The Death in Custody of a man at HMP Wandsworth – May 2005

Report by the Prisons and Probation Ombudsman for England and Wales

January 2006

This is the report of an investigation into the circumstances of the death of a man at HMP Wandsworth on 7 May 2005. The man, who was 33 years of age, died as a result of intoxication by Nefopam. This was a drug that the man had been prescribed and the evidence suggests that he hoarded it in his cell.

I would like to extend my condolences to the man's mother and family, and to all those touched by his death.

The investigation was led by one of my Fatal Incident Investigators. An independent review of the prisoner's medical care in prison was commissioned from the Clinical Governance Lead for Wandsworth NHS Primary Care Trust. The report was prepared by the Medical Director for Wandsworth NHS Primary Care Trust. I am grateful to them all and to the management and staff at HMP Wandsworth for their assistance and co-operation during the course of this investigation.

The man suffered from depression and chronic back pain, and was under medication for both conditions until his death. Nefopam was the drug prescribed for his back pain.

This is an important report and I have made eight recommendations.

Stephen Shaw CBE
Prisons and Probation Ombudsman **January 2006**

Contents

Summary

The man was 33 years old and was serving a three year sentence at HMP Wandsworth. He was born in South London in 1971. He was a heavy goods vehicle driver and had been employed variously as a doorman and security guard. Before sentence he lived in Kent with his mother and sister.

At Wandsworth, the man was located on H wing on the Onslow Unit, designated as a vulnerable prisoners unit. He lived here from his reception into Wandsworth on 12 July 2004 until his death on 7 May 2005.

The man was generally fit and well, but had suffered from back pain for some years and more recently from depression brought on by his conviction. He also suffered from hay fever, haemorrhoids and constipation for which he was receiving the appropriate medication. The man was being treated by prison healthcare staff four times daily with Co-codamol for his back pain and with Efexor, an anti-depressant, once daily. He had also been prescribed Nefopam for his chronic back pain which he took three times daily. He held this medication in his possession. The man was given seven day's worth of in possession medication at a time. He was also in possession of medication for hay fever and haemorrhoids.

The man had disclosed to a counsellor in the prison a previous overdose at the age of 14, but he had not seemed to be currently suicidal to the counsellor at their last meeting on 5 May. The man had also told his cell mate of taking 60 tablets on one occasion, but then waking up the next morning none the worse.

Shortly after 10.45pm on 7 May 2005, the man's cell mate said there was a sudden violent shaking of the bunk bed. The man fell from his top bunk and landed on the floor. His cell mate saw that he was shaking and having what appeared to be a fit. He immediately pressed the cell bell to alert staff. Two staff arrived, saw that the man was having what appeared to be an epileptic fit, and called for medical assistance and the assist night orderly officer.

When these staff arrived, some four to five minutes later, the cell was unlocked. At this time the man did not seem to be fitting, but was unconscious. The nurse shook the man and tried to get a response from him. The man began to respond and so the nurse went to fetch some medical equipment. On her return, the man's condition had deteriorated and he was only semi-conscious and incoherent. The man suffered another fit lasting about two minutes. At 11.07pm, the nurse asked that an emergency ambulance be called. The man continued to deteriorate and he stopped breathing. The staff began resuscitation techniques and continued until the paramedics arrived at 11.18pm. Resuscitation techniques were again continued unsuccessfully until 11.50pm.

The post mortem was performed and the subsequent report prepared by a Home Office Pathologist and Consultant Forensic Pathologist. The report states that the man died as a result of Nefopam intoxication. Nefopam in high

doses is known to produce fits or seizures. The man was probably not aware of this fact.

The police found a large quantity of tablets in The man's cell, primarily Nefopam. The man had taken over three times the fatal dose of Nefopam. He did not leave a suicide note.

The clinical review was carried out by the Clinical Director for the Wandsworth NHS Primary Care Trust**.** No major concerns were raised by the clinical reviewer regarding the medical care that the man received during his time in prison. However, he did have some concerns about the standard of clinical record keeping at Wandsworth and recommended clarification of the policy about the holding by prisoners of large quantities of analgesic drugs.

I make eight recommendations.

The Investigation Process

My practice in investigations into a death from apparently natural causes is to conduct an initial review to determine the extent of investigation required.

My colleague first visited Wandsworth on 19 and 20 May 2005 and met with Head of Safer Prison Governor. The then Governor was in the process of handing over the prison to an incoming Governor.

My investigator was given a full briefing about the circumstances surrounding the man's death and the current situation regarding family contacts and actions instigated by the establishment. Offers to meet with a Prison Officers' Association representative and the Independent Monitoring Board (IMB) were made and were taken up by both parties. Notices to staff and prisoners were published in the prison. These invited anyone who might have information relating to the man's death to make themselves known to the inquiry team. Two prisoners who knew the man well and had eye witness accounts of his death came forward. Four other prisoners who were the man's immediate neighbours also spoke to my investigator.

My investigator took away the relevant files and records relating to the man and commissioned a clinical review from the Clinical Governance Lead, for Wandsworth NHS Primary Care Trust. A post mortem report was also requested from the Westminster Coroner.

One of my family liaison officers contacted the man's mother. She said that she wanted to raise some concerns about the man's care whilst in Wandsworth prison. She explained that he was depressed whilst at Wandsworth and felt that staff should have been more aware of that fact. She also felt that, had his transfer to Maidstone been carried out earlier, his depression would have been lessened. She was also concerned as to how her son was able to hoard the drugs he had.

The man's mother was informed that the man had passed away by the police on the morning following his death. A personal visit was made to her home by the Safer Prison Governor and a member of the Chaplaincy two days later on 9 May 2005. Both have subsequently telephoned the man's mother on a number of occasions. The Resettlement Governor and the prison's Family Liaison Officer, followed the visit by his colleagues with a letter of condolence.

