

**Investigation into the death of a man at hospital  
in June 2012, while a prisoner at HMP Wakefield**

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

**October 2013**

This is the investigation report into the death of a man who died at hospital in June 2012, while a prisoner at HMP Wakefield. His death was the result of an overdose of some of his prescribed medication complicated by his existing health problems. He was 54 years old. I offer my condolences to his family and friends.

A clinical reviewer was appointed to conduct a review of the care the man received at Wakefield. The prison cooperated fully with the investigation. I am sorry that the issue of this report was held up initially by a delay establishing the cause of his death and then by police enquiries.

The man returned to Wakefield in March 2012, after spending 30 years as a patient in secure hospitals. He had a number of physical and mental health problems for which he took a range of medication.

When he first came back to prison, the man was monitored briefly as a risk of suicide and self-harm and spent two weeks in the prison inpatient unit for further monitoring. He appeared to settle quickly into prison life and moved to a cell on a standard prison wing. Records show he said that he received good support from other prisoners on the wing.

The man was used to receiving his medication daily under supervision, but in May 2012, he was given his medication in weekly supplies which he kept in his cell and was responsible himself for taking the correct doses. I am concerned that there was no appropriate risk assessment to support this decision. In June, the officer unlocking his cell in the morning did not check his wellbeing, as should have happened, and later in the morning other prisoners found him unconscious in his cell. Officers found that his medication box, which should have contained over 100 tablets, was empty. He was taken to hospital, but died the next day. He did not leave any note and we do not know if the overdose was intentional or accidental, nor do we know what happened to the rest of his medication.

When the man was taken to hospital he was restrained by an escort chain, despite his very poor mobility and poor health. He continued to be restrained even when he was placed in a medically induced coma until a hospital consultant asked for the restraints to be removed. I am not satisfied that decisions to restrain him were justified by an appropriately considered risk assessment. It is also disappointing that his family was not informed of his hospitalisation until some hours later and not with the speed required in Prison Rules.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**October 2013**

## **CONTENTS**

Summary

The investigation process

HMP Wakefield

Key events

Issues

Recommendations

NOMS action plan

## SUMMARY

1. In 1978, the man received a life sentence for sexual offences, and was held initially at HMP Wakefield. In 1981, he moved initially to a high secure hospital for treatment. He spent the next 30 years as a patient in secure hospitals but, in late 2011 it was decided that he should be returned to prison. He arrived at Wakefield on 29 March 2012. He had a range of physical and mental health problems and was prescribed numerous medications.
2. The man threatened to kill himself when he was first told he was returning to prison. However, later seemed to accept the move. He had no recent history of self-harm. For the first 24 hours at Wakefield, he was monitored under suicide prevention procedures and spent the first two weeks in the prison inpatient unit for further monitoring.
3. On 10 April, the man moved to one of the standard wings. A mental health nurse saw him regularly, but his physical and learning disabilities were not assessed. His health and mobility were poor and a fellow prisoner helped by collecting his meals and cleaning his cell. He said other prisoners gave him good support.
4. The man had always collected his medication from a nurse each day and taken it under supervision but, at some point in May 2012, he was given weekly supplies of medication to keep in his cell and was responsible for taking the correct doses himself. There is no record of how the decision was made or that any risk assessments were carried out.
5. One morning in June, a prisoner found the man unconscious in his cell. Two officers came but then left him alone while they sought medical help. Nurses began resuscitation efforts and he was taken to hospital. He should have had over 100 tablets in his cell, but none were found and he was treated for an overdose of prescribed medication. He died in hospital the next day.
6. The man's death was the result of an overdose of prescribed medication, complicated by his existing health problems. We cannot say whether he intentionally or accidentally overdosed. His brother considered that he was depressed before his death, but no one at the prison had any concerns that he might be contemplating suicide. He did not take all his medication when he overdosed but neither we nor the police who investigated his death have been able to establish what happened to the rest.
7. We are concerned about the decision to give the man weekly supplies of his medication. We do not consider that the decisions to use restraints was humane or justified by a properly considered risk assessment and the prison waited too long before informing his family that he had been taken to hospital. We make six recommendations.

## THE INVESTIGATION PROCESS

8. The investigator issued notices informing staff and prisoners at Wakefield of the investigation and asking them to contact her with any relevant information. There was no response.
9. The investigator visited Wakefield on 28 June and met members of the prison management team, healthcare and wing staff and the prison family liaison officer. She obtained copies of the man's records and closed circuit television (CCTV) footage from a camera facing his cell, for the morning of the incident. She listened to recordings of telephone calls he made between 16 and 24 June.
10. The local PCT appointed a clinical reviewer to review the clinical care the man received at Wakefield. The clinical reviewer and investigator interviewed staff in April 2013. The Governor was given written feedback about the initial findings after the interviews.
11. HM Coroner for West Yorkshire Eastern district was informed of the investigation and provided the results of the post-mortem and toxicological examinations in January 2013. The Coroner has been sent this report.
12. In accordance with the Ombudsman's terms of reference, the investigation was suspended while the police conducted a criminal investigation into the circumstances of the man's death. The investigator met detectives from West Yorkshire Police twice to discuss the progress of their investigation. The police shared with our office information they had gathered as part of their investigation. We are sorry that the time taken to establish the cause of death and the police investigation meant that the Ombudsman's investigation and publication of the report was delayed.
13. One of the Ombudsman's family liaison officers contacted the man's brother outlining the purpose of the investigation and inviting him to raise matters for the investigation to consider. These are summarised below:
  - He was transferred from a secure hospital (where he had been for a number of years) to prison despite his mental ill health.
  - His physical health problems meant that he should not have been placed on a normal prison wing at Wakefield.
  - Whether the medication prescribed to him was appropriate.
  - That he had been allowed to keep his medication in his cell when his mental health problems meant he was not capable of administering it correctly.
  - Whether he had been bullied or threatened at Wakefield.
  - That he had spoken regularly by telephone with him and knew that he was not well and was depressed.
  - His brother was disappointed that the process for security clearance took so long that he had not been able to visit him at Wakefield before he died.

14. The man's brother received a copy of the draft report. The solicitor representing him wrote to us pointing out a factual inaccuracy. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.
15. The service also received a copy of the draft report. They did not raise any factual inaccuracies. The service response to our recommendations is included in this report.

## **HMP WAKEFIELD**

16. HMP Wakefield is one of eight high security prisons in England and Wales. It holds 750 Category A and B prisoners. There are four main residential wings, a healthcare centre, segregation unit and close supervision centre. Initially, the man was initially a Category A prisoner (requiring the highest security conditions), but was re-classified to Category B shortly before his death. He lived on A wing. All cells are single.
17. Spectrum Community Health CIC provides primary care services. Nottinghamshire Healthcare provides mental health services and services for older prisoners. Humberside Trust staffs the inpatient unit.

## **Her Majesty's Inspectorate of Prisons**

18. The most recent HM Inspectorate of Prisons (HMIP) report followed an inspection in May 2012. HMIP found that Wakefield was reasonably safe and security arrangements were appropriate for a high secure prison. There were some concerns about the high rate of diversion and misuse of prescribed medication, and the role this played in incidents of bullying.
19. The report noted that healthcare services had improved and the range of primary care services was judged as good. Pharmacy services were generally better but inspectors considered that the oversight and management of the medications prisoners kept in their possession needed attention to prevent the diversion of drugs subject to abuse.
20. Suicide and self-harm monitoring procedures were generally sound with low levels of self-harm. There were two half day sessions each week for the large population of older prisoners, but there little to occupy older prisoners who could not work or afford hobby items.

## **Independent Monitoring Board**

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In the latest published IMB annual report the board noted that lockers had been installed on the wings to help manage medication securely.

