Investigation into the circumstances surrounding the death of a man at HMP Wormwood Scrubs in January 2009

Report by the Prisons and Probation Ombudsman for England and Wales

July 2009

This is the report of an investigation into the sudden death of a man at HMP Wormwood Scrubs, in January 2009. The man was discovered by his cellmate in their shared cell on B wing at 7.50am. It was clear that the man had passed away earlier in the night and no efforts were made to resuscitate him.

The man's history and family circumstances are not known, but he was in his mid-50s. I would like to offer my sincere condolences to all those who knew him and have been affected by his death. This includes those prison staff who I know were saddened by the man's passing.

An investigator conducted the investigation on my behalf. An independent review of the man's medical care was undertaken by a panel, chaired by a doctor, on behalf of the local Primary Care Trust. I am very grateful to the panel for their contribution.

I would also like to thank the Governor of Wormwood Scrubs and his staff for their cooperation. I am particularly grateful to the prison liaison officer who, as in the past, provided a high standard of prison liaison and ensured the documentation was in exceptional order. The prison's Family Liaison Officer also made a very valuable contribution to my investigation.

The man did not have a known history of heart or other serious health problems. Neither had he complained of feeling unwell to healthcare staff, officers or to his cellmate. I make two recommendations in my report. The first relates to the need for staff completing the reception healthcare assessments to ensure that arrangements are made for prisoners who have raised blood pressure to have regular reviews. The second asks the Head of Healthcare to remind all healthcare staff of the requirement to keep legible and accurate records.

The prison's attempts to find the man's next of kin reflect very well both on Wormwood Scrubs and on the Prison Service as a whole. To date, these efforts have been unsuccessful and the man remains a mystery. Indeed, it is entirely possible that the name he used was not his real name at all.

The Prison Service has responded to and accepted my recommendations and their response is on pages 16 and 17 of this report.

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.

Stephen Shaw CBE
Prisons and Probation Ombudsman **June 2009**

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SUMMARY

On 9 December 2008, the man was remanded into custody at HMP Wormwood Scrubs. At his First Reception Healthscreen interview, he told healthcare staff that he did not have a family history of any serious illness, but was receiving medication in the community for glaucoma, asthma and gout. The man contacted healthcare on three occasions for these and other minor illnesses between 9 December and his death on 23 January 2009.

The man's cellmate recalls that on the evening of 22 January, they both watched a film on the television beginning at 9.00pm. He said he fell asleep before the man and he did not hear or see anything unusual during the night.

The man's cellmate woke at around 7.47am. It was clear from the man's physical condition that he had died. He raised the alarm and staff responded immediately. The officers contacted the communications room using the radio net and asked for healthcare staff to attend and for an ambulance to be called. Given that the man had clearly passed away earlier in the night, they judged that it was not appropriate to start cardio pulmonary resuscitation. At 8.04am, the prison duty doctor, arrived on the wing at the same time as the paramedic ambulance crew and confirmed the man's death.

A 'hot debrief' was held at 9.00am on the same day at which staff were given an opportunity to discuss and share initial thoughts and feelings on the man's death. It was acknowledged that some staff would be upset as he had routine contact with them every day in his role as tea orderly. Staff were told that a meeting would be held at 2.30pm that afternoon and the Care Team Leader would be attending to offer support to staff.

The prison made an extensive search for next of kin of the man, but sadly without success. With the help of colleagues in the police, National Health Service and probation, every address, contact detail, or telephone number found for the man was explored. They were either found not to exist or he was not known. The prison noted that the man spoke with what was thought to be a South African accent but the South African High Commission was unable to provide any information. The prison's Family Liaison Officer (FLO) explored every possible avenue but to no avail. He subsequently made arrangements for the man's funeral.

I make two recommendations in my report. I am also pleased to commend the prison's FLO for his tenacious efforts to find next of kin for the man.

The man's death was sudden and unexpected. My investigation found that the prison had no reason to suppose he was at risk and responded appropriately to his passing.

THE INVESTIGATION PROCESS

1. I was notified of the man's death on 23 January 2009. Terms of reference and notices were issued to staff and prisoners at Wormwood Scrubs telling them that an investigation would be taking place, and inviting those who wished to see the investigator to make themselves known. My investigator requested copies of the man's core record, clinical record, and other records relevant to his time in custody and his death.

