Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Wise, a prisoner at HMP Wandsworth on 15 December 2021

A report by the Prisons and Probation Ombudsman

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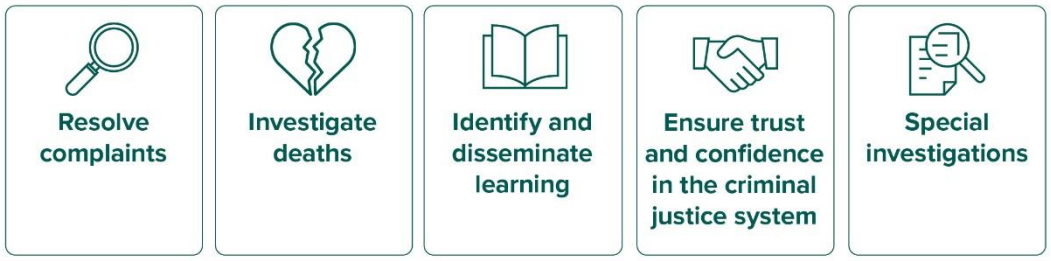
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr David Wise died after he was found unresponsive in his cell at HMP Wandsworth on 15 December 2021. He had only been at Wandsworth for 10 days. The post-mortem examination was inconclusive, so the cause of Mr Wise's death is not known. He was 46 years old. I offer my condolences to Mr Wise's family and friends.

The clinical reviewer found that the clinical care Mr Wise received at Wandsworth was equivalent to that which he could have expected to receive in the community.

Not knowing the cause of Mr Wise's death has, I am sure, left his family and friends with many questions. I hope it is of some reassurance that we found no significant gaps in the care that he was provided with in prison. However, we were unable to obtain CCTV evidence from Wandsworth and have experienced the same issues in other investigations at the prison. We also found that Body Worn Video Cameras were not switched on during the emergency response. Although these issues did not impact on the outcome for Mr Wise, they should be addressed to ensure responses can be appropriately evidenced in future.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **March 2023**

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Summary

Events

1. On 6 December, Mr David Wise was remanded in custody and taken to HMP Wandsworth.

2. Mr Wise had a history of drug use and was monitored for withdrawal symptoms during his early days in custody. He was prescribed an antidepressant and other medications for his mental health issues.

3. On 8 December, Mr Wise presented with symptoms of Covid-19 and was required to isolate, pending test results. On 11 December, tests confirmed he did not have Covid-19. However, a mental health assessment did not take place on 12 December, because a wing officer thought Mr Wise was still required to isolate.

4. On 15 December, at around 4.07pm, an officer unlocked Mr Wise's cell and found him unresponsive. The officer radioed a medical emergency code (requesting an ambulance) and started CPR. Paramedics arrived and continued resuscitation, but at 5.08pm, declared that Mr Wise had died.

5. The post-mortem results were inconclusive, and the cause of Mr Wise's death is unknown.

Findings

6. The clinical reviewer concluded that the care Mr Wise received was equivalent to that which he could have expected to receive in the community. She identified issues with clinical processes that do not appear to have impacted on Mr Wise's death but should be addressed by the Head of Healthcare to improve future care.

7. In the days before he died, staff raised concerns that the cells on Mr Wise's landing were too hot. A prison manager confirmed that high temperatures on the wings were a known problem at the time that Mr Wise was at Wandsworth. There is no evidence that the cell temperature was linked to Mr Wise's death, and we found that the works department acted quickly to address the issue.

8. The investigator was not provided with CCTV footage of the emergency response when Mr Wise was found unresponsive in his cell. The provision of CCTV footage has been an issue in other investigations at Wandsworth.

9. No Body Worn Video Cameras (BWVCs) were switched on during the emergency response when Mr Wise was found unresponsive.

Recommendations

- The Governor should ensure that, as set out in PSI 58/2010, staff provide all relevant material to the Ombudsman.

- The Governor should remind staff to switch on their body-worn cameras during reportable incidents and remind control room operators to prompt staff to do so, as set out in PSI 04/2017.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Wandsworth informing them of the investigation and asked anyone with relevant information to contact her. No one responded.

11. The investigator obtained copies of relevant extracts from Mr Wise's prison and medical records.

12. We informed HM Coroner for Inner West London of the investigation. The investigation was suspended on 10 January, pending the post-mortem examination and a cause of death. It was resumed on 16 August, following receipt of the results. We have sent the coroner a copy of this report.

