The death of a man at hospital, whilst in the custody of HMP Wandsworth, on 4 November 2007

Report by the Prisons and Probation Ombudsman for England and Wales

August 2008

This is the report of an investigation into the death of a man who died at a hospital, whilst in the custody of HMP Wandsworth. At 8.00am on 4 November 2007, the man's cell mate had reported that he was unwell. Staff responded and called for an ambulance. The ambulance staff arrived at the prison promptly and were about to take the man to the hospital when he suffered a cardiac arrest. Despite the efforts of paramedic staff and staff at the hospital to revive the man, he was pronounced dead at 9.44am. He was 48 years old. The cause of death was entirely natural.

I would like to add my personal condolences to those already expressed to the man's family on behalf of this office by one of my Family Liaison Officers.

This investigation was carried out by one of my investigators. A clinical review was undertaken by Wandsworth Primary Care Trust (PCT) for which I am most grateful. I included the clinical review as an annex to the draft report.

I would also like to take the opportunity to thank the Governor of Wandsworth, and his staff for their help and support during this investigation.

The main issue to arise from this investigation relates to delay by staff in answering the emergency cell bell that was rung by the man's cell mate. In addition, because of concerns that the man's ill health might have been brought on by use of an illicit substance, that cell mate subsequently found himself in the prison's segregation unit where an incident occurred.

I make three recommendations in my report.

Stephen Shaw CBE
Prisons and Probation Ombudsman **August 2008**

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SUMMARY

The man was convicted and sentenced to 19 months imprisonment at Southwark Crown Court on 9 October 2007. On first arrival in prison he was assessed by doctors and nursing staff and, aside from drug problems, he had very little in the way of health concerns. The man initially asked for anti-depressant medication to help him through a depressive episode after his mother's recent death. However, he was not prescribed anti-depressants, but was given support with a methadone maintenance programme for his drug addiction.

On the morning of 4 November 2007, the man got up early and started to clean his cell. According to his cellmate, this was something he used to do regularly. The man's cell mate was woken up by the sound of the man falling against the cell door. When his cell mate realised that the man was in pain (because he was clutching his chest and was struggling to breathe), he immediately summoned assistance from staff. Staff on the wing took some time to respond to the man's cellmate's call for help, but they eventually arrived. They called for nursing staff, who responded quickly.

The man started to have what appeared to be fits or seizures after the nursing staff attended and they summoned an ambulance. After some initial tests and observations, the paramedics decided to take the man to hospital.

When the paramedics and the man reached the ambulance, he suffered what was probably his fatal heart attack. Throughout the journey to the local hospital, paramedics tried to revive him using cardiac pulmonary resuscitation (CPR) and defibrillation techniques. Efforts to revive the man continued once he arrived at the hospital's emergency resuscitation unit. Sadly, at 9.44am his death was pronounced by doctors at the hospital.

Meanwhile, the man's cellmate was being supported by staff at the prison. However, there was some concern by prison staff that he might also become unwell if it turned out that the man had died from taking some illicit substance. Staff were not certain what had happened to the man and were therefore cautious in how they dealt with his cellmate.

The duty governor and the chaplain personally informed the man's wife of the death of her husband.

THE INVESTIGATION PROCESS

1. My investigator visited HMP Wandsworth on 15 November 2007. He was given access to the man's prison record and shown the wing where he was resident at the time of his death. Notices of my investigation for staff and prisoners were in evidence on the wing and at other points within the prison. One prisoner asked to see my investigator as a result of these notices. Both the local branch of the Prison Officers' Association (POA) and the Independent Monitoring Board (IMB) asked to see my investigator on this visit. The IMB raised a matter of concern that is dealt with later in this report.

2. Wandsworth Primary Care Trust (PCT) undertook a clinical review of the care the man received while in custody. The reviewer was asked to look at the entries in the man's clinical record and assess their quality. The clinical reviewer was also invited to judge whether the care the man received at HMP Wandsworth was the same as he would have expected in the community.

3. One of my Family Liaison Officers contacted the man's wife to discuss the aims of the investigation and to offer her the opportunity to raise any concerns or questions she would like addressed. On 25 January 2008, my family liaison officer and investigator visited the man's wife at her home. The man's wife said that her husband had no previous history of either cardiac problems or suffering fits. She found it difficult to accept that he would die from any such illness or conditions. The man's wife was also concerned that her husband had complained of pains in his arm prior to his collapse. There was a further concern regarding the provision of help for the funeral expenses. I hope this report provides the man's wife with answers to her questions.

