Investigation into the circumstances surrounding the death of a male prisoner at HMP Wormwood Scrubs in January 2010

Report by the Prisons and Probation Ombudsman for England and Wales

November 2010

This is the report of an investigation into the death of a man, who died on 24 January 2010 whilst in custody at HMP Wormwood Scrubs.

The loss of any family member is acutely painful, but especially so whilst they are in custody. I offer my sincere condolences to the man's family and friends.

The man had a history of serious medical problems. He had a heart transplant in 1999 after being diagnosed with congenital heart conditions. He then suffered an acute rejection of his transplanted heart in 2004. When he arrived at Wormwood Scrubs in 2009, the man was taking a complex regime of medications which required close monitoring. Further investigations revealed that he had diffuse transplant coronary vascular disease which resulted in the suppression of his immune system.

At 11.30am on 24 January 2010, the man was found collapsed in his cell by an officer. Nursing and discipline staff attempted to resuscitate him and an emergency ambulance was called. Paramedics arrived and they continued cardio pulmonary resuscitation (CPR) for a further 20 minutes. A doctor attended and, as there were no signs of life, pronounced death at 12.02pm. A post mortem examination later confirmed that the man had died from a heart attack.

The investigation was conducted by one of my investigating officers. In addition, Hammersmith and Fulham Primary Care Trust (PCT) appointed a panel to review the medical care the man received whilst at Wormwood Scrubs. The review was led by the associate director of quality and safety for the PCT, and I am grateful to her and the panel for their timely and informative review.

I am also grateful for the co-operation of the Metropolitan Police, who shared information with us, and to the Governor of Wormwood Scrubs, and in particular his liaison officer, for the assistance they gave to my investigator.

I am pleased that the man was given a suitable cell, and that his medical needs were well catered for. In particular, equipment was provided for him and regular medical and follow up appointments were made for him. I make four recommendations in this report, two are to the Head of Healthcare and two to the Governor of Wormwood Scrubs. The recommendations concern record keeping and care planning in healthcare, recording significant incidents in the prison and the role of the family liaison officer.

Jane Webb
Acting Prisons and Probation Ombudsman **November 2010**

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SUMMARY

The man was born with a hole in his heart. On 16 April 1999, he had a heart transplant after being diagnosed as having pulmonary artery disease. After the transplant, he had to take immunosuppressant drugs in order to prevent the rejection of his new heart. This heart suffered from acute rejection in August 2004, as the man did not take his medication.

On arrival at Wormwood Scrubs in August 2009, after receiving a three year custodial sentence, the man was given a comprehensive health assessment. Due to his increased breathlessness, he was sent to the local hospital on 8 September. Investigations showed that the man had developed diffuse transplant coronary vascular disease (a disorder of the blood vessels after a transplant) and he was given additional immunosuppressant drugs to inhibit or prevent activity of the immune system. As this disease put him at an increased risk of contracting infections, he was moved to a single cell on the least populated E wing.

On 3 November, the man went to the local hospital again and was diagnosed with cardiac allograft vasculopathy (a disease of the arteries following a transplant) and extensive coronary artery disease in his transplanted heart. This increased his chances of future heart failure and mortality depending on how well he adhered to, and his disease responded to, treatment. The possibility of a second transplant was discussed by surgeons and they concluded that this would not be an option. The man agreed that his condition would be managed medically.

When he returned to the local hospital on 2 December, he was found to be active, able to cope with exercise and had no major fluid retention or weight gain. He was regularly seen by doctors at Wormwood Scrubs and, on 7 January 2010, when he complained of experiencing pain and had increasing shortness of breath, an appointment was made with the local hospital for 13 January. However, on 9 January, the man collapsed unconscious in his cell, falling onto a hot pipe and sustaining secondary burns to his right arm. He was taken to the local hospital by emergency ambulance, and was later transferred to a burns unit before finally being taken to the local hospital for further review.

On 22 January, having complained of abdominal pain, nausea, vomiting and blackouts, the man was again seen at the local hospital, when a 48 hour heart monitor was fitted to him in order to record his heart rate and rhythm. Changes were made to his medication and a further check up scheduled for 28 January.

At 11.30am on Sunday 24 January, the man was found collapsed in his cell by an officer. Nursing and discipline staff tried to resuscitate him, and when paramedics arrived they continued CPR for a further 20 minutes. A doctor attended and at 12.02pm resuscitation was ceased, and his death pronounced.

