

**Investigation into the circumstances surrounding the death of a
man who was a prisoner at HMP Wandsworth in May 2005**

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

February 2008

This is the report of an investigation into the death of a man in May 2005. He was 39 years old when he died. The man was a sentenced prisoner at HMP Wandsworth. A post mortem was carried in May, and the cause of death was recorded as bronchopneumonia, emaciation and previous left pneumonectomy (removal of the left lung) for a gunshot wound.

I would like to extend my sincere condolences to the man's family for their untimely and sad loss.

One of my investigators conducted this investigation. The Wandsworth Primary Care Trust conducted a clinical review into the man's care and treatment. In light of the man's age, the unique aspects of his physical and mental health, and deep family concerns over his welfare and treatment, my investigator also asked for an independent clinical review to be undertaken.

I am grateful to the Governor at Wandsworth and his staff for their help and co-operation during this investigation.

This is an unusually long report into a death from natural causes. That length reflects the very unusual circumstances surrounding the man's death. Since the man's death Wandsworth have taken action to address the recommendations in my draft report and this report has been amended to reflect the steps they have taken to address the identified learning.

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SUMMARY

1. At approximately 8.24am one day in May 2005, a man died in Kearney Unit at HMP Wandsworth. The post mortem indicated that the man died of bronchopneumonia, emaciation and previous left pneumonectomy (removal of left lung) from a gunshot wound. He was 39 years old.
2. This was not the man's first experience of prison. He entered Wandsworth in November 2004 with unusual and complex physical and mental health problems that were undoubtedly challenging to manage. The man found it extremely difficult to come to terms with his predicament and was described as a man who could not cope with prison. In light of his low mood and his history of self-harm, he was placed immediately on Assessment, Care in Custody and Teamwork (ACCT) procedures, designed to help those at risk of self-harm or suicide.
3. Despite being subject to ACCT procedures and regular reviews by mental health staff, including the prison psychiatrist and the Dual Diagnosis team, the man continued to be a prolific self-harmer. He seems to have wanted to be detained in hospital rather than in prison, but psychiatric assessments on 7 March and 29 March, established that he was not suitable to be compulsorily detained under the Mental Health Act 1983. From 30 March until his death, the man was placed on constant watch. In April, the prison psychiatrist was sufficiently concerned about the man's condition to consider that the decision about compulsory detention should be reviewed once more. On 27 April, he made a further referral to a doctor from the Kingston and Richmond Mental Health Team in order to assess again, in the light of the man's current condition, whether compulsory hospitalisation was appropriate. The referral was not made to the correct organisation, and was not properly pursued. The man did not therefore receive any further assessment. This was not the only time that referrals to outside agencies were not properly pursued, and the investigation has highlighted this as an area of weakness in the way the prison cared for this man.
4. The prison psychiatrist prescribed Depixol to curb the man's ideations of self-harm. The use of this drug has been the subject of comment by the man's family who firmly believe his health and wellbeing deteriorated as a result of its use.
5. In March 2005, the man stated that it was his intention to starve himself to death. When he entered prison, the man was a frail man who had experienced gradual weight loss and was described as an erratic eater. Although he had gained some weight whilst he was in prison, he refused to eat properly in April and May, and his weight dropped dramatically. This report is critical of the prison's failure to implement appropriate procedures to monitor the man's weight or seek specialist advice, particularly in the last weeks of his life.
6. Throughout his time at Wandsworth, the man was often referred to outside hospital either because of his direct self-harm attempts or because of his unique and frail physical condition. In December 2004, he was hospitalised following the diagnosis of a chest infection. In January 2005, he was diagnosed with a

further chest infection that was treated with oral antibiotics. Despite only having one lung, the man continued to smoke and his poor diet made him particularly susceptible to infection. In early May, he contracted yet another chest infection. He was initially prescribed oral antibiotics, but later was taken to hospital where he received intravenous treatment. He was discharged back to Wandsworth the same day. The man again refused to eat properly or comply with his medication regime and continued to be focussed on being treated in an outside hospital. Some days later his physical condition had deteriorated and he was described as emaciated and weak. The prison healthcare team were concerned at his appearance and he was referred to the prison doctor. The doctor's view was that the man's condition did not warrant an urgent referral to hospital. During the last night the man was alive he vomited intermittently and was seen to be shaking. In the early hours of the morning his condition was of concern to the constant watch observer who alerted the night nurse. Following the nurse's examination and a brief verbal response from the man, no other documented clinical observations were taken. At about 7.38am, the man was observed to be sitting upright on his bed and then collapsed unconscious, apparently not breathing. Subsequent resuscitation efforts by healthcare staff and paramedics were unsuccessful.