## **Previous deaths at Wakefield**

22. The man was the 13<sup>th</sup> prisoner to die at Wakefield in the period 2011 – 2012. In four previous reports we have made recommendations about the use of restraints on prisoners in hospital and, in one case, we recommended that prisoners' families be contacted if the prisoner is seriously unwell.

## KEY EVENTS

### Background

23. In September 1978, aged 21, the man was arrested and charged with attempted rape. He also admitted committing sexual offences against children and, in December 1978, he received a life sentence.
24. Before sentencing, a medical report was produced which noted that the man suffered from familial cerebellar ataxia, a hereditary condition affecting the nervous system which worsens with time. Sufferers sometimes have problems controlling muscle movement and symptoms can include difficulties with balancing, walking and speaking. He also had learning disabilities.
25. The man began serving his sentence at HMP Wakefield but, in 1981, transferred to a high secure psychiatric hospital for treatment for a psychopathic disorder. In 2001, he moved to a low secure hospital where he stayed until March 2012.
26. Before the man returned to Wakefield in 2012, his doctors at the hospital compiled a discharge summary, outlining his treatment over the previous 30 years. He had been prescribed strong tranquilisers in 1982 to manage frequent violent outbursts, irritability and suspicion. In 1983, his mental condition had stabilised with the prescription of anti-psychotic medication. In 1996, he was further assessed and doctors concluded that he had borderline intellectual ability. The following year, he completed the Sex Offenders Treatment Programme but staff reported that he showed little empathy for his victims.
27. The man suffered a heart attack in 2003.
28. By 2008, doctors considered that the man's mental state had largely stabilised, although he was still subject to periods of anxiety and was prone to make inappropriate sexual comments to female staff. He continued to have physical health problems including chronic obstructive pulmonary disease (COPD, a progressive lung condition affecting the breathing) and chronic heart disease. In 2009, tests revealed that he had probably suffered a number of small strokes caused by the heart disease. His mobility had deteriorated to the extent that he needed a wheelchair to move long distances and he used adapted bathing facilities.
29. The discharge summary included information about the man's past history of self-harm. His doctors noted that he started cutting his arms and neck in July 1980 (it is not clear whether this was a continued pattern of behaviour). That month, he barricaded his cell at Wakefield and tied bedding around his neck. The discharge summary indicated that he had harmed himself as a result of the depressive effects of a medication he was prescribed, which was then discontinued. He said that he had tried to

hang himself because his father had died and he had been sexually assaulted by another prisoner.

30. While at hospital the man was given his medication each day by a nurse and was supervised as he took the tablets because he was considered too disorganised to self-medicate. His medications were listed in the discharge summary:
- Depixol (anti-psychotic medication delivered by monthly injections),
  - Ramipril (to treat high blood pressure, heart problems and to prevent strokes),
  - Salbutamol (an inhaler to treat asthma and other breathing problems),
  - Simvastatin (to control cholesterol levels),
  - Diltiazem (to treat heart problems),
  - Amitriptyline (an anti-depressant which can also be prescribed to treat nerve pain and as a night time sedative),
  - Chlorpromazine (an anti-psychotic medication),
  - Diazepam (a sedative medication sometimes prescribed to treat anxiety),
  - Omeprazole (to treat conditions caused by excess stomach acid),
  - Aspirin (which can help to prevent heart problems),
  - Prednisolone (to control inflammatory and allergic disorders),
  - Quinine sulphate (often prescribed to help prevent muscle cramps)
  - Seretide (an inhaler for asthma or breathing problems),
  - Calcium
  - Baclofen (a muscle relaxant) and,
  - Zopiclone (for insomnia).
31. In November 2011, a multi-disciplinary meeting of medical and prison staff was held at hospital to discuss the man's possible return to prison. The group recorded that his mental condition was the result of a combination of a mild learning disability, an anti-social personality disorder and a psychotic illness, which was controlled by regular injections of long-acting anti-psychotic medication. They concluded that there was no clinical need for him to remain at the hospital. He said he would kill himself if he was sent back to prison.
32. On 10 January 2012, the multi-disciplinary group met again. The man seemed to accept his likely return to prison and had not harmed himself. His social worker described him as ambivalent about the prospect. One of the psychiatrists questioned whether Wakefield was the most suitable prison for him but was told that prisoners must return to the prison from which they originally transferred to hospital. The notes indicated that he said that he preferred to return to Wakefield because he had been there before and it was familiar.
33. A consultant psychiatrist and the man's responsible medical officer at hospital, wrote to Wakefield on 13 January summarising why professionals believed he should return to prison. The psychiatrist explained that he had

initially threatened suicide but that he seemed to accept his return to prison as a matter of fact and spoke “as if looking forward to it”. The psychiatrist also outlined his physical health problems, writing that he used a walking stick within the hospital grounds and a wheelchair on escorted community trips.

34. On 29 March, the man returned to Wakefield. He was 54 years old and had been in secure hospitals for over 30 years. He was initially classified a Category A prisoner as he had been before his transfer to hospital 30 years earlier. The psychiatrist completed a Person Escort Record (PER) to accompany him from hospital to Wakefield. (The PER highlights any risks the escorted prisoner might pose to themselves and others.) The psychiatrist noted his past history of self-harm and also completed a suicide/self-harm warning form, which outlined his earlier threats to harm himself if he returned to prison. A detailed discharge summary was forwarded to Wakefield.

### **Events at Wakefield**

35. When the man arrived at Wakefield, a mental health nurse carried out the reception health screen to establish immediate physical or mental health problems requiring referral to the doctor or another specialist service. She recorded that he had learning difficulties, struggled to write but could read a little. He said that he needed glasses for reading and watching television. She noted that he had reduced mobility and could only walk short distances, using a walking stick. The nurse noted that he might need help with everyday tasks and she referred him to the older person’s team for assessment. She recorded his history of small strokes, COPD and heart disease. There is no information in his medical record to indicate that he was assessed by anyone from the older person’s team or that his disabilities were ever formally assessed at Wakefield.
36. The nurse took the man’s pulse, blood pressure and oxygen saturation level which were all within acceptable ranges. He said that he smoked around 20 cigarettes a day and the nurse gave him advice about stopping. She recorded the medications that he was prescribed but missed quinine sulphate and calcium from the list.
37. At 3.30pm, the nurse and a healthcare Senior Officer (SO) (who is also a qualified mental health nurse) opened an Assessment, Care in Custody and Teamwork plan (ACCT)<sup>1</sup> because of the man’s previous threats to harm himself. He told them that he felt alright and they concluded that he seemed quite relaxed. They noted that he would need input from the mental health team and should be monitored while he adjusted to life in prison. They decided that he should be placed in a camera cell in the healthcare inpatient unit (a cell fitted with CCTV for continual observation). The SO noted in his medical record that his medication was out of date

---

<sup>1</sup> Assessment, Care in Custody and Teamwork (ACCT) procedures aim to help and monitor prisoners at risk of harming themselves. The key aims of ACCT are to create a safe and caring environment, identify a prisoner’s individual needs, and provide individualised care and support.

and invalid, and would need to be reviewed by a doctor the following morning.

