Investigation into the circumstances surrounding the death of a man at HMP Wandsworth in February 2008

Report by the Prisons and Probation Ombudsman for England and Wales

January 2009

This is the report of an investigation into the death of a man who died from natural causes on 18 February 2008 in his cell in HMP Wandsworth. He was 35 years old.

I would like to add my personal condolences to those already expressed to the man's family on behalf of my office, by one of my Family Liaison Officers.
The investigation was undertaken by one of my investigators. Both he and I would like to thank the Governor and his staff for their participation and assistance. Wandsworth Primary Care Trust were asked to undertake a review of the man's clinical care, and I also appreciate this. I must apologise for the delay in issuing this report and for any additional distress caused to the man's family.

The man was the 17th prisoner to have died in HMP Wandsworth since I was entrusted with responsibility for investigating all deaths in prison custody. I do not believe there are any significant common features between this investigation and those into any of the previous deaths.

I make one recommendation to the Governor. I am pleased to see that the recommendation has been partially accepted and that the prison are arranging heart start training and refresher training for staff who have contact with prisoners. My report also draws attention to a number of other matters that the Governor will wish to take forward by way of renewed advice and guidance to his staff. In particular, I note that those staff 'first on scene' did not commence resuscitation as they did not feel confident of their ability to do so.

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

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SUMMARY

The man was 35 years old and nearing the end of a two year prison sentence in HMP Wandsworth. He had not encountered any problems during his sentence, and was noted as a good worker who got on well with both staff and fellow prisoners.

On 18 February 2008, the man and his cellmate were taking an afternoon sleep in their cell. When the cellmate awoke, he immediately became concerned about the man's wellbeing. He was not breathing and would not respond, so the cellmate alerted staff. Officers came to the cell and could see that there was a problem. They called for a nurse. The officers did not attempt to resuscitate the man.

A nurse attended very quickly, and efforts to resuscitate the man began. Although he was on the top bunk bed and staff had to stand on furniture to reach him, my investigator was told that this did not hamper the attempts to revive the man. Other staff arrived quickly to assist with the resuscitation and an ambulance was called. Other prisoners were taken away from the area and back to their cells, and the man's cellmate was relocated and given support.

The prison's medical emergency responder was called. After initially being sent to the wrong location, she joined colleagues in the man's cell as they continued to try to resuscitate him. Ambulance staff arrived and took over, but sadly were unsuccessful.

The post mortem found that the man died as a result of a problem with his heart. The clinical reviewer has likewise concluded that the man died from natural causes.

THE INVESTIGATION PROCESS

1. My investigator visited HMP Wandsworth and spoke to staff who had dealings with the man during his imprisonment and prisoners who knew him. He interviewed eight members of staff and two prisoners. Eight of these interviews were recorded and transcripts are annexed to this report. Copies of these transcripts were sent to the interviewees to check and agree that they were accurate. (Four signed copies were returned.) The other two interviews were not recorded but notes of the meetings were taken and forwarded to the interviewees to confirm the content. Neither of these interviewees returned signed copies.

2. Notices were posted to staff and prisoners about the investigation. There was one response from a prisoner. In addition, my investigator studied all relevant prison records relating to the man. These included his main prison record, medical records and statements made by staff. My investigator also visited the wing where the man lived, including his cell and the staff office.

3. Wandsworth Primary Care Trust identified a clinical reviewer to carry out a review, which was received on 1 September 2008. I am most grateful for the review. My investigator discussed aspects of the response to the man's collapse with both healthcare staff at Wandsworth and with the clinical reviewer.

4. The investigator also contacted HM Coroner to inform him of the nature and scope of my investigation and request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist his enquiries into the man's death.

5. One of my Family Liaison Officers spoke to the man's mother. She said that she wanted to know the cause of her son's death, and to see my report. I hope that my report answers any questions that the man's family may have.

HMP WANDSWORTH

6. Wandsworth is one of the largest prisons in Western Europe. It was first opened in 1851. It has the capacity to hold over 1,400 prisoners and a recently-opened refurbished wing has added extra cells.

7. The Onslow Unit is the Vulnerable Prisoners Unit and is separate from the main accommodation units. It holds up to 300 prisoners.

8. Wandsworth has 24-hour healthcare cover. There is at least one doctor on site until 10.00pm, and on-call cover out of hours. However, the doctors act as General Practitioners and do not necessarily expect to respond to emergencies. Hotel Three is the radio call sign for the emergency response medical officer in the prison, and this will be taken on rota by medical staff.

Inspectorate report

9. The most recent inspection of Wandsworth by HM Chief Inspector of Prisons was a full follow-up inspection in July 2006. The subsequent report does not touch on any of the issues raised in this investigation.