13. NHS England commissioned a clinical reviewer to review Mr Wise's clinical care at the prison. The investigator and clinical reviewer jointly interviewed three prison and healthcare staff and the investigator interviewed a prison officer and prison manager. The prisoner who had previously shared a cell with Mr Wise declined to be interviewed.

14. The Ombudsman's family liaison officer contacted Mr Wise's mother to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. Mr Wise's family reflected that contact with the prison FLO was difficult and there was a delay in the return of Mr Wise's belongings.

15. Mr Wise's family received a copy of the initial report. They did not identify any factual inaccuracies.

16. The prison also received a copy of the report. They did not identify any factual inaccuracies.

Background Information

HMP Wandsworth

17. HMP Wandsworth is a local Category B prison in London, with a Category C unit. It holds up to 1,452 men in eight residential wings. Oxleas NHS Foundation Trust provides physical and mental healthcare services at the prison. Mental health services were provided by South London and Maudsley NHS Foundation Trust at the time of Mr Wise's death.

HM Inspectorate of Prisons

18. In 2020, HMIP carried out a Short Scrutiny Visit at Wandsworth to look at how the prison was responding to the Covid-19 pandemic.

19. HMIP reported that primary mental health applications had increased due to prisoners' anxieties about their health and regime restrictions, but these were managed through in cell assessment forms, in-cell work packs and health information leaflets.

20. In June 2022, HMIP conducted an independent review of progress at Wandsworth. Inspectors found the new mental health provider (Oxleas) had made progress in addressing the widespread deficiencies identified at the previous inspection in 2018, and there was now better identification of the mental health needs of new arrivals.

21. Inspectors reported that standards and living conditions for prisoners on the wings remained poor.

Independent Monitoring Board

22. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 31 May 2021, the IMB reported concerns about the availability of illicit substances at Wandsworth, which seemed to trigger aggressive behaviour. The IMB reported that the effects of the Covid-19 pandemic had impacted on healthcare service delivery.

23. The IMB noted the inhumane living conditions at Wandsworth. They outlined in their report that conditions will only improve when there are substantial structural changes to the 170-year-old residential buildings and their occupancy. Problems with heating were noted to be frequent and disruptive.

Previous deaths at HMP Wandsworth

24. Mr Wise was the 12th prisoner to die at Wandsworth since December 2019. Of the previous deaths, three were from natural causes and eight were self-inflicted. There has been one natural cause and one self-inflicted death since, and another where the cause of death is yet to be established.

Key Events

Arrival at Wandsworth

25. On 6 December, Mr David Wise appeared in court charged with possession and production of Class A drugs and having an offensive weapon. He was remanded to HMP Wandsworth, with his next appearance in court scheduled for 23 December. Mr Wise had been to prison before.

26. On his Person Escort Record (PER - a document that accompanies all prisoners when they move between police stations, courts and prisons which sets out the risks they pose), the police recorded that Mr Wise had threatened to harm himself in 2020 and flagged that there was a risk of suicide and self-harm. The PER also documented that Mr Wise said he had several physical health conditions, including testicular cancer, asthma, Crohn's disease (inflammation of the bowel) and that he had broken his back a few years previously. Mr Wise told prison staff that he had psychosis, attention deficit hyperactivity disorder (ADHD) and anxiety. Mr Wise also disclosed that he was dependant on diazepam and amphetamines.

27. A nurse completed Mr Wise's initial health screen. She noted his physical and mental health conditions and that Mr Wise had tested positive for amphetamines. She referred Mr Wise to the prison GP in reception and made referrals to the mental health team and substance misuse services for further assessment of his needs. Like all new receptions at the time, Mr Wise was tested for the Covid-19 virus.

28. A prison GP assessed Mr Wise in the reception area. Mr Wise said he had been diagnosed with testicular cancer around three years prior, which had resulted in surgery. He was concerned the cancer had returned. The GP said he would ask another GP to examine Mr Wise the following day. It was not appropriate to complete this examination during the reception screen because it was a busy area, without sufficient privacy. The GP assessed that Mr Wise's mental health appeared stable.

29. Mr Wise told the prison GP that he had anxiety, depression, and several other mental health diagnoses, for which he was prescribed medication. He also talked about his daily use of unprescribed medications (benzodiazepines and diazepam). The GP completed an assessment of Mr Wise's withdrawal from these medications and found that his symptoms were mild. He noted that Mr Wise's anxiety levels might have played a part in the result. He continued prescriptions of Mr Wise's medications, including an inhaler for his asthma, antipsychotic medication (quetiapine) and sleeping tablets for three days (zopiclone). Mr Wise was required to collect his medications from a hatch on the wings because he was not assessed as suitable for self-administering. The GP created a five-day care plan for the integrated drug treatment services (IDTS), to monitor Mr Wise's withdrawal symptoms. He also noted Mr Wise was unvaccinated and at high risk of developing complications if he contracted the Covid-19 virus.