38. The man asked to be locked in his cell at 6.10pm. Staff talked to him several times during the evening and reported that he seemed settled and relaxed. He was constantly observed via CCTV overnight. He slept little, but told a nurse that this was because he was in strange surroundings.
39. On 30 March, the psychiatrist faxed a written risk appraisal to the prison. He wrote that the man had not (to staff's knowledge) ever previously hoarded medication or acquired objects to harm himself, but recommended a period of observation. He wrote that there was no evidence that the man suffered with clinical depression and that his mental health conditions were well controlled with medication, with which he was compliant. There was no evidence to suggest that he had used unprescribed medication or illegal drugs at the hospital. The doctor advised that he was vulnerable to physical exploitation.
40. At 10.05am on 30 March, a mental health nurse wrote in the man's ACCT that she had talked at length to him and he seemed settled, mixing with other prisoners and watching television. He said that he enjoyed watching television, smoking, playing snooker occasionally and eating meals. He said he had no thoughts of suicide or self-harm had only harmed himself once in the past. The nurse recorded that he was unsteady when walking and used a stick, but could maintain his own hygiene and was generally able to look after himself. Although the nurse detected no shortness of breath, she noted that he was a heavy smoker and was asthmatic. She referred him to the respiratory consultant for review.
41. A nurse devised a mental health care plan for the man, which instructed nurses to build a therapeutic relationship with him, monitor him for thoughts of self-harm or suicide, administer his prescribed medication and encourage medication compliance. Nurses were also directed to monitor his presentation, diet, sleep pattern, social interactions and for any signs of mental illness. He was due for review on 2 April.
42. The nurse told the investigator that all of the staff on the inpatient unit knew the man was returning to Wakefield after many years in secure hospitals and that he might find the transition difficult. However, she said that he seemed to settle into life on the unit very quickly and appeared relaxed. He told her that he missed the hospital, which she reassured him was normal. She said that she saw him quite frequently while he was an inpatient and had no concerns about his mental health. She said that he asked staff if he needed anything and appeared stable and able to concentrate well. The nurse said that she did not have any concerns that he might try to harm himself.
43. At 2.30pm on 30 March, the healthcare SO carried out the ACCT assessment interview. This is a detailed interview where the prisoner's feelings are discussed. The man told the SO that he did not mind being at

Wakefield, but he chain smoked and was worried about running out of tobacco. The SO noted that there were no obvious signs of psychosis, paranoia, depression or thought disorder. He said that he had promised his mother that he would not harm himself and that it would not be fair to his brother or brother-in-law. The SO recorded that he wanted to move to a normal prison wing as soon as possible.

44. The SO told the investigator that he had no concerns about the man's risk to himself during the assessment process. The SO said that he knew he had been eating well and engaging with staff appropriately. He said that his learning and physical disabilities made him more vulnerable to exploitation by other prisoners but that this did not mean that he needed to stay in the inpatient unit. The SO said that he appeared to understand what he was told about prison processes but that, in his early days at the prison, staff took time to explain things carefully to him.
45. After the assessment interview, the man and several staff met for the first ACCT case review. He said that he felt fine and had no thoughts of self-harm and that he was happy to move to a wing. The group decided that he posed a low risk to himself and that the ACCT could be closed. Two entries were made on the ACCT caremap (a chart of a prisoner's problems with actions recorded alongside them to manage the issues and support the prisoner). The first was that he should contact his family, and staff noted that he had done so that day. The second noted that healthcare staff should help him to maintain his health which was recorded as an ongoing action. He moved from the camera cell to a standard inpatient cell.
46. The healthcare SO told the investigator that the review group decided the ACCT could be closed because they did not think that the man had any thoughts of self-harm or suicide. The SO said that while he remained an inpatient he was surrounded by experienced staff who could re-open the ACCT if they had any concerns about him. The SO said that he was also subject to regular checks by nurses, including mental health nurses, while he was an inpatient.
47. A prison doctor reviewed the man's prescribed medication on 30 March and prescribed omeprazole, prednisolone, baclofen, amitriptyline, aspirin, seretide, diltiazem, salbutamol, quinine sulphate, ramipril and zopiclone. He did not prescribe simvastatin, diazepam or calcium and told the clinical reviewer that this was an oversight. The man did not receive simvastatin or diazepam while at Wakefield but calcium was later prescribed. The doctor told the clinical reviewer that a psychiatrist was tasked with prescribing depixol and chlorpromazine, in line with Wakefield's procedures.
48. Over the following few days, staff made frequent entries in the man's medical record, noting that he seemed relaxed and settled and was coming out of his cell during association periods (when prisoners can mix, use the telephones, showers and other facilities). He appeared to be

eating and sleeping well and was compliant with his medication. He continued to say that he had no thoughts of self-harm and healthcare staff recorded that there were no signs of low mood, paranoia or hostility. On 4 April, the SO recorded that a cell on A wing had been identified for him, and that he would move there the following week.

49. The healthcare SO told the investigator that all the wings at Wakefield are similar and equally suitable for holding older prisoners and those regarded as more vulnerable. Several staff commented that, while the man was recognised as vulnerable, many prisoners at Wakefield are similarly vulnerable because of their age, disabilities, mental or physical health problems or convictions. The SO said that there was an available cell on the first floor (known as the “2s” landing) of A wing. This was considered the best location for him because the servery (where prisoners collect their meals), showers and medication room were on that landing, so he did not have to climb any stairs.
50. On 6 April, a healthcare Principal Officer (PO) carried out an ACCT post-closure review (to review the reasons the ACCT was opened and check whether it was safe for it to remain closed). The man said he was in contact with his family and reiterated that he had promised his mother he would not kill himself. The PO recorded that he wanted to move to a normal wing and carry on with life in prison. He wrote that his suitability to keep his medication in his cell and take the correct doses would need to be clarified before he moved to A wing. There is nothing in his medical record to suggest that any formal consideration of whether he could look after his own medication took place before he was discharged as an inpatient.
51. The man moved to A wing on 10 April. A SO recorded that he had completed the wing induction and had no concerns. The SO noted in the wing observation book that he would need support because of his learning and physical disabilities. He wrote that there were currently no concerns about his risk to himself, but that he might be vulnerable to exploitation by other prisoners.
52. The SO told the investigator that he and other A wing senior officers had been briefed about the man’s arrival. He thought that the 2s landing was an appropriate allocation because there were a number of other older prisoners who supported each other. The SO said that he understood that he would move back to the inpatient unit if he did not settle on A wing.
53. The SO said that he thought the man was vulnerable because he seemed to trust people readily and “would go along with absolutely anything you suggested to him”. The SO said that he was concerned that he would be manipulated by the more problematic prisoners on the wing but he was confident that other prisoners on his landing would support him and tell officers if there were any problems. Officers would challenge inappropriate behaviour and routinely gathered information about the more difficult prisoners.

54. A consultant forensic psychiatrist prescribed the man depixol injections and chlorpromazine on 11 April. He did not see him and said he was unsure why a doctor had asked him to prescribe the medications as they could have been prescribed by a GP. The man did not receive chlorpromazine between 30 March and 11 April. The psychiatrist said that he would not have felt any side-effects from this delay because the chlorpromazine dose was small and he was also prescribed a long-lasting dose of depixol.
55. On 11 April, a nurse from the mental health team visited the man on the wing and recorded that he was bright and chatty. He said he had no thoughts of self-harm and wanted to spend the rest of his life in prison because it would be too difficult to be released after so many years in institutions. He said that he was happy on A wing but said he had problems collecting his meals because he could not carry his meal tray. He said he was finding it difficult to adjust to being locked in his cell all day, after having a great deal of freedom at the hospital. The nurse noted that he would ask the wing SO to unlock his cell during the day, which was done that day.
56. The nurse also asked the wing SO to help the man arrange his telephone credit so that he could call his brother. He arranged an appointment for him with the psychiatrist and referred him to the GP, the optician and the physiotherapist. He noted that he would contact the Safer Prisons team to arrange a wing carer for him (another prisoner to help manage day to day tasks).
57. In hospital and since arriving at Wakefield, the man had to collect his medication from a nurse several times a day and was observed as he took it. He told a nurse that he did not think he could cope with having his medication in-possession (where prisoners keep their own medication to administer themselves) because he had never done so before and had to take around 50 tablets each day.
58. The nurse said his role was to see the man frequently to check for any signs that his mental health was deteriorating and to help resolve any problems. The nurse said that when he met him for the first time, he had no concerns that he might be thinking of harming himself. The nurse said that his general demeanour and body language were appropriate and wing officers did not alert him to any problems.
59. On 11 April, the man's personal officer recorded that his immediate neighbours had been asked to "look out for him". She told the investigator that his neighbours were older prisoners like him, who spent most of their time on the wing. She said that they seemed happy to help him settle on the wing.
60. A SO said a certain officer was the wing disabilities officer and also responsible for working with the older prisoners. There is nothing in the

man's records to suggest that that officer saw him on A wing or that she was involved in allocating a carer. There is also nothing to suggest the Safer Prisons team were involved in finding him a carer. The SO said that some prisoners acted as unofficial carers and that wing officers would challenge them if they doubted their motives or considered the relationship was inappropriate.

