PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

Investigation into the circumstances surrounding the death of a man at HMP Wandsworth In September 2011

Report by the Prisons and Probation Ombudsman for England and Wales

August 2012

This is the report of an investigation into the death of a man, a prisoner at HMP Wandsworth. He died in his cell one afternoon in September 2011, having been taken ill shortly after returning from the prison gymnasium. A post mortem report established the cause of death as a myocardial infarction (heart attack). I offer my sincere sympathy and condolences to his family and friends.

A review of the man's clinical care in custody was carried out by a clinical reviewer on behalf of the local Primary Care Trust. I am grateful to him for his review. I would also like to thank the Governor and staff of Wandsworth for their assistance during the course of the investigation.

Early in the investigation, a member of my staff received an anonymous telephone call suggesting that the man's gym induction paperwork had been falsified by staff at Wandsworth. Although several flaws have been uncovered in the gym induction process, I am satisfied that the papers we have seen are the originals and were completed and signed by the man. Nonetheless, the investigation found that his gym health questionnaire was signed by another prisoner and not by the Physical Education Officer whose name was on the form. It appears to have been standard – and inappropriate - practice for prisoners to sign these forms on behalf of staff. As a result of these failings, the man was not considered for a supervised exercise programme as ought to have been the case. These procedures have now been reviewed and revised but it must be concluded that he did not receive the remedial gym that may have been appropriate.

The investigation also identified a number of shortcomings in the management of the man's physical and mental health. However, it is unlikely that these shortcomings were a factor in his death. I make a total of nine recommendations in this report for the prison to learn from his tragic and untimely death.

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 **August 2012**

CONTENTS

SUMMARY

1. The man arrived at Wandsworth on 10 August 2011, having been convicted that day of an offence in relation to the London summer riots. At the time of his imprisonment, he had various physical health conditions and had recently spent time in a psychiatric hospital. Although he was promptly referred to the prison's mental health in-reach team, the investigation found that he did not see a member of the team for a formal assessment during his time at Wandsworth. There was also some confusion regarding the medication that he had been prescribed by his community GP, and it was around two weeks after his arrival that his full prescription was completed. Recommendations are made to the head of healthcare in relation to these shortcomings.

2. On 16 August, the man attended the prison's gymnasium for an induction session. In the early stages of our investigation, the Ombudsman's office was contacted anonymously by a member of staff at Wandsworth, who said that gym staff had attempted to hide or falsify the man's gym induction paperwork. No evidence was found to support this allegation. However, significant failings in the gym induction process have been identified following his death. It emerged that prisoners, whose health questionnaire deemed it necessary, were not referred to healthcare staff before being listed as having completed their gym induction. He was one such prisoner. The gym induction process and health questionnaire have subsequently been reviewed and amended.

3. In addition, the man's gym health questionnaire was signed by an offender health trainer (a prisoner who has completed relevant courses and assists with gym induction), rather than a member of staff as should have been the case. Although it was denied by the member of staff who supervised his induction, it is apparent that such practice was common. A recommendation is made to the Governor that such practice ceases. It is the responsibility of staff to ensure that these forms are properly completed and the appropriate referrals are made.

4. Shortly after returning to his cell following a session in the gym in September, the man began to struggle for breath. A nurse was called and, following her arrival, he lost consciousness and stopped breathing. Cardiopulmonary resuscitation (CPR) was commenced and a defibrillator (a machine able to give the heart an electric shock in cases of cardiac arrest) used. He did not respond and was pronounced dead by a prison doctor. The clinical reviewer concludes that the life support that he received was appropriate.

5. A total of nine recommendations are made in this report. As well as those highlighted above, we recommend that prisoners' with raised blood pressure are appropriately followed up and that there is suitable provision of emergency equipment around the prison.

THE INVESTIGATION PROCESS

6. The investigation was opened on 14 September 2011 when the investigator issued notices announcing the investigation to staff and prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known. One member of staff at Wandsworth contacted the Ombudsman's office anonymously. They suggested that gym induction staff had attempted to hide or falsify the man's gym induction paperwork.

7. As a result of these allegations, the investigator and an Assistant Ombudsman met with the deputy governor on 22 September. During the visit they viewed the man's original gym paperwork and took copies. They were also provided with copies of his full prison records, including the medical record.

8. The investigator returned to Wandsworth on 4 October, and interviewed two members of staff and one prisoner (the man's cell mate). Both members of staff were re-interviewed by the investigator and Assistant Ombudsman on 18 October, along with another two members of staff. A further five members of staff were interviewed on 20 October, with one final interview taking place on 25 October. During his visit on 20 October, the investigator provided feedback to the Governor. This was followed up in writing.

9. A review of the man's clinical care in custody was undertaken by a clinical reviewer on behalf of the local Primary Care Trust. The clinical reviewer is a general practitioner (GP) and member of the National Clinical Assessment Service (NCAS) panel.

10. One of the Ombudsman's family liaison officers wrote to the man's foster father, his nominated next of kin, on 7 October. She explained the purpose of the investigation and provided the opportunity for the foster family to ask any questions or raise any concerns they might have. The man's foster father subsequently wrote to her and asked that the investigation address the following questions:

    - Was the man receiving the appropriate medication in prison?

    - Was his physical and mental health properly assessed on admission to prison and prior to his use of the gym?

    - Did he receive prompt and appropriate medical treatment?

11. The man's foster father also kindly provided a copy of a letter which the man had written to his foster brother, in which he wrote about problems he had experienced receiving his medication at Wandsworth.

12. The man's foster family received a copy of the draft report as part of the consultation process. We have received feedback from his foster father, mother and brother, and are grateful for the time they have taken to consider the report. Their response to the investigation findings can be found on page 24, and

additional comments have been included as appropriate in the report. Some issues have been more appropriately addressed outside of this report in separate correspondence with the foster family.

13. The report was also sent in draft to the Prison Service. Their response to our recommendations is included on page 28, and additional comments have been addressed as appropriate in the report.

HMP WANDSWORTH

14. Wandsworth is the largest prison in England and Wales. Its catchment area includes courts in central and South West London and the neighbouring Home Counties. Wandsworth is a category B local prison. (Category B prisoners are those who do not require maximum security, but for whom escape needs to be made very difficult.) Some prisoners will serve the whole of their sentence at Wandsworth, while others will be moved to other prisons, including lower category ones, as appropriate.

15. The man lived on the Heathfield unit throughout his time at Wandsworth. This is a large residential unit consisting of five wings (A-E), each of which has four landings. The five wings all lead off a central zone, known as the 'centre'. E wing, where he lived in his first week, is the first night centre and detoxification unit. He then moved to A wing, a standard residential unit for remand and convicted prisoners.