2. My investigator also contacted HM Coroner to inform her of the nature and scope of my investigation. The Coroner has requested a copy of my report and I am happy to comply. A copy of a post mortem report was not available to my investigator at the time of writing this draft report. However, she has seen a copy of the man's death certificate. While the cause of death is to be established at inquest, the man is believed to have died from natural causes.

3. The investigator visited Wormwood Scrubs in April 2009. She met and spoke at length with staff on B wing who knew the man and with the prison's FLO. She also toured the wing and saw the cell where the man died.

4. A clinical review of the man's medical care was commissioned from the local Primary Care Trust (PCT). The clinical review panel was led by a doctor and focused on the medical care the man received at Wormwood Scrubs. The review appears as an annex to this report.

5. The man gave next of kin details to the reception officer when he was received into the prison in December 2008. Very shortly after his death, the prison, assisted by the police, attempted to contact the man's next of kin through the details he had given to the reception officer. The addresses and telephone numbers he had offered did not exist. The prison then searched their records of past sentences the man had served for next of kin details but again without success. The man had told staff and his cellmate that he had made telephone calls to family. However, a search of the pinphone records showed that he had made no such calls. He did not receive visits. The email address and telephone contact number he gave his cellmate were not valid and he was found not to have lived at the address claimed prior to imprisonment. Staff noted the man spoke with a possibly South African accent, and the prison therefore made enquiries of the South African High Commission and the United Kingdom Border Agency (UKBA), but once more without success. Staff questioned whether his given name was in fact his real name. The man had served previous sentences under this name, but all other personal information he had given to the prison proved unhelpful and his previous convictions listed four aliases.

6. My investigator telephoned the police officer assisting the prison in finding the man's next of kin. He told her that he had passed the case to a specialist financial

HMP WORMWOOD SCRUBS

7. HMP Wormwood Scrubs is a local category B prison, principally serving the courts of West London. It has a maximum capacity of 1,277 prisoners and holds remand and convicted adult males. The prison holds a high number of foreign nationals as Heathrow falls within the catchment area.

8. There are five main residential wings. The man was located on B wing. This wing has a capacity for 176 prisoners and is situated near to the healthcare centre.

9. HM Chief Inspector of Prisons made a full unannounced inspection of Wormwood Scrubs in June 2008. HM Chief Inspector of Prisons subsequent report judged that progress that the prison had made since her previous inspection had halted, and there had been “an appreciable drift” in all the key areas namely safety, respect, purposeful activity and resettlement. However, HM Chief Inspector of Prisons acknowledged the difficulties the prison faced in coping with constant daily pressure.

10. A report by the prison’s Independent Monitoring Board (IMB) for the period 1 June 2007 to 31 May 2008 mirrored the concerns raised in HM Chief Inspector of Prisons’ report. The IMB also highlighted problems resulting from a shortage of staff. The IMB report said that they had seen positive signs of improvement in healthcare services, but these had come at a cost in the cancellation of clinics and longer waiting lists while the department underwent necessary refurbishment.

11. In September 2007, the prison’s healthcare department was placed under special measures as part of the Primary Care Trust’s improvement plan.

KEY FINDINGS

12. The man served a number of sentences at Wormwood Scrubs for offences of fraud and dishonesty. While serving part of his sentences on licence in the community, he repeatedly re-offended and was recalled to prison on a number of occasions.

13. In December 2008, the man went to Wembley police station and surrendered himself to the police. Again, he had breached his licence and said he had committed further offences.

14. At the police station, the man asked to see a doctor about his asthma. The police Detained Person's Medical form was completed by the police doctor at 5.08pm. At the man's request, the doctor left a salbutamol inhaler with the instruction to staff that it was to be given to the man every four to six hours if necessary. (Salbutamol is a generic inhaler used to treat severe breathing problems in people with lung disease.) The medical advice to staff was that the man was to be observed on CCTV at half hourly intervals.

15. In December, the man was remanded into custody. The Prisoner Escort Record completed by staff driving the man from the court to the prison showed that he had an (unspecified) medical condition. The boxes indicating the man was at risk of self-harm or suicide and was vulnerable were also ticked.