7. The independent clinical review takes the view that re-admission to hospital on the earlier date in May would have benefited the man and might have had a direct effect on the final outcome. It also states that there were subsequent occasions when the man's condition could have warranted referral to outside hospital, although it was a difficult judgement call for the clinical team at Wandsworth to make.

THE INVESTIGATION PROCESS

8. My investigator visited HMP Wandsworth in late May 2005. The Governor and his staff produced the man's core record and a number of other documents for examination. Notices were issued to staff and prisoners telling them of the investigation. My investigator was able to speak to and interview members of staff and prisoners who knew the man. Interviews took place at Wandsworth over July and August.
9. A Family Liaison Officer from my office contacted the man's mother. He offered her the opportunity to meet with him and the investigator to discuss the purpose of the investigation and to raise any concerns or questions that they would like explored and addressed. The Family Liaison Officer and my investigator met with the family in July and noted the concerns and issues in relation to the care and treatment of the man. Issues were also raised in respect of the treatment the family received after the man's death. A meeting with the family and their legal representative took place on 1 June 2006, to discuss the draft report. Several issues were raised which I have sought to address.
10. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist him in his enquiries into the man's death.
11. The Wandsworth Primary Care Trust was contacted in order to conduct a review into the man's care and treatment. The brief review was undertaken by a doctor. Because of the man's age and the initial circumstances of his death, my investigator also commissioned an independent clinical review into the man's care and treatment at Wandsworth.
12. The police were also contacted. Their investigation has not highlighted any third party involvement or any criminal negligence issues.

The Man

13. The man was born in London. He was one of six children and was from a very close knit and supportive family. His family are devastated by his death and extremely critical of the Prison Service, taking the view that the man did not receive a satisfactory level of care for his particular physical and mental problems.
14. The man left school at 15 with no qualifications. At an early age he had a history of substance, drug and alcohol abuse. He had been in prison on a number of occasions for a range of offences, mostly for theft. The man was known to the Community Drug and Alcohol Team (CDAT) prior to his arrest in 2004. He claimed that he had a crack cocaine habit and was paying significant amounts of money on a daily basis to fund his habit. At the time of his arrest he said that he committed the offence in order to pay for his drug addiction.
15. The man had previously been involved in an incident where he was shot by police. The man sustained serious injuries that necessitated approximately 10 months intensive treatment in hospital. As a result, the man had a left pneumonectomy (removal of left lung) and traumatic damage to the left side of his chest. During medical treatment for these injuries, he had suffered three cardiac arrests. Since that episode, the man had suffered from neuropathic pain, shortness of breath, left chest pain and gradual weight loss. He was also prone to suffering extreme anxiety and bouts of depression. The man claimed to have no recollection of the events leading up to his being shot.
16. Since the late 90's, the man had been seen at a Hospital for his psychiatric condition. It was noted that the man's use of drugs combined to make him someone who could not cope easily in a prison environment. He had been diagnosed as suffering from a personality disorder.
17. In 2003, the man entered the Springfield Hospital to embark on a 10-week drug detoxification programme. It was during this time that the man met his fiancée. However, she later committed suicide by taking an overdose. The man witnessed her death and was very much affected by it.
18. The man's family had attempted to have him compulsorily detained under the Mental Health Act 1983. However, the family say that the National Health Service was not very helpful in this quest. As a consequence, the family claims that the man's condition deteriorated and that he was more prone to get into trouble. The family was also very concerned that the man would harm himself should he end up in prison again. Indeed, the man had attempted suicide by overdose and hanging. This necessitated a fortnight in hospital. He had been discovered by his sister.
19. In November 2004, the man was remanded in custody to HMP Wandsworth charged with robbery against the person. At the time of his arrest, he was unemployed. He was registered disabled and was living in adapted council accommodation. Whilst in custody, the man's affairs were looked after by his

mother, who was his nominated next of kin and his primary carer. The man's needs were also taken care of by other members of his family.