30. Following the completion of a cell sharing risk assessment, Mr Wise was moved to a shared cell on E Wing, the reverse cohorting unit (RCU – where newly arrived

prisoners were located for 14 days to prevent the spread of Covid-19). Overnight, Mr Wise slept and showed no signs of withdrawal.

Early days in custody (7 – 14 December)

31. On 7 December, a nurse met with Mr Wise and completed his secondary health screen. He described Mr Wise as 'mentally vague' and referred him to the mental health team. Mr Wise's clinical observations were all within normal range and he declined a Covid-19 vaccination.

32. Another prison GP met with Mr Wise later the same day. He assessed that Mr Wise's mental health appeared stable and calm, but that his medication should be reviewed urgently by the mental health team because of his 'mentally vague' presentation that had been reported. Mr Wise was later discussed at a mental health team meeting who agreed that he was not considered an urgent case but would be seen within five working days. There is no record that the GP examined Mr Wise for testicular cancer, as requested the previous day. A pharmacist confirmed all of Mr Wise's medications.

33. A substance misuse service recovery worker completed an initial assessment of Mr Wise's substance use needs through the window in Mr Wise's cell door. Mr Wise outlined his drug use and the recovery worker provided information on harm reduction. He said he would complete another review as part of his IDTS care plan.

34. On 8 December, a resettlement officer completed a Basic Custody Screening (a screening tool which covers needs, e.g., accommodation, finances, health) for Mr Wise. Mr Wise told her that he was homeless, had no physical or mental health needs, no thoughts of suicide or self-harm but struggled with alcohol and substances. She referred Mr Wise for a full assessment of his ongoing needs.

35. At 11.18am, a healthcare assistant (HCA) recorded in Mr Wise's medical record that he was feeling unwell and that he was having withdrawal symptoms. She completed his basic observations and the results were normal. At 2.56pm, wing staff asked healthcare to assess Mr Wise again following complaints that he was feeling unwell with a temperature, muscle pain and a sore throat. Mr Wise's blood pressure was slightly raised, so he and his cell mate were placed in isolation pending a Covid-19 test result. Basic observations were repeated two hours later and were all within normal range. He was given paracetamol and later told healthcare that he felt okay. Mr Wise slept throughout the night. He was observed regularly and reported no further issues. The next day, Mr Wise declined to speak to healthcare staff or have his clinical observations taken, but there were no obvious signs of concern noted by staff.

36. On 10 December, a substance misuse worker and a pharmacist tried to complete a routine assessment of Mr Wise, regarding his substance misuse and five-day IDTS care plan. Because Mr Wise was isolated pending his Covid-19 result, they found it difficult to speak to him through the cell door. The review was re-arranged to take place once Mr Wise was no longer in isolation.

37. Later that day, an officer recorded in Mr Wise's prison record that he felt unwell and was waiting for the results of a Covid-19 test. She noted that a nurse had completed a routine assessment of Mr Wise and given him his medication.

38. On 11 December at 1.19pm, an advanced nurse practitioner recorded that Mr Wise had tested negative for Covid-19 (this result was from the routine test taken shortly after he arrived at Wandsworth). However, at 5.00pm, an HCA recorded in Mr Wise's medical record and made an entry in the wing observation book that Mr Wise was positive for Covid-19 and was required to isolate until 21 December. He informed wing staff and put a notice on Mr Wise's cell door. The HCA later updated both the medical record and wing observation book to say Mr Wise was in fact negative for the virus and removed the notice from Mr Wise's door (he had confused the results with another prisoner).

39. The next day at 1.34pm, the advanced nurse practitioner recorded that Mr Wise did not have the Covid-19 virus (the result of the Covid-19 test taken when he was symptomatic on 8 December). At 4.00pm, a community psychiatric nurse recorded that she had visited Mr Wise to complete a mental health assessment. Although Mr Wise said he felt well and would see her outside his cell, an officer (who we have not been able to identify) advised that he could not unlock him as they thought, incorrectly, that he was still required to isolate. She told Mr Wise that she would complete the assessment at a later date, once he had completed his isolation period. Later, Mr Wise moved to a single cell on the same wing because he was not getting on with his cell mate.

