

**Investigation into the circumstances surrounding the
death of a man at HMP Wandsworth
in February 2009**

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

March 2010

This is the report of an investigation into the death of a man in hospital in February 2009. The man, a prisoner at HMP Wandsworth, was 56 years old. I would like to offer my condolences to his family for their loss.

My investigator conducted the investigation on behalf of the Ombudsman. The local Primary Care Trust (PCT) were commissioned to conduct a clinical review into the standard of healthcare the man received while in custody. The clinical reviewer, Joint Medical Director, Wandsworth PCT carried out this review for which I am grateful. I would like to thank the Governor of Wandsworth, and his staff for their co-operation and assistance. I am particularly grateful to a particular member of staff for making all the practical arrangements for the investigator.

The man was a man with chronic and complex health needs. He had been receiving kidney dialysis at St Pancras Hospital three times a week since his reception at Wandsworth. In addition to renal problems, he was also diabetic and suffered from high blood pressure with some heart problems. The medical team at Wandsworth managed these conditions and he was seen daily on his residential wing by a nurse when collecting his medication.

In February, the man was due to go for his routine dialysis. However, severe weather conditions rendered the roads dangerous and the prison was advised only to make journeys considered to be essential. On receiving this advice, the healthcare team at Wandsworth contacted the renal unit at St Pancras. They were told that it was not necessary to bring him for his appointment and it would be alright for him to wait until the Wednesday. St Pancras advised the prison that in the meantime, if he was to complain of feeling ill he should be taken directly to the emergency department. The man raised no concerns about his health over the following two days.

One evening in February, the man collapsed in his cell. Medical staff attended quickly and administered first aid which continued until emergency paramedics from London Ambulance Service arrived. He was stabilised and taken to hospital where he remained in a critical condition. Further tests were carried out by medical staff that indicated that he had suffered severe brain damage and sadly, at 9.40pm he died.

I conclude that the man received appropriate medical care. Despite family concerns about the dialysis appointment that was missed, there is no medical evidence to suggest that this in any way contributed to his death. I made no recommendations as a result of the initial investigation, but have made one in relation to Prison Family Liaison Officer's as a result of feedback from the family on the draft 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.

Jane Webb
Deputy Prisons and Probation Ombudsman

March 2010

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SUMMARY

The man was remanded into custody in May 2008 and taken to HMP Wandsworth. It was his first time in prison custody. He was 55 years old. On his reception, a member of the healthcare team completed a routine health screen. It became apparent during the screen that he had serious health problems. The most serious was the need for him to undergo kidney dialysis at St Pancras Hospital. However, he also had other chronic illnesses that required regular monitoring. They were type 2 diabetes mellitus, diabetic retinopathy (blindness caused by diabetes) and peripheral vascular disease (obstruction of the large arteries).

The man's medical conditions were managed by the healthcare team at Wandsworth. He was prescribed regular medication and advised on his diet. In order for him to receive renal dialysis, he went to St Pancras Hospital three times a week. (St Pancras Hospital is one of a number of satellite hospitals offering renal services on behalf of the Royal Free hospital.) During his custody, the man raised no concerns about his medical treatment other than to enquire about his place on the renal transplant list. The prison discussed his concerns with the consultant at St Pancras who confirmed that the man remained on the list.

In February, severe weather conditions resulted in the prison cancelling the man's scheduled dialysis appointment after seeking advice from staff at the renal unit. They were informed that it was alright for him to miss the appointment, but his fluid intake should be closely monitored. The healthcare staff were also advised that should he complain of feeling unwell before his next dialysis session he should be taken to the accident and emergency department at St Georges hospital. The man reported no problems to healthcare staff.

The next day, the man seemed to be well. He collected his meals and took his prescribed medication as required. Shortly before 7.30pm, an officer went to his cell as the cell bell had been pressed. The man's cellmate told him that he had collapsed and he was unable to get a response. The officer immediately went to the treatment room and told a nurse. She returned with him to the cell and, on seeing the man, called for further medical assistance.