20. When he was remanded in custody at Wandsworth, the man had additional health conditions that included a heart murmur, curvature of the spine, an arthritic left hip, borderline diabetes and asthma. He was also known to be a carrier of MRSA.
21. The man was a very slight man. On admission to Wandsworth it was documented that he weighed 47.7kg (7.5st) and was 5'9", although the post mortem report records his height as 5'7". He had been losing weight since 1999.
22. The man had been prescribed Dihydrocodeine, Temazepam, Diazepam, vitamins and Ensure by his GP. The man was given Ensure when he lost his appetite and was noted to be losing weight. The man's family said that, since the removal of his left lung, he had often found it difficult to ingest food normally and experienced pain in his chest cavity. He was also prescribed an inhaler to help his breathing.
23. The man had a son. He maintained contact with his son and his ex-partner, although his son did not visit him in prison. The man's mother and his siblings kept in close contact with him by letter, telephone and visits. The man's family remained fully supportive of him and are highly critical of the judicial process and the position that the man found himself in.
24. The man also had a girlfriend at the time of his imprisonment and he maintained regular contact with her, mainly by telephone. Staff say that on several occasions the man was very upset following telephone calls to his girlfriend.
25. In April 2005, the man was sentenced to two years imprisonment. A pre-sentence psychiatric report concluded that the man's substance misuse and dependence had undoubtedly had a great impact on his life and had led him to committing crimes, but confirmed that he was not thought to be suffering from an enduring mental illness. The man was deemed fit to be sentenced to a term of imprisonment.

HMP WANDSWORTH

26. Wandsworth is a category B local prison that was built in 1851 and has been extensively refurbished in recent years to include integral sanitation. The establishment houses a large number of prisoners with drug and mental health problems. Her Majesty's Chief Inspector of Prisons, in their 2006 inspection, HMCIP noted that Wandsworth continued to suffer a shortfall in staff numbers. The Chief Inspector also recorded that Wandsworth was not meeting the standards of a 'healthy' prison.
27. Wandsworth has 274 staff who are trained in suicide awareness and ACCT. There are 33 members of staff who have been trained as ACCT assessors.
28. The Kearney Unit at Wandsworth is a small unit of 12 beds that deals primarily with prisoners on drug detoxification. Along with the Addison Unit that treats prisoners who are deemed to have mental health problems, healthcare is provided under a dual diagnosis system which deals with both detoxification and mental health problems. The Kearney Unit also has a gated cell that affords uninterrupted observation of a prisoner if required.

EVENTS LEADING UP TO THE MAN'S DEATH

29. On entering prison in November 2004, the man was given an initial health screen. His physical and mental health condition was noted by healthcare. In light of his low mood and previous attempts at self-harm, he was placed on the ACCT regime and located in a shared cell. The man was advised about the prison Listener scheme, as well as the Samaritans. There is no evidence to suggest that he used either of these support networks whilst he was in custody. Following his initial health screen, the man was referred to the prison In Reach Team. However, following a meeting with the In Reach Team he was referred to the Dual Diagnosis Team that deals with both mental health and substance misuse problems.
30. Having tested positive for opiates, benzodiazepines and cocaine, the man was put on a detoxification regime. The man was also prescribed appropriate medication for his other medical conditions.
31. In December, the man was assessed by the Dual Diagnosis Team. The assessment established that he regularly attended the pain clinic at a hospital local to where he lived following his pneumonectomy. The man also stated that following the shooting incident he had had a nervous breakdown and was being treated at a psychiatric hospital. It was established that he had suffered bouts of depression and had a history of self-harm. Following this initial assessment he was referred to the prison psychiatrist. In the meantime, a fax was sent to the man's GP requesting his medical history and confirmation of the medications that he was receiving. The prison also made contact with the man's Probation Officer, who was described as being very unhelpful in disclosing information about him.
32. Also in December, the man was seen by the Dual Diagnosis Psychiatrist. The man told the psychiatrist that he was in physical and mental pain, but denied any thoughts of self-harm. However, he stated that he was hearing voices inside his head. Following the assessment an appropriate care plan was drawn up that included obtaining the man's medical and mental health history. Because of his low mood, the man was kept on an open ACCT. Staff on his residential wing were made aware of the man's mental health status.
33. Later in December, during a family visit, the man collapsed with breathing difficulties and was taken by ambulance to St George's Hospital, where he was admitted and treated for a respiratory infection. The man was discharged back to Wandsworth three days later. The same day, an ACCT review was undertaken and the decision made to keep the document open.
34. Whilst he was in hospital the prison had received a letter from the man's mother, who had been present when her son had collapsed on the visit. She was distressed about her son's physical condition and appearance, and was annoyed that she could not accompany her son in the ambulance. The man's mother also complained that the prison did not have the courtesy to inform her of her son's condition, despite assurances that were given to her by staff. In her letter she stated that her son should not be in prison and that he was not