HMP Wandsworth

HMP Wandsworth is a category B local prison for adult male prisoners with a certified normal accommodation of 1,371 prisoners.

Onslow Unit is designated as a vulnerable prisoners unit. Onslow Unit has three wings (G, H & K Wings) holding approximately 275 prisoners in a mixture of single and double cells. All wings on Onslow Unit have access to in cell televisions which are of the hand held type.

Onslow Unit has a population somewhat older than the rest of Wandsworth. During my investigator's visit, the regime was relatively relaxed and informal. However, he found a number of staff who relied on shouting up the length of the wings to gain the attention of specific prisoners or staff. This was most often done whilst standing on Onslow centre immediately adjacent to the telephones used by prisoners talking to family and friends. This being the main area for the congregation of staff and prisoners, the general noise level is quite high. Any telephone conversation is affected either by distraction or is liable to be overheard because of raised voice levels necessary to cope with the background noise. This destroys any privacy between the prisoner and the person he is speaking to. I draw this general issue to the Governor's attention.

Prisoners work on the unit or in the laundry. There are also educational classes available.

Wandsworth Healthcare has a consulting/dispensing room on the unit which is staffed during the day. At night, a healthcare night patrol (radio call sign Hotel three) covers Onslow Unit from the main prison healthcare unit. Wandsworth has a code system for use during a medical alert (codes one, two, three) to notify medical staff of the level of seriousness of a particular incident. An emergency bag is taken to all serious incidents.

Healthcare in Wandsworth transferred to the local PCT from 1 April 2005. All staff working in Wandsworth healthcare are medically qualified. At the time of the man's death HMP Wandsworth had a 14 bed in-patient facility (Kearney Unit) and others were supported in their detox by substance misuse nurses working on the wings. A full time doctor is available each week day. Medical cover is provided during the weekends and evenings by two GPs from a local practice. Appointments to see a doctor are triggered by wing application. The waiting time to see a doctor varies from a few days to a few weeks dependent on the urgency of the request.

The man

The man was born in 1971 in South London. He was a single man, who lived with his mother and sister in Kent. His work history - according to the people he told, who included the police on 3 July 2004 - was latterly as a heavy goods vehicle driver. Before this, he worked as a doorman and did other personal security work the nature of which, according to his cellmate, he was reluctant to discuss. The man did not have alcohol or drug misuse problems. He smoked whilst in prison.

He was a physically big man, at 6ft 3in tall and weighing 20 stones on reception into Wandsworth. He had a history of back pain for which he received regular medication, but was generally fit and well.

The man was described by those staff and prisoners who knew him on Onslow Unit as pleasant, happy and friendly, known as a “gentle giant” because of his size and demeanour. He was also a man who generally kept himself to himself. However, it was recognised by some of the prisoners he lived with that he could become a “handful” if he lost his temper. He shared his cell with a prisoner some 35 years his senior. They were friends. When the man saw a need in someone else, he would be willing to help. In particular, one prisoner described how the man had helped him with his written and spoken English, when he got into difficulty because English was not his native language.

Whilst at Wandsworth, the man spent all of his time on Onslow Unit.

The man was remanded into custody in July 2004. Subsequently, he was convicted at Middlesex Guildhall Crown Court in October 2004 for a number of sexual offences and was sentenced by that court in February 2005. His sentence was a total of three years imprisonment. Given the time he had spent on remand, the man was due for conditional release in December 2005.

The man denied his offence and was appealing against the conviction. This was his first custodial sentence and he had no criminal history. His main support was from his mother and sister, who were also his main visitors. He had a girlfriend who had five children from a previous relationship, with whom he also corresponded and telephoned regularly.

Events Leading Up To 7 May 2005

The man was remanded into prison custody on 5 July 2004 at HMP Highdown. His first reception health screen form indicates that the man told staff he had back problems, and that diabetes ran in the family although he was not a diabetic himself. He also stated that he was not epileptic and had never tried to harm himself. Medical staff noted that he was overweight. The man signed the Highdown Inmate Medication Policy which indicated he understood that any medication prescribed and issued to him may only be used for the purpose for which it was prescribed. It also states that medication must only be taken by the person to whom it is prescribed and that hoarding of medication is not permitted. A visit to the Wellman clinic on 7 July 2004 indicated that, apart from the ongoing back pain, he was in good health.

The man was received into Wandsworth following a remand hearing on 12 July 2004.

The man first saw medical staff on reception at Wandsworth that day and a Healthcare Reception Screening form was completed, identifying the problems he had with his back and again stating that he was not diabetic or epileptic. He also said he was not suicidal. His GP was contacted and confirmed that the man had had an MRI and CAT scan some eight years previously regarding the back pain he suffered but "no lesions were found". He was given co-proxamol and ibuprofren for 28 days, being reviewed at the 14 day point. Pain relieving drugs for the back pain were given daily throughout his sentence until his death.

The man was allocated to a shared cell but a note was made on his cell sharing assessment that he "gets angry quickly but not violent". He was exempted from heavy work and excused lifting. The man also stated that he could neither read nor write. This is at odds with the help that he gave another prisoner whose first language was not English.

On 22 July 2004, the man reported to nursing staff that he was suffering from hay fever for which he was prescribed Zirtek for 14 days and a Beconase nasal spray.