I make four recommendations in this report, two to the head of healthcare and two to the Governor of Wormwood Scrubs. The recommendations concern record keeping and care planning in healthcare, the recording of significant incidents in the prison and the role of the family liaison officer.

THE INVESTIGATION PROCESS

1. My office was notified of the man’s death on 24 January 2010. Notices announcing the investigation were supplied by my investigator and displayed by the prison to staff and prisoners, who were invited to contribute any relevant information. No prisoners or staff made contact.

2. All the relevant prison records relating to the man were studied by my investigator. They included the man’s main prison record, medical records and statements made by staff to the police.

3. Hammersmith and Fulham Primary Care Trust appointed a panel to review the medical care the man received whilst at Wormwood Scrubs. They examined the systems, processes and quality of healthcare services.

4. Her Majesty’s Coroner was contacted by my investigator to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, a copy of this report will be sent to the Coroner to assist his enquiries into the man’s death.

5. One of my family liaison officers contacted the man’s mother, who wished to know:

   - Why her son was not in the hospital wing?
   - Why the man died alone?
   - Why it took so long for her to be informed that her son had died?
   - Why it was that the police informed her and not the prison?
   - Why the police informed her the time of death was 12.02pm?
   - Why the prison later informed her the time of death was 08.23am?

   I hope that my report addresses the family’s concerns.

6. My investigator visited HMP Wormwood Scrubs on 24 February, to familiarise himself with the general environment where the man was located when he died. He also visited the man’s cell, and spoke with members of staff, including the liaison officer.

7. On 30 March, my investigator returned to Wormwood Scrubs where he interviewed the head of healthcare, a doctor, two nurses and a prison officer. Present with my investigator in the appropriate interviews, from the clinical review panel, were the associate director of quality and safety, NHS Hammersmith and Fulham, and the clinical governance manager, NHS Hammersmith and Fulham. The interviews were recorded and a transcript was made for each one.

HMP WORMWOOD SCRUBS

8. HMP Wormwood Scrubs was constructed in the last quarter of the 19th century. During the Second World War it was used by the War Department. In 1994 a new hospital wing was completed. In 1996, two of four wings were refurbished and a fifth wing completed. Mainly serving the courts of North West London, it holds both convicted and remanded adult male prisoners. On 24 January 2010, the roll count was 1,253 persons in custody.

9. Hammersmith and Fulham Primary Care Trust commission primary care services from Central London Community Healthcare for the prison. Healthcare is provided seven days a week via five wing based surgeries with extended hours in the reception and first night units. Provision includes induction to the prison environment, treatment and care for the unwell, inpatient and primary care/GP (General Practitioner) services.

10. There is a portable automated defibrillator located on each wing. These machines analyse the heart rhythm and then give the user advice as to whether a shock should be administered. Defibrillation consists of delivering a dose of electrical energy to the affected heart with the defibrillator. This halts abnormal electrical activity in the heart and can allow normal beating to be re-established.

Previous deaths at Wormwood Scrubs

11. There have been 26 deaths at the prison since April 2004 when the Ombudsman became responsible for their investigation. Eight deaths have occurred through natural causes. None of the circumstances of the previous investigations are similar to those in this case, although I have raised concerns about family liaison issues in the past.

Her Majesty's Inspectorate of Prisons

12. Her Majesty's Chief Inspector of Prisons conducted a full unannounced inspection of Wormwood Scrubs between 9 and 13 June 2008. The report of the inspection includes the following comments:

> "The wing treatment rooms were staffed throughout the core day and evening. Staff operated an open door policy, and we observed some good interactions between health professionals and prisoners.
>
> "There was continuity of primary care through teams of wing-based nurses and the first night centre/reception arrangements, which could be replicated by other establishments."

Independent Monitoring Board (IMB)

13. Each prison is monitored by an Independent Monitoring Board, members of which are drawn from the local community. They have full access to prisoners and every aspect of the establishment. They were not involved with any issues or applications regarding health, family or transfer matters relating to this investigation. In their

latest published report, covering the period from June 2008 to May 2009, they highlighted the difficulty recruiting permanent healthcare staff and the consequent reliance this placed on agency staff.

KEY FINDINGS

14. The man was born with a hole in his heart. At the age of 14 he left school as he required further medical attention and he was ill for nearly two years. On 16 April 1999, he had a heart transplant, after being diagnosed as having pulmonary artery disease (damage to the right ventricle of the heart which, if untreated, can lead to right-heart failure and death). Following the transplant the man was required to take immunosuppressant drugs (which reduce the effectiveness of the immune system) in order to prevent the rejection of the transplanted organ.