16. Healthcare at Wandsworth is commissioned by the local Primary Care Trust, with primary care services provided by St George's Healthcare NHS Trust. Mental health services are provided by South West London and St George's Mental Health NHS Trust. Medication is administered by nursing staff from a hatch in the treatment room on each wing. It is supplied as either supervised (meaning that prisoners collect it on a daily basis and take in front of the nurse) or 'in possession' (where, following a risk assessment, a prisoner is given a week or several weeks supply to keep in their cell and take as prescribed). On the Heathfield unit, resuscitation equipment is stored in the B wing treatment room.

17. HM Chief Inspector of Prisons last inspected Wandsworth in March 2011. The Chief Inspector concluded that the treatment of many prisoners at Wandsworth "fell below what could be classed as decent". He highlighted that prisoners' compliance with medication was "poorly monitored". He found that prisoners' had "good access" to a "well resourced" mental health in-reach team. He also found that there were "appropriate links" between gym staff and the healthcare department for prisoners referred for remedial physical education (PE).

18. The Independent Monitoring Board (IMB, a body of unpaid local people who independently monitor and report on the prison) annual report for 2010-11 described the high number of prisoners with mental health problems as challenging for officers and specialist staff. They reported that the primary and secondary mental health teams worked effectively.

19. This is the 15th death that the Ombudsman has investigated at Wandsworth since January 2010. Six of these previous deaths were due to apparent natural causes. In our report into the most recent of these deaths, we commented that an ambulance might have been called earlier when the man in question was taken ill.

KEY EVENTS

20. The man pleaded guilty to an act of criminal damage committed in July 2011. Whilst awaiting sentencing he was arrested during the riots of August 2011. The man was convicted at a court appearance on 10 August, after which he was remanded to Wandsworth to await sentencing. This was his first time in prison. In the year before his imprisonment, the man was admitted for a period to a psychiatric hospital in London.

21. The man arrived at Wandsworth at around 7.30pm on 10 August. Shortly after his arrival he saw a nurse for a reception health screen (a routine health screen for all new arrivals into custody). He explained that he suffered from Crohn's disease (an inflammatory bowel disease that can cause a variety of symptoms including abdominal pain and diarrhoea), arthritis, and had high blood pressure and asthma. He also told the nurse that he had recently been admitted to hospital and had tried to harm himself in the past by cutting his arms. The man told the nurse that the medication he currently took was zopiclone (a sleeping tablet), prednisolone (used to treat flare ups of Crohn's disease), tramadol (a painkiller for moderate to severe pain), and calcium and vitamin supplements. He also used inhalers for his asthma. Omeprazole and ramipril (respectively for indigestion and high blood pressure) were listed by the nurse as possible medications, indicating that he was not certain if he had been prescribed them before. The nurse also noted when considering his mental health that he was prescribed lorazepam (for anxiety disorders) and citalopram (an antidepressant). She referred him to a prison doctor.

22. Later in the evening, the man saw Prison Doctor A. The doctor noted that his medication should be verified with his community GP and asked that a request form be sent. The man told the doctor that he drank heavily on a daily basis. The doctor placed him on an alcohol detoxification programme. He prescribed the medications chlordiazepoxide (for anxiety and symptoms of alcohol withdrawal) and zopiclone, plus two vitamin supplements. A nurse took the man's blood pressure, which was 135/94. The clinical reviewer comments that this is slightly raised, although understandable given that he was anxious.

23. The man spent the night in a cell on E wing, on what is known as the 'first night centre'. On their first full day in Wandsworth, prisoners normally move to C wing for their main induction to the prison. However, those who are undertaking an alcohol or drugs detoxification programme usually remain on E wing for a period of five days. The man therefore stayed on E wing, although he moved to a cell on a different landing.

24. On the morning of 11 August, the man saw Prison Doctor B for review. He said his asthma was well controlled with the use of inhalers and that he was unsure of the medication he took for Crohn's disease. He added that he had harmed himself in the past and "tried to commit suicide three weeks ago". He also said he was feeling very anxious due to not having had any alcohol. In addition to those medications prescribed the previous evening, the doctor prescribed citalopram and the man was given an inhaler and corresponding medication. The doctor also made a referral to the prison's mental health in-reach team. She

marked the referral as 'urgent' which, as the form explains, requires that the patient be assessed within one week.

25. That afternoon, a fax was received from the surgery in Surrey with whom the man had said he was registered. The fax said that he was no longer registered with the practice. Healthcare staff were, therefore, not able to confirm his medication at this stage.

26. During observations on 12 August, as part of the detoxification programme, the man's blood pressure was taken and recorded as 197/70. The clinical reviewer comments that this is high but that there is no record of any action being taken. The following day no concerns were raised about him during observations. His blood pressure was not checked.

27. On 15 August, a fax was received from a GP surgery which confirmed the man's medication that had been prescribed on 19 July. The medication listed was a calcium tablet and omeprazole to take daily, an inhaler, and tramadol to take as required. A seven day course of prednisolone had also been prescribed. No changes were made to the man's prison medication. On the same day it was noted that his case had been discussed at a referrals meeting of the mental health in-reach team and he had been accepted onto their caseload.

28. On the morning of 16 August, the man went to the prison gymnasium for an induction session. This was a large induction class, consisting of 30 men who had arrived at the prison on various days in the last week. The gym induction was taken by two Physical Education Officers (PEOs). They were assisted by offender health trainers (commonly known as gym orderlies), who are prisoners who have completed courses and gained qualifications in gym instruction. Gym induction involves familiarising prisoners with the environment, the courses available and how to use the equipment. Prisoners also complete a health questionnaire, known as a Physical Activity Readiness Questionnaire (PAR-Q). This is a form consisting of eight health related questions with yes/no tick box answers. There is space for the prisoner to expand on any question to which he has ticked the 'yes' box. The form which was used when the man completed his induction contained the following advice:

> "If you answered YES to one or more questions, you have a responsibility to talk with healthcare in person BEFORE you start becoming much more physically active. Tell the healthcare worker about the PAR-Q and to which questions you answered YES."

29. The man answered 'yes' to three questions on the form. These questions, and his responses, are detailed below (the complete form is included as annex 18):

Question	Answer
Do you have any medical problems or health issues?	Severe mental health problems
Do you ever suffer from shortness of breath?	I have asthma
Is your doctor currently	Meds for Crohn's/anti-depression

prescribing you any medication?	sleepers, tranqs [tranquilisers] etc

30. The PAR-Q is signed and dated by the prisoner. There is also a line for a member of staff to print their name, sign and date the form. PEO A printed his name on the man's form. However an orderly told the investigator that he signed and dated the form. There is no indication that a member of staff spoke to the man about seeing a member of healthcare staff or wrote the word 'referral' on the form, as should have been the case given the answers he provided. There is also no indication that the man spoke to a member of healthcare staff about his answers at any time.