40. At 11.49pm, night patrol an operational support grade (OSG) made an entry in the wing observation book that Mr Wise had been using his emergency cell bell constantly and asking for his door to be unlocked because he wanted to go home and should not be in prison.

41. On 14 December, an officer unlocked Mr Wise for association and noticed he was hot and sweating profusely. He encouraged Mr Wise to use the showers. He said Mr Wise needed help because he did not know how to change the temperature in the showers. Mr Wise was later found in another prisoner's cell; this prisoner said he was scared and described Mr Wise as acting 'weird'. The officer said the temperature on E Wing, particularly on the 4s landing where Mr Wise lived, was very hot. He had reported the problem to the Works Department. He said he took Mr Wise to the medications hatch to collect his prescription and asked the pharmacist if Mr Wise should be seen by healthcare. There is no record of this in Mr Wise's prison or medical record.

42. At 11.26am, a nurse noted in Mr Wise's medical record that he had submitted an application requesting to see someone from the mental health team urgently, because he was very unwell. The nurse noted that another nurse had attempted to assess him the previous day but was unable to do so due to Covid-19 isolation procedures. He recorded that Mr Wise would stay on the 'green list' (for low-risk cases, who should be seen within five working days) and he would complete a telephone assessment.

43. At 4.09pm, a prison GP completed a review of Mr Wise's IDTS plan and noted on his medical record that a further review would be completed after his assessment with the mental health team.

44. Later in the afternoon, the Works Department attended E Wing in response to reports that the temperature was too high (there are four separate entries in the wing observation book between 12 – 15 December that different prisoners had

complained about the excessive heat). On the record of the visit, the works officer noted that all the cells on E Wing were hot and requested that the plant room, which controlled the heating, turn the temperature down. There is a handwritten comment that the works officer had spoken to Mr Wise, who had not complained about the temperature.

15 December

45. On 15 December, an officer said he unlocked Mr Wise for association in the morning (typically lasting around 40 minutes) and encouraged him to have a shower, but he declined. Mr Wise did not complain about the heat in his cell, but the officer said he was very sweaty, so he left his door open for longer to allow the air to flow through. He said he tried to telephone the Works Department about the heating numerous times, but his calls went unanswered.

46. At 10.05am, a plumber from the Works Department recorded that the pumps to E Wing had been turned off to help reduce the temperature.

47. At 11.26am, Mr Wise was discussed at the mental health referral meeting. The meeting noted that a nurse was unable to see Mr Wise to complete his assessment as he was thought to have tested positive for Covid-19, but that he should have a full assessment. This did not take place before he died.

48. At around 12.10pm, the officer gave Mr Wise his lunch and locked his cell door.

49. At around 4.07pm, the officer went to Mr Wise's cell to unlock him for his evening meal. He said that when he opened the door there was excessive heat emanating from Mr Wise's cell. He saw Mr Wise lying on his bed, unresponsive and white in colour with his eyes and mouth open. His lips were dry. He also described Mr Wise's cell as messy and observed that he had not eaten his lunch. He shouted that a prisoner was not breathing, and he needed help, but said he panicked and did not use his radio to call a code blue (a medical emergency code used to indicate that a prisoner is unconscious or having breathing difficulties).

50. A Custodial Manager (CM) was very close by. She heard the officer's call for help, radioed a code blue and responded to the emergency along with other prison officers and healthcare staff who were on the wing. Mr Wise was moved to the floor and healthcare staff started cardiopulmonary resuscitation (CPR). They attached a defibrillator which indicated there was no shockable rhythm. Mr Wise was described as warm to touch, but his eyes were fixed and dilated, there was discolouration to his skin and signs of cyanosis (indicating a lack of oxygen).

51. London Ambulance Service received a request for an ambulance at 4.07pm. Paramedics arrived at 4.15pm and continued resuscitation attempts. However, at 5.08pm they declared that Mr Wise had died.

52. At 4.20pm, a nurse recorded that he had tried to contact Mr Wise via his in-cell telephone, to follow up his reports that he was feeling unwell. His intention was to complete a triage (an initial assessment) and a welfare check, but there was no answer. We have not been able to establish exactly when the nurse rang Mr Wise's cell telephone.