61. Prisoner A from A wing was interviewed by the police after the man's death. He said that the man had some difficulties speaking and had a very quiet manner. He said that he could hold a normal conversation but had difficulty understanding some simple tasks and prison procedures. He said that he quickly realised that he needed help because of his mobility problems. He spoke to officers and offered to collect his meals, as he was already helping another prisoner. The man's personal officer told the investigator that Prisoner A was a trusted prisoner and she was happy for him to help the man.
62. Prisoner A said that after about a week, a female officer asked him to consider becoming the man's official carer and gave him a form to complete. He said the man was nervous about this and was adamant that he did not want a carer. However, he said that the man was happy to receive help informally and he began to clean his cell for him and collect his meals.
63. On 18 April, the man received notification that a parole hearing (to decide if and when he might be released from prison) would take place by March 2013.
64. When he moved to A wing, the man was booked into various induction sessions to familiarise him with prison procedures and services. The sessions were recorded in his induction 'passport'. He completed some of his prison induction with his offender supervisor on 20 April, receiving information about resettlement and sentence planning. The officer noted that he seemed to understand what was said to him.
65. On 23 April, the man received his monthly injection of depixol. Two nurses administered the injection and recorded that he seemed well, although he looked dishevelled and unkempt. One nurse said that he never noticed any decline in his appearance and thought that he was looking after himself well.
66. The man's planned education induction on 25 April was cancelled but he attended the Safer Prisons induction on 26 April. One of the officers responsible for delivering the session noted that they had explained what he should do if he had any concerns about bullying or diversity.
67. The prison physiotherapist visited the man in his cell on 30 April. He said that he did not need any physiotherapy but agreed to have a mobility assessment. He told the physiotherapist that he was getting help with collecting his meals but was finding it hard to keep his cell clean. The

physiotherapist concluded that physiotherapy would not help improve his mobility.

68. A nurse visited the man on A wing on 3 May and recorded that he was bright and smiling and had settled well on the wing. He said that he preferred it to the inpatient unit and that people were kind and supportive. The nurse asked him whether anyone ever took anything from him or asked for anything and he replied that he was an “old timer” and would know if anyone was acting inappropriately. He denied any mental health problems and said he was eating, sleeping and interacting well. The nurse noted that wing staff had no concerns about him.
69. The nurse told the investigator that he asked the man several times whether he was being bullied and whether the attention he got from other prisoners was appropriate. He said that he always denied that anybody took advantage of him.
70. On 9 May, the man’s personal officer noted in his electronic prison record (P-Nomis) that he seemed to have settled well and had made a few friends on the wing who were keeping an eye on him. She told the investigator that she had no concerns about the prisoners who befriended him and did not consider any of the relationships to be inappropriate. She said that, had she been worried, she would have questioned the prisoners concerned.
71. The man had an appointment with a psychiatrist on 9 May. The psychiatrist noted that he seemed stable on his medication and had settled into life at Wakefield. He said that he spent most of the day watching television in his cell but got along with other prisoners, who helped him. He denied any thoughts of suicide or self-harm or any psychotic symptoms. The psychiatrist concluded that he should remain on his prescribed medication and be reviewed in three months. The psychiatrist told the investigator that he had no concerns about him after the appointment and that he did not appear to be low in mood. The psychiatrist said that, as far as he could tell, he understood what he was told and did not have any problems expressing himself. He had no concerns about his ability to cope on the wing. He did not form a view about whether he was capable of looking after his own medication and was not asked to do so.
72. On 16 May, the man had an appointment with a nurse for routine blood tests and an electrocardiogram (ECG, which measures the electrical activity of the heart and detects abnormalities). None of the tests revealed any immediate problems. His blood pressure was 105/77 mmHg, within normal limits. He was jovial and said he had no concerns on the wing and continued to receive support from other prisoners and staff. However, the nurse noted that he remained in his cell a lot because there were few activities for him. He recorded that he had chased various departments and would continue to liaise with them to find suitable activities for him.

73. Around 18 May, the man was given his medication in-possession. His medical record contains no information about how the decision was made or who made it. There is no evidence that a risk assessment was carried out or that anyone who knew him was consulted.

74. The prison pharmacist told the police that the man was given a week's supply of tablet medication in a dosette box that he kept in his cell. (A dosette box is a plastic box divided into seven sections. Each section is marked with a day of the week and is divided into four compartments marked breakfast, lunch, dinner and bedtime. Healthcare staff place the medication in the right compartments in the right doses. A printed sheet detailing how much of each medication should be taken and when is also placed in the folder.) At the time of his death, he was prescribed the following medications in tablet form:

- Chlorpromazine (anti-psychotic medication, one tablet to be taken twice a day)
- Baclofen (a muscle relaxant, ten tablets to be taken daily – three in the morning, two at noon, two in the afternoon and three at night)
- Amitriptyline (pain relief medication also prescribed as a night time sedative, one table to be taken at night)
- Diltiazem (for high blood pressure and heart problems, one capsule a day)
- Aspirin (to combat heart problems, one tablet a day)
- Omeprazole (to treat problems caused by excess stomach acid, one tablet a day)
- Quinine sulphate (to prevent muscle cramps, one tablet to be taken at night)
- Prednisolone (to treat inflammatory conditions, one tablet to be taken in the morning)
- Calcichew (calcium supplement, one tablet to be taken in the morning)
- Ramipril (to treat high blood pressure and heart disease, one tablet to be taken daily)

75. The healthcare SO was asked whether, in his view, the man was suitable for keeping his medication in his cell. The SO said:

“I think my view [was] quite firmly that he shouldn't have his medication in-possession. I don't think he'd quite understand or be able to cope with the variety of medications he's got.”

The SO said that he was not consulted about the decision to give the man his medication in-possession.

76. A nurse told the investigator that she spoke to the man after he moved to A wing and was pleased at how well he had adapted. She said that she was not involved in the decision to give him his medication but thought he could cope. The nurse said that he knew which tablets he was due and when, and could correct nurses if they gave him the wrong medication.

However, she was not sure whether he understood what each medication was for. She said that he did not express any concerns to her about it. She said that had she been consulted she would not have been particularly concerned about his ability to manage his medication, although she might have had concerns about other prisoners taking the medication from him. However, she believed that he was able to stand up for himself.