The man reported on 5 October 2004 that he was feeling depressed, emotional and was tearful particularly when speaking to his family on the telephone. As noted earlier, the lack of privacy and the general level of noise on the wing is not helpful when prisoners are discussing sensitive issues over the phone. He also reported that he was sleeping poorly. He was prescribed Efexor (37.5gm), an anti-depressant, twice daily and took this until 23 December. On 21 and 24 December, it appears that only one dose was given. As from 30 December, the man's Efexor prescription was reduced to a single 75mg dose daily given in the afternoon until 12 January 2005 when it was then given twice daily until 3 February. At this time, it was again reduced to a single daily dose until 17 February when the dose was doubled to two lots of 75mg given in the morning. On 12 April, the dose prescribed was repeated for 28 days which was re-confirmed on 5 May. This dose was given in the afternoon until the man's death on 7 May.

On 6 October 2004, the man was deemed unfit for work for a period of five days, returning to work on 11 October. On 29 November, he reported sick with paronychia (whitlow) affecting his left middle finger. This was treated with fludoxacillin and he also had a four night course of Nytol to help him sleep. The man was excused work for one week followed by a second week on 6 December. On 14 December, he was located in the Care and Separation Unit (CSU) where he was deemed fit for adjudication on 15 December.

On 30 December, the man complained that he had backache at night because he had been prescribed no analgesia during the evening and insisted that his medication be issued at night. He said to medical staff that outside of prison he took Brufen three times daily and Co-proxamol four times daily. The man was then prescribed Diclofenac 50mg tablets, Co-codamol four times daily, and Efexor one dose daily, all for a 28 day period. He held the Diclofenac in possession but the other medication was issued to him by nursing staff.

On 14 January 2005, the man complained that the Diclofenac was not relieving his backache and asked for Ibuprofen. This was not prescribed because at that time he was also complaining of nausea and vomiting and bleeding from his rectum after passing a stool. The medical staff explained that they could not prescribe Ibuprofen whilst he was still bleeding per rectum. Instead, he was prescribed a 28 day course of Nefopam for his back pain in the form of Acupan to be taken at the rate of 60mg three times daily. Medical staff at this time noted that the man was having difficulty coping with his impending trial which had been adjourned from 10 January until 4 February. Subsequently, the doctor prescribed Nefopam medication for periods up to 84 days, the last prescription being on 11 April.

The man held in possession the Nefopam and Diclofenac medication. The prescription of in possession drugs at Wandsworth is as follows. The doctor prescribes the medication and the period for which it is applicable. The pharmacist issues enough medication for 28 days to the wing treatment room and the wing medical staff issue to the prisoner medication sufficient for seven days. Receipt of the medication is acknowledged by the prisoner by signature. Each stage of this procedure is noted on the Prescription and Administration Record Chart. In the “Items Issued” section of the man’s chart, the word “issued” is evident where the prisoner signature is required. This is so for all his in possession medication since reception at Wandsworth. When asked on interview, the Staff Nurse explained that, up until about four years ago, the medical room on Onslow Unit was run by a single nurse and that on all occasions the issuing nurse would sign in the appropriate place as having issued the medication and the prisoner’s signature obtained as having received the medication. Since that time, there have been two nurses present whilst drugs are issued and the prisoner’s signature is no longer sought because both nurses are able to confirm that the drugs were issued to the appropriate person. The final column is now simply noted with the word “issued”. She added that, when time allows, prisoners do sign in the required column. This appears never to have happened in the man’s case.

The policy at Wandsworth regarding medication held in possession by the prisoner is for a doctor or nurse to perform a risk assessment and, if suitable, the prisoner

signs an In Possession Medication Compact Agreement. Neither of these documents is available for the man and the indication is that they were not completed. The opinion of the Healthcare Manager at Wandsworth is that, had those documents been completed properly, it was likely that the man would have been allowed the medication in possession anyway. Nevertheless, the correct procedures were not followed.

On 20 January 2005, the man reported sick with influenza and a cough for which he was prescribed simple linctus and given four days exemption from work. On 2 February, he was fit and well prior to going to Middlesex Crown Court for sentencing on 4 February. He was sentenced to three years imprisonment.

After the man was sentenced, he reported to medical staff that he was still feeling low and depressed. The Head of Onslow Unit, referred the man to the psychology department. The man began to have counselling sessions with a trainee counselling psychologist at Wandsworth. The counsellor had been briefed that the man was not happy at Wandsworth and that he was under a lot of pressure. The counsellor described the man as a happy person and quieter than most prisoners he works with. He said that, unusually, the man did not become emotional during his counselling meetings with him. He added that the man's demeanour was exactly the same whether on the wing or in a counselling session.

In April, the man reported falling asleep during the day and then could not sleep at night. He also still had constipation and haemorrhoids for which he was given Fybogel, Lactulose and Xyproct. Treatment for hay fever in the form of Zirtek and Beconase nasal spray was also prescribed.

The man did not like being held at Wandsworth and had started an apparently successful campaign to be transferred to HMP Maidstone. No documentation is now available to track the transfer application to Maidstone. (The documents were apparently destroyed when the transfer unit moved offices within the prison.) The man wanted to move because Maidstone was closer to home for visits and he had heard that it was a better prison in which to serve his sentence. The man was looking forward to his move to Maidstone. A prisoner in a neighbouring cell believes that during a conversation about the man's transfer between the man and himself two days before his death, the man had mentioned "fitting" or epilepsy. He had the impression that the man had used that as a lever to bring pressure to bear on the Prison Service to ensure his move went ahead.

During the first counselling session on 7 April, it emerged that the man had attempted suicide by the taking of an overdose of analgesics when he was about 14 years of age. The attempt was obviously unsuccessful and by the man's own account went unknown to those around him. The man told the counsellor that he had again attempted suicide when a relationship he was involved in became problematic, although no details of this attempt were given. He then told the counsellor that he had attempted suicide when he first came into prison, but again no other person knew about that attempt and no details were given. The man also told his cellmate about a previous attempt to commit suicide which had involved

the taking of about 60 tablets. The man said he had merely gone to sleep and awoken the next morning, none the worse for the experience.