receiving the appropriate care and treatment for his particular physical or mental health needs. She gave a list of her son's ailments and the medication that he had been taking outside prison. The list included strong painkillers for his chest pain. In February, the Head of Healthcare responded offering reassurance that her son was receiving appropriate treatment and was making reasonable progress. The letter also asked for clarification from her in respect of the disclosure of her son's medical notes to her following permission by the man. It was clear during the investigation that the man's family, and in particular his mother, had many concerns over the man's physical and mental health whilst in prison and frequently sought information and reassurance from healthcare staff. In response to my draft report the family told my investigator that the man's mother had sent a number of letters to the prison and made a number of telephone calls to staff highlighting her concerns in respect of her son's care and treatment. However, most of this correspondence was not recorded or retained on his medical record.

35. In December, the prison doctor requested that the man be admitted to the healthcare centre for closer observation of his physical condition, as well as give him a better sense of security. The man stated that as a police informer he was in danger. He also stated that it would not take a lot to kill him as he was so weak.

December 2004 to January 2005 – Kearney Unit

36. In December 2004, the man was admitted to the Kearney Unit so that his physical condition could be observed following his discharge from hospital. This small unit deals specifically with prisoners who are on detoxification in an informal, therapeutic setting. The man was not prescribed anti-depressants and healthcare staff were of the opinion that the man's anxieties were attributable to his recent withdrawal from opiates. His physical condition was described as reasonable.
37. A mental health assessment was conducted as part of the Counselling, Assessment, Referral, Advice, Throughcare (CARAT) process. The assessment established that the man had attempted self-harm on numerous occasions, the most recent being in June 2004. An undated note on the man's medical record, written by the man and addressed to his mother indicates that he was an anxious man who experienced episodes of depression. Indeed, the man stated that since the summer of 2004, he had been hearing voices in his head telling him to kill himself. At this time, the man's weight was recorded as 54kg, indicating that the man had gained about 6kg in weight, since entering Wandsworth.
38. The medical record indicates that the man was experiencing psychological problems associated with the withdrawal from opiates. The man also stated that, if he was located in the general healthcare unit, this would be the solution to all his anxieties.

39. Late in December, the man was found collapsed and taken by ambulance to St George's Hospital, complaining of chest pain and shortness of breath. He also appeared to be fitting and paramedics gave him medication for this. Oxygen was also administered. The man was seen by pain specialists at the hospital who noted that the problem was associated with post operative pneumonectomy. The man was prescribed appropriate painkillers to control the pain and discharged back to Wandsworth on the same day.
40. In the late evening one day in early January 2005, the man was again taken by ambulance to St George's Hospital. He was complaining of shortness of breath and chest pain. The man was discharged back to Wandsworth in the early hours of the following morning having been diagnosed with neuropathic pain. On discharge, St George's Hospital wrote to Wandsworth advising that the man would benefit from a referral to the Chronic Pain Consultant in order to investigate and manage his neuropathic pain. In mid January, the prison doctor wrote to the consultant asking for the man to be assessed for his neuropathic pain. However, it appears that this referral was never followed up.
41. Meanwhile in early January, the man attempted to strangle himself with a bed sheet in his cell. He was prevented by other prisoners and moved to a 'safer cell'. This episode followed an argument over his medication. Later the man apologised to staff for his behaviour.
42. Following a telephone call to his mother and his girlfriend, the man appeared to be in better spirits.

