Investigation into the circumstances surrounding the death of a man at HMP Wormwood Scrubs in March 2008

Report by the Prisons and Probation Ombudsman for England and Wales

March 2010

This is the report of an investigation into the circumstances of the death of a man at a local hospital on 9 March 2008. The man was a remand prisoner at HMP Wormwood Scrubs. He died from a sudden brain haemorrhage and chronic alcoholism. The post mortem also found that he had a fractured skull.

The man who died had been in police custody overnight on 7 March 2008. The following day, he was remanded into custody at Wormwood Scrubs. He was in the prison for around two and a half hours before being taken to hospital where he died in the early hours of 9 March. The man's death was sudden and unexpected. I would like to offer my sincere condolences to his family and friends.

This investigation was carried out by one of my investigators with some assistance from another member of my team. It was conducted after a mandatory police investigation that ended in July 2008. (The police investigation was required as the man had died within 24 hours of release from a police station and any police inquiries take precedence over my own.) I am most grateful for the assistance given by the Detective Inspector who conducted the police investigation. However, I am conscious of the time my investigation has taken and how difficult this has been for the family. The events surrounding the man's death proved to be complex and I have wanted to provide as full a picture as possible.

I also wish to thank the Governor of Wormwood Scrubs and his staff, particularly the Deputy Governor, for their co-operation. I am also indebted to the prison liaison officer and his successor for their assistance.

Two clinical reviews were carried out to assist the investigation, which meant a further regrettable, but necessary delay before I could finalise this report. Both focussed on the man's clinical care and looked at how discipline and healthcare staff managed him during his short time in prison custody. The first clinical review was undertaken by a panel chaired by a doctor on behalf of the local Primary Care Trust for which I am grateful. With the assistance of a Senior Public Health Adviser, Offender Health, I commissioned a second review to explore further some of the issues that had emerged during the course of the investigation. They appointed a doctor to undertake this review, and I am grateful to them for their valuable contribution. Their work has assisted my investigation to highlight lessons for staff employed by the local Primary Care Trust and the Prison Service, and to provide some answers for the man's family.

My investigation has found a series of failures from the time the man entered custody to when he collapsed and was taken to hospital. I am disappointed I must make no fewer than 12 recommendations. The most serious matters relate to the failure of healthcare staff to recognise his collapse as a serious medical emergency. This has raised a number of important issues regarding staff response to incidents, their supervision and training, and I have made recommendations in respect of these matters. In addition, I judge that nursing staff failed in their duty of care towards the man and, in some instances, their approach demonstrated a lack of common sense.

Wormwood Scrubs is an extremely busy local prison with a First Night Centre that functions under great pressure. It appears that healthcare staff have adopted the practice of sending sick prisoners to the First Night Centre if the healthcare centre is

full. This was certainly inappropriate in this man's case given his condition and I recommend that the practice ceases.

The clinical reviewer makes some observations about the man's time in police custody that fall outside the remit of my investigation. I will therefore ensure that these matters are drawn to the attention of the Independent Police Complaints Commission.

The National Offender Management Service has accepted ten of my twelve recommendations and their response is documented on page 33 of my report.

The family have responded to my report through their solicitor. They have raised issues that do not directly relate to the circumstances surrounding the man's death and I have raised these separately with the Governor.

Stephen Shaw CBE
Prisons and Probation Ombudsman **March 2010**

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SUMMARY

The man who died was arrested on 7 March 2008 and taken to a Police Station where he remained overnight. He had a long history of abusing alcohol and was drunk when he was arrested. He was assessed by a police doctor while he was in police custody. He was taken to a local Magistrates Court the following day and remanded into custody at HMP Wormwood Scrubs, arriving between 3.00pm and 3.30pm. Prison escort staff, and the other prisoners he travelled with in the vehicle, said that the journey to the prison was uneventful and he seemed fine.

Two reception officers recall that the man had a head injury when he arrived at the prison but there is no documentary evidence to support this. The nurse who carried out the first reception health screen did not make a full assessment of the man's alcohol abuse. Nor did the nurse fully complete the necessary paperwork or carry out a physical examination. After his medical interview, he waited in the reception holding room to be escorted up to the First Night Centre (FNC). An Officer arrived to escort the man and two other prisoners to the FNC. As the man followed the Officer from the holding room, he collapsed in the corridor. When the nurse who conducted the first reception health screen heard a call for help, they left the medical room to attend to the man. They were joined by another nurse who brought the emergency bag.

The nurses have said they checked the man's vital signs and that he responded verbally. They helped him to his feet and, with the assistance of another Officer, into a wheelchair. A decision was made to take the man to the FNC. The Officer that helped the man into the wheelchair told the investigator he wheeled him into the lift and took him to the FNC, accompanied by the nurse who conducted the first reception health screen. He described the man as hallucinating by this stage.

FNC staff were busy serving tea when the man arrived. An Officer who was in the FNC said he was shocked at the man's condition and felt that the FNC staff would be unable to meet his needs. The only space available in the FNC was in a dormitory with three other prisoners. After he was left there, the man's health deteriorated further and he fell out of his wheelchair. He was reported as vomiting, hallucinating and staggering around. CCTV coverage in the dormitory shows that the other prisoners became agitated and anxious.

Because of a misunderstanding at the prison gate when she arrived, the prison doctor was in the security building rather than the FNC when the man arrived. The nurse who conducted the first reception health screen left the man and went to escort the prison doctor from security to the FNC. The prison doctor examined the man and immediately recognised the gravity of the situation. She asked healthcare staff to call an ambulance.

The man's health continued to deteriorate and the prisoners in the dormitory became very agitated at the lack of immediate response to their calls for help. The man was eventually removed from the dormitory by the nurse who conducted the first reception health screen and another Officer. Although a wheelchair was by the man's bed, they walked him down the lengthy corridor to a single cell at the end of the FNC.

The ambulance arrived at 5.04pm. One of the paramedics told the investigator he asked for the man's cell to be opened and was surprised to see he was not placed in the recovery position. While being taken to hospital in the ambulance, restraints were applied as he was not known to the staff and was assessed as a risk. The restraints were applied at 5.35pm and removed at 5.50pm at the request of medical staff.

At around 7.00pm, a neurosurgeon at the hospital told the escort officers that the man would not benefit from surgery and had only hours to live. The man had named his solicitor as his next of kin and the prison had no record of family details, but a note was found in his belongings that gave contact details for his family. The prison asked the police to visit the family to tell them. The man's family went to the hospital where they said their private farewells to him. He was given the last rites.

My investigation has found that the man suffered from chronic alcohol abuse but that his treatment and care in custody were inadequate. There was a series of failures in the short time that he was at Wormwood Scrubs arising from the inability of staff to recognise the seriousness of his condition and to take appropriate action. I make 12 recommendations. Ten of these recommendations have been accepted by the National Offender Management Service.

THE INVESTIGATION PROCESS

1. I was notified of the man's death on 10 March 2008. Terms of reference and notices were issued to staff and prisoners at Wormwood Scrubs telling them that an investigation would be taking place, and inviting those who wished to see the investigator to make themselves known. My investigator requested copies of the man's reception records, clinical record, and other records relevant to his time in custody and his death.

2. My investigator also contacted HM Coroner to inform her of the nature and scope of my investigation. The Coroner has requested a copy of my report and I am happy to comply. The post mortem report indicated that the cause of death was:

    1a Spontaneous intracerebral haemorrhage
    2 Chronic Alcoholism.

3. The police provided statements they had taken during their investigation and a closed circuit television recording (CCTV) in July 2008. The contents of the police statements and the CCTV have proved invaluable in piecing together events before and after the man's death. (My investigator was originally told by prison staff that no CCTV coverage was available.)

4. My investigator visited Wormwood Scrubs on three occasions. During the first visit, she toured the reception area and the First Night Centre where he was located following his collapse. She visited twice in January 2009, accompanied by a colleague. My investigator and colleague met the Deputy Governor and spoke informally with other members of discipline staff.

