Investigation into the circumstances surrounding the death of a man in December 2010 at HMP Wandsworth

Report by the Prisons and Probation Ombudsman for England and Wales

March 2012

This is the report of an investigation into the circumstances of the death of a man who died on 1 December 2010. He was 43 years old. I extend my sincere condolences to his family and friends.

The investigation was led on my behalf by a senior investigator, assisted by another investigator. I apologise for the delay in issuing this report.

The man had a history of cardiac problems for which he had received treatment in the community and during his time in prison. He had been in prison for a little under two months when he was found unresponsive in bed in his cell. Efforts to resuscitate him by prison nursing staff and paramedics were unsuccessful. A post mortem examination concluded that the causes of the man's death were hypertrophic obstructive cardiomyopathy (HOCM), a condition which causes the heart muscle to thicken and cardiac sarcoidosis, an inflammatory disease that can severely affect heart function.

A review of the man's healthcare at Wandsworth was commissioned by Wandsworth Teaching Primary Care Trust. I am grateful to the clinical reviewer for carrying this out.

I would like to thank the Governor of Wandsworth and his staff for their co-operation. I am particularly grateful to the investigation liaison officer for his effective liaison with my office.

One of my family liaison officers contacted the man's nominated next of kin to explain the investigation process and learn of issues they wished to raise. In October 2011, our office was contacted by other members of the man's family who have commented on the draft version of this report. I am very grateful to them for taking the time to consider the contents. Some amendments have been made in light of their comments. Amendments have also been made following the National Offender Management Service's response to the draft report.

My investigation has found that the man's death was unforeseeable and Wandsworth's actions to address his health needs were reasonable and appropriate. Although I make no recommendations, this report considers issues particularly relating to effective communication with families.

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.

Thea Walton
Acting Deputy Ombudsman **March 2012**

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SUMMARY

1. The man was arrested in 2006 for an offence of offering a bribe. Released on bail, he did not attend court for his trial and was sentenced in his absence to 18 months imprisonment in 2008. When he returned to the United Kingdom from Lebanon in October 2010, his sentence was confirmed and he was taken to HMP Wandsworth.

2. On his arrival at Wandsworth, he told a nurse that he had a history of heart problems and strokes. He also said that he had suffered with mental health problems in the past and had tried to harm himself.

3. Wandsworth obtained his community medical records. They confirmed that he had a history of left ventricular hypertrophy (LVH) and hypertrophic obstructive cardiomyopathy (HOCM), both of which cause the thickening of the heart muscle in parts. HOCM is a significant cause of sudden, unexpected cardiac death in adults. The man was assessed by a prison doctor who prescribed a number of medications.

4. The man told the nurse that he was feeling anxious. She made a referral to the Primary Care Mental Health Team on his behalf. He described feeling particularly anxious when locked in his cell for long periods and spoke about attempts he had made in the past to harm himself.

5. On 6 November, the man complained of right-sided chest pain and difficulty breathing. He saw a doctor who asked him about his symptoms and conducted an electrocardiogram (ECG – a test which measures the heart's electrical rhythm) which gave readings within the normal range.

6. At about 8.10am on 1 December, the man's cell was unlocked so that he could collect his medication. He did not stir and appeared to be asleep. When the man's cell mate tried to wake him five minutes later, he could not, so he rang the cell emergency bell to summon help. Staff responded and, realising that the man was not well, requested medical help.

7. Healthcare staff responded quickly to the request. They assessed that the man was not breathing and began cardiopulmonary resuscitation (CPR) until paramedics arrived. After about 20 minutes of CPR without response, a paramedic declared that the man had died.

8. The man's family raised a number of concerns about the care he received and the circumstances of his death. I have considered these carefully. I am satisfied that healthcare staff at Wandsworth properly assessed and managed the man's health problems while he was in their care. Given the post mortem result I do not think that his death could have been reasonably foreseen or prevented. I make no recommendations to Wandsworth in the light of the man's death. However, I have discussed in some detail the prison's liaison with the man's family, and there may be lessons that can be learnt.

THE INVESTIGATION PROCESS

9. The Ombudsman's office was notified of the man's death on 1 December 2010. A senior investigator was appointed to conduct the investigation into the death, assisted by another investigator. The investigator visited Wandsworth on 7 December to begin the investigation.

10. Notices to staff and prisoners were issued, informing them that an investigation would be taking place and inviting those with relevant information to contact the investigator. There was no response to the notices. The investigator requested and was provided with copies of records relevant to the man's time in custody and his death.

11. The investigator contacted HM Coroner for Inner West London to inform her of the nature and scope of my investigation and to request a copy of the post mortem report. A copy of this report will be sent to the Coroner to assist with her inquiries.

12. A review of the man's healthcare was commissioned by Wandsworth Teaching Primary Care Trust. The review was undertaken by a Medical Director. His findings are annexed to the investigation report.

13. On 16 December, 4 April and 18 April 2011, the investigator visited Wandsworth and interviewed a number of staff and prisoners who knew the man or who had cared for him during his time there. Following the interviews, the investigator met the Deputy Governor and provided verbal feedback. This was followed by written feedback to the Governor.