16. The First Reception Health screen document was completed by a healthcare worker in December. The man gave the name and address of his doctor at a medical centre and said he had been prescribed medication for an eye condition and asthma. He said he did not have any of the conditions listed on the form including chest pain. The man said he did not smoke, drink or misuse drugs but indicated he suffered from depression. He revealed to the healthcare worker that he had cut his wrists in January 2008 and had been admitted to a hospital for two weeks for psychiatric treatment.

17. The healthcare worker recorded an impression of the man as: "mental health issues, states he would not harm himself, co-operative, settled in mood." The man said he did not need to see a doctor but the healthcare worker noted that a referral to a doctor for mental health matters should be made. He was judged fit to live on the normal wings and in a shared cell.

18. My investigator noted that in a separate interview on the same day, the man gave different information to an officer who completed a Personal Summary form. The Personal Summary form contained personal details including next of kin. The man told the officer that he was allergic to yeast. However, he had told the healthcare worker completing the First Reception Healthscreen that he did not have any allergies.

19. On the second, undated, General Health Assessment completed by a nurse, the nurse said there was no history of illness in his family. He refused a referral to the Asthma or Well Man clinic but said he might want to see a doctor in the future for his eye problem. The clinical review panel has identified two risk factors in the assessment that in isolation are not a problem, but together are associated with heart attack and were not acted upon. These were that the man's blood pressure was 157/77 and his weight was 88.8kg, indicating that his blood pressure was high and he was slightly overweight.

20. The man's medical record suggests that during the six weeks he was at the prison, he had contact with healthcare on two occasions. He had a consultation with a medical professional on the day he arrived. The signature to the entry is illegible and, although likely, it cannot be assumed that the person he saw was a doctor. At that appointment the man said he had a history of glaucoma and was prescribed Trusopt (a brand of eye drops to treat glaucoma and raised pressure in the eye). He described suffering from gout for which he took Ibuprofen for pain relief (he had not mentioned this condition during his first health screen interview). He relieved his asthma with a Ventolin inhaler.

21. The next entry on the medical record says that the man was not seen but was "okay at the moment". It is not clear whether this meant he had not been seen by a doctor and had given this information to a member of healthcare staff, or whether it was an assumption by the member of staff who made the entry and had observed or spoken with him at some point.

22. The man was located on B Wing. He moved to A wing for a short time and returned to B wing in January 2009. In January, he returned to court and was sentenced for committing further offences while on licence.

23. The man's cellmate said that at around 9.00pm in January, they both decided to watch a film on television. The man was in the top bunk, lying with his head towards the cell door in order to watch it. The cellmate said that he fell asleep during the film and awoke around 1.00am. He recalled that the television was off. My investigator confirmed with wing staff that, because the cells are small, it is possible to reach the television controls from the top bunk. The man's cellmate said that he did not hear anything during the night.

Events of 23 January

24. My investigator spoke with the Senior Officer (SO) on B wing, regarding observations carried out on the wing during the night patrol state. The SO said that prisoners were observed through the flap in the door at 10.00pm, 2.00am and 6.00am. This was simply a count of prisoners confirming that two remained in the cell during the night and nothing was obviously wrong. Officers did not routinely unlock cell doors and physically check prisoners for movement during the night. The SO told my investigator that, if a prisoner was subject to monitoring under the

25. The SO recalled that the man would normally be dressed and ready in his cell by 7.00am. On this occasion it was unusual that he was not.

26. The wing observation book records that a special cell search was to be carried out at 7.30am on a specific cell on B wing. The noise of the search woke the man's cellmate at 7.47am. He noticed that the man showed obvious signs of having died and raised the alarm.

27. The first Officer went to the cell and opened the door. He attended with a second Officer, a Principal Officer (PO), and the Governor. The PO's role was Oscar 1 on that morning. (Oscar 1 is the operational officer in charge of the day to day regime of the prison.) The communications room incident log shows that at 7.52am the first Officer asked healthcare to attend B wing immediately as a prisoner had died. He also requested an ambulance. The log confirms that an ambulance was called at 7.53am. In line with policies and procedures regarding a death in custody, the police were asked to attend.

28. At the same time and on arrival at the prison duty doctor, received an urgent message to go to B wing immediately. He later recalled that he arrived at the man's cell at the same time as the paramedic ambulance crew at 8.04am.