Mid January to Late January – return to ordinary location

43. One day in mid January, the man was discharged from the safer cell in Kearney Unit back to a residential wing. An appropriate care plan was drawn up for him. The medical record indicates that he looked emaciated and was not taking his Ensure. The man admitted to being anxious, but not suicidal. Plans were discussed to refer him to the Chronic Pain clinic, although the referral was not followed up. The record indicates that the man had developed a persistent cough and he was prescribed oral antibiotics for a chest infection.
44. Two days later healthcare staff were called to see the man who was experiencing breathlessness. The man admitted to being anxious and was given reassurances by staff.
45. Four days after this the man was found collapsed on the wing landing and appeared to be fitting. His blood pressure, heart rate and temperature were taken and gave no cause for concern, although he was referred to the prison doctor later that day. The medical record indicates that the man may have attempted to set his penis alight, although there were no apparent injuries. In view of this, the man was placed on one to one observation in order to prevent further episodes of self-harm. The man was also clinically monitored every thirty minutes. Following this, an ACCT review recorded that the man did not express any suicidal thoughts.

46. The medical record shows that the man could be uncooperative and prone to the occasional verbal outburst. In view of his low mood he remained on one to one observation.
47. The man was reviewed by the dual diagnosis nurse who noted that, whilst the man stated that he felt a lot better, he was tearful and not happy with his situation. Reassurance and support was given. Two days later a further review under ACCT was undertaken.
48. Late in January, the medical record indicates that the man had tied a shoelace around his left arm and cut himself. The injury was not serious and he was treated on site. The man stated that he was depressed, could not cope in prison, and was finding it hard to cope with life and the circumstances that he found himself in. The man was told again of the help and support he could receive in the form of a Listener or the Samaritans. However, the medical record indicates that the man was determined to go to an outside hospital, whatever the cost. Following his latest attempt at self-harm, the man was reviewed once again in compliance with ACCT.

Late January to Mid March – return to Kearney Unit

49. At the end of January, the man was found in his cell with a ligature around his neck. He was conscious and said he could not cope with prison and wanted to die. He was tearful and stated that he heard voices in his head telling him that the policemen were going to kill him. Arrangements were made for the man to be transferred once again into a gated cell in Kearney Unit where observations of his mood and behaviour could be made. The man told staff that he wanted to go to a psychiatric hospital to be treated.
50. The following day the man appeared to be more settled and the record indicates that he was coherent and well kempt.
51. Three days later the man was again found in his cell with a ligature tied around his neck. His skin colour and vital signs were of concern to staff. He was given oxygen and taken to St George's Hospital. At the hospital, medical staff recommended that the man underwent a psychiatric review, particularly in light of his frequent attempts at self-harm. The man was discharged back to Wandsworth at 6pm that day. At 6.30pm, the man again attempted self-harm by pulling out the intravenous access needle from his left arm, which had been left in after discharge from the hospital. He stated that he wanted to die because his girlfriend had left him. He continued to claim that he heard voices inside his head telling him to kill himself. He was also not eating or sleeping well. Following his discharge from hospital, the man's property was removed from his cell and a safe blanket was given to him. The man was subject to one to one observation.
52. At the beginning of February, the man stated that he wanted to live for his young son. The prison psychiatrist noted that the man continued to complain of hearing voices in his head telling him to kill himself. The psychiatrist thought that the man might be relapsing into a psychotic depression and prescribed the