31. It was recorded that the 30 prisoners, including the man, had completed their gym induction. They were now free to attend gym whenever a session was available to them. Later on 16 August, having completed his prison induction and detoxification programme, the man moved to A wing, where he was allocated cell A3-36. On the same day, a request was sent to the hospital to confirm his medication and treatment.

32. On 22 August, the man spoke to a registered mental health nurse. This was not a scheduled appointment, as he stopped the nurse having seen her on his landing. He was anxious as he said he had not received any information about his legal position, although he added that a visit from his solicitor had been arranged for the afternoon. He also spoke of his previous admissions to psychiatric hospitals and said that he was not presently receiving any medication for Crohn's disease. The nurse noted that she would advise the mental health in-reach team of his concerns.

33. That afternoon, Prison Doctor C acknowledged the prescription confirmation received from the Croydon surgery. He added calcium tablets and omeprazole to the man's prescription.

34. The man saw Prison Doctor B on the afternoon of 25 August. He told the doctor that he had not received all of his medication. The doctor recorded that he had been prescribed "part" of his medication, but also required tramadol for his reactive arthritis. This was subsequently prescribed. The man also said that his Crohn's disease had "flared up", as a result of which he had experienced some rectal bleeding. The doctor therefore prescribed a six week course of prednisolone.

35. That evening, the man wrote a letter to his foster brother. In his letter, he described the medication system at Wandsworth as a "disgrace". He said that, despite being in the prison for two weeks, he had only that day been prescribed medication for Crohn's disease (meaning prednisolone) and this only happened because he had started to bleed and therefore saw the doctor. He also said that he was still waiting for an appointment with a community psychiatric nurse (CPN) despite having "persistently asked".

36. Over the following two weeks the man settled into life on A wing. He was described by officers as quiet, pleasant and polite. He had no recorded contact

with healthcare staff during this period, other than collecting his medication from the treatment hatch on A wing. He was on 'supervised' medication, meaning that he collected it three times a day and took it in front of the nurse. Officer A, a wing officer on A wing, said that the man and his cell mate were keen on taking their medication on time and often spoke to staff if the treatment hatch opened late for any reason. However, the officer added that they missed their morning medication on several occasions as they preferred to stay in bed (morning medication is dispensed at around 8.00am).

37. Officers A and B remembered seeing the man on the day on 8 September. Officer A recalled that he looked "well and healthy" and Officer B recalled that there was nothing out of the ordinary. At around 1.00pm, a member of the prison works department came to the man's cell to repair the cell toilet, which had begun to leak. His cell mate said that the workman gave him and the man a cigar each, which they smoked in the cell.

38. At around 3.00pm, the man and his cellmate went to the gym. His cellmate said that the man used the rowing machine, lifted weights and then used the exercise bike. In a statement to the police, his cellmate said that the man was "training really hard, going for it". He recalled that the man experienced some chest pain and had difficulty breathing during exercise, which the man thought was because he had smoked the cigar beforehand. The man's cellmate did not think that anyone else noticed that the man was not well or that he told a member of staff. The PEO who supervised the session did not recall speaking to the man and said that no one approached him to say that he was unwell. He added that, in his experience, prisoners usually tell gym staff if someone is feeling unwell.

39. The man's cellmate recalled that the man seemed to be alright when they walked back to their cell. They arrived back shortly after 4.00pm. The man's cellmate said that, around five to ten minutes later, the man told him that he "could not breathe". He went onto the landing to get help and called Officer A to the cell. The man's cellmate recalled telling the officer that the man was "holding his chest and struggling to breathe". However, the cellmate went on to say that the officer did not do anything and told the man to "stop mucking about".

40. The officer gave a different account of these events. He said that when the man's cellmate called him to the cell he found the man standing by the window. When the officer asked what was wrong, the man walked over to him and said he could not breathe. The officer then asked him if he had used his inhaler. He replied that it was not working. The officer said that he then went to the landing office to get help.

41. Officer B was in the office at the time. He recalled that Officer A came in and explained that the man was feeling unwell. Officer B telephoned the control room and asked them to contact Hotel 3 (the on-call response nurse) to ask her to contact A wing. He recalled that the nurse called back a minute or two later and he asked her to come to the wing to see the man. Officer B told the investigator that his understanding was that it was not an emergency at this time and this was a standard request for the nurse to come and see a prisoner.

42. After Officer A left the cell, the cellmate went onto the landing and shouted for help, saying “my cell mate is having a heart attack”. He recalled that the man was now “on his hands and knees trying to regain his breath”. Officer C heard his shout and came up the stairs from the landing below. He described the man’s condition when he arrived at the cell as follows:

> “I found him on his hands and knees struggling for breath. He couldn’t speak … his breathing was very shallow but quite loud. You could hear him breathing and he couldn’t actually speak. I was trying to ask him ‘are you alright’ and [he just made a] very loud moaning [noise].”

43. As a result, Officer C made a ‘code one’ call for assistance on his radio. (Code one is an emergency call for urgent medical assistance. The officer was carrying a radio because he was the designated response officer on A wing that day.) It was recorded in the control room incident log that this call was made at 4.19pm. After making the call, he waited with the man for the nurse to arrive. He was soon joined by Officer B and a Senior Officer (SO).

44. The response nurse on 8 September was Nurse A. When she received the code one call, she was on E wing collecting dressings to treat a B wing prisoner who had harmed himself. On receiving the emergency call, she returned to B wing to collect the emergency bag from the treatment room, where it is stored. (The emergency bag contains resuscitation equipment including an oxygen canister and a defibrillator.) Whilst in the treatment room she received another call to check on her whereabouts. The time of this call is not recorded. She subsequently made her way to the man’s cell.

45. Officer C recalled that it was around three minutes after he made his initial radio call that he made the subsequent call to check on the nurse’s progress. He added that it was very shortly after this, just a few seconds, before she arrived at the cell. She thought it was around two or three minutes before she arrived at the cell from when the first call was made. The officer thought it was around three to five minutes until the nurse arrived. The cellmate thought it took considerably longer, around 15 minutes.

46. The nurse described the man’s condition on her arrival at the cell:

> “He was on the floor, on his knees. He clearly seemed in some sort of distress, quite confused … He was at the time conscious but not very coherent.”

47. With the assistance of one of the officers, the nurse helped the man to sit on a chair and gave him oxygen from the canister she had brought. Both the officer and the nurse told the investigator during their interviews that they wanted an ambulance at this point and that the officer therefore made a request over his radio. However, this call was not recorded in the control room log. (All requests for the emergency services are made via the control room.)

48. The nurse also asked that her colleague, carrying the Hotel 2 radio, be contacted to attend and provide assistance. It was recorded that this call was made at

4.30pm. At 4.31pm, the control room operator contacted the nurse to ask if she required an ambulance. When she replied that she did require an ambulance, the operator dialled '999'. He recorded that this call was initiated at 4.32pm.