15. The new heart suffered from acute rejection in August 2004, as the man had not taken his medication for some time. (Acute rejection is common and can be treated with medication.) This resulted in his heart experiencing complications with the transplant and he developed diffuse transplant coronary vascular disease, which in turn led to chronic rejection and his immune system started to attack the transplanted heart. The man was given further immunosuppressant drugs.

16. In August 2009, the man was sentenced to three years imprisonment at a local Crown Court. He was sent to Wormwood Scrubs and placed on B wing, which is the induction wing. During his reception health screening, the man was initially assessed by a nurse. The nurse documented that the man had undergone heart transplant surgery and that there were no outstanding hospital or doctor's appointments. The man was recorded as having asthma, but there were no concerns about his physical health or risk factors for tuberculosis and he said he had no self harm or suicidal thoughts.

17. The man was then assessed by a doctor who documented the man's medication from the local hospital. The man did not have any medication with him but he had taken some that morning. He had no symptoms or medical problems and consented that medical information be urgently obtained from the local hospital.

18. The following day, the local hospital transplant ward was contacted for a treatment list and a response received. A general health assessment form was then completed for the man and he was put on a special high protein diet and provided with an extra pillow for medical reasons.

19. Four days later, on 2 September, a comprehensive assessment was completed by a doctor at the prison. He requested a chest x-ray from another local hospital as a result of the man's increasing breathlessness.

20. The following day, the man refused to go to hospital for the chest x-ray and other diagnostic procedures as he did not want to be handcuffed in public. (On each occasion a prisoner is taken to hospital, a risk assessment is completed. This determines the level of security used on the visit, which can include the use of handcuffs or other restraints.) The doctor explained to the man the importance of going to hospital because of his condition, but he remained adamant. The doctor deemed the man to be capable of making an informed decision, giving him the responsibility of informing prison staff should he change his mind. A

refusal of treatment form was signed by the man. The doctor decided to refer the man to the local hospital.

21. The next day, 4 September, an inpatient bed at the local hospital was arranged. The importance of attending was again explained to the man and he was told that an appointment had been confirmed for 8 September. The man agreed to attend and to be handcuffed whilst attending the appointment.

22. On 8 September, the man was taken to the local hospital and, the next day, he had a coronary angiogram (heart disease test) and an endomyocardial biopsy performed (a probe inserted into both chambers of the heart to investigate it). These investigations showed that the man had developed diffuse transplant coronary vascular disease (a disease which primarily affecting the blood vessels) due to hypercholesterolemia (high levels of cholesterol in the blood).

23. In view of the ongoing chronic rejection and transplant coronary heart disease, the man's immunosuppressant medications were increased to help slow down this process. This treatment, however, put him at an increased risk of contracting infections. He returned to Wormwood Scrubs on 11 September. The local hospital advised the prison that the man should not be in close proximity to individuals with obvious infections and being in an overcrowded environment should be avoided if possible.

24. On 21 September, the man started work as a library orderly. Two days later he was moved from B wing to E wing to minimise the risk of him being immune compromised. (E wing is the least populated wing, and only has single cells. This was thought to be the best place within the prison for him, as here he would be less likely to catch an infection.) His blood was checked weekly and sent to the local hospital for analysis. He also had his weight, pulse, blood pressure and temperature taken daily. The doctor that initially referred him for an x-ray saw the man regularly and liaised with the transplant team at the local hospital, and they worked together to decide how to best manage his disease.

25. The prison duty doctor saw the man on 14 October when he again refused to go to second local hospital for a chest x-ray. The man told the doctor he was aware his health was deteriorating steadily. He had been informed by the local hospital that it was very unlikely he would survive further heart surgery, whether for a second transplant or some other intervention. He expressed his gratitude to the doctors in the local hospital but had decided not to go back for any further follow ups because he did not see the point. He believed his life expectancy to be six to 12 months, which he would spend in prison. He also thought further medical intervention would be unpleasant, with no prospect of any benefit. The prison duty doctor advised him to attend the next appointment, but the man felt there was no need as he had expressed his feelings to the doctor at the local hospital. The doctor suggested he apply for release on compassionate grounds when his health deteriorated to the extent that he was unable to climb the stairs to E wing. (The criteria for release on compassionate grounds are set out in Prison Service Order (PSO) 6000. The PSO states that "early release on compassionate grounds may be considered on the basis of a prisoner's medical condition or as a

result of tragic family circumstances. It is granted in only the most exceptional cases".