Independent Monitoring Board (IMB)

10. Each prison in England and Wales has an Independent Monitoring Board responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are maintained. The last report published by the IMB before the man died does not raise any issues of relevance to this investigation.

KEY FINDINGS

11. The man was convicted on 30 January 2007, and on 12 March 2007 was sentenced to two years imprisonment. He was allocated to HMP Wandsworth, and located in the Onslow Unit. He worked as a cleaner and received good reports and several commendations for his work.

12. After the initial health screening at reception, the man did not have any proper contact with healthcare staff until 11 February 2008 when he complained of a dental abscess. He was prescribed antibiotics and painkillers.

13. A fellow prisoner and the man had been on a cleaning course together, and knew each other reasonably well. On the Friday before he died (Friday 15 February), the man complained to the other prisoner about pain in his chest. The prisoner asked him to point to where this pain was, and the man pointed to his side just above his hip. The prisoner joked that this was not really chest pain, but advised the man to speak to medical staff if he felt any more pain. It does not appear that the man took this advice. At interview with my investigator, the other prisoner wondered whether the man felt a degree of stress about his imminent release. The man was due to be released within a matter of weeks, and had expressed some concern as to how he would cope and be received on his return to society.

14. Because of a staff absence, the office where the man worked as a cleaner was not open for a time in February. The man therefore did not go to work for a few days. This was the case on Monday 18 February. The man's cellmate had only recently arrived in Wandsworth, he did not yet have a job. The man's cellmate told my investigator that the man enjoyed his job, and was a little unsettled by having nothing to do. They played cards and Scrabble up until lunchtime, which was approximately midday. They went from their cell on the fourth floor landing (K4 landing) down to the servery on the second floor, where they collected their lunch and brought it back to their cell. Once they were back in their cell the door was locked.

15. After lunch the man said that he was tired, and asked his cellmate if he minded if he went to sleep. His cellmate said that was fine by him and decided to sleep as well. The man was in the top bunk bed and his cellmate in the bottom one. Each retired to his bed, setting a reminder on the television to wake them in time to listen to the draw for the quarter-finals of the FA Cup at 1.25pm.

16. The two men woke in time to listen to the FA Cup draw, then talked about football for a time. They then turned the television off so they could sleep some more. The man's cellmate told my investigator that the man began to snore very loudly, so much so that he thought he was putting it on for comic effect. He kicked the bed to shake it, but the man did not stop snoring. They were friends, and the cellmate decided to let him enjoy what he assumed was his joke. The snoring generally subsided, but with an intermittent loud snore every now and again.

17. After a while, the man's cellmate got out of his bed to use the toilet. He noticed the man's arm hanging out of his bed, but did not disturb him and went behind the privacy curtain. When he came back out he saw that the man's eyes were open and he was looking towards the ceiling. There was nothing unusual in that: The man had often silently reflected on things, and his cellmate went back to his bed.

18. About 30 minutes later the cell door was unlocked. This was not a prison roll check and the officer unlocking would not be expected to look into the cell. The man's cellmate saw that the man's arm was still hanging out of his bed, but now it had changed to a purple colour. The man's cellmate immediately suspected that something was not right and got out of bed. He looked at the man, and noticed that he had no colour in his skin and his veins were protruding. He called the man's name a few times but, getting no response, ran out of the cell to get help.

19. An officer was patrolling on K wing, and was only a few doors along the corridor when the man's cellmate came out of the cell. This was at approximately 2.20pm. He was the nearest member of staff and the cellmate told him that the man was not breathing. The officer went into the cell and noted that the man's skin was discoloured, and that he did not appear to be breathing. The officer had not received any first aid training beyond that which he received as part of his initial prison officer training, and told my investigator that he did not feel confident that he could resuscitate the man. He also thought it important to alert other staff rather than commencing resuscitation and not being able to summon help. He came out of the cell and called to a colleague on the second landing, telling him to get a nurse. The officer then ran down the stairs to the second landing to alert other members of staff and get medical assistance from someone in the treatment room on the second floor landing. On the way there he passed a second officer on the stairs and told him what was happening. While the officer went to the treatment room, the second officer ran back up to the fourth landing and into the cell.

20. Like the first officer, the second officer had received no first aid training beyond his initial prison officer training. He saw the man, and was taken aback by how he looked. He stepped back out of the cell. Only certain staff in each area of the prison carry radios. On that day another officer was one of the staff on Onslow Wing who had a radio. The second officer called over the balcony to the third officer on the second landing that there was a Code Three situation. (Code Three is a radio call sign used to indicate that someone is not breathing, and is understood by staff throughout the prison.) The third officer immediately notified the control centre over the radio, and then went to the fourth floor landing so a member of staff with a radio was available if required. This was at 2.25pm.