5. The Terms of Reference for the Ombudsman's office require co-operation with the National Health Service in order to review the clinical care of the deceased. Accordingly, my staff do not generally have clinical qualifications and rely on the advice of the clinical reviewer. In this investigation, my investigator would have benefited from carrying out formal joint interviews led by a clinical reviewer. However, the local Primary Care Trust were unable to assist my investigator with the joint interviewing of healthcare staff. The first clinical review of the man's medical care was commissioned from the local Primary Care Trust and received by my office on 2 May 2008. It was undertaken by a review panel chaired by a doctor.

6. The Metropolitan Police conducted a separate investigation into the man's time at the Police Station where he had been in custody before his remand to prison. They disclosed the outcome to my office in early July 2008. The information revealed in the police statements raised a number of questions relevant to the man's clinical care that had not been addressed by the panel review. On 10 July, my investigator emailed the Clinical Governance Manager asking for the panel to revisit their findings in the light of the additional information. In the absence of a response, on 19 August 2008 my investigator wrote to the Chief Executive of the PCT asking for a suitably qualified member of the PCT to accompany her to conduct joint interviews at the prison. Again, she received no reply.

7. In September 2008, my investigator spoke with the Commissioner of the local PCT, reiterating her request for reconsideration of the initial review. This was followed on 30 September by a further conversation and an email outlining my investigators outstanding concerns for the panel's consideration. The panel reviewed the additional information from the police, but their conclusions regarding the man's clinical care remained the same.

8. As I felt that fundamental questions about the actions taken by healthcare staff remained unexplained, on 29 October 2008 my investigator wrote to the Coroner explaining the lengthy delay and seeking a view as to whether it would be helpful to commission a further clinical review.

9. In January 2009, my investigator and a colleague interviewed healthcare staff. Regrettably, they were unable to interview the nurse who helped the man on his collapse, who was Hotel 1 at the time of his death as she was not available. (Hotel 1 is the code name given to a member of the healthcare staff with the task of responding to emergency medical situations that may occur throughout the prison.) The investigator subsequently discussed the absence of this evidence with the clinical reviewer who conducted the second clinical review. He was of the opinion that, as the failures were systemic, it was not crucial to the overall findings of the investigation to interview the nurse.

10. My investigator emailed the Detective Inspector who conducted the police investigation on 30 January 2009, telling him that a further line of enquiry had emerged during interview as reception staff recalled that the man had arrived at the prison with a head injury. She gave him the opportunity to investigate further. The Detective Inspector replied that there was no evidence to suggest any injury prior to or during the man's detention in police custody.

11. Given the outstanding concerns raised by the investigator the Deputy Ombudsman asked for the assistance of a Senior Public Health Adviser, Offender Health, to appoint a further clinician to review the man's medical care. A doctor was appointed and reviewed the papers available to my investigator, including those from the police investigation. My investigator and a colleague met the doctor on 16 July 2009 to discuss clinical aspects of the investigation.

12. One of my Family Liaison Officers spoke with one of the man's sisters on a number of occasions. In July 2008 the family liaison officer and investigator met the man's sisters and their solicitor. They raised a number of concerns which I hope I have addressed in this report:

    - That he did not receive any medication from the point of his arrest until he died and whether this was a factor in him falling and hitting his head.
    - The lack of privacy for the family given by escorting staff at the hospital
    - Lack of dignity and privacy at the hospital for the man and his family during his final hours when the last rites were given and the family said goodbye to him.
    - The appearance that the prison appeared to do nothing to assist him from the time he collapsed to the time the ambulance arrived.

HMP WORMWOOD SCRUBS

16. HMP Wormwood Scrubs is a local category B prison, principally serving the courts of West London. It has a maximum operating capacity of 1,239 prisoners and holds both remand and convicted adult males.

17. HM Chief Inspector of Prisons carried out a full unannounced inspection in June 2008. Her subsequent report described the reception area as spacious but dirty in parts, shabby and depressing. However, she found there was a well rehearsed system in place for progressing prisoners through the reception process although prisoners were not always aware of the procedures and what to expect. In summary, the inspection report judged that progress the prison had made since her previous inspection had halted, and there had been "an appreciable drift" in all the key areas: safety, respect, purposeful activity and resettlement. However, she acknowledged the difficulties the prison faced in coping with constant daily pressure.

18. The First Night Centre (FNC) is annexed to B wing and is located above reception, with healthcare located on the third floor. The FNC can be reached by flights of stairs or, alternatively, by a very large lift. There are 34 beds in shared dormitories, with some single cells.

19. The Conibeere Unit provides inpatient detoxification and maintenance for prisoners suffering from substance misuse. The unit has 51 beds and is staffed by doctors and other specialist treatment providers, providing a multiagency approach tailored to an individual prisoner's needs. HM Chief Inspector of Prisons commented in her inspection report that prisoners who needed substance detoxification generally went to the Conibeere Unit. However, prisoners bypassed the unit if it was full and nothing was in place to prioritise their needs. HM Chief Inspector of Prisons described this as 'unsafe'.[1]

20. Healthcare cover is provided by the local PCT. In September 2007, the prison's healthcare department was placed under special measures as part of the Primary Care Trust's improvement plan. A three year strategy was put in place with an executive board to oversee the project management. My investigator was told that the special measures were to expand and improve the clinical quality of the services provided to the prison. Staff training had been found not to be patient-focussed. At the time the man died, the staffing complement did not include a lead nurse role. HM Prisons Inspectorate found records stored unsuitably and that resuscitation training was not up to date. There were wing based surgeries but no chronic disease registers or clinics. A dentist had not been available since February 2008. Nursing staff were employed by the PCT and a team of doctors worked on a rota system to provide cover. However, staff did not wear uniforms and were not easily identifiable.

21. In every prison in England and Wales there is an Independent Monitoring Board (IMB). The members are volunteers who monitor the day-to-day life in their local prison and ensure that proper standards of care and decency are maintained.

[1] HMCIP report: June 2008 First Days in Custody para 1.28

The Board is required to produce an annual report on the prison to the Secretary of State, highlighting good practice and flagging up areas of concern. A report by the prison's Independent Monitoring Board (IMB) for the period 1 June 2007 to 31 May 2008 mirrored the concerns raised in HM Chief Inspector of Prisons inspection report.

22. The IMB also highlighted problems resulting from a shortage of staff. They acknowledged that they had seen positive signs of improvement in healthcare services, but they had come at the cost of cancelling clinics and longer waiting lists while the department underwent necessary refurbishment.

23. There are 19 beds in the in-patient healthcare centre. The IMB's 2006 report expressed concern that prisoners who could not be accommodated in the segregation unit or healthcare centre were located occasionally in the FNC. This practice appeared to be prevalent at the time the man died in March 2008.

KEY FINDINGS

Friday 7 March - Detention at the Police Station

24. Police statements show that the man who died was arrested on Friday 7 March in North London and taken to a Police Station. The custody officer, a police sergeant, completed a risk assessment at 4.27pm. He recorded that the man was capable of understanding the questions asked. The man indicated that he suffered from depression. He confirmed that he had seen a doctor previously for a "condition" but the nature of this was not recorded. The form asked whether he was "supposed to be taking any tablets/medication" and the response was "normally takes tabs" but no details were noted. The man denied that he had ever tried to harm himself. The custody officer completed a Detained Persons Property Record at 4.35pm, and it was dated and signed by the man himself.

25. The man was referred to the police doctor. Page 2 of the form shows that the doctor was called at 4.44pm, but no doctors were present in the police station and an estimated arrival time of 5.45pm was agreed between the police and the doctor.

26. The doctor arrived earlier than expected and saw him at 5.35pm. His assessment was:

> "… chronic alcohol abuse. depression. no thoughts of sef [self] harm. 5 cans today. BP 119/84. Pulse 104/min.normal heart and breath sounds. dothiepin[2] and atenolol.[3] Last night had medication. Co-operative not intoxicated fully orientated."