Other nursing staff and a doctor quickly arrived and began cardio pulmonary resuscitation (CPR). An ambulance and paramedics were also called and arrived at Wandsworth within 20 minutes. Paramedics continued to try to resuscitate the man. A pulse was eventually established and he was transferred by emergency ambulance to hospital where his condition remained critical.

Hospital tests indicated that the man had suffered damage to his brain as a result of a heart attack and was unlikely to recover. The hospital staff informed the prison of his condition and asked for permission to begin contacting his next of kin.

The prison finally contacted his next of kin the following day. They arrived at the hospital and were spoken to by representatives from the prison and medical staff. After being informed of what had happened and the severity of his condition, they spent time with him alone. He was made comfortable by nursing staff but no further treatment could be given. Sadly at 9.40pm he died.

I conclude that the man's care was managed appropriately. I make one recommendation in light of feedback received to the draft report.

The inquest into his death concluded that he had died as a result of natural causes.

THE INVESTIGATION PROCESS

1. The investigator opened the investigation in February 2008 when he visited Wandsworth and collected documentation. Notices were issued to staff and prisoners informing them of the investigation process and inviting anyone who had relevant information to come forward. The investigator received a number of letters from prisoners who asked to speak with him.
2. The investigator interviewed four members of staff and three prisoners when he visited Wandsworth again in March. Copies of the transcripts of the interviews are attached as annexes to this report. Interviews conducted with the prisoners were not recorded but written notes were made.
3. In accordance with the terms of reference, Wandsworth PCT was commissioned to conduct a clinical review into the care and treatment of the man at Wandsworth. The clinical reviewer conducted the review and a copy of his report is attached.
4. A Family Liaison Officer (FLOs) contacted the man's family and explained the role of my office in relation to the investigation. The FLO and investigator visited the family in April. During the visit, the man's family raised a number of concerns. Their questions related to the medical treatment he received, events after his death in particular the post mortem and family liaison by the prison and also about seeing him before his death. I have sought to answer the questions raised by the family in my report.
5. The investigator wrote to HM Coroner to inform him of the nature and scope of the investigation. A copy of the draft report and the annexes will be made available to the Coroner to assist him with the inquest. In turn, the Coroner provided a copy of the post mortem report to the investigator, which confirms the cause of the man's death as coronary artery disease.

HMP WANDSWORTH

6. HMP Wandsworth is a local prison in South London. It has the capacity to hold up to 1,644 sentenced or remand adult males. There are two main wings, Heathfield and Onslow. Heathfield is the main prison, while Onslow houses up to 300 vulnerable prisoners. In addition to the two wings, there is also a healthcare unit with an inpatient facility. Secure Healthcare has delivered healthcare services at the prison since July 2007 under contract to the local PCT.
7. In the summary of their most recent annual report, the Independent Monitoring Board (IMB) at Wandsworth said:

“... Wandsworth continues to improve its overall performance. In an overall climate of over-crowding and staff shortages, the prison is clearly still moving forward and the well-being and management of prisoners has improved. The days of “bang ‘em up and forget” are now a distant memory and it is gratifying to be able to report positively about a much more meaningful and acceptable regime for prisoners. The opportunities for prisoners to improve their employability through education and meaningful courses have improved significantly ...”
8. HM Chief Inspector of Prisons carried out a follow up inspection of Wandsworth in July 2006. In her report, she concludes that:

“... This inspection found an effective and united management team that was taking steps to move the prison forward. They had inherited a prison that was performing even less well than it had been at the time of the last inspection, in spite of having undergone a performance improvement programme. Since then, the prison had clearly improved, with greater confidence among staff and managers, more time out of cell and more activities for prisoners, and an improved focus on safer custody. There were, for example, effective first night and induction arrangements, and improvements to fundamentals of cleanliness, hygiene and food. All prisoners were out of their cells for a period of time each day, and for the first time, Wandsworth offered vocational training opportunities – even if these were available to only 96 out of 1400 prisoners ...”
9. Since the Ombudsman was given responsibility for investigating all deaths in prison custody in 2004, five other prisoners have died from apparent natural causes at Wandsworth. There is nothing from investigations into these previous deaths that is relevant to this investigation.