14. One of my family liaison officers contacted the man's family outlining the purpose of the investigation and inviting them to raise any concerns. On 4 January 2011, the family liaison officer spoke to the man's brother by telephone and noted the family's questions and concerns about the care the man received at Wandsworth. The family asked whether all of the man's personal belongings had been returned to them. They also said that the prison had not offered to contribute to the cost of the man's funeral, or offered them the opportunity to visit Wandsworth. The family said that they were upset by the way that news of the man's death had been broken.

15. On 2 March, the family liaison officer and the investigator met with two of the man's brothers and a family friend. The family liaison officer provided the man's family with an opportunity to ask any questions about the care he received in prison. The family asked:

    - Why the man had been sent to a 'high security' prison.
    - Whether he had been prescribed the appropriate medication.
    - Whether he had been offered illicit drugs by other prisoners.
    - Who had found the man and whether he had died in prison or at hospital.
    - Whether all of his personal belongings had been returned to them.

- Why the man's cell was covered in blood and why there were traces of blood on his body.
- Why the prison had not taken action when the man's wife emailed the Governor raising concerns about her husband's health.

I hope that my report helps to answer their questions and concerns and gives them a clearer picture of the man's time in prison, particularly the days leading up to his death.

16. In April 2011, my investigator contacted the man's criminal defence solicitor. He said that the man told him that, although he was feeling "stressed" by being in prison, Wandsworth knew about his health conditions and he had been prescribed medication.

17. In October 2011, the Ombudsman's office was contacted by other members of the man's family. They considered the contents of the draft version of this report and raised a number of concerns as a result. They were particularly concerned that medical staff at Wandsworth did not adequately treat the man's existing heart condition.

HMP WANDSWORTH

18. Wandsworth, a large Victorian prison in south west London, is the largest prison in England and Wales holding up to 1,665 unconvicted and convicted adult men. Its catchment area includes courts in central and south west London and neighbouring Home Counties. It is a category B local prison. Prisons and prisoners are categorised in four ways. Category A is the highest security categorisation, meaning that the prisoner must be held in secure conditions which make escape very difficult. Category B prisoners must be held in secure conditions which make escape difficult (the majority of prisoners will be category B at the point of sentencing.) Category C prisoners do not need to be held in the tightest of security conditions, but are not suitable for open conditions. Category D prisoners, the lowest security categorisation, are suitable to be held in open conditions, where physical security measures are limited. 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.

19. The former HM Chief Inspector of Prisons (HMCIP), Dame Anne Owers' last published inspection report of September 2009 detailed positive changes at the prison. The Inspectorate recognised the considerable effort many staff had undertaken to improve relationships between staff and prisoners and that out of cell time had increased.

20. Primary care healthcare at Wandsworth is currently provided by NHS Wandsworth. In relation to healthcare services, the chief inspector's report noted that there were "gaps in the provision of care" and that

> "there were a number of staff vacancies on the primary care team, resulting in an over-dependence on bank and agency staff and an inconsistency of approach to prisoners. Healthcare staff did not work as an integrated team."

21. Although patients with complex needs had care plans, inspectors found that

> "prisoners who had lower levels of need but would have benefited from distinct care plans did not necessarily have these; their care was recorded in their main clinical record, which meant that staff had to search through previous entries to find up-to-date information …"

22. Each prison in England and Wales is monitored by an Independent Monitoring Board (IMB), consisting of volunteers from the local community. The Board must produce an annual report for the Secretary of State. The most recent report by Wandsworth's IMB covering June 2009 to May 2010 identified some of the issues already covered by HMCIP such as difficulties in the recruitment of staff for permanent posts, the lack of a multi-disciplinary approach and the slow pace of implementing planned initiatives such as clinics for long-term initiatives.

23. The man's death was the tenth to take place due to natural causes at Wandsworth in 2010. There are no apparent similarities between the circumstances of the eleven deaths, or the recommendations made in previous investigation reports.

KEY EVENTS

24. In July 2006, the man was arrested and charged with three offences under the Prevention of Corruption Act. He was released on bail pending trial and returned to Lebanon. As a result he was considered to be unlawfully at large.

25. On 6 September 2007, Southwark Crown Court issued a warrant for the man's arrest on the basis that he had failed to appear at court. The trial went ahead in his absence and, on 11 January 2008, he was convicted and sentenced to 18 months imprisonment.

26. The man's criminal defence solicitor told my investigator that the man telephoned him from Lebanon to say that he was visiting his mother who was unwell and that he himself was suffering from heart problems. His solicitor informed him that when he returned to England, he would be arrested and sent to prison.

27. When he returned to the United Kingdom (UK) on 3 October 2010, the man was detained at Heathrow Airport. The following day, he appeared at Southwark Crown Court where his 18 month prison sentence was confirmed.