The counsellor noted that he asked the man during his second session, on 14 April, how he felt currently and he told him that he was not feeling suicidal. However, he was worried about being on the sex offenders register and was feeling negative and worried about the future. During the counselling session on 21 April, the man was still worried about his future and spoke about having thoughts regarding ending of his life. He stated that he would not do anything about the thoughts because he did not want to end up dying in prison.

The man's last session with the counsellor before his death was on 5 May and he appeared to be more positive. He was still concerned about being alone and isolated and spoke about being depressed because he was locked up and had lost his possessions, family and dog. There was no discussion regarding suicide during this last session.

It was the counsellor's professional judgment that the man was not a suicide risk and therefore no ACCT form was opened on him.

The man's cellmate was aware that he was hoarding prescribed drugs in readiness for his prison transfer so that they would be available to him should there be any delay in prescribing them at Maidstone. The prisoner in the cell next door to the man, was told by the man's cellmate about this store but is not certain whether this was before or after the man's death. Police took away 65 pills from his cell on the morning of 8 May for analysis. The Coroner's Officer has since confirmed that the majority of the pills were Acupan, which contain Nefopam. The man's cell mate maintains that none of the pills was his and that he did not give any drugs prescribed for himself to the man.

The man had maintained contact with his family and girlfriend throughout the duration of his sentence by telephone and letter. Whilst on Onslow Unit, the man was good tempered. However, the prisoner in the next cell said that he had overheard the man become quite rude, aggressive and even vicious whilst having a telephone conversation with, he believed, his mother. This prisoner's opinion is that the man would bottle his emotions up and would let go of them when speaking to his family.

According to his cellmate, on or around the 5 May, the man wrote to his girlfriend suggesting that their relationship should cease until at least the time he was released. This appeared to be because she has five children and the nature of the man's offence would preclude him from going to live with her after release. However, he was looking forward to moving out of his mother's house and buying a place of his own and restarting the relationship with his girlfriend. According to those prisoners he was closest to, the man appeared positive and hopeful for the future.

The day of the man's Death

On the morning of 7 May 2005, the man was his normal self: cheerful and speaking in passing to the other prisoners on his landing. He and his cellmate maintained their normal routine of meals and medication. During the afternoon, between two o'clock and five o'clock, the man received a visit from his mother and was expecting his girlfriend to visit with her. She did not visit and this may be due to her receipt of the letter sent two days earlier by the man suggesting that their relationship should go on hold until his release. The visit ended badly, leaving the man angry and his mother in tears. The man's mother has since told my Family Liaison Officer that she had rarely seen the man so dejected, and feels that staff at Wandsworth should have picked up on this earlier. She added that, had her son been transferred to Maidstone sooner, his death might not have occurred.

The man picked up his meal on returning to the wing, having missed the 4pm meal. Later, his cellmate persuaded him that he should contact his mother and not leave the bad feeling in place between them. He recalled saying to the man "after all, you only have one mum". The man agreed to telephone his mother the following morning when he had the opportunity. He seemed down to his cellmate, who offered to talk the situation through with him should he want to.

Later in the evening, the cellmate said he and the man watched *Dr Who* on television and talked as was normal for them. Soon after the television programme had started at 7pm, An Officer collected the man from his cell to go down for his evening medication, the last of four issued medications he took during the day. Occasionally, the collecting Officer, if requested, allowed the man to make a quick social telephone call at this time. The man did not make a call on this occasion.

The cellmate occupied the lower bunk and recalled saying to the man at 9.30pm that he was going to bed, which he did. The cellmate said he normally just lies there while the man watches another programme. Towards 10.45pm, the cellmate says that he heard the man turn the television off and put it away in the cupboard. The man then settled into bed on the top bunk. The cellmate was getting tired and began drifting off to sleep. The man, on the top bunk, had covered his eyes and the top of his head with a towel and placed a makeshift cover over the light bulb to diminish its glare. The light was situated just above the man's head. This practice is common, although banned, in Wandsworth. On H wing, the practice is discouraged by staff when they discover it happening.

The cellmate said there was a sudden enormous shaking of the bed. The cellmate thought the man was having a bad dream which he said the man was prone to and was about to ask him if he was alright. Before the cellmate could speak to him, the man fell from his bed onto the floor and was lying on his back. The cellmate said the bed sheet was wrapped around the man's feet and the towel was still in place over his eyes. The cellmate could now see that the man was shaking and described it as having a fit. Although he did not know it at the time, he said that the man was having a fit before he fell to the floor.

The cellmate got out of bed and rang the cell bell continuously, only stopping to look at the man whom he described as breathing through his lips, with bubbly froth

at his mouth. The man still had his shirt, jeans and socks on, which was unusual at that time of night. The cellmate thought the second button was pulled up a little bit too tightly to his throat so he undid it whilst the arriving officer was peering in through the observation hole. The cellmate requested a number of times that the officer get the keys and open the door because the man was having a fit.

All the occupants of the immediately adjacent cells said that the man and his cellmate were very quiet and normally no noise was heard from their cell. The man and his cellmate's bunk beds were positioned on the left hand side of the cell against the wall.