- appropriate medication. The man's response to the medication was subject to a 48 hour review.
53. Two days later the man was reviewed again by the psychiatrist who noted that there was not much change in his mental status. It was also noted that the man had developed dry lips as a side effect of the medication he was on. He was to be reviewed the following week and he was still subject to one to one observation. The man requested again to be transferred to an outside hospital for treatment.
 54. Five days later the man was reviewed by the psychiatrist. Although he was still complaining of hearing voices inside his head, his mood was described as more stable. The medical record indicates that the man was not eating or sleeping well. He was kept on one to one observation and was to be reviewed by the psychiatrist the following week.
 55. One week later the man was reported to be more stable in his mind and not presenting with any identifiable psychotic features. In light of his improvement, it was decided to downgrade one to one observations to level two observations (every 15 minutes).
 56. Eleven days after this review the man admitted to staff that he had received bad news that was making him feel very low. He did not elaborate or share his anxieties with staff. He also claimed that the medication he was receiving was making him feel suicidal. In response, he was seen by the psychiatrist, who described the man as a manipulative individual rather than someone who was mentally ill.
 57. At 5.30pm one day late in February, the man attempted to hang himself in his cell with a shoelace. The man pressed his cell bell in order to alert staff to his attempt. Whilst waiting for the ambulance to arrive to take him to St George's Hospital, he was given oxygen. The man again claimed that he heard voices in his head telling him to kill himself. He also stated that he wanted to be referred to an outside hospital. He was discharged back to Kearney Unit that same evening.
 58. The following day the man stated that he had heard voices telling him to kill himself and that he felt suicidal and depressed. In view of his mood, the man was transferred to a safer cell in Kearney Unit and placed on constant observation. The man was also offered the services of a Listener but declined. When asked later why he had attempted to hang himself, the man stated that he had received some bad news, but again he would not elaborate any further.
 59. At the beginning of March, the man was sent to hospital for a routine physical check up. It was determined that his physical condition was satisfactory and he was duly discharged back to the prison. On his return to prison, the man was seen once again by the psychiatrist who asked him why he had tried to hang himself. The man again stated that he had received some bad news, but declined to say more. He also said that the medication he was being given was making him feel suicidal. The man did not present to staff as being depressed.

- His speech was coherent and relevant, leading the psychiatrist again to conclude that he felt the man was 'manipulative' rather than mentally ill. With the agreement of the man it was decided that he should be discharged in the near future back to a normal residential wing, with the same level of one to one observations. The man was content to share a cell with someone that he knew.
60. The man continued to request that he be sent to an outside hospital to be treated for his mental condition. Whilst the man's request was acknowledged by staff and noted in his medical record, he was told that there was no guarantee that he would be transferred to an outside hospital. A note by the psychiatrist again indicated that the man was not mentally ill but manipulative. When the man was informed that he was not going to be referred to an outside hospital because of his mental condition, he became upset and verbally aggressive to staff.
 61. Again, early in March, the medical record indicates that the man felt a lot better in himself. After discussion with staff, the man was content to transfer from Kearney Unit to a residential wing.
 62. Three days later, the man told staff that he had been responsible for the murder of a woman two years previously. He wanted to confess to police. Late in April, police interviewed the man. Police have since confirmed that the man was not involved in the murder and that the information he gave them does not form part of the ongoing investigation into this crime.
 63. In early March, a pre-sentence report was prepared on the man by a Consultant Forensic Psychiatrist from the psychiatric hospital where the man had previously been treated. The report established that the man was not suffering from an enduring or severe mental illness within the meaning of the Mental Health Act 1983 that would justify compulsory detention. The man was diagnosed as suffering from Moderate Depressive Episode with some mild psychotic features. Overall, he was considered to be suffering the symptoms of anxiety, but his mental state was otherwise reasonably stable. The report highlighted the death of the man's girlfriend in 2004, and the effect that this had on him, and suggested that bereavement counselling might be beneficial. However, there is no evidence that he was ever referred for or received such counselling.
 64. In early March, the medical record indicates that the man was requesting stronger pain relief. However, he was not compliant in respect of his medication and was prone to self-harm. The man was also taking other analgesics and his request was refused. The medical record also indicates that he was continuing to suffer with a poor appetite and was not feeling well. On the other hand, dual diagnosis staff noted that he was attending the servery for meals and was eating quite well. The medical record noted that his general physical condition did not reflect poor health due to poor food intake.
 65. Mid March the man was found to be experiencing breathing difficulties and holding his stomach. He was taken by ambulance to St George's Hospital for a check up and told the doctor that he had vomited several times, although there

was no evidence of this at the hospital. The man was discharged back to Wandsworth the same day with the recommendation that he would receive an ultrasound scan if the symptoms persisted.

66. The following day the man claimed that he was vomiting blood and appeared to be experiencing breathing difficulties. He was given his salbutamol inhaler and oxygen although this did not appear to relieve his distress. He was taken once again to St George's Hospital for investigation. It was later discovered that he had swallowed a plastic badge in order to induce vomiting and bleeding. Whilst at hospital, the man told staff that he was going to starve himself to death, reiterating that he wanted to be treated in an outside hospital.
67. A couple of days later the man again declared to staff that it was his intention to starve himself to death and handed a note to the agency nurse who was carrying out the one to one observations. The note, undated, stated that he was tired of living and in pain. However, staff noted that soon after his declaration he was eating some food. In view of this, it was not considered appropriate or necessary to record his refusal in the Food Refusal Book.