77. A nurse said that he was not consulted before the man was given his medication in-possession, and that his concern would have been whether he understood what to take and when. The nurse said that because some of his medications were prescribed for mental health problems, someone from the mental health team should have been involved in the decision. He said that general nurses were responsible for checking that prisoners collected their in-possession medication and he thought that they carried out periodic checks to make sure that prisoners with their own medication were taking it as prescribed. He said that the man did not mention any concerns about his medication once he was expected to keep it in his cell and he did not see any signs that he was not taking his medication as prescribed. There is nothing in his medical record to indicate that anyone checked he was taking his medication as prescribed after being given it to keep in his cell.
78. A SO said that officers are not consulted about or informed when a prisoner moves to in-possession medication. He said that it was clear to other prisoners who had their medication in their cell because they would see them carrying their dosette boxes from the treatment room to their cells. He said that he considered the man to be very vulnerable to having his medication taken by other prisoners and talked to him about this. He showed the SO that he locked the medication in his cupboard and did not seem to have any concerns. The SO said that he told him that if anyone tried to take his medication he would defend himself and tell staff about it. The SO said:
- “I remember him saying ‘I need this medication.’ He was quite clear he knew he had to take that medication and he knew that if he didn’t, [if] somebody else was taking it off him, he’d become very ill ... Although a lot of times he didn’t come across that clear, that was one point where he was absolutely, totally clear...”
79. Prisoner A said that he saw that the man now kept one week’s supply of his medication in his cell and told him to hide it because other prisoners on the wing would take it if they could. He told the police that in the weeks leading to the man’s death he noticed a few prisoners, who he described as drug users, becoming frequent visitors to his cell. He said that he asked him if any of the prisoners were taking his medication, but he denied there were any problems and said that they were giving him tobacco and cigarette papers.
80. Other prisoners who said that they helped the man were also interviewed by the police. They said that once he kept his medication in his cell, he

received more visits from prisoners known to use drugs. They said that they checked that he was okay after such visits and he raised no concerns. One said that the man was a chain smoker and would often borrow tobacco from other prisoners.

81. The police interviewed a number of A wing prisoners, including some of those named as possibly taking the man's medication. They also studied CCTV footage but were unable to find proof that other prisoners were pressuring him for his medication or taking it against his will.
82. A nurse saw the man again on 21 May. He said that he had been allocated a carer who was helping him collect meals and keep his cell clean and that he had other prisoners to talk to. A SO told the investigator that he received support from other prisoners because of his obvious disabilities and because he was always pleasant and grateful for any help he was offered. The SO said that officers were sometimes aware that inappropriate relationships were developing on the wing. When this happened, he said that officers would speak to the prisoners in question and warn them to stay away from more vulnerable prisoners. He did not think that officers had had to warn any prisoners to stay away from him.
83. On 24 May, a doctor saw the man and recorded that he had a number of physical health problems and that he would ask the psychiatrist whether he should be referred for a neurological examination.
84. On 28 May, the man's security categorisation was reviewed and, on 19 June, was downgraded to Category B at the National Offender Management Service (NOMS) headquarters.
85. A nurse met the man on A wing on 29 May and noted that he was now unlocked during the day and wanted to complete another sex offender treatment programme to show he had changed. The nurse wrote that his meals were brought to him by other prisoners and that he had no problems on the wing. He saw no signs that he was experiencing any mental health problems and noted that wing officers had no concerns about him. On 30 May, an officer noted in the P-Nomis record that he seemed to be managing on the wing with help from Prisoner A.
86. The man had an appointment with the respiratory consultant on 1 June during which he said that he had been asthmatic for five years and smoked 20 cigarettes a day. He complained of a cough, but said that he did not cough up sputum and described having a good appetite. He said that his voice had been hoarse for years. The consultant wrote that he was probably not asthmatic but experiencing the symptoms of COPD. The doctor referred him for a chest X-ray and for two other tests to measure how effectively his lungs were working. The consultant noted that he would review him in six to eight weeks. He had not had the X-ray before he died.

87. A nurse met him again on 11 June when the man told him that he had borrowed some tobacco from another prisoner the previous night and had smoked most of it already. The nurse advised him to learn to ration his use. They also discussed his medication and the nurse wrote that he thought he was prescribed depixol to treat “side effects” and depression. He said he did not hear voices or experience any hallucinations, paranoia or anxiety. He said that he was happy on the wing and asked for help completing an application to work in the prison shop. The nurse recorded that he had asked wing staff to assist him.
88. The nurse told the investigator that he was not overly concerned that the man was borrowing tobacco from other prisoners because he knew wing officers and his carers were keeping an eye on him. He said that he would have been concerned if he had thought he was getting into debt to other prisoners (which can cause problems for prisoners) but that there was no evidence that this was the case and he denied any problems.
89. On 13 June, the man had a random mandatory drugs test (which tests for illegal substances). The test result was negative, indicating that he had not recently taken any illegal drugs.
90. Between 15 and 20 June, entries in the A wing observation book noted that a number of named prisoners were suspected of diverting and trading prescribed medication on the wing. There was also information suggesting that a prisoner had bullied another for his medication. A SO said that such information was logged on a Security Information Report (SIR) which was shared with healthcare staff who he expected would monitor medication more closely. (An SIR must be submitted by anyone working in a prison who has information which might compromise the safety of the public, prison staff or other prisoners, or the security of the prison. SIRs are dealt with by the prison’s security department.) He said that wing officers were not involved in monitoring whether prisoners took their medication correctly but looked out for any signs that medication was being diverted or misused.
91. On 16 June, the man’s personal officer noted in P-Nomis that he had no problems on the wing and that a small group of his friends looked out for him. She wrote that he seemed to manage to get around the wing without problems and saw healthcare staff often. She noted that he had applied to be an enhanced level (the highest level) prisoner under the Incentives and Earned Privileges (IEP) scheme and was awaiting a decision. (The IEP scheme operates in all prisons to encourage good behaviour.)
92. On 18 June, two nurses gave the man his monthly depixol injection. The nurses recorded that he seemed to be in good spirits, had no issues with his medication and seemed motivated to work and progress through the prison system.
93. On 20 June, the man did not attend his education induction session and had previously missed two other booked appointments. A member of staff

working in the Offender Management Unit told the police that because he had missed three induction dates his pay would be docked. (Prisoners receive wages for attending work or education sessions, including induction which they can use to buy items such as tobacco.) Some prisoners told the police that he was upset that his pay was going to be docked and worried about how he would afford his tobacco. The member of staff did not think that he had been formally notified of the decision before his death.

94. On 22 June, the man was subject to a routine cell search. (Prisoners at Wakefield are subject to random cell searches about once a month.) No unauthorised items were found. One of the officers responsible for the search told the police that he could not remember whether he saw any medication in his cell, but during a search, officers always check that any medication in the cell is prescribed to the prisoner and that they do not have more than they should.
95. On 23 June, the man collected his weekly medication in the dosette box. The pharmacist confirmed he received 140 tablets to last the week.
96. One of the man's friends on A wing said that the man seemed a bit withdrawn in the week before his death and was selling items to pay for tobacco. However, he saw him on Saturday 23 June and thought he seemed happy as he was laughing and joking with everyone on the wing. He said that he had never talked about suicide. None of the prisoners interviewed by the police had any concerns about him and none had ever heard him talk about harming himself. A SO said that there were no signs that he was feeling vulnerable or was being pressured by other prisoners. He said he was sure that he would have told officers if he had any problems. His personal officer said that he never gave her any reason to think he might try to harm himself; an officer said the same.
97. The investigator listened to recordings of the man's telephone calls between 16 and 24 June. (All prisoners' telephone calls are routinely recorded and can be listened to by staff if there is any information to suggest this is necessary.) His brother told us that he could tell he was not himself in the days leading to his death despite his reassurances that he was fine. In the investigator's opinion, there is nothing in the content of the calls to suggest that he was thinking of harming himself. He did not complain of any problems on the wing and assured his brother that he was all right.

### **Day of the incident**

98. One morning in June an officer carried out a roll check on A wing. Roll checks are primarily conducted for security reasons, to ensure that the correct number of prisoners is in the prison. Officers must look through the observation panel in each cell door and confirm the prisoner is present. The officer told the investigator that during the early morning roll checks,

officers were not expected to wake prisoners up but looked for signs of life, such as breathing and movement.