26. On 17 October, the man was moved to an open-window, single cell to help with his health issues. The following day the doctor that sent him for an x-ray initially saw the man again. He was still concerned about the man's medical state and the outcome of a meeting held at the local hospital regarding surgical intervention which might improve his life expectancy to six to 12 months. He also said he had asked his solicitor to write to apply for release on compassionate grounds.

27. The same doctor saw the man on 29 October, as he was complaining of shortness of breath and contacted the local hospital for advice. They informed him that they would see the man. On 3 November, the man went to the local hospital, where he was seen by a cardiology consultant, who diagnosed that the man had cardiac allograft vasculopathy (extensive coronary artery disease following a transplant). Its presence increased his chances of future heart failure and mortality depending on how well he adhered to, and his disease responded to, treatment. The issue of re-transplantation was discussed by surgeons and they concluded that this was not an option. The man agreed to his condition being managed medically rather than surgically and he returned to Wormwood Scrubs on 14 November.

28. When he returned to the local hospital on 2 December, the man was seen by a staff physician. He found the man to be active and his exercise tolerance stable (exercise tolerance is a test designed to measure how efficiently the lungs and heart are working). There was no indication of major fluid retention or weight gain, which is a risk of the man's heart condition. The man had a non allergic acne form rash, possibly due to treatment with immunosuppressant drugs, and his medication was altered to deal with this.

29. The man saw the prison duty doctor on 24 December, complaining that he had a lump in his left flank for several months and that over the last few days it had become bigger and painful. The local hospital were aware of this but were not concerned. The doctor documented that the man had a history of cervical spondylosis (degenerative osteoarthritis), and would need a chair with a higher back. Officers on E wing were told to accommodate this request and the chair was provided.

30. The doctor that initially requested for him to have an x-ray saw the man on 7 January 2010, when he said he had been experiencing a week of retrosternal pain (a pain behind the sternum that usually occurs on swallowing) when walking and exercising, with the pain subsiding on sitting down. The doctor contacted the local hospital the next day, after reviewing the man again. They asked for an early appointment as the man was complaining of increasing shortness of breath, even when getting dressed in the morning and walking. An appointment was made for 13 January.

31. The following day, on 9 January, the man collapsed whilst reaching for a drink on the window sill in his cell, and was unconscious for an unknown period. Having

fallen onto a hot pipe, he sustained secondary burns to his right elbow and arm. When he was discovered by an officer during the daily roll count (where the officer confirms that the correct amount of prisoners are on each wing), the man was lying on his bed fully conscious, shivering, and complaining of having difficulty in breathing and chest pain.

32. A nurse called for an ambulance, gave oxygen to the man and checked his blood pressure, pulse and breathing. A prison duty doctor also attended and the man was taken to the second local hospital by emergency ambulance. The following day, he transferred to the burns unit at another hospital for the burn to his arm to be reviewed. The man was then transferred to the local hospital for review by the staff physician. His diagnosis was that the man had severe graft vascular disease (where damage has been done to the arteries bringing blood into the transplanted organ; this is sometimes also known as chronic rejection). It was not suitable for intervention at that stage. He also had an impaired left ventricular function (the chamber that pumps blood to the rest of the body), a history of acute rejection and a hiatus hernia. Cardiology experts recommended that the man be fitted with a 24 hour heart monitor (to record heart rate and rhythm) when he returned to prison and, given his immunosuppression, a biopsy of the abdominal nodules (lump or swelling) was conducted.

33. On 13 January, the man returned to Wormwood Scrubs. The dressing on his arm was changed every other day by a nurse. The man was also given an appointment to attend the burns dressing clinic at a local hospital on 20 January.

34. A doctor recorded that, on 19 January, the man developed a sudden burning sensation in the middle of his chest. He stood up, made himself a cup of tea, sat back down and felt dizzy. He then turned onto his side to find that he had become incontinent.

35. The following day the nurse that had previously called an ambulance for the man saw him. He refused to go to an outside hospital for an appointment for his burns, stating he was unwell, did not want to be seen by the duty doctors at the prison, and wanted to be left alone. The nurse noted there was no obvious shortness of breath and his colour was fine. When she returned and found him still in bed in the afternoon, she informed the doctor that had initially referred him for an x-ray.