Mid March – Ordinary residential location

68. One day in mid March, the man was taken to St George's Hospital once again, claiming to be vomiting blood. It was established that he had again swallowed a plastic object. The man was discharged back to Wandsworth the same day. As his bed space had been taken by another prisoner in Kearney Unit, the man was placed in a residential wing although he was still subject to one to one observation. In the meantime, a case conference was held in Kearney Unit and the decision was made to discharge the man back to an ordinary location subject to the same level of observations.
69. Two days later the man was seen by the dual diagnosis nurse. The medical record states that he was feeling a lot better and had no thoughts of self-harm. One to one observations on the man continued.
70. However, four days later the man was taken by ambulance to the Chelsea and Westminster Burns Unit after setting fire to himself with newspapers and a lighter in his cell. The man sustained burns to his chest and abdomen. Whilst in hospital, the man was subject to appropriate bed watch conditions and restraint by prison officers.
71. One week later and in light of his most recent attempt to self-harm, the man was assessed by two psychiatrists from the Community Mental Health Team (CMHT). The Mental Health Assessment took place at the Chelsea and Westminster Hospital and was carried out in order to determine whether the man had a severe or enduring mental illness that merited further consideration of compulsory detention under the Mental Health Act 1983. The man was interviewed by the psychiatrists. As part of the assessment, the man's mother and former partner were invited to attend the assessment. The man was escorted by two prison officers and handcuffed in accordance with the local security operating procedures. The assessment indicated that a dual diagnosis

nurse was contacted among other agencies by telephone prior to the assessment. The Healthcare Manager later confirmed to my investigator that the duty of care would have passed to the Chelsea and Westminster Hospital and would not have included direct input into the assessment by staff from Wandsworth.

72. The assessment was described as a highly charged and emotional affair. It determined that the man could not be compulsorily detained under the Mental Health Act. The assessment considered that the man suffered from a personality disorder. It was established that the man's condition could be treated with long term psychotherapy, drug therapy and observation. It was envisaged that this treatment would assist the man with his self-harm behaviour and psychological distress. The Community Drug Action Team (CDAT) and the man's GP were also informed of the diagnosis. Following the meeting, the man stated that the psychiatrists would have blood on their hands, intimating that he would die in prison. He was discharged back to prison that day. Although the assessment recommended that the man had psychotherapy, there was no indication that this was considered further or offered.
73. The Home Secretary may exercise his powers under sections 47 or 48 of the Mental Health Act 1983, only if he is satisfied by reports from at least two registered medical practitioners, one of whom must be approved under section 12 of the Mental Health Act that the prisoner is suffering from mental illness, psychopathic disorder, severe mental impairment or mental impairment; and that the mental disorder is of a nature or degree which makes it appropriate for medical treatment or in the case of a prisoner suffering from psychotic disorder or mental impairment, that such treatment is likely to alleviate or prevent a deterioration of his condition. For a prisoner to be transferred from prison under the Mental Health Act, both medical reports must agree that the prisoner is suffering from the same form or one of the same forms of disorder and the Home Secretary must be of the opinion, having regard to the public interest and all the circumstances, that it is expedient to direct the prisoner's transfer. The initial action to identify prisoners where a transfer might be appropriate rests with the Head of Healthcare.
74. Between April 2004 and March 2005, 802 prisoners were transferred to hospital as restricted patients by direction of the Home Secretary. However, my investigator has found no evidence to suggest that the man was identified or that procedures were initiated by Wandsworth to consider transfer to a hospital, under section 47 of the Mental Health Act 1983.

End of March – return to Kearney Unit

75. Following the man's psychiatric assessment at the Chelsea and Westminster Hospital, a care plan was drawn up by Wandsworth that included placing the man in a gated cell in Kearney Unit where he could be observed constantly rather than on a normal residential wing. The care plan included constant one to one observations by a dedicated team of agency nurses in order to monitor and record his mood and behaviour. Observations were recorded at 15 minute intervals in a Special Observation Log. The observers were employed

specifically in order to establish a rapport with the man and to encourage him to eat properly and to comply with his medication. The man was also reviewed regularly by dual diagnosis staff. The Safer Custody Group at Wandsworth and the Independent Monitoring Board (IMB) were also informed and encouraged to have input into supporting the man. However, the man continued to tell staff that it was his intention to starve himself to death, unless he was transferred to a mental hospital. Staff told my investigators during interview that the man's main obsession was to get out of prison and that he would achieve this by whatever means.