28. The man was taken to HMP Wandsworth. He was taken through the reception process where his personal details were written down in his prison file by an officer. The man named one of his brothers as his next of kin and provided the family restaurant (although it was not clear at this stage that the premises was, in fact, a business) as the address at which his brother could be contacted.

29. As part of the reception process, a Cell Sharing Risk Assessment (CSRA) was completed the same evening. (This assesses whether the prisoner is suitable for sharing a cell and whether they pose a risk to other prisoners.) The man was classified as low risk. This meant that there was no immediate risk, and he was suitable for sharing a cell.

30. As he was new to Wandsworth, Nurse A interviewed him to gather information about his physical and mental health. The man told her that he had heart problems and had suffered three strokes in the past, the last one being three months previously. He said that he had recently undergone a test which the nurse noted "sound[ed] like cardiac catherization." (During this procedure, a thin, flexible tube is passed through a blood vessel until it reaches the heart. The process helps to identify any heart problems, including narrowed arteries or poorly functioning heart muscles.)

31. The man told Nurse A that he had seen a doctor in Lebanon three days previously for a check up. He said he was a social drinker and a smoker. He admitted that he had used cocaine in the past month. The man said that he suffered from anxiety and had tried to jump from a building while in

Lebanon. His urine was tested for various substances, illegal drugs and medications and the results showed that he had recently used cannabis and cocaine. Nurse A referred the man to the doctor for further assessment.

32. Later that day, Dr A examined the man so that appropriate medication could be prescribed. In the clinical record, Dr A described his consultation with the man as "difficult" because the man's spoken English was not perfect and he did not seem clear about the medical conditions he was suffering. He recorded that the man had arrived at Wandsworth with Rivotril (an antianxiety medication), Cipralex (an antidepressant) and risperidone (a mood stabiliser), which the man believed were to stop him having a stroke. Dr A was uncertain whether the man had epilepsy or anxiety. He prescribed carbamazepine (a mood stabilising drug), citalopram hydrobromide (an anti depressant medication) and risperidone.

33. Rivotril is a benzodiazepine based medication with sedative effects. Benzodiazepines are sought after drugs in prison as they are often taken illicitly and, as a result, their prescribed use is limited as far as possible. It is not uncommon for prisoners who are being prescribed benzodiazepines in the community to have the prescription altered to a different medication once they arrive in prison. The clinical reviewer, confirms that carbamazepine was a suitable alternative medication for the man. He notes that carbamazepine, citalopram and risperidone are often used together and are a safe combination.

34. On 5 October, the man saw Nurse B who explored his health needs further. The man described several health concerns. He told the nurse that he had suffered "several heart attacks/strokes" and that he had heart surgery at St Mary's Hospital in Paddington, London three years previously. The man said that his father had died aged 61 years of a heart attack and that one of his brothers had heart problems.

35. The man described having fits when upset and that his last one was three weeks previously. The nurse recorded that she was not clear whether he suffered with epilepsy or not. The man also said that he used to use an inhaler for asthma and although he had not needed one for three years, he felt he needed one again because of anxiety. Nurse B wrote in the medical record that the man was "[v]ery concerned re breathlessness while in cell. During consultation was not breathless and symptoms appear to be related to anxiety". She took pulse and blood pressure readings, which were both within the normal ranges. (The normal range for blood pressure is 100/70 to 140/90, although the pressure does vary throughout the day depending on the individual's activities. A blood pressure reading of greater than 140/90 is classed as high and a reading of 90/60 or below is classed as low.)

36. The man spoke of meeting with a psychologist weekly and having seen a psychiatrist in Lebanon. Nurse B noted that the man had been admitted to a psychiatric hospital in Lebanon for two nights. He said that he took ten

milligrams (mg) of citalopram, 200mg of carbamazepine and two mg of risperidone every day for mental health problems. The nurse assessed the man as fit for work and for any cell and that he did not need to be in the healthcare unit for health reasons. Nurse B recorded that "no immediate action [was] required" although she noted that the man had been referred to the mental health team.

37. The man moved from the First Night Centre (where most prisoners will spend their first night in prison, with additional support from staff) to C wing. On 9 October, Officer A began the process of assessing the man's correct security categorisation (which takes into account his offence, length of sentence, previous convictions and compliance with bail or previous release conditions).

38. The officer recommended that the man should go to HMP Camp Hill, a category C prison on the Isle of Wight which is a lower security category than Wandsworth but not an open prison. (The investigator asked prison staff whether any progress had been made towards moving the man to a lower category prison before his death. They found no evidence to suggest that progress had been made.)

39. The man moved to B wing on 11 October, where he shared a cell with Mr A. At interview, Mr A told my investigator that he and the man got on very well as they helped to cheer each other up and the man liked to have a laugh and a joke. He described the man as "a really nice guy, who was bubbly with a good character." Neither he nor the man had been to prison before. Asked whether the man discussed issues of physical health with him, Mr A replied that the man mentioned having heart problems and that he had a stroke some years before.