The examination concluded at 5.50pm. The Once Only Medication box indicated that the 75mg tablets of dothiepin were to be given at 10.00pm. There is no evidence to show whether or not the man received the medication. The second clinical reviewer has observed that there is no evidence that he received the appropriate medication to manage his alcohol withdrawal. He has also commented that his pulse of 104 was very high and should have indicated that all was not well.

The journey to the prison on 8 March

27. Prisoner escort services were carried out by SERCO. The Prisoner Escort Record (PER) Part A says that the man left the police station to go to Magistrates Court at 7.30am the following day. In his police statement the escort officer for SERCO said that he travelled in the back of the van while his colleague drove. The journey was unremarkable and the man was described as co-operative and fine.

28. The "Further information about risk" box on the PER Part A was completed. One of his raised risk factors was recorded as "Head But Police" (sic). The

[2] Dothiepin is a drug prescribed for clinical depression.
[3] Atenolol is a beta blocker drug used to treat high blood pressure and coronary heart disease.

investigator emailed the police to ask how the information should be interpreted and who had provided it. The police responded that the officer concerned could not recall completing the form, but would have found the information on the man's police national computer record.[4] My investigator considered the man's previous convictions. She noted that on 27 March 2004 he had been convicted of violent behaviour in a police station, but no other information was given.

29. The Prisoner Escort Record Part B shows that he went before the magistrates at 11.10am. The hearing ended at 11.14am and he was remanded into custody until 12 March. He was taken to Wormwood Scrubs. In a statement to police, a Prison Custody Officer said that it was his duty to transport prisoners from the Magistrates Court to Wormwood Scrubs. He recalled that six prisoners were transferred, including the man who died. He said that the journey took around 20 minutes and was uneventful. He did not recall any incident involving the man and did not have any specific conversation with him during the journey.

30. In his statement to the police a prisoner said that he travelled in the prison van from the court to the prison. He said that the van left the court at around 3.00pm. He recalled travelling with five other prisoners, including the man who died, with whom he later shared a dormitory. His recollection of events was that it was very quiet in the van as "you don't know anyone and don't know who you are talking to". He said that around 20 minutes later they arrived at Wormwood Scrubs where they waited in the van for about five minutes before going into the prison. The men struck up a conversation and the prisoner recalled that the man who died told him why he was in prison. He said that the man also told him that he was an alcoholic and homeless. The prisoner remarked that the man did not appear ill, just fed up. The next time he saw the man was around an hour later when he was in the FNC and he was wheeled into the room.

Events in reception, Wormwood Scrubs

31. A temporary senior officer was the officer in charge of reception when the man arrived at around 3.30pm. In interview with my investigator, the temporary senior officer said that he had worked in reception for around seven and a half years. His responsibilities included identifying, receiving and discharging prisoners and checking relevant documentation. This was the first step in the reception process.

32. The temporary senior officer remembered the man who died "very well". He explained that the reason for his good recall was that he saw the man had a "severe head injury on the top of his head, it had blood clotted up". The temporary senior officer said the injury was on the back of the crown of the man's head. He agreed that the injury would not have been visible on the photograph taken of him when he came in to the prison.

33. The temporary senior officer said that, as he did not want the prison to bear the responsibility for the injury, he insisted that the man was speedily processed through reception to healthcare so a form F213 could be completed by

[4] Email: Metropolitan Police to my investigator dated 22 April 2008.

healthcare staff. (A form F213 is a report of an injury to a prisoner.) During interview with my investigators, the temporary senior officer searched for the form but could not find it. (There is no record of the form having been completed by healthcare staff and the prison did not include a copy with the other documents provided to the investigator.) He told my investigators that he did not have a chance to follow up his concerns as, very shortly afterwards, he heard voices raised because the man had collapsed. The temporary senior officer did not mention any injury to the man in his police interview. In the absence of the form or written entries in other documents, there is no other evidence to support the temporary senior officer's statement that he saw an injury to the man's head when he arrived at the prison.

34. The officer that helped to escort the man to the FNC was working in reception when he arrived at the prison. In her statement to the police, she said it was her responsibility to enter the details of new prisoners on to the prison computer system. She explained that this did not involve talking to any of the prisoners as she would get the information from their files. She was located behind the reception desk, out of the view of most people. She told the police that the man seemed well and she did not see any injuries on his head.

35. In January 2009, during one of my investigator's visits to the prison, the temporary senior officer handed her a handwritten statement from the officer that helped to escort the man to the FNC confirming that she had also seen an injury on the man's head. The officer that helped to escort the man to the FNC said she had asked him how he got it and he had told her that he had been assaulted by the police. Neither officer mentioned the man's injury to the police during their respective interviews, and there is no other record or evidence to confirm that the officer that helped to escort the man to the FNC saw an injury to the man. There is no suggestion of an injury to his head in any prison documentation given to my investigator other than that 'head but police' is identified as a risk factor on the PER Part A completed by the police.

36. In a police statement another officer said that he too worked in the reception area. He recognised the man from a previous sentence. He completed a cell sharing risk assessment by asking the man a number of routine questions. He admitted that he was an alcoholic and said he would prefer not to share a cell. The officer told the man that he would go to the FNC where he would have to share a cell as there were no vacant single cells. Once the risk assessment was completed, the man went to the reception medical area and the officer had no further contact with him. The officer told the police that the man answered his questions and did not appear unwell or intoxicated.

37. The nurse who was the reception healthcare nurse completed the man's first reception health screen document. Together with the other officer working in the reception area, he signed the cell sharing risk assessment to say that the man should be located "flat and low for medical reasons". (This means that the man should be located on the ground floor.)

38. The first clinical review commented that the first reception health screen document reported a significant alcohol misuse history. The man described

himself as alcoholic and said that he suffered from epilepsy. The second clinical reviewer found little evidence that a significant alcohol misuse history had been taken from the man. The document showed that he specifically said that he suffered from alcoholic fits, the last time being around six months before. The nurse who conducted the first reception health screen noted that the man looked unwell "due to alcohol withdrawing," and that he was unkempt.

39. A General Health Assessment records his height and weight. The opportunity for information on blood pressure, family history, smoking cessation and other clinical referrals was lost as the rest of the form was not completed. It was not signed by the healthcare worker nor dated. The questions asking whether there is anything the prisoner wishes to ask or the healthcare worker should know, or if there is any reason why a prisoner might need to see a doctor, were also not completed. The First Night Centre Tuberculosis Assessment was not completed and gave the man's name and prison number only. In interview with the investigator, the nurse who conducted the first reception health screen said he did not see an injury on the man's head. In his police statement, he said that he took him to the waiting room to go to the FNC.

40. In a statement to the police, the officer that helped the man into the wheelchair after his collapse said he was working in reception, searching prisoners arriving at the prison. He recalled that the man arrived between 3.00pm and 3.30pm. He remembered that he did not speak but did everything that was asked of him and "appeared stable" at the time. The officer explained that the next time he saw the man was when the nurse who conducted the first reception health screen put him into the recovery position, put clothing under his head and wiped saliva from his beard. The officer recalled that the nurse who helped the man on his collapse was getting ready to put an oxygen mask on his face but he appeared to recover before she could do so. The man did not speak, but the officer helped him to sit up which took some time. He described it as a "struggle" to get him to rise to his feet, and so it was decided that a wheelchair should be used.

41. Another prisoner who was in the holding room at the same time as the man and six others said in his statement to the Governor that he had no contact with the man before this point. The prisoner and the man did not speak, and he described him as very agitated and pacing back and forth. The prisoner described himself as "very close to panic attack but the man seemed worse". It is the prisoner's recollection that the prisoners were called out of the holding room and that he and the man were the last to leave. He said that as they left the room, he did not look at the man but heard a noise like a thud or slapping sound. When he looked around he saw him lying on the floor, appearing very stiff and "in what seemed a convulsion". The prisoner recalled that the man was holding the bags he had been carrying to his chest so he would not have been able to protect himself during the fall. (In her police statement, the officer who escorted the man to the FNC said that the prisoner shouted to her that the man had fallen.) The prisoner then heard the officer call for assistance.