36. The doctor went to see the man and suspected that he was not taking his medication. He stated that he had stayed in bed because of the pain he was experiencing in his epigastric area, a sharp pain dependent on his position when lying, and worse on his left side. This was aggravated by walking. The doctor explained that the local hospital would not admit him if he had not taken his medication. The man then took his medication. The doctor spoke to the staff physician at the local hospital and arranged an urgent appointment for 22 January.

37. The next day, 21 January, blood samples were taken from the man and sent off to the local hospital as usual. The burn to his arm was cleaned and dressed by the nurse that had previously called an ambulance for the man. The doctor that

initially referred the man for an x-ray sent a letter to the staff physician at the local hospital listing the medications that the man was receiving (he held most of these in his own possession). These were:

Sirolimus – an immunosuppressant drug to prevent rejection in organ transplantation.
Ciclosporin A(Neoral) – an immunosuppressant drug which reduces organ rejection.
Mycophenolate Mofetil – an immunosuppressant used extensively in transplant medicine.
Prednisolone – an immunosuppressive drug for organ transplants.
Pravastatin – used for lowering cholesterol and preventing cardiovascular disease.
Frusemide – a diuretic used in the treatment of congestive heart failure.
Clopidogrel – inhibits blood clots in coronary artery disease.
Ramipril – used to treat hypertension and congestive heart failure.
Lansoprazole – prevents stomach producing gastric acid.
Flucloxacillin – an antibiotic.
Septrin – an antibiotic.
Pen V – used for treatment of mild to moderate infection.
Lactulose – for constipation.
Senna – a laxative.
Piriton – an antihistamine.
Cocodamol – an analgesic for relief of mild to severe pain.
Aspirin. – for pain relief
Bactroban – an antibiotic cream for burns.
Gelonet – used as a dressing.

38. On 22 January, when seen at the local hospital by the staff physician, the man explained that he had episodes of upper abdominal pain, severe and prolonged at times, mostly after eating. He also complained of nausea, vomiting and blackouts. He had been given codeine tablets two days previously and this given him some pain. Having been seen at the local hospital following his first blackout on 9 January, when he had a 24 hour ECG monitor connected, he said that in the past week he had experienced a further two similar episodes. To investigate this further, the staff physician connected a 48 hour Holter monitor (which records the activity of the heart for the defined period) to record the man's heart rate and rhythm. Medication changes were made, and he was given ranitidine (which inhibits stomach acid) 150mg daily and the dose of frusemide increased to 80mg. His next check up was scheduled for 28 January.

39. The man returned to Wormwood Scrubs later that afternoon. He had been asked to keep a diary of how he felt, noting the times, so that they could be compared to the readings of the heart monitor. On this handwritten record, the man wrote that after returning to the prison he walked back to E wing from reception and suffered severe pain and shortness of breath. He took some painkillers, rested and the pain eased. At 4.30pm, he had dinner, lay down for an hour, then ate some crisps and had some water. He then became light headed, was breathing heavily and his legs felt a little weak, so he sat in his armchair. At 6 – 6.17pm he wrote; 'Sudden back pain between shoulder blades. Went to bed, got up 8.20, felt ok, just a bit lethargic.' At 9.30pm he took his

tablets and went to bed.

40. At 3.30am on 23 January, the man recorded that he woke to go to the toilet and went back to bed. He continued his diary with the following times and notes:

> "8.50am. Got up, dressed, went to toilet, got out of breath (tablets)
> 9.00am. Worked [the man had a job cleaning] on landing, breathing heavy, slight pain.
> 10.00am. Tablets, dressing changed, obs [clinical observations] done, ok.
> 11.45am. Had dinner, pain killers.
> 12.00noon. Went to bed.
> 1.53pm. Woke to tightness in chest, dull pain light headed, tension in stomach at base of sternum, felt nauseated, sat in armchair, cup of tea, dosed in armchair.
> 3.30pm. Got up pain gone felt ok.
> 4.20pm. Cold sweat, light headedness, weak at knees.
> 4.37pm. Kinda felt better.
> 4.45pm. Dinner, pain killers, sat in armchair watched football.
> 7.10pm. Pain killers, bowl of frosties, watched telly, fell asleep.
> 11.50pm. Woke up took 10 oclock tablets. Watched telly for a while. Relaxed, no pain. Breathing ok, whoop whoop joy."

41. On 24 January, the man recorded that he went to bed at 2.00am and woke for the toilet at 5.10am. At 7.00am, an officer checked the man during the daily roll count. He opened the inspection flap of the cell door, saw that the man was in bed with his head towards the door as usual and there was nothing obviously untoward. From the analysis of the heart monitor that the man was wearing, his heart stopped beating at 8.23am.