KEY FINDINGS

10. There is little known about the man prior to him being remanded into custody in May 2008. He was 55 years old and it was his first time in custody. When he arrived at Wandsworth, a Healthcare Officer (HCO) completed a medical screening. She recorded that he had been seen recently by a doctor and was receiving regular kidney dialysis at St Pancras Hospital. (Dialysis is a way to mechanically filter the blood to remove toxins and waste that are usually removed by healthy kidneys.) The HCO also recorded that he was diabetic and had high blood pressure. (Diabetes is the failure of the body to produce sufficient insulin, resulting in abnormally high blood sugar levels.) His diabetes had led to diabetic retinopathy, which had left him blind in his right eye and with only partial sight in his left eye. He also had a history of peripheral vascular disease. In view of his medical needs, the HCO referred him to be seen by the doctor. During the reception process he was also asked to provide the name of his next of kin. He gave the name and address of his brother and there is no evidence that he made any reference to other family members.
11. A prison doctor assessed the man later that day in the first night centre and confirmed that he was required to attend for a dialysis appointment that evening. The doctor also recorded the medication that the man was taking and asked for staff to arrange for him to go to St Pancras Hospital. Another doctor at Wandsworth telephoned the hospital to confirm the dialysis appointment. She was told that he required dialysis every other day and it was important that he attended, as otherwise he could become “toxic”. She informed the duty governor who arranged for him to be taken to St Pancras.
12. A nurse examined the man the following day and recorded that he had a history of diabetes mellitus in addition to kidney failure. She did not consider that he required any further immediate action other than his ongoing treatment and dialysis appointments, and confirmed him fit to be located on a residential wing. Due to the nature of the offence for which he had been charged, the man was located on the vulnerable prisoner wing (Onslow Unit.)
13. The prison doctor recorded in the man’s medical notes in May that St Pancras Hospital had asked staff not to handcuff his left hand when he attended future dialysis appointments as his fistula was in the left arm. (A fistula is created when an artery is joined to a vein. The blood vessels of the arm are chosen, either at the wrist or at the elbow. The operation makes it possible to put two needles into the enlarged vein so that blood can be taken out of the body, sent through the dialysis machine and then returned through the second needle.) To ensure that this happened, a nurse submitted a form F35. (This is a form completed by medical staff to make a medical request on behalf of a prisoner to another prison department, regarding medication, diet or any other matter relating to a prisoner’s care.) This form would have been submitted to the security department.
14. Due to his serious medical conditions, healthcare staff closely monitored the man. He attended St Pancras Hospital for dialysis every Monday, Wednesday

and Friday at 2.00pm. He settled into the daily routine at the prison and received favourable reports from the officers on the unit.

15. On 12 June, the prison doctor assessed the man who asked the doctor about likely bail conditions. His solicitor felt that his medical condition could not be fully treated in custody. She advised that his solicitor should write to Secure Health who provided the healthcare services at Wandsworth. During the appointment, the man said that he had been feeling more stress recently due to his case and this had aggravated his irritable bowel syndrome (IBS). However, when he was asked about the symptoms he said that he was not experiencing any abdominal pain. She prescribed medication and recorded that the condition should be kept under observation.
16. The renal team at St Pancras raised concerns with the prison doctor in July regarding the condition of the skin on the man's feet. They were concerned as foot health is especially important for people with diabetes, because of the risk of complications due to limited blood flow. She prescribed antibiotic cream and a nurse referred him to be seen by the chiropodist the following week.
17. Later that week, another nurse assessed the man after he went to the treatment room on the Onslow Unit and complained of feeling dizzy. She checked his blood pressure, which was not elevated, and advised him to return to his cell and lie down. She told him that if he did not feel better he should report to a member of the nursing staff and they would monitor him. No further concerns were reported by the man.
18. In July, the prison doctor examined the man and recorded that he was well and pain free. It was also noted that there had been recent problems with his fistula which had led to incomplete dialysis. However, this was being dealt with by the renal team at St Pancras and had not led to any deterioration in his health.
19. The man had a recurrence of problems with his feet in September. The prison doctor diagnosed an infection in his left heel and prescribed a course of antibiotics. He continued to be seen by the healthcare team as a matter of routine but no further problems with his feet were noted.
20. In October, the man was seen in the Genito-Urinary Medicine (GUM) clinic at St Pancras after he was diagnosed with a water infection. Tests were carried out and the results, reported in November, showed that there were no other infections.
21. In December, the man told another prison doctor at Wandsworth that the dialysis team at St Pancras had advised him to ask for antibiotics to be prescribed at the prison for the water infection. He also complained of constipation. The doctor prescribed antibiotics and medication to relieve the constipation.
22. Later in the month, the man was sentenced to two years imprisonment. At the end of December, he was seen by a prison doctor and complained of having pain in the arm with his fistula. She prescribed pain relief medication. During