42. The officer who escorted the man to the FNC told the police that, at around 4.40pm, the temporary senior officer asked her to take three prisoners to the FNC. She said the man answered to his name and seemed well. She led the

way down the corridor with the prisoners following behind. She recalled that, as she was unlocking the doors at the end of the corridor, she heard the other prisoner from the holding room shout that the man had fallen. She saw the man lying on the floor, shaking and foaming at the mouth. At that point, she called for the nurse who conducted the first reception health screen who was around two metres away in the medical room. She said that the nurse came out and immediately tried to put the man in the recovery position.

43. The officer that escorted the man to the FNC said that the nurse who conducted the first reception health screen told her to call Hotel 1. (Hotel 1 is the code for the nurse whose duty it is to respond to medical emergencies.) The officer who escorted the man to the FNC called to the temporary senior officer to phone for Hotel 1. In his interview with my investigators, the temporary senior officer said that, although he had a radio, it was quicker to dial 222 on the telephone as it was a direct emergency line straight through to the communications room. He explained that using the radio meant waiting for a response before passing on his message. The officer that escorted the man to the FNC took the other prisoners to the FNC so they were removed from incident.

44. The nurse who conducted the first reception health screen was assessing a patient when the man collapsed at around 4.30pm to 4.40pm. He responded to an officer asking for help as a prisoner (the man who died) was having a fit. The nurse told my investigators and the police that, although he had already assessed the man, he did not recognise him or recall who he was because he had dealt with a large number of prisoners that day. His recollection was that the nurse who helped on the man's collapse arrived very quickly and that the man's fit stopped. He said he asked if the man was alright, and recalled that he opened his eyes so he knew that he had heard him but was confused.

45. The nurse who conducted the first reception health screen said he and the nurse who helped on the man's collapse carried out checks of his vital signs. He could not recall whether he or the nurse who helped took his blood pressure. They took his pulse, checked his breathing, blood pressure and pupil reaction. He said that a pulse oximeter was used to check the oxygen saturation of the man's blood. (A pulse oximeter is a medical device that indirectly measures the oxygen saturation of a patient's blood as opposed to measuring oxygen saturation directly through a blood sample and changes in blood volume in the skin.)

46. In her statement to the police, the nurse who helped on the man's collapse said she checked his eyes for pupil reaction, and his pulse on his right wrist which appeared normal. She also assessed his respiration rate as normal. She did not mention taking his blood pressure. The nurse who conducted the first reception health screen also did not record taking his blood pressure. He recorded other vital signs such as pulse and respiration, but not who took the readings.

47. An entry in the clinical record made by the nurse who helped on the man's collapse at 4.44pm says that she had arrived in reception in response to an emergency call over the radio net. The nurse who conducted the first reception health screen was already there and she had helped with overall care such as ensuring that the man's airway was maintained. Both nurses recorded that the

man responded. (This may give a somewhat different impression from the nurse who conducted the first reception health screen's earlier police statement and clinical record entry when he described him as slightly confused.)

48. The nurse who conducted the first reception health screen helped the man to sit up by propping him against the wall. He asked the man how he was but could not understand his mumbled response. In his statement to the police, the nurse who conducted the first reception health screen said he asked him if he was ready to walk but he appeared confused. He decided that the man should be put into a wheelchair.

49. The officer in the FNC told my investigator that he was on duty in the FNC when the man collapsed in reception. In his statement to police, the officer said his main role was to ensure new prisoners receive a basic induction and that their worries are addressed. The officer was in the FNC and received a call from the nurse who conducted the first reception health screen telling him that the man needed to be in healthcare but was coming on to the FNC and needed to be in a cell with other prisoners.

50. The accounts of the nursing staff agree that the man was disorientated and unsteady on his feet by this time. This contrasts with his demeanour in reception when it is documented that he was mobile and able to answer coherently when asked questions.

The First Night Centre

51. The officer that helped the man into the wheelchair said there was a discussion as to where the man should be taken. It was decided to take him to the FNC, but it is not clear who made that decision. Section 2 (b) of the Report of Injury to Prisoner form completed by the nurse who helped on the man's collapse says that he was "transferred to the FNC for further observation and management," but it is not clear who was to undertake these tasks. The nurse who helped on the man's collapse returned to her office (as she confirms in her statement).

52. My investigator was told by discipline officers that the FNC was under great pressure. They commented upon inappropriate use of the FNC by medical staff over the past two to three years as a hospital overflow when in-patient beds were not available in the healthcare centre.

53. The nurse who conducted the first reception health screen wheeled the man into the lift to take him to the FNC. In his police statement, the officer who helped the man into the wheelchair after his collapse said that he started to hallucinate in the lift. He kept asking for water and started feeling around the rail in the lift as if looking for taps. The officer made the assumption that the man had "probably been on drugs". He reassured him and took him straight to the nurses' office.

54. The nurse in the office was on duty in the FNC. The officer who helped the man into the wheelchair said the nurse was aware that the man had collapsed but told him to wheel him back out. The officer assisted her in taking the man into a dormitory.

55. It seems from the nurse in the offices' statement to the police that, like the reception healthcare staff, she did not recognise that the man was ill. It is not clear whether the nurse who conducted the first reception health screen had explained what had happened to the man in the reception area during their telephone conversation. The nurse who conducted the first reception health screen's recall was vague and my investigator found no entry of their conversation in the clinical record. (The investigator was unable to interview the nurse that was in the FNC office as she had left her employment at the prison.)

56. The nurse that was in the FNC office told the police that she introduced herself to the man. She described him trying to touch the door hinges with his fingers. She had told him to be careful but he had paid no attention and continued. She said he was taken to dormitory 17 where he was left with three other prisoners while he waited for the doctor.

57. The officer in the FNC said that the man arrived in the FNC late in the afternoon as staff were preparing to serve the tea meal. He recalled him arriving in a wheelchair with an officer (the officer who helped the man into the wheelchair after his collapse) and a reception nurse. Although he had no medical background, the officer in the FNC said that he could see that the man was very ill. He described his reaction as one of "shock" at his condition. He said that, in his view, healthcare should have made space for the man or sent him to hospital. The officer told my investigator that he was not at all happy that discipline staff had had to deal with the situation. He said he needed to seek advice as to where the man should be located as it was clear that he was very unwell.

58. The man was placed in a dormitory with three other prisoners. The officer in the FNC said that the five bed dormitory was the only available space. He recalled that the man was "staggering and bumping" into the other prisoners and began to cause distress to them as they were unable to deal with him.

59. There are references within the medical record to the man refusing to see a doctor. My investigator felt that reception healthcare staff had assumed there was a doctor on duty in the FNC when he collapsed. However, this was not the case. The nurse who conducted the first reception health screen said that he telephoned the nurse in the FNC office between 4.40pm and 4.50pm to ensure the man was seen immediately by the doctor as he had just had a fit. This conversation is not documented and there is no evidence to establish whether the nurse in the FNC office told the nurse who conducted the first reception health screen that there was no doctor on the FNC at the time he called, or suggested what alternative action should be taken.

60. The prison doctor said in her police statement that she was in the security building with two Governors around the time the man collapsed. She remembered being told on the telephone that a patient had had a fit and she thought it was the nurse who had conducted the first reception health screen who told her. The doctor said that the nurse escorted her to the FNC. On the way there, the nurse told her that the man had fallen and banged his head during a fit. In interview with my investigators, the nurse said he did not recall that there was

no doctor in the FNC. Neither did he remember escorting the doctor from the security building.

61. Another officer was also on duty in the FNC when the man arrived in the lift. Her duties included inducting new prisoners, supervising their meals and handing out smoking or non-smoking packs to them. She described the FNC as very busy. She was in the induction room, giving out canteen packs to the previous group of prisoners and supervising tea with the officer that helped to move the man from the dormitory, when the man arrived at around 4.30pm with the officer that helped him into the wheelchair after his collapse. She remembered interrupting the meal service to ask the man if he wanted a smoking or non-smoking pack but he did not reply. His eyes were open but he did not acknowledge her. The officer said she did not know what had happened to him, and did not press the man for an answer as she was aware that some prisoners do not want to talk. She returned to supervising the tea meal. She recalled that the other officer in the FNC was in the corridor and they decided to place the man in a dormitory so the other prisoners could watch over him.