40. On 13 October, Wandsworth requested the man's clinical records from his last known community doctor, who provided them the following day. They showed that, in 2007, an ECG showed an abnormal reading which was thought to be caused by left ventricular hypertrophy (LVH) and hypertrophic cardiomyopathy (HOCM). The man had been assessed by specialists from the cardiac clinic who prescribed simvastatin (to reduce his cholesterol level) and bisoprolol (a beta blocker to treat heart conditions). His doctor placed the man on the coronary heart disease register (a list of patients suffering with the disease which allows their condition to be monitored). In June 2007, the man was admitted to St Mary's Hospital, Paddington for a suspected myocardial infarction (heart attack). The results of tests showed that he had not had a heart attack but the problems were linked to his suspected HOCM. His doctor attempted to monitor his heart disease in 2008, but the man was in Lebanon. (On 15 October, Wandsworth received confirmation from St Mary's Hospital that the man had undergone a coronary angiogram (a specialised test which gives a detailed examination of the coronary arteries) and was suffering from LVH and HOCM.)

41. Ms C of the Primary Care Mental Health Team interviewed the man on 13 October. She wrote in the clinical record that she saw the man at the

request of nursing staff as he felt anxious and said that he had deliberately harmed himself in the past. The man told Ms C that he felt anxious when spending long periods in his cell and requested several times "something to help him sleep". Ms C suggested that he try herbal teabags instead. She also encouraged him to try to stop smoking, but he said that it helped to calm him. Ms C noted that he would benefit from attending work or education, as being busy helped him to feel less anxious. She concluded that the mental health team should follow up his progress in one month's time.

42. A member of healthcare staff took the man's blood pressure reading on 15 October (which was within the normal range). During the consultation, the man complained that he had not been prescribed his asthma medication. The wing nurse was informed and agreed that he should see a doctor about this. (There is no evidence to suggest that the man was prescribed asthma medication while at Wandsworth. However, his previous medical record, obtained by Wandsworth, makes no mention of him being diagnosed as asthmatic, or ever having been prescribed medication for asthma. On his arrival at Wandsworth, healthcare staff linked his breathlessness to anxiety, rather than asthma.)

43. On 22 October, the man saw Dr B who recorded in the clinical record that the man had "several vague complaints" and was again asking for sleeping tablets. Again, he was advised to use herbal teabags at night time.

44. Three days later, on 25 October, Nurse D took the man's blood pressure reading of 113/76 and a pulse rate of 73 beats a minute after he said he felt dizzy. Nurse D recorded in the clinical record that the findings were within normal limits.

45. Mrs E of the Primary Care Mental Health Team saw the man on 5 November as a follow up to his previous session on 13 October. He complained of chest pain and of being unable to sleep. Mrs E advised him to make an appointment with the doctor. He said that he had already done so but was not given medication. She advised him to seek a second opinion and persevere with herbal tea.

46. On 6 November, nursing staff were called to see the man as an emergency because he was complaining of chest pain. He said that he experienced the pain every day, but that it felt worse on this occasion. His blood pressure and pulse readings were taken again and were within normal limits. The nurse recorded that the man should undergo an ECG and be examined by a doctor.

47. Dr C examined the man later the same day. He recorded that the man was feeling pain in the right side of his chest and had difficulty breathing. The doctor obtained an ECG reading. The man was able to move all his limbs, and examinations of his chest and heart indicated no acute problems. Dr C wrote in the clinical record that he found nothing "sinister" in his

examinations and that the man might be suffering with panic attacks. He advised the man to breathe slowly.

48. Later on 6 November, the man saw Nurse F and again complained of chest pain. She explained that the ECG result seemed stable and asked him to think about stopping smoking as it would help him. This is the last entry in his clinical record until 1 December.

49. The man's Prescription and Administration Record Chart shows which medications he had been prescribed but could not keep in his cell. According to the chart, Dr B prescribed the man simvastatin (40 mg), bisoprolol (5 mg) and aspirin on 15 October, once St Mary's Hospital had confirmed the man's community prescriptions. Risperidone, citalopram and carbamazepine were prescribed on 30 October.

50. Because he was not allowed to keep any of the medications in his cell, the man had to visit the wing treatment room each morning and afternoon to collect the correct dose of each of his prescribed medications. Generally, he collected his medication as prescribed every day. However, he failed to collect his citalopram on 9, 11 and 12 November. He did not collect his Bisoprolol on 16 and 24 November and did not collect aspirin on 16 November. In general, prisoners are responsible for collecting their medication as they would be in the community. It is not routine practice for staff to remind prisoners to collect their medication.

51. At Wandsworth, officers working on residential units are assigned a number of cells and are responsible for monitoring the welfare of the prisoners in those cells as part of their duties. Such officers are known as personal officers. On 18 November, Officer B (who has worked at Wandsworth since October 2006) and was the man's personal officer, wrote in the man's contact log that he was

> "a quiet individual who spends most of his time talking and praying with [Mr] B, works in the kitchen afternoons only, with positive feedback from his employers. Has requested a re-cat appointment, as he believes he should be a D Cat prisoner."

