

**Investigation into the circumstances surrounding the
death of a man
on 21 November 2010, at St George's Hospital,
whilst in the custody of HMP Wandsworth**

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

July 2011

This is the report of an investigation into the death of a prisoner at HMP Wandsworth, who died aged 64 on 21 November 2010 at St George's Hospital.

My colleague conducted the investigation, assisted by another colleague. I would like to thank the Governor of Wandsworth and his staff for their co-operation and assistance with the investigation.

One of my family liaison officers contacted the man's family to inform them of our investigation and give them with the opportunity to raise any issues about the care that the man received whilst in custody. I would like to offer my condolences to the man's family and friends for their loss.

Wandsworth Primary Care Trust (PCT) was asked to review the standard of healthcare given to the man while he was in custody. A clinical reviewer was commissioned to conduct the review and his report is attached in full at the first annex.

The man suffered from problems with his heart for a long time. When he came into prison in 2006, he was aware of his condition, but was still in reasonable health. However, his health declined over the years and, by the summer of 2010, he had undertaken frequent trips to hospital for treatment. He was told in June 2010, that his condition was no longer treatable and he had only a matter of months to live. He went back to prison, where he lived in the healthcare unit. He was allowed extended visits from his family. He would sometimes refuse treatment, although he seems to have got on well with members of the healthcare staff.

The man's partner was content with the care provided to the man and, although his sister raised a number of issues, the clinical reviewer has not identified any gaps in the clinical care given by the prison. The man was a patient in Wandsworth's healthcare centre for nearly six months and, while I accept that there may have been times when the care could have been improved, I am satisfied that overall it was of a good standard. Indeed, it is clear from my investigation that staff and prisoners liked the man and formed a good rapport with him. I make no recommendations in this report and highlight the good practice of inviting the family to healthcare meetings and appointing a family liaison officer when the man's condition was diagnosed as terminal. I believe that individualised and flexible arrangements were made to look after the man and maintain his quality of life, such as allowing other prisoners to visit him when he was in healthcare.

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SUMMARY

1. The man was born on 11 August 1946. He had been in prison a number of times before he came to Wandsworth in 2006. When he arrived at the prison on the last occasion, the man had suffered from heart problems for a number of years, but was still in reasonable health.
2. The man initially lived in the main prison wings but, as his health worsened, he spent more time in hospital for treatment for heart failure. During his stay in hospital in June 2010, the man's condition was assessed as no longer treatable. The hospital told the prison that the man's life expectancy was only months, rather than years.
3. When the man returned from hospital in June, he was admitted to the prison's healthcare unit. The Governor agreed to vary the usual security arrangements and leave his cell door open 24 hours a day, assigning an officer to sit outside the cell as a security measure. The prison appointed a family liaison officer in June. The man's family were authorised to have extra visits, which were also longer than usual.
4. Heart failure can cause fluid to build up in the body, and the man was prescribed medication to try to expel it. However, this was not always effective and the man frequently had to return to hospital for treatment with a more powerful diuretic. He preferred being in prison because he felt he had more freedom as he was not restrained, and was able to smoke. (Prisoners are risk assessed before going to hospital, and are usually restrained by handcuffs or an escort chain between themselves and the bed watch officer.) The man did not always cooperate with his treatment and would sometimes remove the tubes inserted into his body. He was advised to restrict the amount which he drank, but would drink without telling staff, which affected their ability to measure his fluid intake. He seems to have found the treatment tedious and, as the clinical reviewer describes, became "fed up" with the restrictions which it placed on him.
5. The man was twice subject to applications for release from prison on compassionate grounds, but both applications were turned down. His health continued to decline and, on 19 November, the man left Wandsworth to go to hospital for the last time. His family were informed and spent time with him before he died two days later.
6. The investigation and clinical review have found that the man's care was thorough and appropriate. No issues have been identified and, accordingly, no recommendations are made as a result of this investigation.