99. The officer remembered checking the man and that he was lying fully clothed on top of his bed covers, apparently fast asleep as she could see him breathing. The officer said that he often slept in his clothes and she had no reason to be concerned about him.
100. The investigator viewed CCTV footage from a camera facing the man's cell door. It is not possible to see into the cell, but the events occurring at the door and the immediate vicinity are recorded. According to the CCTV footage his cell was unlocked at 8.50am. The prison said that another officer was responsible for unlocking the cells on the 2s landing that morning. According to the CCTV footage, the officer did not enter or look into the cell, but simply unlocked the door. The officer told the investigator that he could not remember whether he had been responsible for unlocking the man's cell on 24 June but agreed that he did not routinely look into cells as he unlocked them.
101. A SO acknowledged that it was good practice for officers to get a response from prisoners as they unlocked them first thing in the morning but said that he did not think it appropriate to wake prisoners up or disturb them if they did not have to get up to attend work or other activities. He did not think that officers on A wing routinely looked into cells as they unlocked them.
102. The man did not come out of his cell or appear on the CCTV footage at any point during that morning. At around 9.36am, Prisoner A and another prisoner went to his cell door and Prisoner A looked briefly into the cell. He looked in on him again at 10.07am. No officers or prisoners went into his cell or, apparently, spoke to him between 8.50am and 11.45am.
103. Prisoner A told the police that when he checked the man at about 10.00am, he appeared to be asleep so he did not disturb him. He said that he went to the cell again at about 11.45am to collect his meal tray. As he went into the cell, he heard him let out a deep breath and said that he thought something was not right. He checked him more closely and realised there was vomit on the bed. He said that he left the cell straightaway and went to tell staff.
104. The CCTV footage confirms that the prisoner went to the man's cell shortly after 11.45am. Another prisoner who was also present waited outside. He quickly left the cell and the other prisoner continued to wait outside. About one minute later, two officers arrived. They went into the cell for about 12 seconds before both leaving. The cell door was left unlocked.
105. Officer A told the investigator that he was in the wing office with Officer B when a prisoner told them that he could not rouse the man. He said that he and the other officer went to the cell and also could not get a response from him. The officer said that the man was lying on his bed fully clothed.

When interviewed in April 2013, neither officer could remember exactly what had happened. Officer A thought that he had left the cell to seek help from the nurses in the treatment room at the end of the landing.

106. Officer B told the investigator that the man was breathing noisily when they checked him and the two officers agreed that he needed medical help. The officer said that not all wing officers carried radios and as the treatment room was only a short distance away, they thought it was quicker to run there than to radio or telephone. He thought that he had stayed outside the cell door while the other officer went to ask the nurses to come and check the man. The CCTV shows that both officers left the cell together. Neither waited with him or outside his cell.
107. Two nurses were issuing medication in the primary care treatment room, at the end of the landing, when the officers came and asked them to check the man because he had been sick and would not wake up. The nurses took the emergency medical bag and went to his cell. The CCTV footage shows them arriving at approximately 11.48am. They found him lying on his bed with laboured breathing and vomit on his face and the bed. He could not be roused and made occasional involuntary movements. The nurses asked for an emergency ambulance to be called which was done at 11.56am. They also asked an officer to get another nurse to bring them the automated external defibrillator (AED – a machine which, in certain circumstances, can deliver an electric shock to re-establish a normal heart rhythm).
108. While waiting for paramedics to arrive, the nurses checked the man's blood oxygen level, which was 80 per cent (and should be above 90 per cent) and his blood pressure, which was very low at 50/40 mmHg. They found that he had a weak pulse and a very slow heartbeat. They administered oxygen and began cardiopulmonary resuscitation (CPR, the delivery of chest compressions and rescue breaths to keep oxygen and blood moving around the body). The defibrillator advised that no shock be delivered and they continued CPR.
109. One of the staff involved in the emergency response searched the man's pockets and found the key to his lockable cabinet. Inside, they found his empty dosette box, which should have contained in excess of 100 tablets.
110. Paramedics arrived at the prison at 12.02pm and at the cell at 12.09pm. After emergency treatment they transferred him to the ambulance which left the prison for hospital at 12.40pm. Before the man left the prison, a risk assessment was carried out to determine the level of security required when he was out of the prison. It was decided to restrain him with an escort chain (a length of chain with a handcuff at each end for the prisoner and an officer).
111. At the hospital, the man was placed in a medically induced coma. The consultant advised that he was very unwell, possibly because he had

overdosed on his prescribed medication, and should not be restrained. The restraints were removed at about 1.30pm.

112. The man was moved to the Intensive Care Unit and, that evening, suffered three cardiac arrests. Hospital staff were able to resuscitate him each time but, after the third, said that they would not attempt resuscitation again. At 3.50pm he died.

### **Contact with the man's next of kin**

113. At 5.00pm a SO was appointed as the prison's family liaison officer (FLO). At 6.00pm, after getting an update from the officers accompanying the man in hospital, he telephoned the man's brother and told him that his brother was unwell and in hospital. The man's brother was unable to visit the hospital until the next day and the FLO arranged to telephone again first thing the next day.
114. The FLO met the man's brother at the hospital at 1.10pm the next day. Hospital staff told him that the man was seriously ill and might not recover. Later that afternoon the FLO was told that he had died and at 6.00pm he and a member of the chaplaincy team went to the man's brother's house to inform him. In line with national guidance, the prison offered to help with the cost of the funeral.

### **Support for prisoners and staff**

115. A SO said that after the man's death officers spoke to all prisoners considered at risk of suicide or self-harm to check that they had not been adversely affected. The officer who was also personal officer to some of the prisoners who helped the man, spoke to them after his death to offer her support.
116. Staff said that they had been well supported by the prison after the man's death. A debrief was held for the officers who were with him in hospital when he died.

### **Results of the post-mortem**

117. When the man arrived at hospital samples of his blood and urine were analysed and found to contain traces of chlorpromazine, diazepam and amitriptyline at therapeutic levels. This means that he was likely to have been taking these medications at the correct doses. However, the concentration of diltiazem (prescribed to treat his heart problems) was about six to seven times higher than expected given his prescribed dose. The pathologist concluded that he had probably taken more than his prescribed dose of diltiazem. Diltiazem toxicity can cause the heart to beat more slowly and lower the blood pressure. He noted that the existing heart condition would have made him particularly vulnerable to the toxic effects of diltiazem. He also noted that it was possible that he had taken more than the prescribed doses of some other of his medications.

118. The post-mortem revealed food particles in the man's lungs, which had led to the development of pneumonia (known as aspiration pneumonia). There was also evidence of emphysema (a lung disease) and severe narrowing of the coronary arteries.
119. The post-mortem identified that the man died as a result of:
- 1a. Prescription drug toxicity with aspiration pneumonia
  2. Ischaemic heart disease and bullous emphysema.

## ISSUES

### The man's return to Wakefield from secure hospitals

120. In 2012, after 30 years in secure hospitals, the man returned to prison at Wakefield. Understandably, his brother was concerned about the decision to discharge him from hospital back to prison. However, mental health specialists working with him at the low secure hospital concluded that there was no clinical need for him to remain in hospital. They decided that, because his mental health problems were managed by medication, he could receive the same treatment in prison as in hospital. Such NHS clinical decisions are not within the Ombudsman's remit. It is usual for prisoners to return to the prison from which they transferred to hospital, even if only until their security categorisation has been reviewed or a more suitable prison has been identified.
121. Once the decision to return the man to Wakefield had been made, prison staff were involved in multi-disciplinary meetings to discuss the transfer. His responsible medical officer at the low secure hospital provided the prison with a detailed discharge summary. Prison healthcare staff told us that they were briefed about his return to the prison and decisions about how best to manage his early days in prison had been made before he arrived. We are satisfied that the prison did its best to accommodate him once the clinical decision had been made to discharge him from hospital.