52. Mr A, the man's cell mate said that the man gave up his job in the kitchen as he did not enjoy it. Other than that, Mr A did not think that the man had any particular problems, except for complaining occasionally that he had not received enough prescribed medication.

53. Mr B, a prisoner living on B wing in a cell adjacent to the man, told my investigator that he got to know the man quite well. Mr B described the man as "generous, warm-hearted and humble." He saw the man every day and said that although he had mentioned needing work on his heart, he seemed fairly healthy. The man had complained that he found his cell airless and that he could not breathe properly. Mr B thought that he meant that the air quality was not good rather than that he was having trouble breathing.

54. At interview, Officer B told the investigator that the man came across as a quiet individual who spent most of his time with Mr B as they were both Muslim and would pray together and read manuscripts. As far as he was concerned, the man and Mr A, his cell mate got on well and he did not know of any problems between them. They had shared the same cell, B4-09, for several weeks together.

55. Dr D re-prescribed the man's medications on 29 November. After the draft report was issued, the investigator sought additional clarification from Dr D, who confirmed that he did not examine the man on that date, or any other. Dr D explained that he made no changes to the man's medication.

Events of 30 November and 1 December

56. On the evening of 30 November, Officer C and Officer D were on evening duty on B4 landing. Officer C did not recall any interactions with the man during the shift. Officer D (who normally works in another part of the prison but was seconded to B wing for the evening) arrived on the wing at 5.00pm. After evening association (when cells are unlocked and prisoners can socialise or engage in leisure activities around the wing) finished, he helped Officer C recount the landing (to ensure all prisoners are present). He said he did not have any interaction with the man. Mr A said that after being locked in their cell for the night, he and the man chatted and watched television.

57. Officer E arrived on B wing at about 8.30pm for the night duty. He told my investigator at interview that he counted the number of prisoners on the wing and patrolled regularly during the night. He knew the man by sight and had previously had limited contact with him when working on the wing during the day. He did not recall any particular reason to check on the man during the night and said that the man's cell bell was not pressed that night. (The electronic log of emergency cell bell usage confirms that neither the man nor Mr A used the bell during that night.) He did not recall anything untoward during his shift. He counted his landing again at about 6.00am on 1 December and handed the wing over to Officer F. Officer E said that, although he had looked into the man's and Mr A's cell in order to complete his count, he could not recall any details about the cell. He did not know whether the man was asleep when he checked him.

58. Officer F told my investigator that he carried out the early morning count of prisoners on 1 December between 6.45 and 7.00am. He said he got to the door of cell B4-09 and "I remember I opened the observation panel and I turned on the night light and then I just saw two people in [their] bed[s] … Everything just looked normal like they went to bed."

59. Along with the other cells in the landing, Officer B unlocked cell B4-09 for the man to collect his medication at about 8.10am. The officer called out to the man and when he did not get a response, he asked Mr A to wake him and said that he would return shortly. The officer locked the cell door behind him.

60. Mr A said that he got out of bed at about 8.15am and put the kettle on. He looked at the man who was on the top bunk and level with Mr A's eye line. The man appeared asleep with his head towards the wall but Mr A said that "something did not seem right." He placed his hand on the man's back and shook him, then called his name but did not get a response. Mr A pressed the emergency cell bell and began banging on the door.

61. At about 8.20am, as Officer B and Officer G were still making their way around B4 landing, they heard the man's cell bell sound and banging on the cell door. Mr A said that the two officers came quickly and unlocked the cell. Mr A told the officers that he did not think the man was breathing.

62. Officer B went into the man's cell and saw Mr A standing in the middle of it, clearly shocked and shaking but not saying anything. The officer saw the man lying in the same position as when he had looked in the cell earlier. He recalled that he tapped the man on the shoulder. On looking further, he realised that part of the man's face was purple in colour, as were his hands and he was not moving. Officer B ushered Mr A to a cell with two other prisoners who were asked to look after him. Officer G stayed in the cell with the man. Officer B, who was not carrying a radio, asked Senior Officer H who had a radio and was "about ten or 20 yards away" to contact the duty nurse. The Control Room incident log shows that a code blue radio call (indicating that urgent medical assistance is required for a prisoner who is not breathing) was made at 8.27am.

63. My investigator asked Officer B whether there were any signs of injury to the man or any blood present. The officer replied, "No, he just appeared to me as if he was asleep. He was face down with his head turned to one side in a normal sleeping motion." Although the officer had received training in first aid, he did not examine the man on the grounds that "we also have a healthcare team and a medical team which is your first point of call before you start to act on anything." He said that nursing staff arrived within minutes.

64. Registered General Nurse (RGN) G was the first nurse to arrive at the man's cell with an emergency medical bag and oxygen, accompanied by student nurse H. They were in the treatment room on B wing when Nurse G received the radio message and went quickly upstairs to B4 and into the cell. Asked if she noticed any blood in the cell or on the man, she replied that there was no blood and that he "just appeared to be asleep". She described the man's face as pushed into his pillow, slightly facing the wall. His face was purple, he was not breathing and she could not feel a pulse. She said that, in her opinion, his heart had stopped beating some time ago. However, the nurse decided that as he was still relatively warm, efforts should be made to revive him.