21. Two nurses were in the treatment room on the second floor landing when the first officer came in and said that a nurse was needed on the fourth floor landing. The first nurse saw from the first officer's manner that it was urgent and ran up to the cell. On arrival he checked the man for signs of life but could not find any. He called out that someone should ensure that Hotel Three was on the way. The man was still lying on the top bunk bed, so the first nurse stood on a chair to

allow him to begin cardiopulmonary resuscitation (CPR). The first nurse told my investigator that he was not hampered in performing CPR by having to do it while standing on a chair.

22. A crowd of prisoners had gathered around the door to the cell, and one prisoner said he thought the man was dead. The first officer and colleagues cleared the crowd and escorted prisoners on the landing back to their own cells. At this point the man's cell mate collapsed. The second officer helped him to the medical room and a doctor briefly checked him before the second officer showed him into an office and took a statement from him. The man's cell mate was quite distressed, and was taken into a Listeners suite. (Listeners are prisoners who have been trained by the Samaritans to provide support for other prisoners). A member of the chaplaincy team, a Reverend, came and spoke to him and he was allowed to make a telephone call. He spoke further with Listeners in the Listeners suite and, after he had changed his clothing, he was taken to another cell to share with another prisoner with whom he was friendly. The second officer opened an ACCT document (Assessment, Care in Custody and Teamwork: support for prisoners who may be vulnerable or at risk of self-harm) for the man's cellmate. He also made sure he spoke informally to the man's cellmate in the following days.

23. The senior officer of staff on Onslow Unit on 18 February was briefed as to what was happening. He arrived at the cell at the same time as the third officer. Neither the senior officer nor the third officer had received any first aid training since their initial basic training. The senior officer told the third officer to assist the first nurse. The third officer took over performing chest compressions, balancing himself with one foot on the chair and one foot on the bed. Again, the third officer told my investigator that he was not hampered by having to perform CPR with the man still on the top bunk bed. The senior officer asked the first nurse if he needed an ambulance, and checked with the control centre to ensure one was on its way. An ambulance was called by the control centre at 2.33pm. The senior officer alerted the duty governor and also ensured that a member of staff was taking a log of what was happening, and that the Orderly Officer (the senior member of staff scheduled that day with responsibility for the prison's operations) was aware of the situation.

24. A sister was the designated Hotel Three medical emergency responder on 18 February. When the control centre had been informed that there was a Code Three emergency, they radioed the sister and told her to go to A4 landing. This was at 2.26pm. The sister was being shadowed by another nurse on that day, so she instructed the nurse to collect an emergency bag and she went straight to A4. On arrival there was no sign of any emergency, and staff there were unaware of one. The sister radioed the control centre and asked for confirmation. The control centre checked, and then informed sister that the emergency was on K4 landing. It took the sister a further few minutes to make her way to the Onslow Unit, where she and the nurse were directed by staff to the man's cell.

25. The duty governor on being alerted by the senior officer, immediately made his way to the man's cell. He ensured that an ambulance had been called and that

a log was being taken, and informed the Governor and Deputy Governor what was happening. He then relieved the third officer in performing CPR. As more medical staff arrived, the third officer left the cell. The duty governor continued performing CPR until he in turn was relieved by the first nurse. The duty governor told my investigator that it was a deliberate decision to carry on performing CPR with the man on the top bunk bed, and to take further advice from paramedics when they arrived.

26. When the first nurse had left the treatment room and gone to the fourth floor landing, the second nurse secured the room and followed on with an emergency bag. He remained outside the cell and passed equipment in to colleagues as required.

27. When the sister arrived at the man's cell, the first nurse was performing CPR. He briefed the sister on what had happened, and the sister checked the man for signs of life. She found none. While first nurse continued with chest compressions, the sister told the nurse to manage the man's airway and provide oxygen. The sister applied a defibrillator (a machine that applies electrical impulses to the heart) to the man's chest. The machine indicated that there was no rhythm. They continued to check the man's heart for traces of rhythm every two or three minutes whilst still performing CPR, but no rhythm was found. The man vomited due to the pressure of the chest compressions. (It is a possible effect of CPR and did not indicate that he was still alive at the time.)

28. The ambulance arrived at 2.45pm. Paramedics went to the man's cell, which non-medical staff had now left. With prison medical staff continuing CPR, the paramedics went through their system of checks on the man. No signs of life were found. They administered drugs to the man to assist the resuscitation effort, but to no avail. Shortly after 3.00pm it was agreed that life was extinct, and that the man had died. The paramedics left the prison and, after medical staff had cleaned the man, the cell was sealed.

29. A hot debrief was held by a principal officer. Members of the Post Incident Care Team attended to offer support to any staff who felt that they needed it, and to let them know that ongoing support would be available afterwards. Uniformed staff told my investigator that they were happy with the support offered. The first officer told my investigator that the principal officer spoke to him in the days afterwards to ensure he was not suffering any delayed anxiety or problems. A round-up meeting was also held the following day (Tuesday 19 February), chaired by a governor.