THE INVESTIGATION PROCESS

7. My colleague undertook the investigation on my behalf, assisted by another colleague. Notices informing both staff and prisoners of the investigation were issued on 22 November 2010. They invited anyone who had information about the man's death to contact the investigator. One prisoner responded and was interviewed by the investigation team.
8. The investigator visited HMP Wandsworth to open the investigation at the prison on 24 November 2010. He visited the wings and healthcare centre and collected the paperwork relating to the man.
9. The investigator and his colleague visited HMP Wandsworth to interview staff on 1 and 25 March 2011. Another investigator interviewed a prisoner on 4 April 2011.
10. Wandsworth Primary Care Trust (PCT) was commissioned to conduct a review of the medical care that the man received in custody. The PCT asked the clinical reviewer to conduct this review. I would like to thank the clinical reviewer for his report.
11. Wandsworth provided the investigator with details of the man's next of kin. One of my family liaison officers (FLO) contacted the man's partner who was satisfied with the care provided, and his sister who raised a number of issues. In particular, the man's sister criticised his diet in prison and commented that he lost weight in hospital. I have endeavoured to address her concerns in my report.
12. My investigation assesses the following aspects of the man's care and treatment:
 - Whether his diagnosis was made in a timely fashion?
 - Whether the man was told about his condition and the treatment which followed?
 - Whether he was treated properly and attended hospital appointments as necessary?
 - Whether the liaison with the man's family was appropriate?
 - Whether the man was accommodated in the most appropriate part of the prison?
 - Whether consideration was given to compassionate release from prison?
 - Whether appropriate palliative care was provided?

HMP WANDSWORTH

13. HMP Wandsworth is a local prison in South London. It has the capacity to hold up to 1,644 sentenced or remand adult males. The prison has two main areas, Heathfield that comprises five separate wings and the Onslow unit which houses vulnerable prisoners. In addition, there is a new healthcare unit with in-patient facilities, called the Jones Unit, which was opened in summer 2010, where the man lived towards the end of his life. The healthcare team is employed by NHS Wandsworth. While the Jones Unit was able to provide in-patient facilities, it does not have access to all the treatments available in hospital. When prisoners become too ill, they are transferred to an outside hospital.

Escort, restraints and bedwatch

14. If a prisoner is admitted to outside hospital, depending on the risk assessment carried out by the prison, they will generally be escorted by two officers who will stay beside their bed at all times. The prisoner may be handcuffed whilst in bed. This is usually done by means of an escort chain, (formerly known as a closeting chain), which allows the prisoner to be attached to a member of staff. The chain is not supposed to be attached to a bed (even though prisoners sometimes ask for this to be done for ease of movement) due to the risk of fire, should the key be lost.
15. Two or three daily shifts of officers will stay with the prisoner until treatment is completed. However, depending on the circumstances, the bed watch may be withdrawn if the prisoner is terminally ill or nearing the end of a sentence. Conversely, the number of staff may be increased if the risk assessment warrants it. A history, recorded by escort officers, of time and events which take place while a prisoner is out of the prison as an inpatient at hospital.

Independent Monitoring Board (IMB)

16. Each prison has its own IMB made up of volunteers from the community. The Board's role is to ensure that the prison is properly run and that prisoners are treated decently. Each Board produces an annual report for the Secretary of State. In its report, focussing on the time period June 2009 to May 2010, Wandsworth IMB wrote that healthcare was an area that had caused the Board particular concern. The report noted that, in September 2009, the healthcare provider's organisation went into receivership, and Community Services Wandsworth (which is part of the National Health Service) took over the role to ensure smooth continuity in services.
17. The IMB noted that waiting times for healthcare appointments were variable and on occasions unacceptably long due to high demand. Planned initiatives, such as clinics for long-term conditions, were beginning to be put into place but progress was slow. The report acknowledged that a lack of information regarding hospital appointments (especially those that were cancelled) is a particular source of frustration and concern to prisoners. However, the report said that senior nurses have been pivotal in maintaining standards of care and

have responded promptly and professionally to emergencies. It also noted that there had been relatively few complaints about the care received by prisoners.