49. While the control room officer telephoned the emergency services, the nurse left the man's cell to return to B wing to collect an electrocardiogram (ECG) machine. (An ECG tests the electrical activity of the heart and can detect problems in heart rhythm, which could show that the patient is having a heart attack.) There was no ECG machine in the treatment room, and she therefore returned to the cell.

50. On her return to the cell, the nurse observed that the man was not breathing very well and was struggling to hold onto the oxygen mask, but was still conscious. He very quickly lost consciousness and appeared to stop breathing. With the help of Officer C, the nurse moved him onto the floor of the cell. At the same time a prison doctor arrived at the cell and began chest compressions, whilst the officer carried out rescue breaths. They used a ratio of 30 compressions to two breaths. The defibrillator was attached to his chest and advised on three occasions that an electric shock be administered.

51. During this time, the control room operator was in conversation with the ambulance service operator. The officer explained that the ambulance service operator would not initially send a priority response because he could not provide the specific information about the man's condition that the operator required. He described this as "very, very frustrating". He recalled that he told the operator that the nurse had said she required a blue light ambulance, which meant that he was gravely ill. The officer told the investigator that it is difficult for the control room to get specific information about a prisoner's condition as they are not at the scene and those that are there are busy trying to help the prisoner and cannot therefore provide detailed information. He explained that, in his experience, the ambulance operator understands this and it is normally enough to say that the nurse has asked for their urgent assistance. However, on this occasion, he thought that the operator delayed the response as she wanted detailed information that he was unable to provide. The officer said that, after some time, the Operational Support Grade (OSG, the grade below prison officer) who was working with him in the control room was able to speak to one of the officers at the cell, who told her that he had been shocked twice and was being resuscitated. The officer passed this information to the ambulance controller, who subsequently upgraded and prioritised the call. It was now 4.45pm, some 13 minutes after he had first called '999'.

52. The ambulance crew arrived at Wandsworth at 4.50pm and took over the resuscitation efforts when they arrived at the man's cell. They were unsuccessful and, at around 5.10pm, the doctor confirmed that he had died.

53. A debrief was held shortly afterwards for the officers involved in the response. The staff who attended were given the opportunity to speak to a member of the staff care and welfare team. Officer C said that he felt well supported in the aftermath. The nurse, however, said that she did not attend a debrief and was not provided with any support other than words of encouragement from her colleagues in the healthcare team. The news of the man's death was broken to

his cellmate privately by a member of staff. He was later able to visit the prison's chaplaincy department and speak to staff there about the events of the afternoon.

54. Later in the evening, the prison's family liaison officer and a prison chaplain visited the man's foster family's home to break the news of his death. They arrived at around 9.15pm but found that no one was home. They therefore left a note for the man's foster father to telephone the prison. He subsequently telephoned Wandsworth at around 10.50pm and spoke to the duty governor. The duty governor broke the news of the death.

55. A memorial service was held in the prison, which was attended by a number of prisoners who knew the man. The prisoners held a collection and bought flowers with the donations. His funeral was held on 27 September. The prison contributed to the arrangements and costs.

ISSUES

Blood pressure monitoring

56. On his first day at Wandsworth, the man's blood pressure was checked and recorded as 135/94. The clinical reviewer comments that this is slightly raised but acceptable given that he was anxious on his first day in prison. At his reception health screen it was queried whether ramipril, a medication used in the treatment of high blood pressure, was prescribed to him in the community. A fax from his community GP's surgery on 15 August confirmed that he was not prescribed this medication.

57. The man's blood pressure was checked for a second time on 12 August. The reading was now 197/70, which the clinical reviewer describes as "significantly elevated". He goes on to say:

> "[The man's] blood pressure should have been rechecked and monitored to ensure that it was normal and he did not have hypertension [chronic high blood pressure]. However, his baseline blood pressure, on admission, was almost normal so it is unlikely that raised blood pressure was a contributory cause to the [heart attack]."

58. The clinical reviewer makes the following recommendation:

> **The Head of Healthcare should ensure there are clear protocols on when and what further action to take if abnormal examination findings, such as raised blood pressure, are identified.**

Medication

59. At his reception health screen, the man listed the medication that he thought he was prescribed. As is standard practice, a request was sent to his community GP for this list to be confirmed. The following afternoon, a fax was received from the surgery with whom he had said he was registered. The surgery said that he was no longer registered with them. The medication could not therefore be confirmed at this stage.

60. In his first 24 hours at Wandsworth, the man was prescribed an antidepressant and medication to contribute to his alcohol detoxification programme. The clinical reviewer comments that the man's initial physical and mental health needs were identified and managed appropriately on his arrival at Wandsworth. He also comments that the alcohol detoxification programme was appropriate to the man's needs.

61. A second fax was received, from a different GP surgery, on 15 August. The fax confirmed the medication that the man had been prescribed on 19 July. The list included several medications which had not yet been prescribed at Wandsworth. No changes were made to his medication on receipt of the fax and it does not appear as though a review was held until 22 August, a week after the prescription was received. On this date, he was prescribed omeprazole and a

calcium tablet. It is possible that prisoners suffering from chronic diseases might be discomforted by such a delay to receiving their medication.

The Head of Healthcare should ensure that a medication review is held promptly on receipt of a medication list from a community GP, particularly for those prisoners who report a chronic disease in their medical history.

62. At a consultation with Prison Doctor B on 25 August, the man complained that he had not yet been prescribed all of his medication. The doctor subsequently prescribed tramadol for pain associated with the man's arthritis. The man also said that he had experienced rectal bleeding as his Crohn's disease had flared up. The doctor therefore prescribed a six week course of prednisolone, with the dose to be reduced in strength each week.

63. In a letter to his foster brother that evening, the man complained that he had only been prescribed his medication for Crohn's disease that day. He added that he was only prescribed the medication because he had seen the doctor on account of his bleeding. The clinical reviewer comments that prednisolone is used to treat a flare up of Crohn's disease (and is not therefore prescribed as standard for patients with Crohn's). He was prescribed a one week course by his community GP on 19 July following a flare up and the course prescribed by the doctor was, presumably, in response to his rectal bleeding. The clinical reviewer comments that this was an appropriate response to his apparent symptoms. However, he goes on to say that there is no record of the assessment carried out by the doctor to confirm that he was suffering a flare up. Such recording is important to ensure consistency of treatment, particularly in a large prison where patients often see different doctors. The clinical reviewer makes the following recommendation:

The Head of Healthcare should ensure that record keeping by doctors is peer reviewed and audited to ensure good quality medical records.