65. At 8.30am, Nurse G asked for an ambulance to be called and for another member of nursing staff to assist her. She asked Officer G who was in the cell and Officer H, Officer I and Officer B to help her to lift the man from the top bunk onto the floor so that CPR could be started. (Ideally CPR should be carried out on a hard surface.) Nurse G placed a plastic tube airway into the man's mouth and throat to aid resuscitation and student nurse H put pads on his chest connected to the defibrillator. (In certain circumstances, a defibrillator sends an electrical shock to the heart which can help to restart the heart or stabilise its rhythm.) The machine advised that a shock should not be administered to the man so Nurse G delivered breaths while student nurse H did chest compressions. After about five minutes, they swapped roles.

66. Senior Sister I arrived to assist Nurse G and student nurse H at about 8.35pm. Sister I took over chest compressions whilst Nurse G attempted to

put a cannula (a small tube) into the man's veins so that medication could be given to him when the paramedics arrived. Nurse G said that she was unable to attach the cannula, which indicated that the man had been dead for a while and his veins had collapsed.

67. A paramedic arrived at about 8.45am and attempted to administer medication via the man's veins, but was unsuccessful. After estimating that staff had been attempting CPR for 20 minutes, the paramedic said that attempts should stop. The paramedic pronounced that the man had died at 8.47am.

68. Following the man's death, Mr B told my investigator that "people" had been seen going into the man's cell during the night of 30 November. He gave no further information except to say that it was "common talk" on B wing that the man had died during the night and nurses had gone into the cell. My investigator sought evidence to support Mr B's claim. Officer E, who was on duty during the night of 30 November, was asked about this. He said that night officers can only unlock a cell by using a key they carry in a sealed pouch. If the seal is broken, staff must complete paperwork to account for the use of the key. In addition, he said that if a cell is unlocked during the night, this must be recorded in the wing log book and must be with the night manager's permission. There is no evidence to suggest that The man's and Mr A's cell was unlocked during the night. As noted earlier, the records show that the emergency bell in the cell was not used during the night. Mr A said that no staff came into their cell during the night.

Contact with the man's family

69. Wandsworth's Family Liaison Officer (FLO), Reverend A, a prison chaplain, and governor A left at 11.25am to break the sad news of the man's death to his family. At 12.25pm, they arrived at the address the man gave on his arrival at Wandsworth, which was the family restaurant.

70. In her record of the visit, Reverend A wrote that there were no customers in the restaurant and they were introduced to the man's sister-in-law. The man's named next of kin, his brother, was in Lebanon but relatives present said they would ask another brother who was nearby, to come to the restaurant.

71. While they were waiting for the brother to arrive, the man's sister-in-law asked if something had happened to him. Reverend A broke the news of the man's death to her. When his brother arrived shortly after, he was also told. Reverend A wrote in her log of contact with the family that she had told the man's family members that Wandsworth would contribute towards the cost of the funeral.

72. Reverend A had contact with one of the man's brothers in the days following to arrange through the Coroner for the man's body to be taken back to Lebanon and for his belongings to be collected by a friend of the

family. A few weeks after the man's death, the family visited Wandsworth to see the cell where he had lived and meet staff and prisoners.

Support for prisoners and staff

73. Following the man's death, Mr A was moved to the Care and Separation Unit (CSU – where prisoners are kept in single cells with a restricted regime). (My investigator was told that this is standard practice until the police are satisfied that there are no suspicious circumstances to a death which occurs in a shared cell.) His clothes and footwear were taken to be examined for evidence. His belongings remained locked in the cell he shared with the man. (When a prisoner dies, the cell must be locked, with all items left in place, and treated as a crime scene, until the police agree that it can be released. This can take a few days.) Mr A told my investigator that he was asked to go into a cell in the CSU and given a cup of tea, some tobacco and a television. He assumed that the man had died. He was then interviewed by a police officer on behalf of the Coroner. After a couple of hours, he was taken back to B wing and given a different cell.

74. The day after the man's death, Mr A felt very shaken. He said that a member of the chaplaincy saw him to check that he was alright. He was offered the opportunity to speak to a Listener (prisoners trained by the Samaritans to provide support to distressed prisoners). He felt low and did not want to stay at Wandsworth but said he was told by a senior officer that because he was awaiting trial he would not be able to move to another prison. He asked if he could move to C wing where he knew another prisoner but was told he could either go to A or D wing but not C wing. Mr A felt the senior officer could have been more sensitive when talking to him. Mr A said that he received reassurance and support from Officer B. The officer also agreed to see if Mr A could move to another wing.

75. Mr A told my investigator that, because he was unable to access his belongings for several days, he did not have any shoes to wear. On the morning of the man's death, he had been given a pair of slippers because he only had socks on. He said that he wore the slippers for five days, until a governor noticed that he did not have shoes when he was on his way to a visit with his wife. The governor arranged for Mr A's family to bring him additional clothing.