42. At 9.00am, another officer was asked to unlock the cells of ten prisoners on E wing who were listed to see the nurse to collect their medication. The man was on this list and the officer unlocked the door, opened it slightly, said 'treatment' and left the door ajar. Without going into the cell, he saw the man on his bed, in a sleeping position on his back, but did not see his face. The officer then carried on with his duties as it was not unusual not to get a response from a prisoner.

43. At around 11.30am, an officer was asked to unlock the cells for lunch. When she got to the man's cell she saw that he did not respond and, when she touched him, he felt cool. She immediately collected the nurse that previously called an ambulance for the man from the nearby E wing treatment room. The nurse saw the man lying on his back on his bed. He did not respond to her and there were no signs of breathing. She went to get the emergency equipment and a defibrillator and commenced CPR. She asked the officer to call an ambulance urgently and for all available medical staff to attend and assist.

44. A nurse arrived at 11.38am and saw the man was on his bed. He showed no signs of breathing, did not have a pulse and was cold to touch. She assisted with CPR. Four other nurses responded and assisted with CPR, using the defibrillator and administering oxygen. The ambulance crew arrived at 11.46am and took over the man's care, and continued CPR for a further 20 minutes. A

doctor arrived and noted that the defibrillator did not advise to shock as the man's heart had stopped. No intravenous access was possible, his pupils were fixed and dilated, and he was centrally cyanosed (a blue coloration of the skin), and remained in asystole. As there were no signs of life, the attempt at resuscitation was ceased. At 12.02pm, the doctor pronounced the man's death.

45. Shortly after the man's death, the prison activated its death in custody contingency plan. The Metropolitan Police, the governor, the Independent Monitoring Board and the Ombudsman were informed. A prison family liaison officer was appointed. The police visited the prison at 1.12pm, interviewed staff and prisoners and took several statements, copies of which were given to my investigator. The police found that there were no suspicious circumstances.

46. At 2.20pm, a debriefing about the man's death took place at the prison. Support and counselling were offered by the prison to the healthcare staff, prison officers and prisoners who had either been directly involved in this incident or who had been affected in any way. Notices to inform prisoners and staff of the man's passing were issued throughout the prison.

47. The man's mother was informed of his death at her home by the police at 3.40pm and she was contacted by a governor, from the prison, by telephone at 4.10pm.

48. At 1.40pm on 26 January, a post mortem examination was carried out at Fulham Public Mortuary by a Home Office Pathologist and Consultant Forensic Pathologist. He found no evidence of any third party inflicted injury, no complications because of the burn, and no other natural disease apart from the heart. The man's heart was referred to a specialist cardiac pathologist.

49. A Consultant in Histopathology at the local hospital examined the man's heart in order to assess whether there was any cardiac disease, including possible rejection of the organ. She concluded that the cause of death was acute myocardial infarction (heart attack), due to thrombosis in the left main stem and left anterior descending coronary artery, in association with a transplant vasculopathy, due to chronic rejection.

ISSUES

Clinical care

50. During his time at Wormwood Scrubs, the man had regular and extensive contact with prison healthcare clinicians and with secondary care services in the community. There are numerous documented incidences of direct communication between prison healthcare and specialist services regarding the man.

51. Clinical records indicate that there was engagement with the man on many levels ranging from assessment and management of his immediate needs to discussions with him regarding his prognosis, his future, compliance and the issue of release on compassionate grounds. I am pleased that this investigation has identified several examples of good practice.

52. The clinical records supplied to my investigator are in three formats. Healthcare introduced a computerised health care record (SystmOne) during this period. The continuous clinical record is therefore a mix of computerised records and paper based records. A temporary paper record was also opened in November, as some staff did not have passwords for the new computer system. A separate care plan was kept by the staff on the wing. This gave a confused impression to the records presented to the clinical review panel. It was clear however that considerable efforts were made to ensure that relevant information was available in each set of records. However, it would be preferable if only one continuous clinical record was maintained.

53. Entries in the paper records were not always legible and the author's names and designations were unclear. The introduction of computerised records ensures that records are legible, correctly dated and timed and that the name of the clinician is clear. The Clinical IT system, however, gave no indication of the role or designation of consulting clinicians. Best practice would ensure that clinical entries clearly indicate the professional designation of the clinician.

54. Communications from secondary care (for example, consultants from the RBHH) often gave no indication of when they had arrived at the prison, that they were seen, and by who, or whether action was taken. I do not make a recommendation but the Head of Healthcare will wish to ensure that a paper trail can be audited with respect to incoming mail.