the appointment, the man also spoke about his concern that he had been removed from the transplant list, and claimed the prison had said that they would be unable to get him to the hospital. She spoke with a governor about his concerns and was told that it was unlikely that anyone would make such a suggestion. She recorded on the medical record that she would speak directly to the doctor in the renal unit at St Pancras.

23. In January 2009, the prison doctor received a telephone call from a doctor at St Pancras Hospital renal unit. The doctor confirmed that the man had not been removed from the list but the transplant had been suspended. She said that the decision had been made as a result of an earlier consultation between the man and another consultant and had not been influenced by anyone from the prison. She informed the prison doctor that she was not sure why the decision had been made but she would enquire and hoped to be able to reverse it. She also informed the prison doctor that the man's blood results had improved since he had been in custody and it appeared that he was taking greater care of himself. She explained that, before he was imprisoned, the man had a long history of poor compliance with the advice given by the renal team.
24. The man reported sick in January and was seen by a nurse. He complained of a burning pain when he passed urine, since his dialysis the previous day. The nurse referred him to the doctor and he was seen later that day. A prison doctor assessed him and recorded that he was also passing some blood. Nursing staff contacted the renal unit at St Pancras but were informed that they were not able to deal with emergencies and had no doctors working at the weekend. As a result, the man was taken to the accident and emergency department at St George's Hospital. He was diagnosed with a urinary tract infection (UTI) and prescribed a course of antibiotics before returning to the prison the same day.
25. A prison doctor saw the man again in January. She recorded that he had been unwell for a few days with a UTI and was due to return for dialysis the following day. The doctor advised him to ask staff at St Pancras to ask about the results of a mid stream urine test carried out to ensure that he was receiving the correct antibiotics. The doctor also recorded that the man had spoken to the hospital doctor about the transplant list and was aware that the prison was not responsible for the suspension. The man told the prison doctor that he intended to look after his health better on his release from prison. Over the next month, he continued to go to his appointments and reported no other medical problems.
26. The man's next dialysis appointment was due in February. Severe weather affected most of the country that day including London. The police and the highways agency advised that only essential travel should be made as a result of heavy snow. The Lead Nurse at Wandsworth asked the healthcare administrator to contact the renal unit at St Pancras and seek advice on taking the man for his appointment. The healthcare administrator was advised by a staff nurse at the renal unit that it would be all right for him to miss the appointment in view of the weather. He should attend as usual for his next appointment. The renal unit staff reminded the prison that the man's sodium

and fluid intake would need to be monitored. If he did report feeling unwell before Wednesday then he should be taken immediately to the accident and emergency department.

27. The man was on Onslow Unit for most of the day and there is no record that he reported any problems to staff. The nurse who was issuing treatments in the Onslow Unit gave him his medication in his cell at 5.15pm. She said that she spoke to him again at around 6.00pm and he seemed in “good spirits”. The investigator interviewed other healthcare staff who said that they were not aware of him approaching any other nursing staff during the day other than to collect his medication. There is also nothing in his medical notes to suggest any concerns had been raised.