Events in the FNC dormitory

62. The mobile heated food trolley is placed directly opposite the dormitory and the prisoners can be seen through the hatch in the cell door. One of the officers on duty in the FNC, who was serving meals, described watching the man walking and stumbling around the cell. She recalled that she and the other officer on duty in the FNC paid attention to what was going on in the cell because they unlocked the cell doors and called for help from the nurse in the FNC office and the nurse who conducted the first reception health screen.

63. One of the officers that was on duty in the FNC said that prisoners in the cell "got excited". The man had vomited and the nurse who conducted the first reception health screen checked his eyes. She also saw the nurse ask the other officer who was on duty in the FNC and the officer who helped to move the man for the man to be moved to a single cell. The officer on duty in the FNC said she supervised a prisoner trained in specialist bio-hazard cleansing while he cleaned the cell. She recalled the ambulance arriving shortly afterwards.

64. Three other prisoners shared the dormitory cell with the man. In his statement to the police one of the prisoners said that the man was wheeled into the dormitory by a prison officer and left there. The prisoner was surprised to see the man in a wheelchair as he had been fine when he had met him in the prison van. (The CCTV on the 17 West camera confirms that, at around 4.27pm, the man was in the dormitory.) (The timings from the CCTV are as translated by my investigator and a colleague. My investigator and a colleague viewed the same CCTV footage as the police but noted far more detail than that set down in the police statement.)

65. Two of the prisoners described in their police statements that the man fell from his wheelchair, was perspiring heavily, violently sick and staggering around in a disoriented manner. One of the prisoners also described him as hallucinating. The CCTV recording at 4.38pm 17 East shows the man walking the length of the dormitory to the door and attempting to open it with a non-existent handle. He was unable to press the cell bell although one prisoner urged him to do so. One of the prisoners says he asked the man if he had taken any Librium as he was aware this medication was taken by those withdrawing from alcohol. The man did not respond.

66. The camera at 4.40pm 17 West shows the doctor arriving. At 4.44pm the man was on his own with the prisoners who were becoming increasingly agitated by his behaviour. One of the prisoners said that he called for the officers through the glass in the cell door and told them to "get him out of here". The man became violently sick and the prisoner shouted for someone to take him to hospital. He said that the officer who helped move the man from the dormitory came to the cell and left immediately. The prisoner said that healthcare staff came in and put a light in front of the man's eyes. He thought they were with him for about two minutes. They walked the man out of the room and then returned to clean the cell. The prisoner commented that healthcare staff should have responded faster, and that he had been trying to get someone's attention through the glass on the door.

67. The prisoner doctor said that she arrived at the FNC at around 4.50pm. The man was very agitated and would not sit still. She described his speech as "incoherent" and he did not respond to questions. His eyes did not react to light. She explained that this information, together with what she had been told by the nurse who conducted the first reception health screen, led her to believe that the man had suffered from an intracerebral haemorrhage (a bleed into the brain). She said that the man needed to go to hospital and an emergency ambulance should be called. Healthcare staff had decided that he should move from the dormitory as his health and behaviour were deteriorating and the prisoners in dormitory 17 were becoming agitated and anxious.

68. Staff were unsuccessful in their attempts to encourage him to lie on a mattress on the floor to reduce the risk of further falls in the dormitory. Accounts by the prisoners and what is recorded on CCTV show their increasing levels of anxiety and stress.

69. The nurse who was in the office in the FNC told the police that she left the room to find out whether there were any spaces for the man in healthcare but was told that none was available. She spoke in the corridor with the prison doctor who told her that an emergency ambulance was to be called. The nurse confirmed that she contacted the communications room to ask for an ambulance and called the orderly officer to tell him that the man would be leaving the prison. (The orderly officer is responsible for the day to day running of the prison wings). She was told that the man was being moved to a single cell because he was vomiting and "walking around the dormitory".

Move to a single cell

70. One of the officers in the FNC said that only one single cell was available in the FNC. Another officer and the nurse who conducted the first reception health screen assisted the man to walk, while he led the way. My investigator asked the nurse and the officer why they did not use the wheelchair. They said that it did not occur to them.

71. The prison doctor completed Section 3 of the Report of Injury form. She described her examination of the man and noted that, while waiting for the ambulance, he became more aggressive and had refused treatment. He was placed on a mattress on the floor of the cell instead of the bed, and the cell was locked. In his statement, the nurse who conducted the first reception health screen said he "started to take precautions in case of any further fits" but did not give any further explanation.

72. The nurse who conducted the first reception health screen called for the nurse who had helped on the man's collapse, in her role as Hotel 1, to bring the emergency equipment. The nurse who helped on the man's collapse said that the communications room called her at around 4.58pm and asked her to take the emergency bag to the FNC. She arrived at around 5.00pm to find that the ambulance crew were already there.

73. The communications room log records that at 4.54pm the FNC asked the communications room to call an ambulance. The ambulance was on its way to the prison at 4.55pm and arrived at the healthcare centre at 5.04pm. The healthcare centre was the nearest entrance to the FNC. The prison doctor wrote a referral letter to the hospital giving very brief clinical details of the man's condition.

The arrival of the paramedics

74. In his police statement the ambulance paramedic said he arrived at the man's cell at around 5.10pm. He was met by the prison doctor who told him that the man had had an alcohol related fit. The doctor told him that she did not know if he had a history of fits but that he had told one of the officers that this was so. The paramedic asked where the patient was and the prison doctor said he was in a locked cell. The paramedic said he had to ask the officer standing outside the cell to unlock it.

75. The paramedic said that, when he went into the cell, he found the man lying on a mattress on the floor and alone. He was lying on his back with vomit around his face and on his clothing. He was surprised that he had not been placed in the recovery position. The paramedic described him as not fully alert. He started oxygen therapy to ease his breathing and then rolled him onto his side to protect his airway. He told the police that, within a minute, he became more mobile and tried to pull himself up into a sitting position.

76. At this point, the paramedic noticed that the man was sweating profusely, was unaware of his surroundings, and that his right arm appeared to be paralysed. The prison doctor noted on the Report of Injury to Prisoner form that she thought the paralysis occurred while the paramedics were there. The paramedic assessed that the paralysis was an indication that the man had suffered a cerebral haemorrhage. The man confirmed to him that he had a headache and said that he had pain at the back of his head. He said he had no chest pain. The paramedic said he told the prison doctor that he believed he had had a stroke and was suffering from a cerebral haemorrhage.

77. The prison doctor asked the paramedic if he had carried out a blood sugar test on the man. The paramedic told her that he had not because he was more concerned with maintaining his airway and making sure he was breathing. The prison staff describe the man as reluctant to go to hospital but that he eventually agreed to do so.

78. The paramedic told prison staff that the man's condition was life threatening and the paramedics had to get him out of the prison without delay. He said one of the staff told him that the man would have to be handcuffed. The paramedic said he explained that the man was unable to move, but he was told that he still had to be handcuffed. He told the police that at that point his condition deteriorated. He said he "became unresponsive and no longer agitated".

79. The paramedic got into the back of the ambulance with the man and two officers. The officers placed prison handcuffs on him. The paramedic said his level of consciousness was measured at a Glasgow Coma level of 3. (The Glasgow Coma Scale (GCS) records the conscious state of a person. The lower the score, the lower the patient's conscious state. A GCS of 8 or less indicates severe injury. The maximum score is 15.) This is a very low score and indicates the gravity of his condition. The ambulance travelled under a "blue light" (urgently) to hospital where the paramedic said they had the facilities to cope with his condition. The man was taken immediately to the resuscitation unit where doctors were waiting for him.