Her Majesty's Chief Inspector of Prisons

18. Her Majesty's Chief Inspector of Prisons last inspected Wandsworth from 1 to 5 June 2009. The inspection report highlighted the lack of inpatient facilities for prisoners with physical illnesses, and a recommendation was made regarding opening an inpatient unit. This was subsequently resolved by opening the Jones Unit.

Previous deaths at Wandsworth

19. Wandsworth experienced five deaths from natural causes in 2010, not including the death of the man. In one of these cases, the prisoner also had a history of heart illness before coming into prison.

ISSUES

Diagnosing the man's terminal illness

20. The man had a history of heart problems. He suffered a heart attack in 1992 and underwent a triple heart bypass operation in 2004. When the man was remanded into custody in 2006, he was in reasonable health and lived on a regular prison wing, although his medical history was noted.
21. In July 2008, the man underwent an operation to treat an atrial flutter (abnormal heart rhythm). On 31 January 2009, the man was admitted to Royal Brompton Hospital for a CRT-D device to be implanted under sedation. (A CRT-D device or pace-maker treats certain types of heart failures by re-synchronising the blood flow of the heart.)
22. The man received a letter from Royal Brompton Hospital in May 2009, diagnosing him with congestive heart failure (when the heart is unable to supply sufficient blood flow to the body). He deteriorated in the first half of 2010, requiring frequent visits to St George's Hospital to drain the fluid retained in his body due to his heart failure.
23. Following one such visit in June 2010, a doctor wrote to the Governor of Wandsworth explaining that the man was suffering from severe heart failure:

"This is something we expect to happen on a regular basis and it is difficult to imagine that he will survive many more of these events."

He later commented "I can say that his prognosis is extremely poor and should be measured in months and not years."

24. The man had been ill for a long time, and the clinical reviewer writes in his clinical review that "Sadly it is usual for heart failure to result in slow deterioration over a number of months." The man's condition was known about for a number of years, it was noted on his arrival to prison, and neither myself nor the clinical reviewer find anything inappropriate regarding the diagnosis that the man was suffering from a terminal illness.

Informing the man about his condition and treatment

25. The man had suffered problems with his heart for many years, and he was aware of his condition before he came into prison. Following the doctors that he was suffering from a terminal illness, a multidisciplinary meeting took place with the man, members of his family, healthcare staff from the prison and hospital to discuss his care. At this meeting, the cardiologist repeated to the man's family that he had months rather than years left to live. It was jointly decided to return the man to HMP Wandsworth.

26. The clinical reviewer comments on how the man was informed of his condition:
- “The hospital and prison health teams looking after the man appear to have been conscientious and explained that sadly his heart failure was not reversible.”
27. The multidisciplinary meeting used to explain the situation to the man and his family, was a sensible approach that ensured that all parties were able to ask whatever questions of healthcare professionals they may have had. It is clear that the man was aware of his condition and prognosis, and I find no fault by the prison in this regard. Including his family in the discussions is by no means routine in prison and it was an example of good practice by the prison and healthcare staff.

Medical appointments and treatment of the man

Appointments

28. The man suffered ongoing problems relating to his heart which required numerous appointments at St George’s Hospital. In March 2009, the man’s partner wrote to the Governor to complain that he had missed some of these appointments. The prison acknowledged that the man had missed a number of appointments and, in attempt to rectify this, healthcare staff met with the General Manager for Central Bookings at St George’s Hospital. They discussed some of the difficulties the prison had with the appointment system and developed a new system where the hospital would contact the healthcare department directly. This appeared to work well in managing some of the problems. There were still some problems relating to the cardiology clinic but the prison attempted to set up a similar meeting to try to improve this as well. I am satisfied that the healthcare manager took reasonable steps to try to avoid further problems and that the man had satisfactory access to the specialist hospital resources.

Liaison with the hospital

29. During interview, a nurse explained to my investigators that the communication with the hospital was very good and the prison and hospital staff spoke on the telephone daily. The doctor at the hospital’s mobile telephone number was made available to staff on the Jones Unit and the doctor visited the man in prison after he was discharged from hospital.
30. Multidisciplinary meetings were set up and on 2 July, it was decided that, as the man was stable, he should be returned to Wandsworth. (He had been in hospital since 23 June.) It was also agreed that the Charge Nurse from the hospital should be informed each week about the man’s condition, and he arranged to visit him every month. Arrangements were made so that, if the man required re-admission to hospital, he could go directly to the ward rather than through the Accident and Emergency department.