Evening in February

28. An officer was on evening duty in February and supervising the association period, which started around 6.00pm. He told the investigator that he became aware that there was a potential problem in the man’s cell when the emergency cell bell had been pressed. The officer said that he went to the cell immediately which was a short walk from where he was standing. On opening the door the man’s cellmate told him that he had collapsed. In a statement written by the cellmate after the man’s death, he said that the man had been all right since his last dialysis appointment the previous Friday. He had been eating normally and taking his medication as prescribed. The cellmate said that he was sitting watching television with him when he “slumped back” before losing consciousness.
29. The officer explained to the investigator that he went into the cell at around 7.30pm, and could see the man lying on his bed apparently unconscious. The officer rushed to the treatment room, which is only 15 or 20 seconds walk away. He told the nurse that the man had collapsed and asked whether she wanted him to radio for Hotel 3 (this is the call sign given to the nurse designated to be first response to a medical emergency). The nurse explained that she was acting as Hotel 3 and so the officer did not make any radio contact at that point.
30. A healthcare assistant was working on Onslow Unit and was in the treatment room with the nurse. She said that at around 7.30pm the officer came into the treatment room and told the nurse that a prisoner had collapsed. She said that the nurse grabbed a bag containing medical equipment and told her to “grab the oxygen tank”. She made her way down the landing and an officer assisted her with the oxygen as it was too heavy.
31. When they arrived at the cell, the man was lying on the bed at an awkward angle. She recalled that his mouth and eyes were open but that there was no movement. She said that his cell mate was also still in the cell. She saw the nurse place a pulse oximeter on his finger to monitor his pulse and an oxygen mask on his face. She says in her statement that at this point he made a “gasp” but that there was no other bodily movement. The nurse asked her to monitor him while she left the cell to get further medical assistance.

32. Another nurse was working with a prison doctor on the same evening in the consultation room on E wing. She said that the doctor received a telephone call from the first nurse at 7.30pm telling her that a prisoner on the Onslow Unit was not breathing. The doctor asked the nurse whether an ambulance had been requested, and was told that this had not been done. The second nurse immediately left E wing and went to Onslow Unit to assist the first nurse. As she made her way there, she asked the Orderly Officer, Principal Officer (PO) to call an ambulance immediately and direct them to the Onslow Unit as a prisoner had stopped breathing. After making the call the nurse returned to the cell.
33. The second nurse arrived on Onslow Unit within two to three minutes of the telephone call from the first nurse, closely followed by the prison doctor and was directed by staff to the man's cell. She said that she observed him lying on his bed in an "unresponsive state", he was pale and no chest movements were evident. She instructed the first nurse and the officer to assist her place him on the floor. She carried out an assessment of his airway, breathing and circulation. She said that no breathing sounds were heard or felt over a ten second period, there was no chest movement or carotid pulse.
34. Following the assessment, the first nurse started CPR by administering chest compressions and the doctor attended to the man's airway. At the same time, the second nurse placed automatic external defibrillator (AED) pads on his chest. (An automated external defibrillator or AED is a portable electronic device which measures electrical activity in the body and advises on action to be taken.) The AED showed that there was no cardiac output (heart beat) and advised that no shock should be administered.
35. The second nurse says in her statement that she then changed over the face mask attached to the oxygen. She replaced it with a bag, valve and mask with 100 percent oxygen, using two breaths to every 30 chest compressions. As this continued, herself, the doctor and the first nurse changed positions to ensure that they did not become too tired. The man had been moved on his mattress onto the landing to allow medical staff more room to administer treatment. Other staff moved the prisoners away to ensure that he was afforded a degree of dignity.
36. The Lead Nurse was working in the reception area when she became aware that an ambulance had been called for a prisoner. The PO informed her that a prisoner on Onslow Unit was not breathing, and she quickly went to the unit. She said that she arrived on the unit at around 7.40pm and could see the medical staff administering CPR. She tried to insert a venous cannular (inserted into a vein, primarily for the administration of intravenous fluids, obtaining blood samples and administering medicines). However, this was unsuccessful as the veins on the man's arms had collapsed, which is common in dialysis patients. The Lead Nurse noticed that the first nurse was upset and asked an officer to take her away and ensure that she had support. The Lead Nurse then took over the CPR attempts along with the second nurse.