55. The care plan based on the wing was a written document. Entries were erratic. It does not indicate an individual care manager. The care plan was not updated either on a regular basis or as a result of new developments in the man's treatment or condition. It is good practice for the care plan to be stored on the wing. I am satisfied that its quality did not affect the standard of care the man received. Nevertheless, the Head of Healthcare should check that all care plans are completed accurately and consistently.

56. The man was a patient with complex needs. It is clear from the records and the interviews conducted with clinical staff, that there were extensive interactions

with him and that senior clinical staff were all aware of the nature of his illness. Establishing a care plan for a patient with complex needs is an example of good practice. However, there was no evidence of a multidisciplinary approach to the care planning. Having established a care planning process, it is advisable that a named clinician manages the care plan, reviews the care plan at specified intervals and ensures that it is followed. It was unclear whether pharmacy staff were ever involved in managing the complex prescribing regime. There was no evidence of an integrated approach between the clinical staff and prison staff. As the man had specific dietary and exercise requirements and as he was immune-suppressed, a more integrated approach to care planning may have been more appropriate.

The Head of Healthcare should ensure that care plans are supported by an identifiable lead and engage a multidisciplinary approach.

57. At times the man did not cooperate with his medication regime. From the clinical record and interview transcripts, it appears that an assessment of his mental capacity was carried out by the GP to decide whether the man was making an informed decision to refuse treatment. However, there is no audit trail to confirm that this was the case.

The Head of Healthcare should develop a formal protocol for assessing capacity to refuse treatment.

58. Despite these comments, neither the clinical reviewer or myself have found any indication that any of the issues identified would have altered the outcome for the man.

Prison records

59. During the investigation, it was found that staff had failed to complete an F213 (a form recording injuries to prisoners) on 9 January, when the man had collapsed unconscious in his cell, burned his arm on a hot pipe and was taken to hospital by emergency ambulance. It was also discovered that from 29 December to 25 January, only one entry relating to the man was made in the wing observation book (used to record significant events). This entry was made by the officer on 24 January, a few minutes after she had found the man collapsed in his cell.

60. When interviewed by my investigator, a senior officer (SO) agreed that wing observation books are used to record significant events, and although she was not on duty on 9 January, a form F213 should have been completed and the events recorded in the wing observation book. This is particularly important for a prisoner like the man with such complex and changing needs. .

The Governor should remind all staff of their responsibility to keep comprehensive records when injuries and other significant events occur to prisoners.

Events on 24 January

61. My investigator looked at the issues surrounding the time between the man's heart stopping and being found just over three hours later. On Sundays there is a limited routine where two officers are allocated to each landing, and prisoners requiring medication are unlocked to make their way to the wing surgery. Others are unlocked to attend religious services, go to the gym or clean the wing. Whilst one officer escorts prisoners to their various locations, the other officer supervises the wing cleaners. At 10.30am, upon returning to the wing, prisoners return to their cells and are locked in. At 11.10am, they are unlocked in order to collect lunch from the second landing servery, before returning to their cells to eat. On 24 January, it was the fours (the top) landing's turn to be served first, followed by the threes and then the seconds, which is when the man was found.

62. The nurse that had previously called the ambulance for the man told my investigator that the man had all his medications in his own possession and only collected his painkillers on a Sunday if he needed them. He did not attend the previous week and it was not unusual for him not to ask for them, especially at weekends, when he would tend to sleep more. When he did collect medication, it would usually be around lunchtime.

63. The senior officer agreed when interviewed that it is likely that the man's cell was locked again as part of the routine movement on the wing on a Sunday morning. I can see how the man was not found until three hours after his heart stopped beating, even though his cell was unlocked for him to collect his medication. It was normal for him not to collect painkillers, especially at the weekend, when he was known to sleep in. It was also usual for staff to lock any cell doors if they were found open, as prisoners were moving to and from chapel. While I do not make a formal recommendation, the Governor may wish to consider the facts in this case, especially when prisoners who are known to be seriously ill have not been seen even though their cell has been unlocked.

Prison Family Liaison

64. A mandatory requirement of Prison Service Order (PSO) 2710 (follow up to deaths in custody) is to arrange notification to the next of kin as soon as possible in a suitable manner, giving an accurate factual account of what has happened. The recommended option is face to face notification by the prison, although the option chosen is dependant upon factors such as risk, location and distance.