76. Mr B said that he would have liked more support following the man's death. However, he said that the man was mentioned in the Friday prayers.

77. Staff interviewed as part of the investigation confirmed that, in line with Prison Service Order 2710, Follow up to a death in custody, a hot debrief was held on the morning of 1 December. (A hot debrief is a staff meeting held after a serious incident. It provides staff with an opportunity to talk about their experience and gain support.)

Post mortem report

78. The post mortem report concluded that there were no external signs of trauma and the causes of death were hypertrophic obstructive cardiomyopathy (HOCM) and cardiac sarcoidosis (a disease that affects the function of the heart). The report comments:

> "HOCM is associated with a significant increased risk of sudden death in adults and children …. In many cases the mode of death is related to … fatal cardiac arrhythmia [an irregular and abnormal heartbeat]. Similar fatal arrhythmia can be seen in cases of cardiac sarcoidosis."

79. A toxicological analysis of a blood sample taken from the man detected no traces of any illegal drugs. Small amounts of the medications he had been prescribed were found.

ISSUES

Clinical care

80. A review of the man's medical care at Wandsworth was commissioned by Wandsworth Teaching Primary Care Trust. It was carried out by a Medical Director for NHS Wandsworth. The clinical reviewer considered the man's clinical notes and the post mortem examination. He considers that Wandsworth put a reasonable and appropriate management plan into effect when the man complained of chest pain. He notes that the man's previous medical records were sought and received and that he was prescribed the correct medication. In his addendum, the clinical reviewer also notes that the man's cardiac care was being managed by specialists at St Mary's Hospital, Paddington.

81. The clinical reviewer writes that, from the prescription charts, it appears that the man took his medication as prescribed. However, he writes that the man would have suffered no ill effects if he missed the odd dose.

Assessment on 6 November

82. The man's family was concerned that when the man complained of chest pains on 6 November, the staff response was inadequate. Dr C performed a number of checks, the results of which were normal. He concluded that the man was suffering with panic attacks. In his addendum, the clinical reviewer explains that chest pain is a "very common presentation … and has many possible causes, including muscular pain, anxiety, cardiac causes such as angina as well as many others". Dr C's examination did not suggest that, on this occasion, the man's chest pain was related to a heart problem. The clinical reviewer concludes that Dr C's assessment and actions were in keeping with what one could reasonably expect from a community general practice.

83. The clinical reviewer concludes that the man's death was caused by his known HOCM, which can be a cause of sudden death. Sufferers do not always experience any symptoms. The clinical reviewer concludes that staff could not have done more to prevent the man's death.

Resuscitation efforts

84. Two discipline officers, Officer B and Officer G were first to respond to Mr A's calls for help. They went into the cell and found the man unresponsive. Officer B, although first aid trained, said that he did not begin CPR, preferring to wait for trained healthcare staff to arrive. In fact, Nurse G and student nurse H were in the B wing treatment room and arrived at the man's cell very quickly. The clinical reviewer concludes that staff attempts to resuscitate the man were appropriate.

85. During the course of the investigation, the investigator asked the Deputy Governor whether officers were expected to attempt CPR in the absence of

medical staff. He explained that formal first aid training no longer forms part of the initial officer training provided to new staff. However, the Deputy Governor confirms that some staff have undergone specific first aid training courses. It is his view that, if a member of staff has not been trained effectively in CPR, they cannot reasonably be expected to deliver emergency first aid. He added that staff could do so if they wished.

86. In October 2010, Mr Michael Spurr, the Chief Executive Officer of the National Offender Management Service (NOMS, responsible for the Prison Service) wrote to establishments. The letter covered first aid arrangements and mentioned a new one day Emergency First Aid at Work (EFAW) course. He noted that the new course made it "much easier to ensure adequate first aid provision".

87. In responding to the draft version of this report, the deputy governor emphasised that a number of staff at Wandsworth have undergone the EFAW course. In fact, as of February 2012, 86 members of staff (amounting to approximately 13 per cent of all staff) had undergone the EFAW course. Current health and safety legislation does not specify the number of staff who must be first aid trained.

88. Understandably, the man's family are very concerned that Officer B and Officer G did not attempt to resuscitate the man while waiting for healthcare staff to arrive. In interview, Officer B said that he had received first aid training but preferred to wait for healthcare staff. I am sure it is difficult for the man's family to understand why he did not attempt CPR. It may be that a lack of confidence prevented the officers from doing so. However it is important to note that nursing staff attended within minutes and did attempt resuscitation. As in the community, non-clinicians must make their own mind up whether to intervene when someone has collapsed or is unresponsive and I am therefore not sure that there is any recommendation that I could usefully make to avoid such a situation occurring in future.

89. The Deputy Governor told my investigator that the Governor was considering equipping the prison with more automated defibrillators. (Automated defibrillators are designed for easy use without extensive training. The machine is fitted with both written and audio instructions.) He said that the machines would be located throughout the establishment and all staff would be expected to use them.