Referral to mental health in-reach team

64. At his reception health screen, the man said he had recently been admitted to a psychiatric hospital in London. The following day (11 August) Prison Doctor B prescribed citalopram, an antidepressant. She also completed a referral to the prison's mental health in-reach team. The referral can be marked as emergency (meaning the patient should be seen within 24 hours as there is an immediate risk), urgent (to be seen within one week as there is some cause for concern) or routine (to be seen within two weeks for assessment). She marked the man's referral as 'urgent'.

65. On 15 August, the man's case was discussed at the mental health in-reach team's referrals meeting. It was recorded that he was accepted onto their caseload. There is no indication that the status of his referral was changed from 'urgent'. However, no formal consultation or review was arranged during his time at Wandsworth. The only contact he had with a member of the mental health team was when he spoke to a nurse having seen her on his landing on 22

August. In his letter to his foster brother on 25 August, he said he was waiting for an appointment despite having "persistently asked".

The Head of Healthcare should review the referral process to the mental health in-reach team and ensure that patients are seen within the timescales specified on the referral form.

Gym induction process

66. Prisoners at Wandsworth who wish to use the prison gymnasium usually complete an induction session during their first week at the establishment. The gym induction is led by Physical Education Officers (PEOs), who are assisted by trained gym orderlies. During their induction session, prisoners' complete a 'Physical Activity Readiness Questionnaire' (PAR-Q). This is a health questionnaire, the purpose of which is twofold; firstly, to determine whether the prisoner has any medical problems that might affect the level of physical activity in which they can participate and, secondly, to determine whether the prisoner should speak to a member of healthcare staff before attending the gym for the first time.

67. When the man completed his gym induction on 16 August 2011, the PAR-Q form used at Wandsworth at the time consisted of eight questions with yes/no tick box answers. The form contained the following advice to prisoners:

> "If you answered YES to one or more questions, you have a responsibility to talk with healthcare in person BEFORE you start becoming much more physically active. Tell the healthcare worker about the PAR-Q and to which questions you answered YES."

68. PEO A explained that those prisoners who answered 'yes' to any question were taken aside by a member of staff during induction. The member of staff then advised the prisoner to see a doctor before they returned to the gym. The emphasis was therefore on the prisoner to refer themselves to healthcare. The doctor could then advise (via an 'Exercise Referral' form) whether the prisoner's health meant that a particular exercise programme should be designed for them (and implemented initially via classes known as 'remedial gym'). However, as discussed later, this action was not taken when the man completed his PAR-Q.

69. The PAR-Q form used during the man's induction was introduced earlier in the year (the exact inception date is not clear). The change was initiated by Physical Education Senior Officer (PESO) A. The PESO explained that he made this change for several reasons; firstly, the remaining copies of the old form had faded due to the number of times they had been photocopied and were therefore hard to read and, secondly, some of the questions on the form were redundant in a male prison (for instance, one question asked if the prisoner was pregnant). In addition, the old PAR-Q did not have space for prisoners to expand on any question to which they had answered 'yes'. The PESO therefore introduced a similar form to that which he had used at his previous establishment, HMP Edmunds Hill (now known as HMP Highpoint North).

70. The original form included a significant difference in the healthcare referral process. As illustrated below, the form of words used placed the emphasis on gym staff to refer the prisoner to healthcare, rather than the self-referral instructed in the replacement form:

> "If you have answered yes to one or more questions you will be referred to the healthcare department and assessed for your suitability for P.E."

71. Although this form appears to place the onus on staff to refer prisoners to healthcare, PEO A told the investigator that it had always been the case that prisoners' self-referred to healthcare on completing their PAR-Q. (The PEO was a member of gym staff at Wandsworth from February 2003 until October 2011.)

72. As a result of the man's death, PESO B completed a review of the gym induction process. (The PESO has responsibility for various areas of the PE department but not, at the time, induction.) Among PESO B's findings were that all PAR-Q forms, regardless of the answers provided, were filed in the PE department and not given to the prisoner to take to healthcare. He also found that no prisoners had been placed on remedial gym for nearly a year, and that there were 64 prisoners currently in the establishment whose PAR-Q indicated they should have seen healthcare before attending the gym but had not done so.

73. A revised PAR-Q form has now been established at Wandsworth. As previously, this form now clearly states that prisoners' answering 'yes' to any question on the form will be referred to healthcare for assessment. All PEOs have been told to refer such prisoners to healthcare and they are not listed as having completed induction until confirmation has been received from healthcare.

74. PESO B told the investigator that the new system was working well and was understood by staff. It has also been reviewed by the regional PE advisor, whose report highlighted that PESO B's revisions were now fit for purpose. It is to PESO B's credit that he has investigated the induction process, highlighted deficiencies and taken suitable action to correct flaws. However, the Governor will wish to satisfy himself that this process remains robust in the long term, and should ensure that procedures are regularly audited.

The Governor should ensure that the gym induction and healthcare referral procedures are regularly audited and that action is taken to correct any deficiencies highlighted. He should ensure that all gym inductees for whom it is appropriate are referred to healthcare and seen by a member of healthcare staff before returning to the gym.

The man's gym induction

75. The man completed his gym induction session on the morning of 16 August. The staff who took the session that morning were two PEOs. Both are experienced PEOs and have led induction sessions at Wandsworth for some time.

76. The man completed the PAR-Q form and gave details of his medical conditions as set out previously in paragraph 29. He subsequently signed the form. The

PAR-Q also has space for a member of staff to print their name, sign and date the form. PEO A printed his name on the form. However, at his first interview with the investigator, the PEO said that the signature and date on the form were not his.

77. The investigator subsequently reviewed the PAR-Q forms completed by PEO A that were stored in the PE department at Wandsworth. They revealed a variety of different signatures under PEO A's name. A form dated 25 August 2011 was confirmed by the PEO as containing his signature. (We also note that other forms completed on 16 August contain the same signature as the man's form.)

78. At his second interview, PEO A was unable to explain why there was a variety of different signatures on PAR-Q forms under his name. However, his line manager, PESO A, told the investigator that forms regularly weren't signed by a member of staff, which he said was because of "laziness". The PESO went on to say that he had been told by one of the gym orderlies that they sometimes signed PAR-Q forms if a member of staff had not done so. When this was put to the PEO he said that it was "definitely not the practice whatsoever".

79. The investigator spoke to two gym orderlies, both of whom had completed levels one and two of the gym instructors course and therefore assisted at gym induction sessions. They explained that it is the gym orderly who hands out the PAR-Q form to inductees and collects them in when completed. Both went on to say that any form in which a 'yes' box has been ticked is handed back to the officer so they can talk to the prisoner individually. They confirmed that forms on which 'no' has been ticked throughout are signed by the orderly. One of the orderlies confirmed that the signature on the man's form was his. He said that he did not remember the man.