31. The clinical reviewer comments positively on the communication between the prison and the hospital:

“I note the prison team liaised with the doctor at the hospital and together they discussed how best to help the man. At the point when the treatment that he needed was not available at the prison he was admitted to St George’s Hospital.”

32. I endorse this view, and am pleased to see the level of contact between the prison and hospital, which ensured that the man received the appropriate continuity of care.

Treatment

33. The man’s heart failure meant that his body was unable to sufficiently expel fluid. This led to swelling as the fluid built up in his body, particularly in his legs. The man was prescribed Furosemide (a diuretic drug to reduce fluid retention). When the Furosemide became less effective, the man was transferred to hospital, where a more aggressive diuretic was used. The clinical reviewer explains this further in his clinical review:

“As heart failure deteriorates the kidneys become less able to respond to diuretics such as Furosemide, even in high intravenous doses and the side effects of low blood pressure and electrolyte imbalance (eg Sodium and Potassium) can become disabling increasing the risks of confusion and falls.”

34. The man’s sister was concerned that her brother did not receive appropriate care in prison and that his weight loss in hospital proves this. The clinical reviewer explains that the hospital had access to stronger treatment than the prison:

“The overall weight of patients with heart failure will vary quite dramatically depending on the level of fluid retention. I note that his weight decreased by 10kg during one admission and this would have been caused by hospital use of intensive diuretic treatment to force the kidneys to excrete excess fluid.”

35. The clinical reviewer points out that it is usual to try to minimise the time that a patient spends in hospital. He also explains that the level of care available in the prison was greater than what would have been available to the man if he had been living in the community:

“The responsible medical team aims to balance these risks and in general this is routinely managed in the community with occasional admissions if specific medical interventions are needed that are not available to GPs. It is normally considered appropriate to minimise the time patients stay in an acute ward in a hospital environment and the prison was able to provide nursing cover on site which would not normally be available in a community setting.”

36. In the last few weeks of his life, the man would sometimes refuse to be cannulated (have tubes inserted into his body) which made administering the Furosemide more difficult. The man also had blood samples taken daily to check on his health. As blood was taken every day, the nurse explained that his veins were increasingly hard to find, which would have been uncomfortable for the man.
37. The investigation team spoke to another prisoner who spent time with the man on the Jones Unit in summer 2010. He described the nurse as “very professional, dedicated, caring, efficient and unique”, and explained that the man got on very well with her. He said that the man came to depend on her, and she was available whenever he wanted to talk.

Fluid restrictions

38. The man was supposed to restrict the amount which he drank to between 800 and 1000 millilitres of fluid per day, depending on his weight. As well, the amount of fluid eliminated by urination was measured. However, the nurse said that the man often did not adhere to his fluid restrictions. He often helped himself to water from the tap and urinated into the toilet. She said that the man’s visitors often gave him more fluid than he was allowed and he used the toilet without telling staff, which made it difficult to monitor the fluids. This meant the staff could not correctly monitor the man’s fluid consumption and elimination. Although the dangers of drinking excessively were explained, the man told staff that he did not care about them.
39. The clinical reviewer writes of the man’s struggle to comply with his treatment:

“His last illness seems to have been very frustrating for the man and the notes record for example on 11th October that he was fed up and not complying with fluid restriction, helping himself to water from the tap. He did not want to ‘have needles stuck in him and he wanted to take what he wanted when he wanted it’. This is clearly understandable given his illness but the difficulties with agreeing a shared management plan between the staff and the man may well have worsened his prognosis.”