29. In his statement the prison duty doctor said that when he arrived at the man's cell it was being "guarded" by officers, and a wing governor was already on the scene. He saw the man lying on his left side on the upper bunk bed with his head towards the cell door. He said the man faced the room as the bed was on the left side of the cell. His left foot was hanging over the edge of the bed. The prison duty doctor saw clear signs of death. He said he felt rigor mortis in the man's left foot and saw post mortem staining. (Post mortem staining means the blood has begun to settle in areas of the body.) He said he talked to the ambulance crew about the man's condition and it was decided that, given confirmation of death, no attempt to resuscitate the man should be made.

30. The prison duty doctor said he spoke with the man's cellmate. He confirmed that, during the time they shared a cell, the man was a non smoker. The cellmate said that he did not see him using his inhaler but was aware that he used eye drops. The cellmate confirmed that the man did not complain about chest pain or any other symptoms. He was calm and a well regarded prisoner. He recalled that the man used to meditate twice a day, did yoga and was vegetarian. He told the prison duty doctor that he recognised from the man's physical condition that he had died.

31. A "hot debrief" was held by the Governor that morning. Staff were given the opportunity to offer their views and express any concerns regarding the man's death.

32. Before his death, the man had told his cellmate that he was considering visiting his son in Florida after his release in March 2009. The prison's FLO told my investigator that the man's cellmate had mentioned to him that the man had given him an email address and a mobile telephone number so they could keep in touch after they were released. The prison's FLO said that the email address was inactive and the telephone number was unobtainable.

33. The prison's FLO made extensive efforts to find the man's next of kin. An entry (inaccurately dated 20/7/08) in the family liaison log highlighted problems at an early stage when the next of kin information the man had given proved inaccurate. The prison's FLO sought information from the man's probation officer. The probation officer said that he had completed a pre-sentence report on the man in January 2009. He described the man as a very reserved individual who did not wish to discuss his family in any great depth. The probation officer said he did not have next of kin details and was unable to give any further information, although he would continue to make enquiries to assist the prison.

34. In January, the police told the prison that they were no nearer finding the man's next of kin and enquiries were ongoing. The prison's FLO spoke to a member of the Community Mental Health Team (CMHT). He was told that in late September 2008 the man had been detained under Section 2 of the Mental Health Act. The CMHT had noted that the man did not wish to disclose family details other than he had three children, two of whom lived outside the United Kingdom.

35. Staff noted that the man spoke with an accent that was possibly South African. In January, an immigration officer with the United Kingdom Borders Agency, was asked to carry out an immigration search. On that day, the prison's FLO log recorded that enquiries with the South African High Commission were also ongoing.

36. A number of other enquiries were made. The prison's FLO checked the religious registration card held in the chaplaincy department but to no avail. The man's property was searched for correspondence or any other documentation giving any information. Prison optician records were searched for any next of kin information but once more without success. The prison's FLO contacted the Health Centre where the man had said he was registered to his GP. He was told by staff that the GP had left the practice seven years before, and a search of their records found that the man had not been registered at the practice and they had no records for him.

37. In February, the prison's FLO contacted the Client Affairs Team at Hammersmith and Fulham Council. The Client Affairs Team deals with deaths where no next of kin

ISSUES

The clinical review

38. The clinical review was undertaken by a panel chaired by a doctor on behalf of Hammersmith & Fulham Primary Care Trust (PCT). Their review is based on prison clinical and non-clinical records. The panel concludes that they could not identify any acts or omissions by healthcare staff directly related to the man's cause of death. There were no documented signs of ill treatment or abuse but they note the results of a post mortem were not available to the panel at the time of the review. In this case, the man died suddenly and without warning. The panel judges that, as the man had "exhibiting advanced signs of death", efforts to resuscitate were not appropriate. I entirely agree.

39. The panel also attempted to follow up contact details the man gave the prison regarding his family doctor in order to find helpful background medical information. They found that the King Street Medical Centre does not exist. Among other enquiries, the panel tried to find a doctor the man was registered with but were unsuccessful. A review of his Mental Health Trust notes, followed by a telephone conversation with staff where the man received inpatient care, could not provide an updated address for his doctor.