### Clinical care

122. At the low secure hospital the man was prescribed numerous medications for his various mental and physical health problems which were listed in the discharge summary. The nurse carrying out the reception health screen listed some but not all of the medications that needed to be prescribed and the doctor who prescribed them missed others. As a result, he did not receive simvastatin (which lowers cholesterol) or diazepam (a sedative medication which helps to relax muscles) at Wakefield. We make the following recommendation:

**The Head of Healthcare should ensure that prisoners' existing prescriptions are continued when they arrive at Wakefield until appropriately reviewed.**

#### *The decision to prescribe the man's medication in-possession*

123. The man had been at the low secure hospital for over 10 years and collected his medication each day from the nurses. According to information from the hospital, he was not considered suitable to keep his medication in-possession because he was too disorganised. Initially at Wakefield, he continued to collect his medication every day. However, at some point in May 2012, he was given his medication in weekly supplies to keep in his cell. When he was found unconscious in his cell his dosette box, which should have contained in excess of 100 tablets, was empty.

The toxicological examination identified that he had taken more than his prescribed dose of diltiazem but had only therapeutic levels of most other medications in his body. In later sections, we consider whether he intentionally overdosed and whether he was diverting his medication to other prisoners, willingly or otherwise.

124. It is extremely concerning that the man's medical record contains no entries to explain how the decision to give him his medication in-possession was made or who made the decision. There is no evidence of any assessments to establish whether he had the mental capacity to manage around 140 tablets a week. Nor is there any evidence that a risk assessment was completed to consider whether he would be vulnerable to pressure from other prisoners to divert or trade his medication, or to having his medication forcibly taken from him. None of the healthcare staff we interviewed, who had the most recorded contact with him, were consulted about whether he should be given his medication in-possession. Some of his prescribed medications were to treat his mental health problems, but it seems that no one from the mental health team was consulted.
125. Since the man's death, Wakefield has commissioned work to consider its medicines management processes, including in-possession medication. We welcome this. We make the following recommendation:

**The Head of Healthcare should ensure that medication is only dispensed in-possession after thorough risk assessments and in consultation with relevant staff. This should be appropriately documented.**

### **Assessing the man's disabilities**

126. The man's brother was concerned that he should not have been housed on a standard prison wing because of his disabilities. Prison Service Order (PSO) 3050, Continuity of Healthcare for Prisoners, notes that it should not be presumed that prisoners with disabilities need to be housed in the prison inpatient unit and we agree. We are satisfied that A wing was not in itself an unsuitable location but we are concerned that his needs were not formally assessed.
127. When the man arrived at Wakefield, the nurse completing the health screen noted that he should be assessed by the older person's team. There are other entries in his medical record indicating that he would benefit from an assessment of his disabilities. There is no evidence that his physical and learning disabilities were ever formally assessed, or that anyone from the older person's team saw him. The A wing disability officer apparently had no contact with him. Formal assessments would have quickly established the level of support he required with tasks such as collecting his meals, cleaning his cell, understanding processes and completing forms. Instead he relied on informal and unsupervised support from other prisoners.

**The Governor and Head of Healthcare should ensure that older prisoners and those with physical or learning disabilities have formal needs assessments and receive appropriate support.**

### **The man's risk of suicide and self-harm**

128. When the man was first told that about his potential move from the low secure hospital to Wakefield, he said that he would kill himself. By the time he transferred to prison, those working with him thought he had accepted the move. He apparently had no recent history of self-harm, with the last recorded incident occurring during his first stay at Wakefield over 30 years earlier. Wakefield staff knew about his threats to harm himself if he returned to prison and he arrived with a suicide/self-harm warning form. He was monitored under ACCT procedures for 24 hours before staff decided that his risk was low and closed the ACCT plan. In our view, monitoring him on an ACCT for such a short time had little purpose and it would have been prudent to leave the ACCT in place until he had had sufficient time to settle in to prison life. However, healthcare staff told us that, while an inpatient, he was closely monitored by general and mental health nurses who would have recommenced ACCT monitoring if they had been concerned. He was not monitored under ACCT procedures again while at Wakefield.
129. Once the man moved to A wing, none of the staff working with him, or other prisoners who spent time with him, had any concerns about his risk to himself. Some prisoners mentioned he was upset that he would lose pay for not attending induction sessions, but he did not mention this to staff. His brother told us that he knew he was depressed and not himself in the days before he died, but apart from his concern about his pay, this was not evident to the people around him.
130. The cause of the man's death was identified as resulting from complications caused by an overdose of at least one of his prescribed medications (diltiazem) but tests revealed he had taken only therapeutic doses of others. He left no note and we cannot say whether he intentionally took too much of his medication, or whether he accidentally overdosed. There is no evidence that we have seen that there were any obvious signs which prison staff should have identified, that he was contemplating suicide.

### **Potential bullying**

131. The man's dosette box, which should have contained more than 100 tablets, was empty when he was found collapsed. Some of his prescribed medications should have remained as there is no evidence that he overdosed on all of them. After his death, some prisoners said that, since receiving his medication in possession, he had been targeted by drug using prisoners. The police found no conclusive evidence to indicate that he was being bullied or pressured into giving his medication to other

prisoners. A nurse and a SO said that they asked him whether this was happening on several occasions and he denied it. Entries in the A wing observation book show that officers were aware that trading and diversion of medication took place on A wing, but none of the allegations or incidents identified involved him. He said that he would tell staff if he felt that any of his relationships with other prisoners were inappropriate and did not raise any such concerns before his death.

132. The man was a heavy smoker and found it difficult to ration his tobacco use. He told a nurse and some other prisoners that he was given, or borrowed, tobacco and cigarette papers from other prisoners. It is possible that he willingly traded his medication for tobacco but we will never know for certain. We appreciate that for his family it will appear very unsatisfactory that neither the police nor the Ombudsman's investigations have been able to discover what happened to his medication. However, there is little evidence to suggest that he was bullied for his medication.

### **Checking prisoners at unlock**

133. An officer carried out the A wing roll check at 5.45am and said that the man was asleep fully clothed on his bed. Prison staff did not see him again until a prisoner raised the alarm at about 11.45am. At 8.45am, an officer unlocked his cell but did not look in or seek any kind of response from him. A SO told the investigator that although it was good practice for staff to check prisoners as they unlocked them, he did not consider it mandatory and thought it was unfair to wake prisoners who did not need to get up.

134. For their own safety, officers are supposed to look at and make contact with a prisoner through the observation hatch before opening a locked cell door. As well as a security precaution, it is also supposed to be a check on the prisoner's wellbeing. The Prison Officer Entry Level Training (POELT) manual states:

“Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead.”

135. It is not possible to say when the man fell unconscious, but had the officer unlocking his door that morning looked through the observation panel as he did so, or interacted with him, he might have been found earlier. An operational manager at Wakefield told the investigator that the Governor issued a notice to staff in February 2013 instructing them satisfy themselves of the safety of prisoners when unlocking cells in response to a previous recommendation by the Ombudsman. This instruction was not in place when the man died, but we interviewed staff after the notice had

been issued and it was clear that many of them had not absorbed the message. We therefore repeat the recommendation:

**The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.**

### **The emergency response**

136. When the prisoner raised the alarm, two officers went to the cell. According to the CCTV footage, they were in the cell for about 12 seconds before leaving together to seek medical help. The man was left alone and his cell door was unlocked while they were gone. When interviewed nearly a year later, neither of the officers could remember what had happened when they found him unresponsive. One officer believed he had stayed behind at the cell while the other officer went to the treatment room. It is unsatisfactory that one of the officers did not stay with him while the alarm was raised. As he had been sick the officers should at least have placed him in the recovery position.
137. Once the alarm was raised nurses began assessing and treating the man within minutes and an ambulance requested promptly. Nevertheless we are concerned about the officers' initial response.