Diet

40. The man's sister told my family liaison officer that she did not believe that her brother was fed appropriately while he was in prison. The nurse said that the hospital recommended that he should have a high protein diet. Arrangements were made with the kitchen to provide additional eggs, tomatoes and bacon. He often bought food from the prisoners' store and also had nutrient supplements. As the man had a poor appetite, the nurse said that healthcare staff tried to obtain the food which he wanted, for example, he had a love of sea food and so they brought in tubs of roll mops. They also made ice lollies on the unit. The nurse said that instead of being given the usual three meals a day, healthcare staff tried to feed him "little and often" due to his low appetite. The clinical reviewer writes of the efforts made by the prison to provide the man with an appropriate diet:

"His dietary intake was carefully monitored and at times food supplements were used. The man's appetite was poor and I think this related to the severity of his heart failure. Unfortunately food supplements such as fortisip and forticreme do not significantly help the prognosis and can be rather unpalatable but it is good practice to consider their use."

41. I understand the man's sister's concerns about his diet but, after consideration of the evidence, I conclude that every effort was made to provide an appropriate diet. I think that healthcare staff were flexible and imaginative, making every effort to encourage the man to eat, without being limited by the constrictions of the prison's regime.
42. The clinical reviewer write of the overall treatment provided to the man in Wandsworth:

"The notes record frequent and appropriate review of his care and attempts of staff to negotiate with the man to try and help him accept nursing and medical care. His deterioration, whilst inevitable, was very distressing and I consider that the health team at the prison provided care that was thorough in difficult circumstances."

43. I concur with this view, and note the efforts made by staff to make the man feel more comfortable.

The man's pain relief and medication

44. During interview, the nurse explained that the man only experienced pain in his legs, which was due to the water retention, (his legs were heavy and swollen). Prison healthcare staff massaged his legs and he was prescribed the painkiller paracetamol but got more relief from the massage.
45. The man was provided with a specialist pressure relieving mattress when he was in the Jones Unit. It was most effective with the least amount of layers in

between, and so the man often wore pyjamas or just a t-shirt. As I have said, the clinical reviewer considers that the care provided was appropriate.

46. The man's sister said that her brother was given sleeping pills by the prison. The clinical reviewer writes in his clinical review:

"I note the man did not sleep well and his medication list when he was discharged from St Georges in August 2010 included a sleeping tablet, temazepam. I note in prison he was taking zopiclone which is now usually considered to be preferable to temazepam, and I note that the dose of zopiclone was halved on 2.10.10 as he became more unwell from heart failure. This seems to have been an appropriate decision as all sleeping tablets can be associated with drowsiness or confusion. "

47. The clinical reviewer is satisfied that the appropriate medication was prescribed to relieve the man's pain and help him sleep at night.

Liaison with the man's family

48. A Governor was appointed as the prison's family liaison officer (FLO) on 28 June. It is worth explaining that prisons are only required to appoint a FLO after a death in custody. Appointing the FLO when a prisoner is diagnosed with a terminal illness is another example of good practice which is by no means universal across the prison estate. The Governor's role included visiting the man and his family and managing their visits. The Governor arranged the multidisciplinary meeting that took place on Friday 2 July and invited the man's family to be there. They discussed the application for compassionate release, prison location and the use of restraints.
49. On 5 August, a meeting took place about a complaint raised by the man's partner about the Governor. It was agreed that the Governor would no longer liaise with the family and another Family liaison Officer was appointed instead five days later on 10 August. The Family Liaison officer checked with the man regarding his next of kin details. On 16 August, the Family Liaison Officer authorised that the man's partner could visit him in his cell, instead of the usual visits hall, as his health had deteriorated. There is a mention in his medical record on 24 September that visits from the man's family should take place on the Jones Unit, rather than in the prison visits centre.
50. The man's friends from the wing were also allowed to visit him on the Jones Unit. Again, I should explain that this is unusual as prisoners are generally confined to their own wing and work place within the prison. The man's sister and partner both had a direct telephone number to the Jones Unit, and were able to call frequently to speak to staff about his care. His sister and partner visited the man on alternate days. They were allowed more visits than would normally be allowed, and were able to spend time with the man in his cell. They were also able to bring DVDs and food in for the man. All of these arrangements exceed the usual arrangements for visiting prisoners.