4. My investigator contacted Her Majesty's Coroner to inform her of the nature and extent of my investigation and to request a copy of the Post Mortem and toxicology reports. Upon completion, a copy of my report will be sent to the Coroner to assist in her enquiries into the man's death.

HMP WANDSWORTH

5. Wandsworth is a Victorian category B local and remand prison in South West London. The prison is able to accommodate 1,644 prisoners, which makes it the largest prison in London and one of the largest in Western Europe. Although the residential areas remain in the original buildings, there has been extensive refurbishment and modernisation of the wings. In June 2008, E wing (which had been closed for refurbishment) re-opened to form part of the new first night centre. At the time of the man's death, C wing (where he was located) was the first night and induction centre and the drugs detoxification centre was located on C4 landing.

6. HM Chief Inspector of Prisons, Ms Anne Owers, conducted a follow-up inspection of Wandsworth in 2006. She noted it was an improving prison, but said it had a significant way to go. During the inspection, C wing (and in particular the detoxification service) was found to have improved its arrangements considerably. However, the Independent Monitoring Board (IMB) in their annual report for 2007 commented on the unhelpful attitude of some doctors towards their patients.

7. The man's death is one of 17 that have occurred at Wandsworth since I began investigating all deaths in prison custody in April 2004. Six of these deaths have been due to natural causes, but none of my earlier reports has any implications for the man in respect of recommendations made.

KEY FINDINGS

8. The man pleaded guilty on 3 September 2007 at West London Magistrates' Court to charges of theft. He was remanded on bail until 9 October when he was sentenced to 19 months imprisonment at Southwark Crown Court. He was sent to HMP Wandsworth.

9. When the man arrived at Wandsworth, he was seen by a nurse who took a full medical history using Wandsworth's modified initial reception screening process. The man said that he had seen a doctor recently for help with his drug misuse and was on a methadone maintenance programme. The doctor had prescribed Amitriptyline for depression and Omeprazole for problems with a duodenal ulcer (an ulcer in the lining of the first inch of the small intestine). He was seen by the prison doctor and referred to the substance misuse team. He was taken to C4 landing, which is the drugs detoxification unit.

10. When the man was seen the following day (10 October), the substance misuse team doctor prescribed a methadone maintenance programme. He was prescribed methadone 30 milligrams to be taken once a day.

11. On 12 October, the man was seen in a follow up clinic by a nurse from the substance misuse team. The nurse assessed the man as being depressed at this interview. The man said this was because he had recently lost his mother and his anti-depressant medication had been stopped when he arrived at Wandsworth. He also acknowledged that he was no longer able to take illicit drugs.

12. The assessment nurse checked with the man's doctor in the community who confirmed that he had prescribed Amitriptyline. On 17 October, the man was seen by the prison doctor. He refused to prescribe Amitriptyline, recording in the clinical notes: "Inform patient HMP Wandsworth does not do amitriptyline."

13. The same day, the man was given an Incentives and Earned Privileges (IEP) warning for his behaviour on the wing. (The IEP system is used by the Prison Service as a means of encouraging and rewarding good behaviour. There are three levels: enhanced, standard and basic.) On 22 October, he was given two further IEP warnings and moved to the basic level of the scheme. This resulted in a restriction in the privileges the man could enjoy.

14. The man was seen again in healthcare on 25 October, this time by a different doctor who referred him to the psychiatric team to asses whether he was sufficiently clinically depressed to require Amitriptyline to be prescribed.

15. The man was re-instated onto the standard level of IEP on 31 October. He had not had any further warnings about his behaviour.

16. On the morning of Sunday 4 November, the man was sharing cell C4.36 with another prisoner. The man's cellmate was woken at about 7.52am by the sound of the man stumbling around within their cell. He realised that the man had collapsed against the door of the cell. The man was clutching his left arm

and said he was short of breath. The man's cellmate helped him to sit on his bed and then summoned staff assistance by pressing the cell call bell.