The hospital 8 and 9 March 2008

80. Part A of the PER form indicated that the man had to be treated as a risk because it was his first day in prison and nothing was known about him. The PER record of events says that, on arrival at the hospital, medical staff wanted the restraints removed. The hourly "cuff check" record shows that restraints were put on at 5.35pm and removed at 5.50pm (meaning he was in handcuffs for around 15 minutes).

81. The communications room incident log showed that the bedwatch officers rang the prison at 6.46pm to say that hospital staff had asked them to contact the man's next of kin. (Bedwatch officers escort prisoners to hospital and remain with them at all times to ensure the safety and security of the prisoner and the public and to keep the prison informed of events.) In his interview one of the

bedwatch officers told my investigators that the prison had difficulty in finding the man's next of kin. A search of his records showed that he had named his solicitor as his next of kin.

82. It is recorded in part B of the PER that, at 7.05pm, bedwatch officers were told by the neurosurgeon that the man had suffered a brain haemorrhage and surgery was unlikely to be of any benefit. They were told that he was likely to die shortly.

83. Contacting his next of kin became a matter of great urgency when, at 7.24pm, the prison was told that he was likely to die. Staff could not predict when this might happen, but an entry in the Bedwatch Log says that nursing staff had told the escort staff that this was likely to be within the next few hours.

84. As noted, the prison had no contact details for the man's family. They looked through his belongings and told the escort officers at 8.12pm that three contact numbers had been found. With the help of the police, the family were informed of the sad events. At 11.20pm, the man's sisters arrived at the hospital. At 3.48am, he died with them at his bedside. His family told my investigator that officers were present when the last rites were given.

85. It is recorded in the Command Suite Incident Log that the Governor spoke to staff following the man's death and offered any help required. An entry dated 9 March 2008 said that staff had told prisoners in the FNC of his death and offered help to those who requested it. There is no evidence that a hot debrief was held. (A hot debrief is a meeting held for staff involved in a serious incident. It is an opportunity to share learning, review procedures and provide support for those who need it.)

ISSUES

Clinical care

86. As noted earlier, the first clinical review was undertaken by a panel chaired by a doctor on behalf the local PCT. Their review is based on prison clinical and non-clinical records and on witness evidence given by Head of Offender Health at the prison. The Head of Offender Health took no part in the events surrounding the man's death. No other healthcare staff were interviewed by the panel.

87. The panel concluded that staff had acted appropriately, and identified no acts or omissions by healthcare staff that directly related to the man's death. They made several recommendations to help improve service provision, but specified that none of the areas identified had been related to the death of the man. Given the circumstances, I judge that it would have been helpful for healthcare staff to have been interviewed by members of the panel to gain a better understanding of their actions and decisions.

88. Healthcare staff were interviewed by the police. At the end of the police investigation in July 2008, my office disclosed the police statements to the PCT for the panel to consider. The panel reviewed the statements and confirmed their previous conclusion that staff had acted appropriately.

89. Following the first clinical review, I felt there were a number of serious questions that remained unanswered and merited further consideration. A Senior Public Health Adviser, Offender Health, appointed the Clinical Director of another cluster of Prisons to undertake a second clinical review.

90. The second clinical reviewer reviewed all the information relating to the man's collapse, including his time at the police station and at the prison. He also considered information in police statements given by prison and healthcare staff regarding his time in custody and the management of his alcohol withdrawal. (He has made some observations in respect of the clinical care the man received at the police station. As those matters are outside my remit, I shall send a copy of my report to the Independent Police Complaints Commission.)

91. The second clinical reviewer has judged that when the man arrived at Wormwood Scrubs he was suffering from alcohol withdrawal. The reviewer comments that, in his opinion, this needed immediate assessment by the prison doctor followed by a prescription for chlordiazepoxide (a sedative/hypnotic drug commonly marketed under the trade name Librium) and carbamazepine (a drug used in the treatment of neuralgia, epilepsy and bi-polar disorder) with added vitamin supplements. These drugs are commonly used to treat people who are detoxifying from alcohol.

92. In considering the man's deterioration and collapse, the second clinical reviewer suggests that they might have been prevented if healthcare staff had understood the important link between alcohol withdrawal and fits. In his opinion, the attempt to see if the man could walk properly after his fit made "no clinical sense whatsoever" and showed the naivety of healthcare staff trying to deal with the

situation. In the second clinical reviewer's opinion, the nursing staff did the best they could in difficult circumstances but lacked specific training in this field.

93. The second clinical reviewers conclusion differs from that of the first clinical review panel (which, as we have seen, concluded that the man's clinical care was satisfactory). In the second clinical reviewer's opinion, his care was not satisfactory. He says that staff were not trained in alcohol withdrawal management at the time he died. There was also no protocol for alcohol withdrawal management (although one is in place now). The second clinical reviewer is concerned that staff are still not trained sufficiently.

Head injury

94. The post mortem identified that the man had a fractured skull although no external head injuries were found. The temporary senior officer and the officer who helped escort the man to the FNC said they saw evidence of a head injury when he arrived at the prison but neither of them recorded anything or reported their observation. As the first member of staff who saw an injury on the man's head, the temporary senior officer should have reported it and not relied upon healthcare staff to do so. Neither officer told the police that they had seen an injury on his head. The officer who helped escort the man to the FNC told the police that the man was well, and healthcare staff recorded no head injury.

95. Whether or not the man had a head injury when he arrived at the prison is crucial. If he was injured, it would suggest that he sustained the injury while in police custody or in the care of SERCO. The police investigation found that he had not been subject to an assault and SERCO staff were clear that all had been well with him during their care. As neither prison officer completed the necessary paperwork regarding observation of an injury, there is no evidence to substantiate their assertion of an injury or give an indication as to when it might have been sustained.

    The Governor should remind reception staff that anyone who sees an injury on a prisoner must take responsibility for completing the appropriate records and not expect others to do so.

First reception health screen

96. The man reported significant alcohol misuse and presented as unkempt and shaking from alcohol withdrawal when he was assessed by the nurse. The second clinical reviewer is critical that a thorough alcohol assessment was not conducted despite his presentation to the nurse, as documented in the first reception health screen. There is evidence in the document that he told the nurse that he had suffered alcoholic fits around six months before. Although the nurse acknowledged that he was suffering from alcoholic withdrawal, he showed no awareness of the link between alcohol withdrawal and fits or convulsions. The second clinical reviewer has criticised the absence of a convulsive history or the completion of other relevant reception healthcare paperwork. He would have expected to see documentary evidence of signs and symptoms of previous alcohol withdrawal experiences and a thorough history of previous fits. He

describes a “complete absence” of physical examination such as pulse rate, blood pressure, and whether he had been shaking.

The Head of Healthcare must ensure that reception healthcare staff are fully trained in substance misuse policies and assessment procedures and carry out a rigorous health and substance misuse assessment on new reception prisoners. The Head of Healthcare must ensure that healthcare staff are aware of their responsibility to fully complete all reception healthcare paperwork.

Alcohol detoxification

97. The second clinical reviewer judges that nursing staff did not recognise that alcohol withdrawal and fits were medical emergencies with a known risk to life. The man’s collapse highlights a lack of staff training crucial in dealing with prisoners suffering from alcohol withdrawal.

98. On this occasion, the Head of Healthcare did not have an alcohol protocol in place; nor was there training for reception and FNC healthcare staff to recognise alcohol withdrawal symptoms and treat them as a potentially serious condition. The second clinical reviewer says healthcare staff lacked specific training to deal with the medical emergency the man presented. In interview with my investigators the Head of Offender Health said that staff supervision was not mandatory and that some staff viewed it with suspicion. However, if healthcare staff do not have one to one supervision with a manager, it is difficult to see how individual training and development needs can be identified and addressed, competence assessed, and a duty of care achieved.

The Head of Healthcare must ensure that staff policies and procedures regarding the identification and treatment of substance misuse are in place. Staff should be adequately trained to identify alcohol seizures and treat them as a medical emergency.

The Head of Healthcare must set up a process whereby all healthcare staff are given regular individual supervision. The aim should be to identify and address training and development needs so staff are able to discharge their responsibilities in accordance with the standards expected by the Nursing and Midwifery Council.