Contact with Mr Wise's family

53. The prison appointed a family liaison officer (FLO). Under normal circumstances, national prison policy requires that the next of kin is informed of a death in person by a FLO, wherever possible. However, at the time of Mr Wise's death exceptional measures were in place due to the Covid-19 pandemic. This allowed for telephone contact with a prisoner's next of kin. The contact telephone number Mr Wise had given for his parents was incorrect, and the police were asked to assist. They informed Mr Wise's family he had died.

54. The FLO contacted Mr Wise's parents the next day and offered ongoing support. After that, she contracted Covid-19, which led to a delay in returning Mr Wise's belongings to his family. The prison contributed towards the costs of Mr Wise's funeral in line with national policy.

Support for prisoners and staff

55. After Mr Wise's death, the Duty Governor debriefed all the staff involved in the emergency response, to ensure they had the opportunity to discuss any issues arising, and to offer support. An officer also attended to support staff in her capacity as a care team member. The officer who discovered Mr Wise said that although he was offered immediate support, he did not feel he was given sufficient support in the days after Mr Wise died.

56. The prison posted notices informing other prisoners of Mr Wise's death and offering support. Staff reviewed all prisoners considered to be at risk of suicide and self-harm in case they had been adversely affected by Mr Wise's death.

Post-mortem report

57. The post-mortem examination could not identify the cause of Mr Wise's death and gave the result as 'unascertained' and toxicology results indicated no signs of illicit drug use.

Findings

Cause of death

58. The post-mortem was inconclusive and Mr Wise's death recorded as unascertained. There is no indication that he took any illicit substances. We do not consider that prison staff could have foreseen an imminent risk to life in the days leading up to Mr Wise's death and we found no significant gaps in the support that he was provided.

Clinical Care

59. The clinical reviewer concluded that the clinical care Mr Wise received at Wandsworth was equivalent to that which he could have expected to receive in the community. She identified some areas for improvement, which are detailed in the clinical review report. These issues did not directly impact on the outcome for Mr Wise, but the Head of healthcare should address the recommendations to improve future care.

Cell temperature on E Wing

60. E Wing was experiencing heating issues during the time that Mr Wise was there, with various sources complaining that the cells were too hot. The IMB has highlighted this issue to prison managers. An officer noted that although Mr Wise did not raise any concerns, several other prisoners had complained, and this was logged in the wing observation book. He reported the high temperature to the Works Department and encouraged Mr Wise to shower and get some fresh air when he was observed to be sweating excessively. A plumber visited on 15 December, to switch off the heating pump. We are satisfied that the response was timely.

Providing evidence to the PPO

61. In line with Prison Service Instruction (PSI) 58/2010 - *The Prisons & Probation Ombudsman*, the investigator contacted Wandsworth's prison liaison officer immediately following Mr Wise's death, and requested relevant information and evidence needed to investigate the circumstances of his death. CCTV was not provided despite numerous requests and this is not the first investigation following the death of a prisoner at Wandsworth where this has been an issue.

62. We note that in their latest report, the IMB raised concerns about the CCTV system stating that it was unreliable and not fit for purpose. However, in other PPO investigations, even after a significant delay in some cases, footage has ultimately been provided. As outlined in the PSI, it is the prisons responsibility to provide the evidence requested in a timely manner. We therefore repeat the following recommendation:

The Governor should ensure that, as set out in PSI 58/2010, Wandsworth provide all relevant material to the Ombudsman.

Body Worn Video Cameras

63. PSI 04/2017, *Body Worn Video Cameras (BWVC),* requires prison staff to use BWVCs during any reportable incident, including medical emergencies. It requires staff to start recording at the earliest opportunity, to maximise the material captured by the camera. BWVC's are an important source of evidence for PPO investigations, and wider learning for prisons following an incident.

64. Body worn video cameras were not activated when Mr Wise was discovered unresponsive. This, coupled with the lack of CCTV footage, meant we had no visual evidence of the emergency response. Based on the other evidence available to us, we are satisfied that the response was appropriate. We also recognise that during an emergency event staff might forget to switch on their cameras. However, the Governor should address this learning to ensure evidence is available in future incidents. We make the following recommendation:

    The Governor should remind staff to switch on their body-worn cameras during reportable incidents and remind control room operators to prompt staff to do so, as set out in PSI 04/2017.

Inquest

65. The inquest into Mr Wise's death concluded in August 2024. The cause of death was due to hyperthermia, secondary to ambient temperature, infection and (therapeutic) amphetamine use. A narrative verdict was reached; issues with the heating system (probably contributing) to past and present health conditions and lifestyle (possibly contributing).

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