80. Both the orderly and his colleague were clear that it was regular practice for orderlies to sign PAR-Q forms on behalf of staff. Although they suggested that this only happened for forms with negative responses throughout, it is apparent that the man's form was signed by the orderly despite the positive responses and additional information provided by him. The PEO was not as open at interview with the investigator. From the evidence available, it is clear that he would have been aware that it was common practice for orderlies to sign the PAR-Q forms and that the signature on the man's form was therefore likely to be that of an orderly.

81. In response to our draft report, the PEO said that it is an "unfair assumption" that he was aware that orderlies were signing PAR-Q forms. He said that he did not give authorisation for them to do this and he was not aware that it was taking place. He went on to say that his focus was on interacting with the prisoners and giving talks about the gym and that the other PEO running the session would primarily deal with the paperwork.

82. We acknowledge the PEO's response. However, his name was on the man's PAR-Q form, along with many others, and as such he must take responsibility for signing the forms. We have seen PAR-Q forms from a range of dates that appear to be signed by orderlies and, from speaking to experienced gym

orderlies, it is apparent that this was seen by them as standard practice. We do not consider it credible that the PEO or his colleagues were not aware of this.

83. We have considered the suggestion made to the office anonymously that the man's PAR-Q form was falsified by gym induction staff. We are satisfied that the form we have seen is the original. The main reason for drawing this conclusion is that it contains the orderly's signature. The handwriting and signature of the man are also similar to that in his letter to his foster brother, and both the form and letter contain similar inaccuracies (for instance, "ect" rather than "etc").

84. Whilst we acknowledge that they have been trained in gym instruction, we do not consider it appropriate that gym orderlies sign PAR-Q forms on behalf of staff. It is the responsibility of induction staff to ensure that the forms are properly completed and that those prisoners for whom it is appropriate are referred to healthcare. It is also inappropriate that gym orderlies have access to other prisoners' confidential medical information that might be included on the form.

    The Governor should ensure that PAR-Q forms are collected and signed by an appropriate member of staff and not an offender health trainer.

85. As a result, it does not appear as though any member of staff spoke to the man about the importance of a healthcare assessment before he returned to the gym. At the end of the session it was recorded that he had completed his induction. He was therefore free to attend the gym whenever a session was available to him. (We have discussed in the previous section the changes made to the gym induction and healthcare referral process at Wandsworth.)

86. The clinical reviewer comments that the man had no history of heart disease and no known medical conditions that precluded exercise. However, he goes on to say that he was asthmatic and was taking prescribed medication. He adds that it would therefore have been appropriate for him to have been assessed by prison medical staff prior to commencing exercise to determine whether he was a candidate for a supervised exercise programme.

87. The man visited the gym with his cell mate on the afternoon of 8 September. This was the first time he had attended the gym since his induction three weeks earlier. The man's cellmate recalled that the man used the rowing machine, lifted weights, and used the exercise bike. He later told the police that the man was "training really hard, going for it". The man's cellmate also remembered that the man had some chest pain and difficulty breathing whilst at the gym.

88. The clinical reviewer comments as follows:

    > "The myocardial infarction [heart attack] occurred soon after a period of vigorous exercise in the gym. This is likely to have contributed to or, possibly, precipitated the myocardial infarction."

Response when the man was taken ill

89. The man returned to his cell from the gym shortly after 4.00pm. His cell mate recalled that he began to struggle for breath around five or ten minutes after they returned. He called Officer A to the cell for assistance. The man's cell mate said he told the officer that the man was "holding his chest and struggling to breathe". He said that the officer did not take any action and told the man to "stop mucking about". The officer, on the other hand, said that he spoke to the man and observed him walking around the cell. The officer went on to say that the man told him that he could not breathe and that his inhaler was not working. The officer said that he then went to the landing office to request help.

90. Officer A's account of events is supported by Officer B, who was working in the landing office at the time. He recalled that Officer A told him that the man was feeling unwell and asked him to telephone healthcare to ask for assistance.

91. As Officer A recalled that the man was walking around his cell and was able to hold a conversation, it is perhaps understandable that he did not request emergency assistance at the time. However, with hindsight, it might have been advisable to request 'code one' assistance at this stage. (We note that it was only a very short time before a request for code one assistance was made.)

92. The clinical reviewer considers the events as follows:

> "The man's collapse occurred in two stages: the myocardial infarction, during which he was, for the most part, conscious and then the cardiac arrest during which he was unconscious … [if there had been a delay to call code one] it is unlikely that this delay would have had a significant effect on the outcome, as he was still conscious when medical staff arrived and had not yet suffered the cardiac arrest."

93. When Officer A left the cell, the man's cellmate called Officer C for assistance. The cellmate recalled that the man was now "on his hands and knees trying to regain his breath", indicating a deterioration since Officer A had left the cell. Officer C gave a similar account of his condition at this time. He therefore made a 'code one' call for emergency assistance. We consider this to be the appropriate course of action.

94. Some minutes passed following the code one call for assistance before the response nurse, arrived at the cell. The specific time of her arrival at the cell is not clear, although it was a number of minutes after the call was made. When she received the message, she was on E wing collecting dressings for a prisoner on B wing. She subsequently had to return to B wing to collect and check the emergency bag before making her way A wing. The distance between these locations is not considerable (all lead off the Heathfield unit centre). However the logistics of locking and unlocking the various doors and moving between different wings adds significant time.

95. The clinical reviewer comments as follows:

> "It is not acceptable for a nurse to be the first on scene to a collapsed prisoner yet have to collect and carry cumbersome emergency equipment. Arrangements on how to ensure optimal delivery of equipment to the scene of an emergency should be reviewed. Furthermore, it would be good practice to have more defibrillators available, along with basic life support equipment, such as gloves and airways, located strategically throughout the prison."

The Governor and Head of Healthcare should ensure that the provision and location of emergency equipment on the Heathfield Unit is sufficient to enable prisoners to be treated by the response nurse as quickly as circumstances allow.

96. There was also some confusion with regard to when an ambulance was requested. Both the nurse and Officer C said that a request was made shortly after the nurse arrived at the man's cell. However, the control room operator had no recollection of this request and it was not recorded in the control room log. At 4.31pm, the control room operator contacted the nurse to ask if she required an ambulance. When she confirmed that this was the case, he called the emergency services. He recorded that this call was made at 4.32pm.

97. Whilst there are different accounts of when staff at the man's cell asked for an ambulance, it is clear that the call was not made until 13 minutes after the initial code one message. In our report into the previous death at Wandsworth, we referred to a letter from the Chief Executive Officer of the National Offender Management Service (NOMS, the organisation responsible for the Prison and Probation Services in England and Wales). In his letter to Governors, he instructed:

> "It should not be a requirement in every case for a member of the prison healthcare team to attend the scene before emergency services are called … The most important aspect of emergency care is that an ambulance is called in all cases where there are grave concerns about the immediate health of a prisoner."