51. At 10.25am on 21 November, the man was in hospital when his health declined further. He was resuscitated at 11.45am, but the prison staff on bedwatch was told he would not survive for much longer. At 12.15pm the prison chaplain was informed and he told the man's family who began to make their way to the hospital. The man died at 12.45pm. Unfortunately, his family were not yet at his bedside.
52. The prison was represented at the funeral by two Prison Advice & Care Trust (PACT) workers. (PACT is a charity that supports prisoners and their families.) The funeral was paid for by the prison and his property was returned to his partner.
53. I am pleased to hear of the support offered to the man's family and the ways in which they were included in decisions about his treatment. They were invited to multi disciplinary meetings as soon as his condition was diagnosed as terminal. Appointing a family liaison officer as early as Wandsworth did is admirable, as it gives the family a consistent point of contact during a difficult time. I also note the willingness of the prison to change the FLO in order to best meet the man's family's wishes. Allowing extra visits in the man's cell is another example of the extra support granted to him and his family during his illness. In my experience, the arrangements made for the man and his family were generous, thoughtful and imaginative.

The man's location within the prison

54. The Family Liaison Officer told my investigation team that the man was the wing orderly (a prisoner trusted to do a prison job) on the first night centre, when he first arrived at Wandsworth and he was in reasonable health. The man used to live on C wing and then moved to E wing. However, in June 2010, it became necessary for him to be admitted as an inpatient in the Jones Unit. The man sometimes changed his mind about where he preferred to be. This indecisiveness continued throughout his time in custody and he sometimes expressed a desire to be in hospital while he was in prison, and in prison when he was in the hospital.
55. The nurse said that, when the man was ready to return to prison from hospital in June 2010, she told the Governor that it would be necessary for the man's cell door in healthcare to remain open in order to give the appropriate level of nursing care. The Governor agreed to allow the man's cell door to remain open 24 hours a day, provided that a prison officer was stationed outside the door at all times. The officer's role was to ensure the security of the prison which is normally achieved by locking cell doors. I recognise that employing a member of staff in this way would have been a very expensive use of the prison's limited resources.
56. However, the man's sister was concerned that the officer outside of the cell was sometimes unhelpful, and did not respond to her brother's care needs. The nurse explained to my investigation team that the officer was there purely as a security measure, not as an auxiliary member of the healthcare staff. She described the officers as very helpful and said that they often assisted the man

with his mobility. She pointed out that, due to their lack of training in personal care, for example, lifting, it would have been inappropriate for them to engage in certain activities. The officers did not have the necessary skills to deliver care.

57. The man's cell was next to the nurse's office. This was deliberately arranged for ease of access with healthcare staff as the man often called for attention. I understand that the man sometimes fell because he would not wait for staff to help him. The risk of falls increased as he became more ill, and the issue was included on his care plan. When the man fell in October, staff informed his partner.
58. The man was provided with a pressure-relieving mattress to aid his comfort. The prisoner interviewed by the investigation team said that staff did not always respond immediately to the man's calls, but said that this was not a frequent occurrence. The nurse told my investigator that delays might be because staff were looking after other patients when the man needed their help.
59. The man's sister was concerned that the decision to discharge her brother from the hospital was made by the prison and that it was against his best interests. The clinical reviewer explains that the decision to discharge the man from hospital could only have been made by the hospital:

"The clinical decision to discharge a patient home is taken by the hospital team rather than the GP or prison health team, but with a clear understanding that patients can be re-admitted if needed. I note the prison team liaised with the doctor at the hospital and together they discussed how best to help the man. At the point when the treatment that he needed was not available at the prison he was admitted to St George's Hospital."

60. The man told staff that he enjoyed being in his prison cell as he was able to smoke and move around. He stayed where he felt most comfortable for as long as he could. I recognise the efforts to involve him in the decision about where he was located and to continue to treat him in prison accordingly. In my view, the man was located in the most appropriate part of the prison and that the usual healthcare routine was varied to meet his particular needs.