Issues raised by the man's family

90. During a meeting between members of the man's family and my investigator and family liaison officer, the man's family raised issues about his time at Wandsworth. I have outlined those concerns in an earlier section of this report and hope that most have been addressed already.

91. The man's family said that his wife had contacted the prison Governor by email on several occasions, raising concerns about her husband's health. They asked why these emails had not been acted on. My investigator

found no evidence of such contact in the man's prison file. The Governor's secretary, responsible for all post and emails directed to the Governor, confirmed that she logged every item of post received. She had no record of any contact relating to the man. The family also suggested that the man's criminal defence solicitor had contacted the prison regarding his ill health. The solicitor told my investigator that he had not raised any concerns with the prison about the man's health.

92. The family had been told that there was blood in the man's cell. They also described seeing blood on his body after his death. Evidence gathered from both staff who responded to the emergency and Mr A indicates that no blood was present in the cell. Furthermore, the post mortem examination found no evidence of trauma or injury to the man's body. It may be that any blood that was seen on his body was the result of the medical interventions which formed part of the resuscitation attempts.

93. The family expressed various concerns about the liaison offered by the prison following the man's death. At the meeting with my staff in March, they said that they had not been offered an opportunity to visit the prison. They were not clear that they had been offered any financial assistance with the cost of the man's funeral. My investigator raised these concerns with Reverend A who said that verbal offers had been made to the family. Reverend A reiterated the offers in writing and both matters were resolved positively.

94. The man's family were upset that the news of his death was broken to them at the family restaurant. They also complained that they were not informed until several hours had passed. When the man arrived at Wandsworth, he was asked to give a name, address and telephone number of someone he would like contacted in an emergency. He named one of his brothers and gave the telephone number and address of the family restaurant. Although I accept that a restaurant is unlikely to be the most appropriate location to receive news of a loved one's death, there was no indication beforehand that it was restaurant premises. In this respect, I do not consider Wandsworth's actions unreasonable.

95. After the man's death was confirmed at 8.47am, Wandsworth followed the local policy for ensuring that the correct procedures were followed. It was proper and fitting that Wandsworth's representatives chose to deliver the sad news to the man's family personally rather than by telephone or by asking the police to do so. Reverend A left the prison for the given address at 11.25am, arriving about an hour later. I am sympathetic to the family's concern that there was a delay. However, I am satisfied that care was taken not to make news of the man's death public until his family had been told and that the delay in doing so was not excessive.

96. Unfortunately, it seems that there was a breakdown in communication between the prison and the man's family. This began at the initial visit, which the family considered unsatisfactory. It is crucial to effective family liaison that, as far as possible, clear channels of communication exist to

avoid misunderstandings and unnecessary stress. In the weeks following the man's death, members of his family were abroad. It appears that effective liaison was difficult at this time. Whilst I make no formal recommendation, the Governor and his team of family liaison officers will no doubt wish to think about the lessons that can be learnt from this experience.

Care for prisoners after the man was discovered

97. The man's cell mate, Mr A, initially alerted staff that the man was not responding. While staff treated the man, Mr A was taken to sit with other prisoners and then to the Care and Separation Unit where he was given a change of clothing and spoke to the police. However, Mr A's belongings remained in their shared cell which was sealed until the police had finished their enquiries. In the days that followed, however, arrangements were not made for him to be allowed some more clothing from home. I am surprised that he was left without shoes for a number of days and that this was not picked up by staff until he was seen with slippers on the way to a visit with his wife. My investigator discussed this with the Deputy Governor who described it as "probably an unfortunate oversight" and said he would take immediate action to prevent it happening in future. As Wandsworth has sought to rectify the situation, I have decided not to make a recommendation on this occasion.

98. I am encouraged by the conduct of Officer B in taking the time to talk with Mr A about the man's death and aftermath. Mr A said he found this reassuring. By contrast, Mr B was somewhat disappointed by the support he was offered after his friend's death. This illustrates that the effects of a death of a prisoner resonates more widely than may be acknowledged by a prison.

CONCLUSION

99. The man suffered from a known medical condition that affected the functioning of his heart. He had undergone tests at St Mary's Hospital before his imprisonment and was being treated. When he arrived in police custody and again at Wandsworth, he gave information about his health and the medication he had been taking.

100. Appropriate treatment was prescribed and advice offered on reducing his anxiety to help him to sleep. When he felt chest pain, he was seen and examined by a doctor who noted his blood pressure, heart rate, blood oxygen level and carried out an ECG. The doctor concluded that the man's symptoms were not suggestive of cardiac pain and may have been related to panic attacks. The clinical reviewer considers this to have been reasonable given that the findings of tests were normal.

101. The post mortem into the man's death concludes that it was a sudden adult death related to his existing heart problem. I am satisfied that Wandsworth took adequate measures before and after he was found unresponsive and his death could not have been foreseen or prevented.

102. While I make no recommendations in relation to the man's death, I have considered carefully the family's numerous concerns. I hope that this report goes some way to reassuring them.