99. The nurse who conducted the first reception health screen told my investigators that he and the nurse who helped on the man’s collapse checked his vital signs. He said he could not recall which of them took his blood pressure. He explained that one of them took his pulse, checked his breathing, blood pressure and pupil reaction. He said that a pulse oximeter to test oxygen saturation was used, but in interview with my investigators he was not able to explain what a pulse oximeter is used for.

100. The nurse who helped on the man’s collapse said she checked his eyes for pupil reaction. She also assessed his pulse and respiration rate as normal. Neither nurse recorded taking his blood pressure. When he collapsed, the nurse

who conducted the first reception health screen did not remember his previous contact with him and might not have recalled that he had told him about his alcohol fits. In his statement to the police he said that the man's blood pressure was taken but did not specify who undertook the task. In the light of the evidence, I am not confident that the nurse who conducted the first reception carried out all the checks he claimed to have made or that they were as thorough as he described.

101. The second clinical reviewer comments that the idea of assisting the man to walk in reception after his fit had no clinical merit and demonstrated the overall naivety of staff in trying to deal with the medical emergency. This is further demonstrated later on in the FNC when the nurse who conducted the first reception health screen, assisted by an officer, removed the man from the dormitory by walking him the length of the FNC to a single cell. On her visit, my investigator noted that it is a considerable distance from dormitory 17 to the end of the FNC where the single cell was located. The CCTV recording timed at 5.51pm 17 East showed that the man was no longer in the dormitory but the wheelchair was there. At this point, an emergency ambulance had already been called because the doctor recognised the gravity of his condition. Against that background, the nurse who conducted the first reception health screen was unable to explain to my investigator why they chose to walk a gravely ill prisoner down a long corridor instead of using the available wheelchair.

The Primary Care Trust should draw my report to the attention of the Nursing and Midwifery Council who should satisfy themselves that the nurse who conducted the first reception health screen is competent to practise.

102. My investigator has considered why reception healthcare staff did not call the FNC doctor to assess the man. A possible reason is that no doctor was available as she was in the security department at the time. It remains open to question whether or not the nurse who was in the FNC office told the nurse who conducted the first reception health screen that a doctor was not available when he telephoned her from reception, as there is no documented evidence of the conversation. I explore the matter of the prison doctor's absence from the FNC later in this report.

Emergency medical equipment in reception

103. On their tour of the reception area in January 2009, my investigators noted that no emergency equipment was held in the medical room in the reception area. The nurse who conducted the first reception health screen did not have access to emergency equipment when the man collapsed. The nurse acting as Hotel 1 had to bring emergency equipment with her. While not critical to this emergency, it might be crucial in the future.

The Governor and Head of Healthcare should ensure that emergency medical equipment is placed in the reception area so reception healthcare staff are able to respond quickly to medical emergencies.

The First Night Centre

104. The second clinical reviewer judges that the nurse who helped on the man's collapse and the nurse who conducted the first reception health screen's decision to send him to the FNC for monitoring and management was flawed. They did not immediately recognise his collapse and deteriorating health as a medical emergency. This might also explain why they did not call a doctor from the FNC. There is no documented evidence that they asked the healthcare centre if there was a bed available when he collapsed in reception. My investigator noted that the first enquiry regarding the availability of a bed in healthcare came after he was seen by the prison doctor. It was made by the nurse who was in the office in the FNC but not documented. In the second clinical reviewer's opinion, the man should have been taken immediately to the healthcare centre or to the accident and emergency department of the nearest hospital and not the FNC. Either healthcare or hospital would have been preferable to moving him to the FNC.

The Head of Healthcare must remind healthcare staff of the importance of accurate and contemporaneous record keeping in accordance with the standards of the Nursing and Midwifery Council.

105. When interviewed by my investigator, one of the officers in the FNC said he was "shocked" by the man's condition when he arrived at the FNC in a wheelchair with an officer. He told the investigator that he was not at all happy that discipline staff had to deal with the situation. Both he and the other officer in the FNC gave my investigator the impression that it was common practice for healthcare staff to use the FNC as an overflow for the prison hospital. On this occasion, it was clear to the officer that the discipline staff would be unable to meet his needs.

The Governor and Head of Healthcare should ensure that the practice of using the First Night Centre as an overflow for sick prisoners is ended.

106. The investigator was told by discipline staff that healthcare staff do not always share necessary information with them. When the man collapsed, FNC discipline staff found themselves coping with a medical situation they were not trained to deal with. The nurse who conducted the first reception health screen told one of the officers in the FNC that the man needed to be in healthcare but was coming to the FNC to be in a cell with other prisoners. It was not appropriate for a seriously ill prisoner to be placed in a dormitory with other prisoners without a member of healthcare staff present to watch him.

107. FNC discipline staff also told my investigator that they have to cope on a regular basis with sick prisoners with very little information shared by healthcare. While I understand the need to preserve medical confidentiality, it should not override every other consideration. In order for discipline staff to care for prisoners effectively, it is necessary for them to have relevant information and some understanding of the nature of any risk. There should be greater shared information and working between healthcare and the discipline staff on the FNC.

A protocol between the Governor and the Head of Healthcare should be drawn up to set out clear boundaries regarding sharing of information between healthcare and discipline staff in the FNC.

Availability of the prison doctor

108. The prison doctor was not available for interview to confirm events as set out in this report as she no longer lives in this country. Given her account of events in her police statement, I conclude that she was not on the FNC when the man collapsed in reception. The investigator made enquiries about the entries in the prison gate log book for 8 March 2008 for the time the prison doctor entered the prison to start her duties and questioned why she would be in the security building.

109. The prison liaison officer said that the gate log book did not record when th prison doctor entered the prison that day. This was because the gate senior officer had decided not to keep a gate log at weekends because of staff shortage at the gate. Contrary to normal practice, the gate log had not been kept for several weekends. My investigator was told that this decision was reversed when managers realised what was happening. It is unfortunate that the decision of the senior officer was not reviewed earlier, but in the circumstances I do not need to make a recommendation on this matter.

110. There are conflicting accounts from staff as to when the prison doctor arrived at the prison. None of these can be verified. The Deputy Governor confirmed that the prison doctor was in the security building due to a misunderstanding by gate staff. From the information available, I am confident that, although the doctor was on duty, she was not immediately available when the man was taken to the FNC. In her statement to the police, the prison doctor recalled being escorted from the security building to the FNC by the nurse who conducted the first reception health screen. My investigator was told that she was escorted because, as a locum doctor, she was not allowed to draw prison keys. Not only did this delay her arrival in the FNC, it also took another member of staff away from looking after the man.

111. The prison doctor's version of events is credible and it is highly probable that the nurse who conducted the first reception health screen did collect her from the security building and escort her to the FNC. It is a matter of concern that the nurse left the man to escort the prison doctor rather than asking another member of either healthcare or discipline staff to escort the doctor while he remained with his patient.

112. Reception staff assumed there was a doctor on duty in the FNC when there was not. Had the prison doctor been immediately available, the man's transfer to hospital might have been quicker.

Closed Circuit Television (CCTV)

113. My investigators viewed the available CCTV coverage at length. However, this proved a difficult exercise because of the poor recording quality due to faulty

equipment. Officers told the investigator that they knew it was faulty and that this had been the case for some time. A police statement from a police officer who viewed the CCTV footage, confirms that staff had told him on a previous occasion that the ongoing problem had not been rectified.

The Governor should ensure that staff report faults in CCTV equipment to managers as soon as they are identified. Regular maintenance checks should be carried out and staff made aware of the importance of reporting any faults in a timely manner.

Hot debrief

114. It is recorded in the Command Incident Log that staff told prisoners of the man's death and offered help to anyone who requested it. The Log also says that the governor spoke to bedwatch staff and offered help if they needed it. However, there is no evidence that a formal hot debrief was held for all staff who were involved in the man's care and the events leading up to his death. A hot debrief is a requirement of Prison Service Order (PSO) 2710 and should follow every death in custody. I have made recommendations in respect of this issue in previous investigations at Wormwood Scrubs and must repeat that message here.