17. The man started to have what the cellmate described as "a fit", which made the cellmate all the more concerned for his wellbeing. The man's cellmate started to call and shout for staff attention and continued to press the call bell. The cellmate repeatedly pressed his call bell and shouted for help from staff.

18. Staff arrived at the cell door some time after 8.00am. It is not clear exactly when, but it is believed to be approximately ten minutes after they were first summoned. The man's cellmate pressed the cell call bell for the last time at 7.59am and it is thought staff did not arrive for one or two minutes after this. That would therefore have been at approximately 8.02am. The first to arrive was a prison officer who quickly left to summon further staff to help. The prison officer went to C4 landing office and summoned assistance from two other prison officers. The three officers went to the man's cell and opened the door at approximately 8.03am, calling for nursing staff as they went (the nurses' station is close by C4 landing office).

19. The first officer into the cell asked the man what was wrong. The man said he had chest pain and was finding it difficult to breathe. The two other prison officers moved the man's cellmate outside the cell.

20. Three nurses arrived at about 8.05am, shortly after the first prison officer had entered the cell. The nursing staff suggested that the man should be put into the recovery position (lying face down with his legs slightly bent). The first nurse took the man's blood pressure and oxygen saturation levels and these were found to be normal. This nurse also asked the man if she could give him some Gaviscon for indigestion pain. The man said he did not want any.

21. Whilst nursing staff and the first prison officer were attending to the man, he started to fit, shaking all over, and looked as though he was losing consciousness. The prison officer protected the man's head during the convulsions which lasted about a minute. A second nurse tried to give the man some oxygen, but the man was so restless that he could not keep the oxygen mask on.

22. The assessment nurse left the cell to try and contact the doctor but she was unable to do so. On her return to the cell the staff decided that the man might need an ambulance. The prison control room was contacted by radio to ask for an ambulance. It was now about 8.20am.

23. The nurses asked the third prison officer to contact the control centre to give more details about the man's condition so that they could be passed on to the ambulance centre. The ambulance centre was informed at 8.21am that the patient was fitting, possibly because of substance misuse. Whilst the man was waiting for the ambulance he had a further three or four fits. Nursing staff continued to monitor his condition.

24. Other staff attended C4 landing including C wing duty manager, the emergency response nurse, and the duty governor. None of these staff had direct contact with the man, but had responsibilities for organising such matters as the staff who would accompany the man to hospital.

25. When the ambulance crew arrived at the prison at 8.27am, the C wing duty manager escorted them up to C4 landing. In interview, he recalled that a rapid response paramedic arrived first at the prison, but that almost immediately another ambulance crew arrived. They all went to C4 landing together and arrived there at approximately 8.30am.

26. The man and nursing staff gave a brief description of what had occurred since he had first become unwell that morning. Paramedic staff were concerned that the man might have taken some illicit drugs that could have been the cause of his illness. The man denied having taken anything. One of the paramedics went and asked the man's cellmate if either of them had taken any substances that might be the cause of the man being unwell. The cellmate also said that neither of them had taken anything to cause illness.

27. The paramedics put the man into a lightweight wheelchair to take him downstairs to the ambulance. On their way down the stairs the C wing duty manager told my investigator he saw the man having another fit. However, as the man was taken across the centre of the prison in the chair he appeared to be conscious according to a fourth prison officer who remembered that he said hello. The fourth and a fifth prison officer were instructed to escort the man to hospital.

28. The two prison officers that escorted the man said that when he was en route to the ambulance they applied a closeting chain (a form of handcuff) to the man and the fifth prison officer. As they arrived at the ambulance, the man had a cardiac arrest. Paramedic staff and prison staff pushed the man into the ambulance and laid him down on the trolley in the ambulance. Paramedics then proceeded with cardiac pulmonary resuscitation (CPR), applying a shock to the man's heart with a defibrillation machine. Unfortunately, when the paramedics administered the first shock, the fifth prison officer was still attached to the man by the closeting chain. He received a minor shock as a result. The officers then removed the closeting chain from the man and did not apply it again. Paramedic staff continued with their attempts at CPR all the way to the hospital.

29. On arrival at the hospital, the man was rushed into the resuscitation area. Staff at the hospital continued efforts to revive the man for a further 25 minutes, but he was pronounced dead at 9.44am by a doctor at the hospital.