Prisoners located in the adjacent cell were watching *Match of the Day* on their television and also heard a loud bang from the man's cell. One of these prisoners said the bang was followed by the sound of someone having a fit on the floor. It is a sound he says he is very familiar with as he had a childhood friend and a cellmate earlier in his sentence who were both subject to frequent epileptic fits. The other prisoner from this cell described the sound as a scuffling either on the wall or on the floor of the next door cell. Another prisoner in the cell adjacent on the other side said he heard a loud shaking and banging of the bed in the man's cell. This prisoner's cellmate had headphones on to listen to the radio and heard only the commotion on the landing after staff had arrived at the man's cell.

At 10.50pm, night patrol officers, two of the three officers on duty on this particular night, were in the Onslow Unit centre office and heard the cell bell continuously ringing on H wing. As regular night patrol officers, they are used to the short rings on the cell call bell when prisoners want something non urgent. They both said they realised that this time it was different and treated it as an urgent request, arriving outside the man's cell within one minute of first hearing the bell. On arrival, one of the officers looked through the cell observation hole and saw the man's cellmate pointing down towards the floor, saying that the man was having fit. The officer asked the cellmate to step back out of his line of sight so that he could see the man on the floor. At this stage, the other officer was also able to look through the observation hole and saw the man lying on his back on the floor by the lower bunk with his head towards the back wall of the cell. Both officers thought that the man was having an epileptic fit and that, whilst not very well, he was not in immediate danger. The officer looking through the observation hole said he could see that he was breathing and moving his head. Both officers said it is not uncommon on Onslow Unit for prisoners to have epileptic fits, and estimated that it happens approximately twice per month. Because of this, neither officer opened the emergency sealed packet they carried containing a cell key. At 11.00pm, one of the officers radioed a code three alert for the attendance of the Assist Night Orderly Officer (Oscar two) and the Healthcare Night Patrol (Hotel three). At this time, the man's cellmate at the request of the staff outside the door, pulled the man towards the rear of the cell to enable the door to be opened when the Assist Night Orderly Officer arrived. This was no mean feat given the size of the cell, the man's size and his cellmate's age and general fitness.

On arrival at the man's cell, some four to five minutes after the request for assistance, the Assist Night Orderly Officer opened the cell door. The Nurse observed that, although the man was reported to be having a fit, she saw no signs

of it. However, he did appear to be unconscious. The nurse began calling the man's name and shook him. He appeared to be regaining consciousness and was pushing her hand away. She asked the man's cellmate what had happened and he told her that the man had fallen from his bed after the bed had been shaking violently. One of the officers who first arrived at the man's cell said this was the first time he became aware that the man had fallen from the top bunk. The nurse then asked the cellmate why the man had a towel around his head and the cellmate told her that the man was bothered by the light so he placed a makeshift cover over the light bulb and wrapped a towel around his head.

The man's cellmate then left the cell and waited outside on the landing whilst the nurse attended to the man. In turn, the nurse left to get the epileptic bag, a blood pressure machine and a resuscitation bag from the Onslow Unit treatment room which is downstairs at the end of G wing.

Because of his hurried exit from the cell, the cellmate was only wearing jeans and was told to put a top on. He was relocated about five minutes later by another night patrol officer on Onslow Unit. The man was still breathing and moaning at this time. The man's cellmate was located in a single occupancy care suite cell for about 45 minutes and was then moved again, on the Orderly Officer's instructions, into a double cell that was occupied by a single prisoner. The man's cellmate complained that he was just let into the double cell without the light being turned on and with no personal equipment. He borrowed a blanket that he found in the cell and remained there until he was reissued with the necessary equipment on the following morning. On unlocking in the morning, the man's cellmate asked to go back to his usual cell and was only then informed that the man had died.

On her return to the cell, the nurse attempted to communicate with the man but he was by then semi-conscious and incoherent. The nurse administered oxygen to the man. When the nurse removed the towel from his head, she saw a large bruise to the left side of his forehead. She then attempted to take the man's blood pressure, but was prevented from doing so by the occurrence of what she described as a grand mal seizure which lasted for about two minutes.

The man was then moved by three officers into the semi-lateral (recovery) position. Whilst he was lying on his side, the man vomited. Because of the head injury, the nurse decided not to administer Diazepam which would be normal in the case of this type of seizure. She noted the man's condition was deteriorating and his breathing was becoming laboured. At 11.07 pm, she requested that an emergency ambulance be called. One of the officers contacted the Control Room by telephone and the night control staff called for an ambulance. The nurse noted the man's blood pressure was low at 80/40 and his pulse was not recordable. His condition further deteriorated and respiration ceased.

The nurse then asked the Officers to come into the cell and help her put the man on his back again. Cardio Pulmonary Resuscitation (CPR.) was started by the three Officers at a rate of five chest compressions to two mouth to mouth inflations. One of the officers' emergency airway broke during its unpacking and the one carried by another officer was used. At 11.15pm, a radio call was made for further medical assistance and the Hotel one night patrol medical officer responded. CPR

was maintained until the paramedics arrived at 11.18pm. (They were escorted to Onslow Unit by the Orderly Officer (Oscar 1).) The paramedics then took over the resuscitation process. A tube to assist breathing was inserted and intravenous medication was administered by the paramedics. At 11.34pm, a second ambulance arrived. CPR. was continued for some time after the paramedics arrived but was ultimately unsuccessful. At 11.50 pm, the man was declared dead one of the paramedics. At 00.20am, both ambulances left Wandsworth prison.

During this time, another night patrol officer maintained his patrol status, particularly of those prisoners with open ACCT forms. He also became aware that some prisoners were watching what was happening through their observation holes. He went to those cells and closed the observation hole covers. One of them was the prisoner who the man had helped with his English and who was located opposite the man. He saw most of what happened and on 9 May wrote a personal letter to the Officers who first responded to the cell bell praising the way in which they had both tried to save the man's life and requesting that they post a letter to the man's family for him.