37. Paramedics from the London Ambulance Service arrived at the Onslow Unit at 7.50pm. They attempted to insert a cannular into the right arm but again failed and they inserted it into the man's neck. The Lead Nurse told the investigator that she continued to assist with CPR. After three doses of adrenaline had been given by the paramedics, a cardiac output was established but was lost after two - three minutes. She said that CPR was then continued on the instructions of the paramedics and the cardiac output re-established. The paramedics placed the man on a portable ventilator, and a blood glucose reading was taken which was 18 millimoles per litre (mmls). (A blood sugar of 18mmols is raised but was in keeping his history of diabetes.) She said that before he was transferred to the emergency ambulance, she checked his pupils with a pen torch and found them fixed and dilated. The ambulance left the prison at 8.40pm.
38. Two members of staff escorted the man to hospital, arriving there at 8.50pm. No restraints were in place as his condition was so poorly. He was taken immediately into the resuscitation room where treatment continued. A brain scan was carried out to see if there was any bleeding but there was not. The medical staff told the officer who was escorting the man that they were unsure as to what had caused his condition. He was placed on a ventilator and, due to the seriousness of his condition, located in the intensive care unit. Hospital staff asked the officer to seek permission from the prison for them to begin contacting the man's next of kin. The officer spoke with the duty governor who said that he was happy for the hospital to make contact. The man's condition remained the same throughout the night and efforts to try and contact his nominated next of kin continued. (On his reception into custody, the man had named his brother as his next of kin.)
39. At 9.00am the next day, a Principal Officer (PO) and another officer took over the escort from the previous officers. The PO had been appointed as the prison family liaison officer. He had attempted to contact the man's brother and had left a message for him to make contact. The PO also contacted the man's solicitor at 12.45pm in an attempt to obtain other contact details for his family.
40. At 2.10pm the PO finally managed to contact the man's sister after being informed that his brother was out of the country. His sister gave the PO her husband's number. The PO informed him of his brother-in-law's condition and told him that hospital staff had advised that he and his wife go to the hospital.
41. The man's sister and brother-in-law arrived at the hospital at 2.35pm. The PO explained what had happened the previous evening. He introduced them to the Imam at Wandsworth prison and the duty governor. Following this, a doctor from the intensive care unit explained to them that the man had suffered a serious heart attack. The family members were told that, although he had been resuscitated, tests indicated that there was no brain function. The doctor said that, given the result of the tests, no further treatment could be provided and he would be made as comfortable as possible until he passed away.
42. The family spent time alone with the man saying prayers. The PO remained and offered advice on the support available to them. During this time there was

no indication that any other family members should be notified. It is also not apparent that the family members present were asked whether any other next of kin needed to be informed. The man's sister left the hospital at around 7.00pm and his brother-in-law remained at his bedside. At 9.40pm he died.

Actions following the man's death

43. After the man's death, the PO gave information to the family about what would happen next in terms of the Coroner's and this investigation. His sister and brother-in-law said that it would be the family's wish for his body to be returned to Bangladesh. The PO told them that he would seek advice and advise on the assistance that could be given.
44. In the evening, the man's wife was informed by a family friend that her husband had been taken to hospital. On hearing this news one of his two daughters telephoned Wandsworth in order to try and gain more information. Unfortunately, the prison would not give any information and advised his daughter to telephone the following day. A message was left for the PO informing him that a person had contacted the prison claiming to be the man's daughter. (The prison had been unaware of any other family members until this point.)
45. The man had been convicted of a serious offence against his wife, and was not allowed to have contact with her. He had not sent visiting orders to his children and so no record of them was held by the prison. However, his children told the investigator that they had attempted to visit him. They said that they had telephoned to ask for messages to be passed to their father asking that he send them visiting orders. It is not known whether he ever received these messages. The prison did confirm that unless the person passing the message had been confirmed as next of kin it would be unlikely that requests via the telephone would be actioned.
46. The man's daughter telephoned the following day and, after it was established that she was a relative, was spoken to by the Imam who informed her of her father's death.
47. The PO spoke with both sides of the man's family (who were not in contact with each other) and advised them that the Coroner would decide who his body would be released to. At the request of the Coroner and to assist him make a decision, the PO contacted the man's solicitor to ascertain whether a divorce had taken place or instructions had been given in a Will. The PO also spoke to the man's stepson who requested permission for the man's children to attend the prison and view the Onslow Unit. The PO arranged this.
48. As there was no Will and no divorce had taken place, the Coroner concluded that the man's wife was legally the next of kin and his body was released to her and his children. His wife and children had concerns about a post mortem taking place and wrote to the Coroner to request that one was not performed for religious reasons. However, a cause of death needed to be established and