The Governor should ensure that, in accordance with PSO 2710, formal hot debriefs take place and are documented.

Escort arrangements

115. I am not convinced that it was necessary for the man to be handcuffed while in the ambulance taking him from prison to hospital.

116. The family have said that two prison officers were present when he was given the last rites. They found that this lack of privacy at such a traumatic time added to their distress.

117. The Bedwatch Log shows that at 7.05pm the man had suffered a massive brain haemorrhage and it was likely that he would die shortly. The communications room log records that the prison bedwatch staff gave this news to the prison at 7.24pm. There is no documented evidence to suggest that the risk assessment was reviewed and consideration given to whether bedwatch officers could have been withdrawn when the family arrived.

When the prison is told of the imminent death of a prisoner in hospital, the Governor should ensure that the risk assessment is reviewed. Consideration should be given to whether some or all bedwatch officers should be withdrawn on the grounds of decency and respect when the family are present.

CONCLUSION

118. My investigation found that the greater part of the man's time in custody following his arrest was spent at the police station. He was in custody for an evening, overnight, and at court the next morning. He did not arrive at Wormwood Scrubs until around 3.30pm in the afternoon. There is no evidence that he received medication for alcohol withdrawal while he was in police custody. The Independent Police Complaints Commission may wish to take a view on his medical care while in police custody.

119. The man collapsed shortly after arriving at the prison and the deterioration in his health was rapid. The second clinical reviewer has concluded that healthcare staff lacked specific training in recognising alcohol withdrawal symptoms. Furthermore, my investigation has revealed a number of questionable decisions on the part of healthcare staff. Actions appear to have been based on quick solutions to problems rather than a considered and professional approach supported by a duty of care. It was an unfortunate coincidence that the prison doctor was detained elsewhere in the prison when he collapsed and was unable to see him immediately in the FNC.

120. The panel who conducted the initial clinical review concluded that the actions of staff were prompt and appropriate and that no acts or omissions contributed to his death. They pointed out that their recommendations, on a range of matters, were not related to the cause of death but were to assist improvements in service. The second clinical reviewer disagrees with their findings. He believes that, with greater knowledge and expertise, the man's fall and the deterioration in his condition might have been avoided. His conclusion is that his clinical care was unsatisfactory and he clearly specifies the areas of deficiency. On the basis of the evidence, including the areas for improvement acknowledged by the panel review, I agree with the second clinical reviewer's assessment that the care given to the man fell significantly short of expected standards.

RECOMMENDATIONS

The Governor

1. **The Governor should remind reception staff that anyone who sees an injury on a prisoner must take responsibility for completing the appropriate records and not expect others to do so.**

   Accepted. A Notice to all Staff, including Reception, was published on 09/11/09. All staff have also been briefed on this within their daily team meetings and through the monthly Violence reduction, Suicide Prevention meetings and Residential meetings.

2. **The Governor should ensure that staff report faults in CCTV equipment to managers as soon as they are identified. Regular maintenance checks should be carried out and staff made aware of the importance of reporting any faults in a timely manner.**

   Accepted. All FNC staff have been made aware of the importance of reporting faults immediately via team briefings and a notice is now displayed above the system which describes the procedure.

   All maintenance checks are carried out as per the system instructions and repairs carried out per the works department small repairs contract.

3. **The Governor should ensure that, in accordance with PSO 2710, formal hot debriefs take place and are documented.**

   Accepted. The process for carrying out hot debriefs have been formally written into the Deaths in Custody Contingency Plans and the DiC checklist.

4. **When the prison is told of the imminent death of a prisoner in hospital, the Governor should ensure that the risk assessment is reviewed. Consideration should be given to whether some or all bedwatch officers should be withdrawn on the grounds of decency and respect when the family are present.**

   Accepted. In any situation such as this the risk assessment is reviewed, in particular the use of restraints and the staffing level. The establishment feels that, quite often, the family prefer the staff to be there to answer questions.

   Standard establishment practice is to review all risk assessments on a weekly basis or upon receiving new information.

   The staff would also give the family privacy but not withdraw altogether. All decisions are taken on available information and fully documented.

   This process is described fully in the Local Security Strategy and published on the Intranet.

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The Head of Healthcare

5. **The Head of Healthcare must ensure that reception healthcare staff are fully trained in substance misuse policies and assessment procedures and carry out a rigorous health and substance misuse assessment on new reception prisoners. The Head of Healthcare must ensure that healthcare staff are aware of their responsibility to fully complete all reception healthcare paperwork.**

   Accepted. The clinical staff have been on a training programme funded by the PCT which includes the use of Patient Group Directives which stipulate how care should be given. This included substance misuse assessment.

   Once the 'System One' (TPP), the clinical information system, is in place, all assessments will be documented on the computer and will 'flag' any areas that have not been completed.

   This is the new 'failsafe'.

6. **The Head of Healthcare must ensure that staff policies and procedures regarding the identification and treatment of substance misuse are in place. Staff should be adequately trained to identify alcohol seizures and treat them as a medical emergency.**

   Accepted. The clinical staff have been on a training programme funded by the PCT including the use of Patient Group Directives to stipulate how care should be given. This included substance misuse assessment.

   Specific policies have been written and are due to be ratified at the next Clinical Governance Forum this month (December 2009). These are:

   - Subutex
   - Stimulants
   - Withdrawal including alcohol
   - Benzodiazepine

7. **The Head of Healthcare must set up a process whereby all healthcare staff are given regular individual supervision. The aim should be to identify and address training and development needs so staff are able to discharge their responsibilities in accordance with the standards expected by the Nursing and Midwifery Council.**

   Accepted. The Interim Modern Matron for H3 is setting up formal managerial and clinical supervision for all staff.

   All staff on Primary Care have 1-2-1 meetings with the Modern matron and all have Performance Development Plans (PDPs).

   All staff on IDTS have clinical supervision.

8. **The Head of Healthcare must remind healthcare staff of the importance of accurate and contemporaneous record keeping in accordance with the standards of the Nursing and Midwifery Council.**

   Accepted. The Clinical Governance manager and Practice Development Nurse will undertake monthly audits of records and feeding results [to] the PCT Trust Board on a regular basis.

   The introduction of 'System One' (TPP) the clinical information system will ensure there is better record keeping.

   This is the new 'failsafe'.

The Primary Care Trust

9. **The Primary Care Trust should draw my report to the attention of the Nursing and Midwifery Council who should satisfy themselves that the nurse who conducted the first reception health screen is competent to practise.**

   Not Accepted. The report has been drawn to the attention of the NWC but it is jointly felt by the prison and the PCT that the nurse's name should be removed from the PPO report and the PPO recommendations.

The Governor and the Head of Healthcare

10. **The Governor and Head of Healthcare should ensure that emergency medical equipment is placed in the reception area so reception healthcare staff are able to respond quickly to medical emergencies.**

    Accepted. The Modern Matron for Primary Care has developed protocols and a resuscitation bag for all areas. However, funding has NOT been made available to ensure all resuscitation bags have the necessary equipment.

11. **The Governor and Head of Healthcare should ensure that the practice of using the First Night Centre as an overflow for sick prisoners when the healthcare centre is ended.**

    Not Accepted. The Healthcare at Wormwood Scrubs has only 16 beds to accommodate the most serious of sick prisoners (including mentally ill patients). The reason the FNC is used as an overflow is because it benefits from its own nursing team, a doctor from 0900 – 2100; access to the in-patient treatment staff and the 24 hour emergency response nurse is based in close proximity.

    Prisoners located on the FNC benefit from an enhanced level of care and removal from this position could further jeopardise their care.

12. **A protocol between the Governor and the Head of Healthcare should be drawn up to set out clear boundaries regarding sharing of information between healthcare and discipline staff in the FNC.**

Accepted. A Sharing Information Policy has been drafted and is awaiting final approval by Clinical Governance. All non-healthcare staff will then be required to sign a form stating they will abide by Data Protection and HealthCare principles.