At 4.45am, the night patrol officers assisted the funeral directors to remove the man's body from the cell and Wandsworth for transfer to their chapel of rest.

According to the man's cellmate, at no point in their two month friendship did the man tell him that he suffered from epilepsy. However, some weeks before his death he did talk to the man who he taught English and mentioned to him that he suffered from epilepsy. During a discussion about suicide with his cellmate, the man confided that he had once, before coming into prison, taken about 60 tablets - a mixture of back pain relief and anti-depressant pills - but had merely gone to sleep and was "as right as rain" on waking in the morning. The man had also shown the cellmate a store of about 50 pills said to have been mixture of back pain relief and anti-depressant pills about a month before his death. Police removed about 65 pills from the cell immediately after the man's death and the Coroner's Officer confirmed that the majority of them were Acupan, which contain Nefopam. The cellmate said he did not witness the man take any pills on the evening or night of 7 May. The cellmate also said that, to his knowledge, the man did not take illicit drugs and had none in his possession. (The man's cellmate suffers from diabetes, high blood pressure and high cholesterol count. He holds a 28 day stock of prescribed medication for the treatment of his medical problems and maintains they are solely for his own use and that there were none missing over the period that he was cellmates with the man.)

The man's cellmate told my investigator that, about three weeks prior to the man's death, an officer had come round to see if the man and his cellmate were willing to take a drug test. The cellmate took one but the man said that he could not take drugs or take a drug test because in his blood there was always a drug from his medication that would show up as a positive.

Between 8pm and 11.50pm on the evening of 7 May, and quite separately from the tragedy of the man's death, there were three other serious incidents in the prison. These were an assault on staff where a prisoner was moved to the CSU; prisoners fighting in a cell, one of whom was removed to the CSU;

and an attempted suicide by hanging which took place in the CSU at 9.45pm. The prisoner concerned was calmed down by staff but attempted to hang himself again at 11.34pm, again unsuccessfully.

The Prison's Response following the Death

At 11.40pm, the Duty Governor was informed at home that a serious incident involving the man was taking place at Wandsworth. He then started making his way to the prison. At 11.50pm, the man was declared dead by a paramedic.

At 00.25am on 8 May, the prison contingency plans for a death in custody were implemented. At 00.27am, Control Room staff informed the police at Tooting that there had been a death at Wandsworth. They then passed the information on to the duty Coroner.

At 1.18am, Kent Police were informed of the death but responded that the man's address for his mother was within the Metropolitan Police District and that the Met should be contacted. The Metropolitan Police were contacted at 1.28am with the details of the man's next of kin. They undertook to break the sad news to the man's mother.

All the necessary people including the Prison Service National Operations Unit, the Area Manager's office, and the Media Relations office, were informed of the man's death at 00.55am. At the same time, the Duty Governor arrived at the prison.

The prison doctor arrived at the prison at 1.10am and the police attended at 1.20am. The police and the doctor entered the man's cell at 1.30am. The doctor noted the injury to the left side of the man's forehead and the vomit in his nostrils. The doctor also noted that the man had an endotrachial tube in his throat and an intravenous drip in his right arm. The doctor checked the man for vital signs. There was no carotid pulse or heart sounds, his pupils were fixed and dilated and were not responding to light stimulation. At 1.40am, the doctor certified the man's death. The man's body was left in place in his cell and the cell was sealed for later examination by the police. The doctor left the prison at 02.45am

At 2.12am, a Sergeant from Wandsworth police station arrived, followed by two Detective Constables at 02.25am. Having examined the man's cell, the two Detective Constables left the prison at 03.08am

At 3.47am, a Scenes of Crime Officer arrived and examined the man's cell, leaving at 4.10am. Simultaneously, the funeral directors arrived to remove the man's body. The sergeant and the funeral directors left the prison with the man's body at 4.45am.

Staff debriefings took place immediately after these events. The Care Team, IMB and Chaplaincy were actively involved the following morning in supporting those prisoners and staff who had been involved. Prayers were also said for the man in the Wandsworth Sunday service. Prisoners to whom the investigation team spoke said that they had supported each other and that some staff had also shown concern for their well being.

The Safer Custody Governor and a member of Wandsworth chaplaincy, went to visit the man's mother on 9 May in order to give any support that they could

following her son's death. The Safer Custody Governor ensured that the man's mother had all of the relevant telephone numbers for people to contact at the prison. The Family Liaison Officer and Resettlement Governor sent a follow up letter of condolence on 12 May.

The man was cremated on Monday 23 May. Representing Wandsworth at the funeral service were the Chaplaincy member of staff who had visited the man's mother and the Governor in charge of Onslow Unit. An offer by the prison to meet the funeral expenses was made, but not taken up by the family.

A memorial service for the man was held in the Onslow Unit Methodist Chapel on Wednesday 25 May. Following the service, a visit onto Onslow Unit was arranged for the man's mother and sister and his girlfriend. During the visit, they walked around Onslow Unit and spoke to staff and prisoners who knew the man. The Duty Governor organised the return of the man's property to his mother after the service. The man's property was returned in plain holdalls. The sensitivity and compassion shown his family and girlfriend during the visit is to be strongly commended. A formal recommendation is not required as I am sure the Governor will wish to share my views with those concerned.

The post mortem was carried out at St Georges Hospital, Tooting on 10 May 2005. Samples of tissue were retained for further examination. On 5 September, the post mortem report confirmed that the cause of the man's death was Nefopam intoxication.