30. Following the man's death, the prison chaplain and duty governor, visited the man's wife at her home to inform her of her husband's passing. They endeavoured to answer as many questions as they could at that time, and gave details of people at the prison who could act as contact points for her.

31. The funeral arrangements proved to be a little complicated as family members wanted to postpone the funeral until the man's father could attend from Jamaica. The man's wife was asked to alter the original arrangements to assist with this. This had some implications for re-imbursement of funeral expenses for the man's wife (a matter she raised with my FLO and investigator at their meeting). My investigator asked the prison to expedite dealing with this matter, and I am pleased to report that they did so.

ISSUES

Delay in responding to initial call for help

32. The main issue raised within this report is one of delay. The man's cellmate first raised the alarm for staff to attend at nine seconds before 7.53am. He again pressed the cell call bell two minutes later, and a third time four and a half minutes after that. The man's cellmate also says he banged on the door and was shouting for staff assistance in between pressing the cell call bell. It took staff approximately ten minutes to respond to the cellmate's call for help.

33. When interviewed about this delay, some staff suggested that it might have been due to their colleagues being used to "line the route" (this is when staff position themselves along a route prisoners are taking to go out on exercise). The C wing duty manager is quite clear he did not require the staff on C4 landing for that duty that morning.

34. Some members of staff informed my investigator that, when there are no discipline staff on C4 landing, there are usually nursing staff present who answer cell bells. Nursing staff confirmed they often answer bells when they are aware that it needs to be done. However, at the time the man's cellmate was pressing his cell call bell, nursing staff were having a handover in their office and there is no system that alerts them to a call bell sounding.

    The Governor should issue guidance and instructions relating to the answering of cell call bells in a timely manner.

Security and operational issues

35. The use of handcuffs for prisoners on escort to hospital has been the subject of recent case law. The Prison Service is currently drawing up new guidance in relation to this matter. Apart from the very unfortunate incident involving the fifth prison officer and the defibrillation machine, it appears that staff from Wandsworth took action with regard to the man that was not unreasonable in the circumstances. It was in line with standard Prison Service procedures to have handcuffed the man in the first instance. At the time the handcuffs were applied, the man was conscious and could have been judged to have posed a security risk on his way to hospital. However, when it became clear that the man was in serious health difficulties, the handcuffs were immediately removed. I was pleased to note that, throughout his journey to hospital, the man remained un-cuffed thereby maintaining his dignity in a time of crisis.

36. The prison's Independent Monitoring Board (a body appointed by the Secretary of State to act as public watchdogs to ensure prisoners are treated humanely and justly) raised a concern with my investigator about the man's cellmate treatment. It appears that, after the man had been taken to hospital, it was decided that the cellmate should be taken out of the cell he had been occupying with him.

37. Staff at the prison were still of the opinion that the man might have taken an illicit substance that could have been the cause of his illness. They were concerned that the man's cellmate might have taken the same substance, or that he might in some way be involved in the man's sudden ill health. With that in mind, they felt it necessary to move his cellmate to a place where he could be properly searched and kept a close eye on (they would also be able to preserve the cell for further evidence gathering should that be necessary).

38. It was decided by a second duty governor on site at this time (the first duty governor had gone to the hospital with the man), that the man's cellmate should go to the prison's segregation unit – the Care and Separation Unit (CSU). The CSU has a higher staff to prisoner ratio than other parts of the prison. The man's cellmate was taken to the CSU by the orderly officer and the C wing duty manager. Not surprisingly, despite the orderly officer and C wing duty manager trying to reassure him that he was not going to the CSU as a punishment, the man's cellmate was very unhappy about going there. When the man's cellmate arrived on the CSU he was subject to normal searching procedures for that unit, but became aggressive and had to be restrained.

39. My investigator interviewed the man's cellmate, the orderly officer and the C wing duty manager about these events. The cellmate maintains that he was still in shock from what had been going on with the man, and felt he was being unjustly treated. He could not accept that staff were also concerned for his safety, because in his mind he was not at risk – he had not taken any substances. He did not understand that staff could not believe or trust him in that. The way this and other related matters were managed has been the subject of internal enquiries by the Governor. I do not believe there is more that I can usefully contribute save to trust that the Governor has kept the man's cellmate apprised of the outcome.