a post mortem was carried out. The cause of his death has been given as Coronary Artery Disease.

ISSUES

Missed dialysis appointment in February

49. The man's family raised concerns that his appointment was cancelled in February and not rescheduled for the following day. The family were also concerned that the person who had made the decision at St Pancras renal unit had done so without knowing his full medical history.
50. The weather in February was extreme and few public services were working normally. Emergencies had to be prioritised and routine dialysis appointments were not classified as such.
51. The staff nurse at St Pancras was a member of the renal team and would have been familiar with the risks of dialysis patients missing appointments when she gave the advice. As the man had been attending the renal unit for some time, the staff nurse would have had access to his medical history and been familiar with the days that he attended. There was nothing to suggest that he needed to be seen in the renal unit any earlier than his scheduled appointment in February. However, the staff nurse in the renal unit did advise the prison that if he was to complain of feeling unwell he was to be taken directly to hospital. The investigator found no evidence that he reported any concerns with healthcare staff after he missed the appointment.
52. According to his cellmate, the man had been eating normally and had taken his medication as prescribed. A prison officer told the investigator that he believed that the man had mentioned feeling unwell during the day but he could not recall whether the man had reported this to healthcare staff. The nurse said in her statement that he had collected medication at 5.15pm and she had also spoken to him at 6.00pm. On neither occasion did the nurse say that he complained of feeling unwell.
53. The man's family were concerned that the missed appointment could have been the cause of his heart attack. The investigator asked the clinical reviewer if he could address this in his report. The clinical reviewer says in relation to the affects of the missed appointment:

"... I note that the man's serum potassium was within normal limits on his admission to hospital. (Potassium is very important for normal heart and nervous system function. A high blood level of potassium can lead to serious and even fatal heart rhythm problems.) If the delay in dialysis had been significant I would have expected the potassium to have been significantly raised ..."

54. The clinical reviewer has made no recommendations following his review of the man's medical care at Wandsworth. He concluded:

"...the man collapsed and was resuscitated and was transferred to hospital and then the Intensive Therapy Unit and despite the best efforts of the clinicians he sadly died. The care of the renal team and

the prison staff seems to have been appropriate, professional and thorough ...”

55. I am satisfied that the clinical reviewer has considered whether missing dialysis was the cause of the man’s fatal heart attack, and find no evidence that it had any impact.

Family concern about the post mortem

56. The man’s family expressed concern over the post mortem process because of religious grounds. They were advised by the Imam at Wandsworth to make written representations to the Coroner. They did so but the post mortem went ahead. The family asked the investigator and FLO whether they could have made more effective representations. The investigator therefore asked the clinical reviewer to provide guidance on the post mortem process and clarity on the requirement for them. The clinical reviewer writes in his report:

“... I understand that the man’s family were keen to avoid a post mortem examination. However, my understanding is that the Coroner has a legal duty to seek to clarify the cause of death and that this in most cases requires a post mortem examination to be performed ...”

57. The investigator also asked the Coroner’s officer if it was possible for a family to request that a post mortem does not take place. The officer explained that if the death has been referred to the Coroner (as with all prison deaths) and the Coroner considers that a post mortem is necessary to determine the cause of death, (as with the man) then a post mortem will take place. If a post mortem is ordered by a Coroner it must take place by law, whether the next of kin gives agreement or not.
58. It would be advisable for the prison to be aware of the post mortem process and any possible religious objections. The FLO and chaplaincy staff should be aware of the requirements of the process. Had the Imam been able to be clarify the inevitability of the process, the family might not have had the false hope that they could dissuade the Coroner.