Issues considered during the investigation

- **Was the man epileptic?**

The man had been through two reception procedures in two different prisons - Highdown on 5 July 2004 and Wandsworth a week later on 12 July. He had denied being epileptic in both instances. He told police on 3 July, and prison staff on reception at Wandsworth, that he was a heavy goods vehicle driver – an occupation that is incompatible with being epileptic. According to the Coroner's Officer, no mention of epilepsy was made in the General Practitioner's report sent by the man's doctor to the Coroner. The man's GP was contacted and confirmed that his medical record prior to being received into prison had no indication of the man suffering from epilepsy. (The man's last visit to his GP was in May 2004.)

The only suggestion my investigator found that the man was epileptic was from interviews with fellow prisoners. The prisoner whom the man had taught English said the man had mentioned, during conversations with him, that he was epileptic. Another prisoner believed the man was using it as a lever to ensure that his move to Maidstone took place. No record of the transfer application is now available to support this belief.

- **The man's transfer to Maidstone Prison**

My investigator was told that the man had requested a transfer to Maidstone prison and that this was being actioned. However, due to the fact that there is now no paperwork regarding this matter, I cannot comment further on when, why and how the man requested the transfer, nor when the prison started to process it. Nor can I say when the man was due to move, or even if a date had been set.

- **Identification of the man's risk of self harm**

During his reception into both Highdown and Wandsworth, the man had denied any instances or thoughts of self harm. There was no police warning on his prison record suggesting that he was a suicide risk. However, the man was treated for depression from 5 October 2004 through to his death in May 2005. The anti-depressant dosage was doubled from 12 April, by which time he had started seeing a counsellor at Wandsworth. His counsellor interviewed the man on four occasions, during three of which some discussion about suicide took place and revelations about past attempts were made by the man. However, it was the counsellor's professional judgement that the man was not a suicide risk and no ACCT form was opened.

The man had also spoken about an earlier attempt to his cellmate. But this was attributed by the cellmate as no more than the normal conversation that takes place between cellmates during the quiet hours of a prison sentence.

Neither medical staff who were aware of his anti-depressant medication, nor the counsellor, felt that the man was at risk of suicide. At his meeting with the

counsellor two days before his death, the man had appeared the most positive out of all his four sessions. Wing staff described the man as pleasant, happy and friendly and it is evident he had never disclosed any previous self harm or suicide attempts to them.

- **Hoarding of prescribed medication**

According to the statement made by the man's cellmate and the fact that drugs were confiscated from his cell by police following his death, it is evident that the man had hoarded drugs. It is not clear whether this was to ensure a supply of the drugs for himself over the period of his expected move to Maidstone or if he intended to use them for a planned suicide attempt.

The fact that the man was able to hoard significant quantities of prescribed drugs may raise questions as to the effectiveness of cell searching on Onslow Unit. I make a recommendation on this subject.

- **In-possession medication**

In common with all large local prisons, Wandsworth has a high proportion of prisoners who require regular medication for a variety of complaints and ailments. The prescribing and dispensing of these medicines is a matter for medical staff at the prison and there are policies and procedures governing this. Normally, a Protocol for In Possession Medication is followed: an In Possession Risk Assessment form is completed by the relevant Healthcare Worker or General Practitioner and the relevant healthcare worker with the prisoner, who must give free and informed consent, completes an In Possession Medication Compact Agreement. In the man's case, none of these documents was completed. The man was not therefore properly risk assessed to have drugs in his possession.

The opinion of the Healthcare Manager at Wandsworth was that, had those documents been completed properly, it was likely that the man would have been allowed the medication in possession anyway. Nevertheless, the correct procedures were not followed. The man was not specifically risk assessed to have Nefopam in his possession.

Wandsworth's policy is to only issue seven day's worth of medication at a time. The man had clearly hoarded a very large amount of medication, the police having taken 65 pills away with them, leaving aside the quantity he had ingested.

- **Proper documentation of prescribed medication**

There is an incomplete record of the issue of in possession drugs. It appears to have become the practice on Onslow Unit that the issue of in possession drugs has relied upon the two nurses in the dispensing room supporting each other, rather than requiring the prisoner to sign for medication issued. The Protocol for In Possession Medication requires that all parts of the "issue" section of the In Possession chart are completed, and that the receipt of the

empty container for the previous issue has been undertaken. In respect of not obtaining the prisoner's signature, this is an unsafe practice and gives no accountability if, as in the man's case, questions are asked later following a serious incident. The receipt of an empty container prior to issue of further drugs raises concerns in that, on its own, this seems more a gesture than an attempt to ensure compliance with the compact. There appears no follow up to ensure compliance with a person's medication regime.

- **Treatment of prisoners after a serious incident**

The man's cellmate was not served well. Sufficient supplies of the basic necessities should be available to allow the relocation of a prisoner to an alternative cell at short notice where it is not possible to recover his personal effects from his normal location. Putting an elderly and shocked man into an unknown and dark cell with another prisoner, with no follow up support until the following day, was insensitive to his needs.

- **Staff statements and action sheets**

My investigator found that the Control Room Incident Log was properly completed. The Death in Custody action checklist was only partially completed with times, dates and names of staff completing the action missing. Only one member of staff present made a signed statement which carried an appropriate amount of detail although there is no indication as to when his statement was made. The Officers who responded to the initial cell bell filled out the HMP Wandsworth Incident Report form soon after the man died. The incident reports give insufficient detail. Three HMP Wandsworth Incident Report forms are completed but the names of the completing staff are not present on the forms. One of the three carries the time of completion and the other two carry no report time. None of the incident reports is signed by the person completing it. No other statements appear to have been made by staff at the time or soon afterwards.

- **The way in which the man's mother was informed of her son's death**

Wandsworth Control Room staff informed Kent Police of the death and asked that they break the news to the man's mother. Kent Police declined to do so because her address was within the Metropolitan Police District. The Metropolitan Police then informed the mother that her son had died.