Incentives and Earned Privileges

40. The man received three IEP warnings within the space of one week in October 2007 (the first on 17 October, the second and third on 22 October). This resulted in him being moved onto the basic level of the IEP scheme. This meant that he had restricted privileges whilst he remained on the basic level.

41. My investigator examined the files and reports and found that the warnings involved three separate officers and two different senior officers. Two of the warnings were issued within ten minutes of each other. Despite this, the reports indicate that the warnings were issued for appropriate reasons, in a proportionate manner, in accordance with proper procedures.

42. The system adopted at Wandsworth should have meant that these warnings would stay in force for up to 28 days. However, when the C wing duty manager reviewed the man's IEP record on 31 October, he determined that the man could be returned to standard level. He was therefore on the basic regime for only seven days. In view of the way the system was operated by

the staff at Wandsworth, I judge this to have been fair and equitable in the circumstances.

Clinical issues

43. The IMB in its 2007 annual report referred to the sometimes unhelpful attitude of some doctors in the following terms:

> *"The dismissive and unhelpful attitude of certain doctors*.
> *The Board has continued to receive complaints about the attitude of certain doctors."*

44. Since the IMB report was completed, the company Secure Healthcare has begun providing primary care services to Wandsworth.

45. When the man was seen by the prison doctor on 17 October, he refused to prescribe amitriptyline because "HMP Wandsworth does not do amitriptyline" (the prison doctor's entry in the clinical record, quoted earlier). The clinical reviewer says that, whilst it may not have been possible to prescribe amitriptyline, consideration should have been given to prescribing an alternative antidepressant.

The Medicines Management Team should review the list of approved medicines and those that could be prescribed as alternatives for use within the prison.

46. On 25 October, the man was referred to the psychiatric team to establish whether a prescription of amitriptyline was appropriate. The man was not seen by the psychiatric team before his death. However, the care the man received for his substance misuse problems was generally good and the provision of methadone for maintenance or drug withdrawing problems was in line with national guidelines for substance misuse services.

47. The clinical reviewer makes the point that it is beneficial to ensure that all members of staff have their resuscitation skills maintained and kept up to date. Although the lack of resuscitation skills was not an issue in the man's care, it is something that I am all too familiar with as regards other death in custody investigations. However, I do not make any formal recommendation in this respect on this occasion.

48. The clinical reviewer also says that it would have been preferable if the nursing staff had contacted the ambulance service straightaway, rather than trying the out of hours service. Although the clinical reviewer makes no formal recommendation on this matter, I feel it appropriate to do so.

The chest pain protocol should be reviewed by Secure Healthcare to ensure it provides appropriate guidance for staff who are assessing patients presenting with severe chest pain symptoms.

Conclusion

49. Both the clinical review and the post mortem report make the point that there was probably nothing that could have been done to have prevented the man's death. Unfortunately, as the pathologist, says:

> *"The clinical features of chest pain followed by seizures accords with the pathological findings. Individuals with such critically occluded coronary arteries are at risk of sudden and unexpected death as a consequence of an ischaemically generated arrhythmia. It should be noted that sudden death may represent the first presenting feature of coronary heart disease."*

The pathologist goes on to say:

> "*This is a natural death that could have occurred at any time."*

RECOMMENDATIONS

The following recommendations were made in the draft version of the report. The Prison Service's responses are included in italics following each recommendation.

- **The Governor should issue guidance and instructions relating to the answering of cell call bells in a timely manner.**

  Recommendation accepted: A Governor's Order has been issued.

- **The Medicines Management Team should review the list of approved medicines and those that could be prescribed as alternatives for use within the prison.**

  Recommendation accepted: The Medicines Management Team (MMT) reviewed the list of approved medicines and clinicians have a choice of both SSRI [Selective Serotonin Re-uptake Inhibitors] and TCA [TriCyclic Antidepressant] medication to prescribe as anti-depressants.

- **The chest pain protocol should be reviewed to ensure it provides appropriate guidance for staff who are assessing patients presenting with severe chest pain symptoms.**

  Recommendation accepted: All nurses within Secure Healthcare are trained annually in emergency response, basic life support, and CPR. In addition, our specific response to presentations of chest pain is currently being reviewed with our colleagues in both the prison and Wandsworth PCT.