65. My investigator spoke to a governor, who was appointed as prison family liaison officer in the man's case, and asked him why the police informed the man's mother of his death and not the prison, and why it took so long to inform her. (The police attended at 3.40pm and a governor telephoned at 4.10pm.) The prison family liaison officer said that there were only two governors on duty for the whole prison and there were no other family liaison trained officers on duty. The police were instructed as soon as they arrived at the prison and they agreed to inform the next of kin. The police then arranged for uniformed officers to attend the man's mother's house. The prison family liaison officer also said the

police gave incorrect information to the family, thinking that the man had died in hospital, where he had been two days earlier.

66. Police officers will have limited information about the incident and it is frustrating for families not to have access to all the information they want. Staff at Wormwood Scrubs were not able to follow the recommended option outlined in PSO2710 in respect of family liaison and, as a result, the man's family were informed of his death later than they might otherwise have been, and were given some wrong information. I have raised questions regarding family liaison in previous investigations at Wormwood Scrubs and I make the following recommendation.

The Governor should ensure that there are sufficient staff deployed as family liaison officers to be able to follow the recommended options provided by PSO 2710 when liaising with bereaved families following a death in custody.

CONCLUSION

67. Upon entering Wormwood Scrubs, the man had already survived a history of serious medical problems, including a heart transplant and an acute rejection in 2004, due to his not taking his medication for some time. Most recent investigations showed that he had diffuse transplant coronary vascular disease. He was taking a complex regime of medications and it is clear that he was aware of his poor prognosis.

68. I have found that Healthcare staff had timely and excellent communication with the specialist team in secondary care and there were close therapeutic relationships between the clinicians and the man. At times he did not cooperate. A separate care plan was kept by the staff on his wing and he went to hospital on several occasions.

69. Following the identification of a medical emergency, prison and healthcare staff performed their duties in line and in accordance with Resuscitation Council UK guidelines. I am satisfied that they all acted appropriately and in accordance with the information available to them. They made extensive efforts to save the man's life.

70. There is no indication that any of the issues identified would have altered the outcome in this case. No concerns were identified relating to cause of death.

71. In light of the findings of the clinical review and my own investigation, I conclude that the man's medical care was appropriate and satisfactory, as well as being equitable, if not better than, he would have received in the community.

RECOMMENDATIONS

The Head of Healthcare should ensure that care plans are supported by an identifiable lead and engage a multidisciplinary approach.

Recommendation accepted. NOMS reply: "We will review those care plans currently available on SystmOne and ensure that they meet the requirements laid out in this recommendation."

The Head of Healthcare should develop a formal protocol for assessing capacity to refuse treatment.

Recommendation accepted. NOMS reply: "There is a formal process in place in terms of the mental capacity (this includes capacity to refuse treatment). All staff have to undertake this as part of their mandatory training within CLCH. There is not currently a standard template for recording this but we will review and introduce a template if required."

The Governor should remind all staff of their responsibility to keep comprehensive records when injuries and other significant events occur to prisoners.

Recommendation accepted. NOMS reply: "A Governors Order will be issued reminding staff of the requirements and their personal responsibilities to record injuries and other significant events that occur to prisoners in their charge."

The Governor should ensure that there are sufficient staff deployed as family liaison officers to be able to follow the recommended options provided by PSO 2710 when liaising with bereaved families following a death in custody.

Recommendation partially accepted. NOMS reply: "There are six trained Family Liaison Officers within HMP Wormwood Scrubs. It is therefore not possible to provide twenty-four hours on duty cover. The work is voluntary and FLO's receive no on-call or standby payment. All have full-time daily positions within the prison.

"The incident under report occurred on a weekend. One FLO was on duty as the second Governor grade in charge of the establishment. Attempts were made to contact off duty FLO's, however these were unsuccessful – Because of the incident type and a need to maintain the order and the safety of the remaining prisoner population, it was considered unwise to deploy the FLO Manager from the prison. He was needed more within the prison. The Police offered to deliver the message on behalf of the prison and to this end the in-charge Governor took an operational decision to accept that offer. Correct details were passed to the Police to enable them to break the news. The family received the news at 3.40pm and were contacted by the prison FLO once confirmation that the message had been passed at 4.10pm.

"Whilst PSO2710 recommends that the message should be delivered in person by prison staff, it is a recommendation and must always be subject to Operational requirements / considerations.

“The Governor is committed to the deployment of FLO’s in accordance with the sighted recommendation contained within PSO2710 when it is operational sound to do so. “