Compassionate release

61. Prisoners who are suffering from a terminal illness and for whom death is thought likely to be imminent can be released from prison early on compassionate grounds. An application must be sent to the Public Protection Unit in the National Offender Management Service headquarters in London. The application form includes sections to be completed by the Governor, a prison doctor and an offender manager. A full prognosis must also be provided. Once the form is submitted, caseworkers in the Public Protection Unit determine whether the application meets the criteria set out in Prison Service Order (PSO) 6000 (the instruction that deals with the release and recall of prisoners). In making this decision, they consult with the Parole Board and specialist medical advisors in the Department of Health. PSO 6000 states:

“The criteria applied in medical and tragic family circumstances cases are as follows:

(i) Medical

- the prisoner is suffering from a terminal illness and death is likely to occur soon; or the prisoner is bedridden or similarly incapacitated; and
- the risk of re-offending is past; and
- there are adequate arrangements for the prisoner's care and treatment outside prison; and
- early release will bring some significant benefit to the prisoner or his/her family.”

62. The nurse recalled that she took the letter of prognosis to the Governing Governor personally to start the compassionate release process in summer 2010. The Governor did not endorse the man's application. The nurse said that she and the man had daily conversations about compassionate release.

63. On 18 August, a letter was received by the Governor from the Ministry of Justice explaining the man's application for compassionate release had been refused. The reasons given were because of a failure to comply with licence conditions (The man had absconded previously in 1993). Attention was also drawn to the fact that in June and July 2010, the man had threatened staff if his application for compassionate release was unsuccessful. The letter acknowledged the man's illness, his inability to walk short distances and noted that his application had not been endorsed by the Governor of Wandsworth. The Family Liaison Officer went to speak to the man following this initial rejection. The governor thought that the man had accepted his application may get rejected, but was still upset by the decision.

64. A second application for compassionate release was initiated by the Governor in autumn 2010, due to the man's decline in health. However, the Ministry of Justice wrote to the Governor on 27 October to inform him that the man's second application for compassionate release had also been turned down. In the letter, attention was drawn to the man being found in hospital with a mobile

telephone, which was against the prison rules. The letter said that the Secretary of State was concerned that this indicated a disregard for prison rules. Attention was also drawn to his previous threat if he did not obtain compassionate release, and his history of absconding.

65. On 28 October, another Governor visited the man to tell him that his second application for compassionate release had also been refused. The man appeared disheartened after the second refusal. The nurse sat with the man once he found out about his application as he appeared quite upset by the news.
66. It is clear to me that the prison assisted the man in his attempts to achieve compassionate release and ensured that he received the Secretary of State's decision as soon as possible. I find no fault in this regard and welcome the support offered by prison and healthcare staff to the man and his family after his applications were turned down.

Palliative care plans

67. The man was referred for palliative care once he was diagnosed as suffering from a terminal illness in June 2010. However, it was not deemed appropriate at that time and the man's palliative care only began when he went into hospital for the last time. As noted earlier, The clinical reviewer wrote in his clinical review:

"His deterioration, whilst inevitable, was very distressing and I consider that the health team at the prison provided care that was thorough in difficult circumstances."

Restraints, security and bed watch

68. In August 2010, when the man was receiving treatment in hospital, his health declined, and staff thought that he was nearing the end of his life. To preserve his dignity and allow the family some time alone, the three officers carrying out the bedwatch duty retired to a side room and the restraints were removed. The man's condition subsequently improved and so the security procedures were reviewed. The officers came back into the room and the security processes were put back into place until the man was well enough to return to prison.
69. On 19 November at 4.30pm, the man left the prison by ambulance. The Governor responsible for the risk assessment authorised that the man should leave the prison without restraints owing to his poor health condition, although two officers accompanied him on bedwatch duty. The man was not restrained at any point from then on until he died two days later. The man's sister was concerned that the restraints used were too tight and may have harmed the man when his arms swelled. My investigator was told by the prison that a separate risk assessment was completed each time the man left the prison which considered all relevant issues. When the man reached the end of his life and his condition worsened, the restraints were removed. I consider that the level of restraints was the least restrictive consistent with the prison's duty to

protect the public. The man's privacy and dignity were promoted by removing the restraints as he reached the end of his life.

