to the prison's liaison officer, to be displayed around the prison. These announced the investigation and invited staff and prisoners to submit to my investigator any concerns or views they wished to express.

I received two letters from prisoners. My investigator visited Wakefield on 21 July 2005 and met with the two men concerned. The first man, had concerns regarding the prisoner's treatment by other prisoners while working in the prison kitchen. It transpired that this treatment had no bearing on the prisoner's death. The second man, had no relevant information for my investigator with regard to the prisoner.

The West Yorkshire Primary Care Trust carried out a clinical review of the management of the prisoner's health needs while in custody.

One of my family liaison officers has contacted both Wakefield prison and West Yorkshire Police, but has not been able to locate any members of the prisoner's family. It is believed that the prisoner's wife and two children were killed in a road traffic accident some years ago.

Background

The prisoner

The prisoner was born on 19 November 1932. He was 73 years old when he died on 19 April 2005 in custody at Wakefield.

The prisoner was sentenced to life imprisonment on 7 October 1996 for sexual offences against children. He had 21 previous convictions dating back to 1941.

Alcohol had played a part in the prisoner's offending. During his sentence, he attended alcohol awareness courses. He is reported to have played an active part in all sessions, receiving a better understanding of the effects of his behaviour on others while under the influence of alcohol.

In July 1994, during an earlier sentence, the prisoner did not return to HMP Wymott following a period of home leave. He was rearrested on 15 December 1995. During the period he was unlawfully at large, he committed the offences which resulted in the sentence of life imprisonment in 1996. He was to serve a minimum of nine years, a period which expired in February 2005. When the prisoner was rearrested he was taken to HMP Belmarsh and then, in May 1997, to HMP Wakefield.

At a recent Parole Board hearing, the prisoner was not granted release on life licence or a move to open conditions in a lower category prison as he was still considered a risk to children. His next review was not due until February 2007.

Wakefield Prison

Wakefield is a prison for men who are serving sentences of four years or more and life sentences. It also specialises in the treatment of serious sex offenders.

The prison provides workshops and an education department offering both full and part time education. The programmes department offers a range of offending

behaviour courses including FOCUS (anti-drug taking programme), the Sex Offender Treatment Programme (SOTP) and the Enhanced Thinking Skills programme (ETS)

Wakefield was last subject to a Security and Standards audit in June 2004. It received a good rating.

The prisoner's time at Wakefield

Following his arrival at Wakefield prison, the prisoner settled into the regime of the establishment. He attended the workshops and made use of the educational opportunities offered to him.

In March 2004, the prisoner took part in the Sex Offender Treatment Programme, and he successfully completed the course in September 2004. He then returned to work in the workshops for a short period of time, before moving to the kitchen.

Events of 19 April 2005

At approximately 1.40pm, an officer started checking the landing after prisoners had returned to work. At 1.45pm, he arrived at the cell occupied by the prisoner, and noticed that the door was closed but not locked.

The officer entered the cell and found the prisoner lying on the floor. His first impression was that he was dead and had been so for some considerable time. He immediately raised the alarm by shouting to another officer to fetch a hospital officer and to tell them that it was a Code Blue emergency. A Code Blue is a method of raising the alarm in a medical emergency. It will ensure that when staff hear the radio calls they know what kind of emergency they are attending, and what equipment might be needed.

The officer remained with the prisoner and tried, unsuccessfully, to find a pulse. He then covered the prisoner with a blanket and removed other prisoners from the cell door where they had started to gather.

Another officer ran to an office on the landing and the telephoned the control room. He asked the control room to call a hospital officer to attend the wing immediately, and said that it was a Code Blue emergency and that an ambulance was urgently required. The control room immediately sent out a radio message. The control room also contacted the duty Orderly Officer and asked him to attend the wing.

After the officer had called the control room, he returned to the prisoner's cell and met a Senior Officer en route. When they arrived at the cell, the Officer explained that he could not find a pulse. The Senior Officer then transmitted an urgent radio message for a healthcare officer and the Orderly Officer to attend.

A Hospital Officer attended at 1.46pm followed by a Healthcare Nurse and they attempted to find a pulse. The prisoner's pupils were fixed and dilated. He was

incontinent of urine and the pooling of his blood was evident. It was therefore decided not to commence Cardio Pulmonary Resuscitation (CPR).

At 1.52pm, a Principal Officer who was the duty Orderly Officer arrived. He was closely followed by the paramedics. The paramedics checked for vital signs and pronounced life extinct at 2.00pm. At 2.03pm, a Doctor arrived and confirmed the death of the prisoner.

Officers from the dedicated search team (DST) arrived at 2.05pm and sealed the cell to preserve any evidence for the police. The police arrived at the prison at 3.15pm, followed by the Coroner's Officer.

The funeral directors arrived at 5.40pm to remove the prisoner's body. By 5.54pm, the police, the Coroner's Officer and the funeral director had all left the prison.

A Post Mortem was carried out on 20 April. The findings were that the prisoner died of:

- 1 (a) Haemopericardium due to
- 1 (b) Ruptured myocardial infarction due to
- 1 (c) Occlusive coronary artery atheroma.

Levels of compliance

Prison Service Order 2710 sets out what action must be taken following a death in custody. Wakefield fully complied with this order.

All necessary documentation was collated for the purposes of this investigation.

Clinical Review

A clinical review was carried out into the care of the prisoner at Wakefield. During the course of the review, the reviewers interviewed the healthcare manager at Wakefield, and reviewed all medical records.

Their report concludes that there was a poor standard of clinical record keeping, and expresses some concerns about the way the prisoner's healthcare needs had been met over the years.

In relation to the events of 19 April, the clinical review says that it was most unlikely that CPR would have been successful given the cause of death. However, the report concludes that clearer guidance should be given to staff as to who has the authority to make the decision whether CPR should be started or not.

The recommendations from the clinical review are: -

- There should be included within the contingency plans at Wakefield a resuscitation policy, giving clearer guidance regarding decisions to resuscitate or not to resuscitate and which members of staff should make that decision.
- Healthcare management are advised to put in place a system of audit to monitor and improve the quality of clinical record keeping.
- Systems to effectively manage coronary heart disease risk factors should be established.

Findings and Conclusions

The prisoner received appropriate treatment for his medical needs and died of natural causes as a result of: -

- Haemopericardium
- Ruptured myocardial infarction
- Occlusive coronary artery atheroma (blocked arteries)

I believe that on the day of the prisoner's death, the staff acted in a professional manner, preserving his dignity while summoning help and assistance.

Recommendations

I support the recommendations of the clinical review.

Good Practice

The use of the term Code Blue to summon help to serious medical emergencies is good practice, as everyone carrying a radio and those within hearing distance of a radio know what help is needed.