The Prison Service regards it as good practice for the prison to send its own staff to break the news of a prisoner's death to their next of kin. This is because prison staff would know more about the person who has died and be better able to explain exactly what happened and to answer any questions the family might have at that point. If the next of kin live a long distance away, then the prison may consider asking the Governor of the nearest prison to that area to break the news on their behalf. Asking the police to break the news should only be considered once these other options have been reasonably discounted.

That said, I recognise the subsequent good family liaison work undertaken by the staff at Wandsworth and the sensitive way in which the family were treated when they visited the prison.

Conclusions and Recommendations

The man was 33 years old and in generally good health. However, for many years, he suffered from a chronic back problem for which he was prescribed pain relief drugs. He had undergone MRI and CAT scans some eight years previously which were inconclusive as to the cause of the back problem. The man also suffered from depression whilst in prison which was being treated with anti-depressant medication. He had become more depressed and his medication was increased to treat this.

During April 2005, he was referred by the manager of Onslow Unit to a counsellor at Wandsworth because he appeared unhappy and under pressure. He had a series of four meetings with his counsellor over a period of four weeks - the final one being two days before his death. On the day of his death, his mother made a social visit to him at Wandsworth and has commented since to my Family Liaison Officer that she had rarely seen him so dejected.

The man had been received into two prisons on this sentence and had, on both occasions, stated that he did not suffer from epilepsy. He did not report to medical staff at any time during his sentence that he was epileptic. Only subsequent to his death did it emerge that he had told other prisoners that he did suffer from epileptic fits. No evidence from his medical records at Wandsworth or those held by his GP was found to support any contention that The man suffered from epilepsy. There is no indication that the man had anything other than a full and active life despite his depression and back pain.

The medical services at Wandsworth and Highdown cared for the man in an acceptable and normal way. That care was comparable to that which he would have received in the mainstream community. The management of the man's health at Wandsworth was sympathetic to his needs, given his age and medical history.

When staff arrived at the man's cell on the late evening of 7 May 2005, the man was treated in a professional manner by staff who had the necessary skills to make a determined attempt to resuscitate him. CPR was maintained throughout the attempt to resuscitate the man. I judge that the failure by the night staff to immediately enter the cell on arrival did not materially affect the outcome of the attempt to save his life. At that time, the man was breathing and moving. The paramedic from the local ambulance service took over control of the resuscitation attempts within a few minutes of his arrival but was also unable to achieve a positive outcome.

Within Onslow Unit, the support of prisoners who knew the man or were affected by his death by the Chaplaincy has been good. However, more support could have been offered to the man's elderly cellmate on the night of the tragedy. The staff who were closely involved in events were well supported.

The man died as a result of Nefopam intoxication. Evidence elicited from his cellmate suggests that the man hoarded Nefopam from the prescribed drugs issued to him at Wandsworth. This is borne out by the fact that about 65 tablets - predominantly Acupan (containing Nefopam) - were taken from the man's cell by police immediately following his death. The levels of Nefopam in his body at post mortem were at least three times the dose required for a fatal outcome. This indicates that there were many more tablets available to him than were necessary to cause his death.

The man had told his cellmate that he had taken an overdose of pain killers in the past but had merely gone to sleep and woken with no effect on the following morning. He also made similar statements to his counsellor at Wandsworth, during the final month of his life regarding previous attempts that had failed and that he had told no-one about.

It seems that the man had a history of covert self harm attempts. The Unit Manager referred the man to a counsellor because he was unhappy and appeared to be under pressure. The man made subsequent revelations to the counsellor about previous self harm attempts but, during their most recent session on 5 May, had appeared to be more positive.

The man's state of mind in the final week of his life was unsettled by a decision to break up with his girlfriend. He had also had an upsetting visit with his mother. The man's reported demeanour on the evening of 7 May and the lack of a suicide note explaining his actions may indicate that, as on previous occasions, he took the tablets with no serious intent to harm himself. Nefopam in high doses is known to produce fits or seizures. The man was probably not aware of this fact.

The man's suitability for in possession medication was never assessed at Wandsworth.

The issue of in possession medication was not documented as fully as it should have been.

Local recommendation 1: The Governor should review the system for the storage of paperwork relating to the process of transferring prisoners in order to ensure that papers do not go missing.

Local recommendation 2: The Governor in conjunction with the PCT should review the procedures in place to ensure that every decision about in possession medication to prisoners is properly risk assessed, authorised and fully documented. The risk assessment should take into account the effect a large amount of a particular drug would have on a person's health if they were to take a quantity of tablets together.

Local recommendation 3*:* The Governor and PCT should review procedures to ensure that the issuing of in possession medication is properly documented and then monitored to prevent the hoarding of prescribed drugs.

Local recommendation 4: The Governor should remind senior colleagues that the Duty Governor in charge of an incident must ensure that all incident logs/action sheets are fully completed and signed.

Local recommendation 5: The Governor should remind senior colleagues that the Duty Governor must ensure that all staff present at an incident write, sign and date a relevant incident report and/or statement, regardless of the extent of the role they took in that incident.

Local recommendation 6: The treatment of prisoners directly involved or affected by serious incidents such as the one on 7 May 2005 should be reviewed to ensure that proper support is given in the immediate aftermath of an incident.

Local recommendation 7: The Governor, in conjunction with the PCT, should remind all clinical staff of their duties in regard to professional standards of record keeping. Medical record entries should be clearly written with a date, time, name, position and signature of the author.

Local recommendation 8: In light of this man's ability to hoard prescribed medication, the Governor should review the effectiveness of cell searching on Onslow Unit.