Record keeping

40. An entry dated December 2008 in the man's clinical record is unclear. It says that the man was "not seen" but was "okay at the moment". The entry does not say whether the man said he was okay or a member of staff judged he was or why he was not seen. The panel has recommended that all clinical records are to be created, maintained and stored in line with national best practice and guidance issued by the Prison Service and Royal Colleges. As I have said repeatedly in the past, proper entries in the clinical record are not an optional extra but a key component of delivering effective medical care. I therefore repeat a recommendation I have made many times before:

    The Head of Healthcare should ensure that all healthcare staff are reminded of the requirements to keep accurate and legible records.

Healthcare risk management

41. The panel has recommended that prisoners who are identified with slightly raised blood pressure, a possible risk indicator for heart and other disorders, should be offered the opportunity to have it rechecked within four weeks. Treatment should be offered as appropriate, with the clinical record reflecting the outcomes of the review.

The Head of Healthcare should ensure that prisoners identified with raised blood pressure are regularly reviewed and the outcome recorded in their clinical record.

Commendation

42. On behalf of the prison, the prison's FLO exhausted every avenue in his search for the man's next of kin. His tenacity in keeping to the task and exploring every option despite the lack of success is highly creditable. The prison's FLO also showed sensitivity in negotiating the arrangements for the man's funeral with Hammersmith and Fulham Council. I believe he is to be commended for his role as prison's Family Liaison Officer.

The Governor should commend the prison's FLO for his commitment to the role of Family Liaison Officer. In particular, for ensuring that every avenue was explored to find the man's next of kin and that he was treated with dignity.

Conclusion

43. The man's death was sudden and unexpected. He did not have a documented history of serious illness and had not complained to staff or fellow prisoners about sudden ill health or chest pain. He had been a tea orderly for staff on B wing and many staff to whom my investigator spoke were saddened by his passing.

44. It was clear that the man had died in the night and had been dead for some hours before he was discovered by his cellmate in the morning. In those circumstances, there was little staff could do and it was entirely appropriate that they did not attempt cardiac pulmonary resuscitation (CPR). The greatest difficulty for the prison has been that the sustained attempts to find next of kin for the man have proved fruitless as he had successfully kept personal information to himself.

45. My recommendations aside, I judge that the medical care the man received for the conditions he disclosed to healthcare staff was comparable to that which he would have received in the community.

RECOMMENDATIONS AND COMMENDATION

1. The Head of Healthcare should ensure that all healthcare staff are reminded of the requirements to keep accurate and legible records.

Accepted. 1.Reinforce Nursing and Midwifery Council (N.M.C.) guidelines
2.Remind GP's of their responsibilities around record keeping
3. Written information re both of the above to be distributed to every staff member and placed on intranet **.**

1,2,3: Guidelines and information is freely available to all healthcare staff on the Shared Drive and instructions are circulated regularly to remind staff of the importance of this

From Oct 07, the IT workstream will be established with a specific remit for placing computers in all clinical areas so that all staff have immediate access to records which should eradicate the issue of having to return to the registry to collect records, often after the event

4. Audit of records to assess understanding and compliance with national legislation

Audits have been conducted to identify the extent of issues to b e addressed – one prior to training: the other three months post. 100% improvement noted in the Don Gruben

5. Identification of training needs
6. Focussed training around completion of Don Gruben Screening

5,6: Training needs analysis completed. Training needs are being identified via the following routes (i) the Wormwood Scrubs Male Establishment (W.S.B.M.) Clinical Governance Forum; (ii) post adoption of PCT policies; (iii) through the PCT training guide; (iv) following the prison needs assessment; (v) recommendations from the PCT; and (vi) post serious untoward incidents and clinical incident reviews. Programme now in place. One record keeping/management session given. Awaiting dates for rolling programme.

Training ongoing as new staff appointed.

7. PCT policy adopted. Record keeping standards and records management policy updated in line with National Health Service Litigation Authority (NHSLA) requirements. Once reviewed will be launched.

2. **The Head of Healthcare should ensure that prisoners identified with raised blood pressure are regularly reviewed and the outcome recorded in their clinical record.**

   Accepted. Patient group Directives are in the process of being developed and implemented. Practice changes are also being developed to address this recommendation.

Commendation

The Governor should commend the prison's FLO for his commitment to the role of Family Liaison Officer. In particular, for ensuring that every avenue was explored to find the man's next of kin and that he was treated with dignity.

Accepted. The Governor will personally commend the prison's FLO.