98. In our previous report we made the following recommendation, which we repeat here:

The Governor should ensure that the local guidance on dealing with an emergency reflects the contents of the Chief Executive Officer's letter of February 2011, and that the guidance is re-issued to all staff.

99. We also note the difficulties that control room operator described in his conversation with the ambulance service operator, leading to a delay of around 13 minutes before an ambulance was despatched (see paragraph 51). The actions of the ambulance service operator are outside of the remit of our investigation. However, we will send a copy of this report to the London Ambulance Service for their information. We note the clinical reviewer's comment that it cannot be known with any degree of certainty if the earlier arrival of the ambulance crew would have affected the final outcome.

100. Shortly after the call was made to request an ambulance, the man lost consciousness and stopped breathing. The clinical reviewer describes this as the cardiac arrest stage of his collapse. The staff in the cell subsequently moved him to the floor and began cardiopulmonary resuscitation (CPR). A defibrillator was applied and advised that he should be shocked on three occasions.

101. During interview, Officer C said that he thought CPR should have started around a minute and a half before it did, but thought he should defer to the nurse as she was a medical professional. The clinical reviewer considers Officer C's comments as follows:

> "The time from the onset of cardiac arrest to first shock is the single most important determinant of survival … The purpose of CPR is to maintain the patient's circulatory system until a cardiac shock can be delivered. Although immediate CPR is essential and recommended, the most important priority is to defibrillate a shockable rhythm and restore cardiac function."

102. He goes on to say that the nurse was present when the man lost consciousness and that he received a shock at the earliest opportunity. He concludes that the "basic life support was appropriate and optimised his chances of survival".

Staff support following the man's death

103. In the early evening following the man's death, a debrief was held for the officers who had been involved in the response. It was chaired by a governor. The purpose of such a debrief is to provide reassurance to staff and provide details of the support services available. Officer C told the investigator that he felt well supported in the aftermath.

104. On the other hand, the nurse did not attend the debrief. She said that she was not provided with any support other than words of encouragement from healthcare colleagues. It does not appear as though any of the other healthcare staff who were involved in the response attended the debrief.

105. We consider it essential that staff are provided with proper support following a death in custody. Not least, this is part of the employer's duty of care for staff.

The Head of Healthcare should ensure that all healthcare staff involved in a death in custody are offered appropriate support afterwards.

FAMILY RESPONSE TO THE DRAFT REPORT

106. We received a number of comments from the man's foster family on the draft report, which we discuss below. We hope that these comments help to clarify any outstanding issues that his foster family might have.

Impact of summer riots on the man's care

107. The man's foster father asked whether the additional population pressures caused by the number of prisoners sent to Wandsworth in relation to the London summer riots had an impact on the care afforded to his foster son. Quarterly statistics published by NOMS[1] show that the population of Wandsworth on 30 September 2011 (the closest date available to his time in the prison) was 1,680. This compares to a population of 1,599 on 30 June 2011 and 1,625 on 30 September 2010 (increases of five per cent and three per cent respectively). Statistics on the number of prisoners sent to each prison in relation to the summer riots are not published. The population on 30 September 2011 is higher than the operational capacity of Wandsworth at the time, which was 1,665.

108. We have considered whether the increased number of prisoners at Wandsworth had an impact on the quality of care that the man received. Whilst some failings were identified in the investigation, there is no evidence to indicate that population pressures or a large number of new arrivals at the prison were a significant contributing factor to these. Indeed, the clinical reviewer comments that his immediate physical health needs were identified and managed appropriately on his arrival.

Mental health referral

109. The man's foster brother asked whether it was appropriate to send him to Wandsworth, given his recent history of self-harm. He queried whether it would have been more appropriate to send him to an establishment better suited to care for patients with mental health issues.

110. Earlier in 2011, the man spent some time as a patient at a psychiatric hospital in London. On his arrival at Wandsworth, he said that he had harmed himself in the past and had recently tried to take his own life. He was prescribed an antidepressant by a prison doctor. The investigator put his foster brother's question to the clinical reviewer, who commented as follows:

> "[The man] did not have any immediate psychiatric problems that required treatment in a special hospital. His past psychiatric illness included self-harm but there were no episodes of this whilst he was in prison. If he had a deterioration in his mental state and self-harmed then this may have warranted transfer to a specialist unit."

111. Whilst we acknowledge that he did not formally see the mental health in-reach team at Wandsworth, as he ought to have done, there is no indication that the

[1] Offender Management Statistics Quarterly Bulletins

man suffered a deterioration in his mental health whilst in prison. We agree with the clinical reviewer's view that he did not have any immediate needs that required treatment in a special hospital.

Gym induction

112. The man's foster brother was concerned that he might not have attended and completed the gym induction and that records might have been falsified to support this. Although we have highlighted a number of failings around the gym induction process, we are satisfied that he did attend his induction session. As we have discussed earlier (paragraph 85) we are content that the PAR-Q form in his name was the original, as completed by him. This form would only be completed during gym induction.

113. The man's foster family also raise concerns about the management of gym induction processes, the resulting failure to refer for healthcare assessment and the impact this had on him. We agree that there were a number of failings surrounding his induction to the gym, and have discussed these in detail earlier in the 'Issues' section of the report. These failings meant that he did not see a member of healthcare staff before returning to the gym and did not have a supervised exercise programme considered, as ought to have been the case.

114. In addition to the changes to the gym induction processes implemented by PESO B, we made two recommendations to the Governor to address the issues highlighted. Both were accepted by the prison. We also note that a local investigation has been commissioned at Wandsworth in relation to the man's gym induction.

Response when the man was taken ill

115. The man's foster mother asked whether the nurse should have called the doctor earlier when he was taken ill. We note that two doctors arrived at the point that CPR was started, which the clinical reviewer considers a key time due to the importance of rapid defibrillation from this moment. Nevertheless, he comments in his report that procedures should be in place to ensure that doctors attend a cardiac arrest without having to be telephoned individually.

116. In addition, the man's foster mother asked why he was not fitted with a cannula following his cardiac arrest. We note the doctor's comment in the medical record that she was unable to do so because his "veins were collapsed". We also asked the clinical reviewer for his view on this matter. He comments that a cannula is necessary following a collapse "but should not detract from the more important need of CPR and/or defibrillation".

117. The man's foster mother also asked whether adrenaline should have been used during resuscitation. She asked why he was shocked three times when he was said to be asystole (the absence of electrical heart activity) and whether the resuscitation met with Resuscitation Council guidelines. The clinical reviewer comments as follows:

> "Adrenaline is mainly given after the third shock if a shockable rhythm persists. [He] did not have a persisting [rhythm] after the third shock. Adrenaline is also given prior to shock for patients in asystole, but as he was shocked presumably he did not have asystole initially.
>
> "An automatic defibrillator … would have recommended a shock based on the identification of a shockable rhythm. Asystole is not a shockable rhythm so presumably he had [a rhythm] otherwise the machine would not have shocked. Persisting asystole was the reason the resuscitation was stopped, and presumably developed once the resuscitation had failed."