Family liaison by the prison

59. The man’s wife and children were extremely upset that they were unable to spend time with him before he died. They asked the FLO and the investigator whether the prison could have done more to try and trace other next of kin. They were also concerned with what they saw as a “speedy decision” to remove the life support without any attempt being made to clarify whether there was any other family.
60. When someone enters prison custody they are asked to provide the name of either next of kin or someone they wish to be notified in the event of an emergency. Some prisoners give no details and, should the need arise, this can make it very difficult and sometimes impossible for the prison to trace

family or friends. When the man came into custody he gave the name of his brother as next of kin.

61. Due to the nature of his offence, the man was subject to restrictions as to who he could contact. This would have included his wife as the victim and possibly his children. It is often possible to identify and trace friends and family through the visits record. However, he had not received visits from his children which may have been for the reasons mentioned.
62. After he was taken ill, the prison quickly appointed the PO as the liaison between the prison and the nominated next of kin. The PO tried a number of different avenues to make contact with the man's next of kin before finally contacting them in the afternoon. After their arrival at the hospital, the man's sister and brother-in-law were informed of the seriousness of his condition. At no time either before or after his death did they mention to prison or hospital staff that he had any other immediate family.
63. Once it became apparent that the man had children and that his wife wished to be treated as his next of kin, the prison ensured that both parts of the family were informed about the Coroner's investigation. After the Coroner had made his decision on the next of kin, the prison assisted in meeting funeral expenses and also ensured that the family were given the opportunity to visit the prison.
64. The decision to withdraw treatment, which is often referred to as "turning off life support" is a medical decision. It is based on the severity of a patient's condition and the likelihood of a recovery. Tests conducted after the man arrived at hospital confirmed that he had no brain activity and, as such, would be unlikely to survive without medical intervention. The decision was taken for him to be kept comfortable but no further treatment was provided to allow him to die peacefully.
65. I consider that the actions of the prison in trying to notify the nominated next of kin were appropriate. Although I fully appreciate the distress that not being able to spend time with the man caused his wife and children, I do not believe that the prison or the hospital could have done more to identify other family members.

CONCLUSION

66. When he entered prison, the man was already suffering from a serious condition that required regular medical treatment. In addition, he also had other chronic conditions that required regular monitoring and treatment. It is evident to me that the healthcare staff at Wandsworth managed all these conditions appropriately.
67. Until February the man had attended all his dialysis appointments. Due to severe weather conditions and, only after advice had been sought, was the appointment cancelled. I fully understand the family's concern that this could have been a contributory factor, having occurred so soon before his death, but there is no medical evidence to support this.

68. The man had been well in the days before his death and was eating and collecting meals as usual. Despite his poor health, his death came as a shock to all those who knew him. I judge that he was well cared for at Wandsworth and that nothing could have been done to prevent his death.

Family response to draft report

69. Unfortunately, the inquest into the man's death was held before the complete feedback was received from the family. The family provided comprehensive feedback and raised a number of concerns, which have been considered by the investigator. Where possible amendments to the report have been made. However, there were a number of points relating to further information that the investigator has been unable to answer, as information is not available. The family have been provided with all the documents that were available to the investigator.
70. One of the main concerns for the man's family was the fact that they were not contacted immediately as his next of kin. The family enquired whether the sister and brother-in-law had been asked if there were other family members who needed to be notified. There was no evidence that this was a question asked by the prisons family liaison officer. However, he had not listed any other next of kin and his sister and brother-in law never mentioned that there were other immediate family members.
71. It is clear that not being notified immediately about his death caused the man's wife and children further upset. To try and ensure that this problem is avoided in the future the following recommendation is made:

The Governor should ensure that when a Family Liaison Officer is appointed they routinely enquire as to the presence of any other next of kin who may need notifying and this is documented.

RECOMMENDATIONS

1. **The Governor should ensure that when a Family Liaison Officer is appointed they routinely enquire as to the presence of any other next of kin who may need notifying and this is documented.**