30. When they had left the man's cell, the sister had asked medical staff to make written statements. She checked that the staff were all okay and asked if anybody had any issues they wanted to raise. There were none. Medical staff were also invited to the hot debrief, but by the time they had completed their statements none actually attended.

31. Prisoners were locked in their cells after lunch. Rumours spread through the wing that this was because a prisoner had taken his own life. Later that afternoon, the other prisoner was in the queue to collect his evening meal when

another prisoner said he had heard that it was the man who had taken his own life. A member of staff confirmed that it was the man who had died, but had collapsed rather than taken his own life. The other prisoner was rather shocked by this news and the way he had found out. He does not recall any official notification being made to prisoners. The other prisoner was aware of the methods of support that were available to him both at the time and subsequently, but does not remember being specifically offered support should he have needed it. Staff told my investigator that all prisoners with an open ACCT document were reviewed within 24 hours.

32. The man's family were informed of his death by the prison's family liaison officer, and the chaplain. They were offered assistance with the funeral costs, and the prison was represented at the man's funeral. The family told my family liaison officer that they were treated well in their contact with the prison.

33. The two nurses told my investigator that no formal support was offered to them. They would have welcomed this. The first nurse did say, however, that a governor personally spoke to him and thanked him for his attempts to revive the man. The sister, his line manager, was also supportive in the following days. The sister told my investigator that, while she did not recall any support actually being offered, she was aware of the good support available from colleagues and from the prison's care team.

34. A church service for the man was held in the prison chapel. The man's family were invited to this service and attended. Prisoners also signed a book of condolence.

Post mortem report

35. The post mortem report indicates that the man died of a prolapsed mitral valve and left ventricular hypertrophy, which are both problems with the heart.

ISSUES

Healthcare

36. The clinical reviewer says that he found nothing significant in the man's medical records. His family have said that the man had heart surgery as a child, but medical notes do not contain any information about this.

37. There is no evidence that there was any infection as a result of the man's dental abscess. There was no evidence of any illegal substances in the man's system, and the clinical reviewer is of the opinion that the man died from natural causes.

38. The call to the control centre informing them of the emergency was made at 2.25pm. An ambulance was not called until 2.33pm. Prison Service Order 2710 says that "local contingency plans must provide for the summoning of an ambulance … and state clearly who should do this". In this case trained medical staff were with The man in a very short time and it is unlikely that the delay had any effect on the outcome. However, while I make no formal recommendation, the Governor will wish to ensure that Wandsworth's local instructions are clear about summoning an ambulance when an emergency call has been made.

Staff first aid training

39. Uniformed staff are given first aid training as part of their induction when they join the Prison Service. Beyond that, there are no further courses or refreshers unless staff elect to undertake these on their own. The first two members of staff who entered the cell looked at the man and then went to seek help. Neither felt confident in attempting CPR. Although I do not believe it likely that their decision not to commence CPR made a difference on this occasion, it could do so in other circumstances. The Governor will wish to consider what further advice or training he should offer his staff about their responsibilities when 'first on scene'.

40. In that light, the second officer told my investigator that he thought annual refresher training would be helpful. The duty governor told my investigator that first aid training is often cancelled through lack of instructors. The clinical reviewer writes that the prison should consider regular updates on basic life support training for uniformed staff. This is a view that I share. Indeed, the question of first aid and life support training arises in very many of my investigation reports.

The Governor should consider refresher first aid training for all staff who come into contact with prisoners.

41. When staff attended the man's cell and needed to perform CPR, The man was lying on the top bunk bed. Rather than moving him before attempting resuscitation, staff stood on furniture to put themselves at the correct height. The clinical reviewer notes in his report that staff were carrying out resuscitation in a satisfactory fashion. I do not underestimate the physical and emotional demands on both uniformed and healthcare staff when attempting resuscitation and intend no criticism whatsoever of the staff members concerned. For that reason, I make no further comment save to note that CPR is best conducted on a firm surface rather than on a bed. Again, this

is something that the Governor may wish to reinforce in his advice to staff about dealing with a medical emergency.

42. When the emergency responder, the sister, was told to respond to a Code Three emergency call she was sent to the wrong location. In this instance medical assistance was already with the man and it does not appear that this had a material effect on the final outcome. I do not make a recommendation here, but the Governor will wish to reinforce to his staff that it is imperative in an emergency that the correct information is passed on.

RECOMMENDATION

The Governor should consider refresher first aid training for all staff who come into contact with prisoners.

The Prison Service have partially accepted this recommendation. They comment that HMP Wandsworth are in the process of organising a “heart start” training programme for staff. All staff who have contact with prisoners will undertake the course and will be regularly refreshed as part of a rolling programme organised by the training department.