The man's family's concerns

70. My Family Liaison Officer spoke with the man's family, who had differing views on the care provided to him. The man's partner described the care as admirable, and particularly praised the work of the nurse and Family Liaison Officer. However, the man's sister was unhappy with her brother's care, and raised the following additional concerns.

The decision to transfer the man to hospital

71. The man was transferred to hospital on 19 November. However, the man's sister told my family liaison officer that she asked healthcare staff whether he should be admitted to hospital on the Tuesday of that week (16 November). My investigator asked the prison for further documentation relating to the week before the man went into hospital. He had not received it at the time of issuing this draft. Although my investigator has not seen any evidence of this conversation, I trust that family concerns are considered and recorded appropriately.

Nebuliser

72. The man's sister said that there was no nebuliser available for the man. (A nebuliser is a device used to administer medication in the form of a mist inhaled into the lungs.) My investigator spoke to the prison who said that there was one on the Jones Unit, and the man used it on a number of occasions. I am unable to definitively determine whether one was always available, and I am sure the Head of Healthcare will wish to satisfy themselves that the appropriate devices are available on the unit.

The man's clothing

73. The man's sister told my family liaison officer that her brother's prison clothing was too tight. The nurse explained to my investigators that the swelling caused by the fluid build-up could make the man's clothes tight. She said that staff would try to help by amending the clothes to fit him. They would dress the man in the manner in which he felt most comfortable. The nurse said that the pressure relieving mattress that the man was given was most effective with the least amount of layers in between, and so the man often just wore pyjamas.
74. The man's sister also said that her brother was occasionally left naked. The nurse said that the man would have been undressed when he was being washed by healthcare staff, but she denied that he was ever left naked without an appropriate reason. Unfortunately, I am unable to ascertain whether this happened, but would remind the prison of the importance of maintaining the dignity of prisoners at all times but especially when their clothing is removed for any reason.

The facilities in the man's cell

75. The man's sister said that the toilet in her brother's cell was broken and the nurse confirmed that the seat was broken at one point. The prison's works department were informed and they fixed it. The nurse said that the man had been offered a different cell, but he preferred to stay where he was as he liked the view of the garden. Additionally the cell was adjacent to the office and so staff were within easier reach.
76. The man's sister also said that the radiator in her brother's cell did not work properly. When my investigator spoke to the nurse, she said that all the radiators in the Jones Unit broke for a while, but this was fixed by the works department. In the mean time, the nurse obtained a large fan heater for the man and provided extra blankets to keep him warm.
77. Thirdly, the man's sister said that panic button in the man's cell was too high, and the position made it difficult for him to use. The nurse explained that the position of the panic buttons is standard in all the cells. However the man's cell was next to the nurses' office and an officer was outside the cell at all times. My investigator visited the man's cell and ascertained that staff would have been able to hear any calls for assistance.
78. I understand that it may be difficult for relatives to see their relative dying in prison, especially as there is little that they can do to provide direct help and assistance. The prisoner is necessarily constrained by the prison rules and the prison regime. I believe that the man's sister has legitimate concerns. However, I hope that she is reassured that staff made suitable efforts to alleviate any problems with the facilities in her brother's cell. From what I have heard, repairs were made, alternative equipment was given and he could have moved to a different cell.

CONCLUSION

79. The man gradually declined in health until the summer of 2010 when he became significantly unwell, and was told that he was dying. The clinical reviewer writes:

“In summary, I consider that the care the man received during his time at Wandsworth Prison was reasonable and appropriate. He had a long history of cardiovascular and respiratory illness and it is clear that the very sad illness leading up to the death of the man was very distressing for him and for his family.”

80. I am satisfied that the man received good care from both the prison and hospital and endorse the view of the clinical reviewer. I appreciate that some of his relatives have concerns about his care and I hope that they are reassured by my findings. I believe that many arrangements were made to meet his specific needs and that there were several examples of good practice. Caring for dying prisoners in a local prison presents a particular challenge to healthcare staff, officers and Governors. In my experience, the care helped to make the man comfortable as he reached the end of his life.