118. In addition, the clinical reviewer notes that Resuscitation Council guidelines recommend CPR with a ratio of 30 chest compressions to two breaths and early defibrillation, which was followed. He concludes that:

> "The procedures applied were consistent with national resuscitation guidelines. The basic life support that he received was appropriate and optimised his chances of survival."

119. Finally, the clinical reviewer considers whether the man's death was preventable. He concludes:

> "I do not think his death was preventable. He had a sudden, unpredictable heart attack, in the absence of a prior history of heart disease, and died of a cardiac arrest."

CONCLUSION

120. During his comparatively brief time at Wandsworth, the man experienced various shortcomings in the management of his physical and mental health. However, it is unlikely that these shortcomings were a factor in his death on 8 September. His heart attack came shortly after he had participated in vigorous exercise in the prison gymnasium and, as the clinical reviewer comments, this exercise is likely to have contributed to the subsequent events.

121. We have highlighted failings in the gym induction process at Wandsworth and the result that the man was not referred to healthcare or considered for remedial gym. In the light of his death, these procedures have been reviewed and revised. However, we have to conclude that he should have been placed on remedial gym and undertaken a supervised exercise programme. The clinical reviewer concludes that he suffered a sudden, unpredictable heart attack which could not have been prevented.

RECOMMENDATIONS

1. The Head of Healthcare should ensure there are clear protocols on when and what further action to take if abnormal examination findings, such as raised blood pressure, are identified.

   Accepted

   - *Introduction of a second day reception screening process ensures BP is recorded within 72 hours of a prisoner's admission to HMP Wandsworth. Should a prisoner present in reception on certain types of medication or with a history of hypertension the BP is taken and recorded on SystmOne prior to first night appointment with reception GP. Prisoners are referred to nurse clinic for BP monitoring as per NICE guidelines protocol.*
   - *If patient presents in reception withdrawing from drugs or alcohol, he is assessed on the withdrawal scale and commenced on the appropriate treatment or symptomatic. Healthcare is currently undertaking updates for staff on signs and symptoms of withdrawal in line with a PGD for chlordiazepoxide administration when no first night GP available (emergency situations only).*
   - *If there is an emergency situation a full set of observations similar to EWS are undertaken and based on these results clinical decisions are made on further treatment or ongoing investigations, including referral to duty GP or placement on next available GP list.*
   - *Triage and treat centre opening in April 2012 will enable patients to be more robustly monitored for ongoing care using NICE guidance and early referral to GP for treatment.*
   - *Early warning score (EWS) to be implemented for nursing staff and uploaded to the electronic clinical system, SystmOne.*

2. The head of healthcare should ensure that a medication review is held promptly on receipt of a list of medication from a community GP, particularly for those prisoners who report a chronic disease in their medical history.

   Accepted

   - *Following GP verification from the community, the duty doctor is notified and a copy of any medication is given to the pharmacy department. A copy of verification is scanned on SystmOne. If necessary an appointment is made with the duty GP in order to review the patient's medication.*
   - *On occasions, especially when patient admitted on Friday or Saturday, medications will be prescribed for a short period (two to seven days) whilst verification sought.*

3. The Head of Healthcare should ensure that record keeping by doctors is peer reviewed and audited to ensure good quality medical records.

   Accepted in principle

   - *Records need to be contemporaneous and accurate. To be discussed with Community Services Wandsworth Medical Director as to how this peer review can work in practice.*

4. The Head of Healthcare should review the referral process to the mental health in-reach team and ensure that patients are seen within the timescales specified on the referral form.

   Accepted

   - *For the time of referral to the date of assessment to be audited each quarter, to check that this falls in line with the timescale stated within the referral form.*

5. The Governor should ensure that the gym induction and healthcare referral procedures are regularly audited and that action is taken to correct any deficiencies highlighted. He should ensure that all gym inductees for whom it is appropriate are referred to healthcare and seen by a member of healthcare staff before returning to the gym.

   Accepted

   - *For any prisoners that declare any medical conditions, their PAR-Q will be kept separately and will be referred to the GP for assessment. They will not be put forward for any gym activity until written advice is received from healthcare (ERF). Remedial gym programmes will be put in place based on advice from healthcare.*
   - *The PE Senior Officer will quality check 10 per cent of remedial gym referrals to ensure this process is carried out effectively and that the remedial gym programmes for these prisoners are appropriate. If the PE Senior Officer finds any faults with the process, it is to be raised immediately with the functional head.*

6. The Governor should ensure that PAR-Q forms are collected and signed by an appropriate member of staff and not an offender health trainer.

   Accepted

   - *PAR-Q forms are now collected and signed by gym induction staff. Offender health trainers will not be involved in this element of the work. The PE Senior Officer will quality check 10 per cent of PAR-Q forms.*

7. The Governor and Head of Healthcare should ensure that the provision and location of emergency equipment on the Heathfield Unit is sufficient to enable prisoners to be treated by the response nurse as quickly as circumstances allow.

   Accepted

   - *Emergency equipment, including a heart start defibrillator and oxygen is located in the centre of the Heathfield Unit in the Trauma Room.*
   - *The emergency nurse is contactable via an emergency radio 24 hours per day, with Hotel 2 as backup should Hotel 3 be unavailable.*
   - *A dedicated Trauma/Emergency room opened on 20 January 2012 in the Heathfield Unit.*
   - *Prison have purchased five automated external defibrillators (AEDs) which will be placed in areas such as visits, centre, prison administration block, industries and Onslow Unit, for easy access to prison officers should a prisoner collapse in their area of work or H3/H2 with a patient.*

8. The Governor should ensure that the local guidance on dealing with an emergency reflects the contents of the Chief Executive Officer's letter of February 2011, and that the guidance is re-issued to all staff.

   Accepted

   - *This has been reissued to all staff as a Governor's order.*
   - *Contingency plans for dealing with such emergencies will be tested and updated.*

9. The Head of Healthcare should ensure that all healthcare staff involved in a death in custody are offered appropriate support afterwards.

   Accepted

   - *St George's Healthcare NHS Trust staff support information circular to be re-circulated to all healthcare staff.*
   - *Further liaison with Safer Prisons team to ensure that healthcare staff are included in the prison hot debrief and have access to Post Incident Care Team (PICT) services.*
   - *Staff line managers to be made aware of staff involvement in a death in custody and make personal contact with staff member within 48 hours of an incident to offer support.*