**The Governor should ensure that all officers understand what is expected of them when they find a prisoner unresponsive.**

### **Contacting the man's family**

138. The man left the prison for hospital at 12.40pm. He was clearly seriously unwell and cardiopulmonary resuscitation had been attempted by nurses at the prison before the paramedics arrived. At hospital, the seriousness of his condition was confirmed by consultants who placed him in a medically induced coma. However, the family liaison officer was not asked to come into the prison until 4.00pm. He arrived an hour later and did not inform the man's brother until 6.00pm.
139. Prison Rule 22 requires that 'If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed'. We consider that the very fact that CPR was attempted and an emergency ambulance was called to take him to hospital is indicative that the prison believed he was very ill and his family should have been contacted at that point.

**The Governor should ensure that the next of kin is notified as soon as possible when a prisoner becomes seriously ill.**

## The use of restraints

140. The Prison Service has a duty to protect the public when escorting prisoners to hospital, and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. 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 which also takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process.
141. Before the man left Wakefield for hospital, a risk assessment was completed. His existing physical health conditions included heart disease, COPD and cerebellar ataxia, which affected his mobility to the extent that he used a walking stick to move short distances. This information was well documented in his file and was highlighted in the security information used as part of the risk assessment process. That day he had been resuscitated by nurses, an emergency ambulance called and he was clearly seriously unwell. Nevertheless, when a nurse completed the medical aspect of the risk assessment, she noted there were no medical objections to the use of restraints and recorded that his medical condition did not restrict his ability to escape unaided. She noted that there was no reason for restraints to be removed during treatment.
142. An Operational Support Grade (OSG) Sheard completed the section detailing the man's behaviour in prison. The OSG wrote that he was a standard level prisoner with no adjudication history who had never been on an ACCT (which was not correct). The OSG wrote that there was no security intelligence about him. His risk to the public was deemed high, the risk to hospital staff was medium as was the risk that he might try to take hostages or try to escape. The likelihood of him receiving any outside assistance in an escape attempt was assessed as low. The OSG recorded that he should be restrained and accompanied by two officers.
143. The security governor at Wakefield authorised the risk assessment once the man had arrived at the hospital. By this time, he had been placed in a medically induced coma and was not breathing for himself. The governor agreed that he should be restrained by an escort chain, writing that this level of restraint was "appropriate whilst in coma". The escort chain was removed later, but only at the hospital consultant's request.
144. In our view, the assessment of the man's risk could not be justified by an objective assessment of the facts. It could not be reasonably concluded that a man in his condition was capable of escape from prison officer escorts and of committing any further offences at the time of the risk

assessment. It was particularly inhumane to conclude that the use of an escort chain was acceptable when he was in a medically induced coma. We have raised concerns about similar issues several times previously at Wakefield, including in relation to deaths that pre-date the man's. We therefore repeat the recommendation here:

**The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.**

## RECOMMENDATIONS

1. The Head of Healthcare should ensure that prisoners' existing prescriptions are continued when they arrive at Wakefield until appropriately reviewed.
2. The Head of Healthcare should ensure that medication is only dispensed in-possession after thorough risk assessments and in consultation with relevant staff. This should be appropriately documented.
3. The Governor and Head of Healthcare should ensure that older prisoners and those with physical or learning disabilities have formal needs assessments and receive appropriate support.
4. The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.
5. The Governor should ensure that all officers understand what is expected of them when they find a prisoner unresponsive.
6. The Governor should ensure that next of kin is notified as soon as possible when a prisoner becomes seriously ill.
7. The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.

## ACTION PLAN: The Man – HMP Wakefield

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that prisoners' existing prescriptions are continued when they arrive at Wakefield until appropriately reviewed.	Accepted	At Reception the SystemOne Health Screen Assessment includes a nurse medication review. If a prisoner is taking medication then an appointment is made with a Doctor for a prescribing review alongside any other medical issues which may need addressing. Alert sent out by e-mail to all healthcare providers to ensure that prescriptions brought in with patients are continued until reviewed by Doctor.	Completed	
2	The Head of Healthcare should ensure that medication is only dispensed in-possession after thorough risk assessments and in consultation with relevant staff. This should be appropriately documented.	Accepted	HMP Wakefield Medicine Possession Policy (June 2013) in place. Work was already in progress from HMCIP recommendation and supported by action as detailed in para 123 of the DIC report. In-possession risk assessments are now completed at Reception screen and on a 12 month rolling programme. Risk Assessments are also conducted when there is any significant change e.g. opening and closing of ACCT, changes to or from supervised medication administration.	Completed	
3	The Governor and Head of Healthcare should ensure	Accepted	Physical and learning disability needs are assessed at the Reception Health Screen	Completed	

	that older prisoners and those with physical or learning disabilities have formal needs assessments and receive appropriate support.		Assessment. Furthermore, as part of the Induction Process the Safer Custody department will make prisoners aware of the support available. If any needs are identified then they are referred to the two LD nursing leads and other providers as appropriate e.g. wheelchair services, physiotherapy etc. In line with PHPQIs a HMP Wakefield LD Disability Pathway is now operational. A LD training session was delivered to all healthcare providers on 10 <sup>th</sup> July 2013. Once a need is identified then the prison and the healthcare services work collectively and in collaboration to best meet the needs of the individual. A formal Older Person's Assessment is conducted by the Older Person's Lead Nurse. At Reception Screen anyone over 55 is automatically referred to the Older person's Nurse for this assessment and any immediate needs are acted upon. In this case a Physiotherapy Older Persons Assessment was completed on 30 <sup>th</sup> April 2013.		
4	The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.	Accepted	A Local Notice To Staff (046/2013) has been issued highlighting the need to check the wellbeing of prisoner on unlock in accordance with PSI 10/2011. This has been supported by specific reference to this requirement at wing briefings and will be reiterated as appropriate to ensure full compliance	Completed	
5	The Governor should ensure that all officers	Accepted	A Notice to Staff will be issued reiterating the appropriate response when discovering a	30/09/13	

	understand what is expected of them when they find a prisoner unresponsive.		prisoner unresponsive		
6	The Governor should ensure that next of kin is notified as soon as possible when a prisoner becomes seriously ill.	Accepted	In accordance with PSI 64/2011, where prisoners have suffered sudden life-threatening harm, the prisoner's wishes on who they would like to be contacted are ascertained where possible. In the event that the prisoner is unable to communicate their wishes, the prison contacts the nominated next of kin to provide them with an accurate account of what has happened at the earliest appropriate opportunity.	Completed	
7	The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.	Accepted	<p>Risk Assessments for attendance at Hospital are based on individual circumstances with consideration of all relevant prevailing and historical information with an underpinning regard to the actual risk the prisoner presents; individual's risk of escape and also their risk to the public including nursing staff.</p> <p>Risk assessments for prisoners in hospital are dynamic and the use of restraints is, as necessary, reviewed to take account of changes in circumstances. Specific ongoing consideration is given to medical opinion as the use of restraints and the prisoner's condition and treatment, with reductions in the level of</p>	Completed	

			restraint as necessary. Such reviews form not only part of the daily management check, but are conducted on the basis of continuous assessment of risk by the escorting staff in attendance.		
--	--	--	--	--	--