76. The following day, following a review by the prison psychiatrist, the man was low in mood and tearful. The man did not present any psychotic features. He told the psychiatrist that he was going to starve himself to death and refused to take his Ensure drink. In light of this, the man was kept on one to one observations. The man stated that he regretted his latest self-harm attempt and denied to staff that he had self-harmed in order to seek attention.
77. At the beginning of April the man attended hospital to have the dressings to his wounds changed. He was advised by medical staff to eat properly and to take his Ensure drinks so that his wounds could heal quickly. He returned to the Kearney Unit the same day and remained on one to one observation.
78. The following day the man demanded Lorozepam, but because he did not present any signs of anxiety he was refused this medication. The following day, the medical record indicates that the man started taking off his burn dressings in his cell as a form of protest. During the course of the day, the man threatened to take his own life self-strangling with his bandages and covering his head with his jumper in order to stop himself being observed. Staff intervened quickly and removed any potential objects that could be used by the man to self-harm. After this episode, the man told staff that he was depressed.
79. Two days later the man attended the Chelsea and Westminster Hospital under escort and restraint, in order to have his burns assessed. Hospital staff advised him to drink plenty of milk and to eat properly as this would assist the physical recovery of his wounds. Up to his death, the man was an erratic eater, although staff state that he was eating very small amounts, including toast when he requested it. At no time was the man referred to a dietician for his eating problem.
80. This same day, a case conference was held in Kearney Unit to discuss the man following his assessment at the Chelsea and Westminster Hospital. The conference was attended by multi-disciplinary staff that included psychiatrists, psychologists and nursing staff. The conference maintained that the man was a "manipulative, determined individual who would not be satisfied unless he was referred to an outside hospital for treatment. He was not amenable to any therapeutic treatment or counselling. Because of his high levels of self-harm, the care plan also included sending a letter to the psychiatrist at the psychiatric hospital who had dealt with him before admission to prison, seeking advice and information on how to manage him. The letter was sent that day, but a response to the request does not appear to have been chased up or received.

The care plan also included writing to the man's family telling them that they could arrange for an independent psychiatric review, at their own expense, if they so wished. The prison psychiatrist noted in the medical record following a review of the man that he might be experiencing relapsed psychotic depression or borderline personality disorder. Medication compliance was encouraged. The doctor also prescribed 20mg of Depixol, an anti-psychotic drug in order to reduce thoughts of self-harm. The conference focussed specifically on the man's mental health rather than his physical condition. Although the man was refusing food at mealtimes, he was eating small amounts, albeit erratically and had been prescribed Ensure. In view of this, it was not considered appropriate to enter him in the Food Refusal Book.

81. The following day the man was still low in mood. He was taking his medication and eating a little food. Staff state that he was fond of herbal tea and would also eat desserts. However, he refused to attend to his own hygiene needs, clean his cell, take exercise, or associate with other prisoners. He would spend a very high proportion of his time in his cell looking at the ceiling.
82. The following day the man told the psychiatrist that his food was being poisoned. He had decided that he would only eat food that was sealed such as sandwiches. Staff have told my investigators that the man would only eat part of a sandwich and throw most of it away. He refused to eat properly and stated that he wanted to die and that he was dying. The man's thoughts appeared to focus on being shot by police, as well as the death of his fiancée. In an effort to convince him that the food was not poisoned, the prison psychiatrist sat down with the man on several occasions and tested the food in front of him. The man was still refusing to take food, but was taking Ensure build up drinks. He continued to smoke despite staff advice and their encouragement to stop.
83. By mid April, the man was still not eating regular meals, maintaining that his food had been poisoned, but he was taking his Ensure. He was also encouraged to take more fluid. The man still complained that he was hearing intrusive voices inside his head telling him to harm himself. The man was advised that he could contact his mother in order to arrange for an independent psychiatric assessment, although this would be at the family's expense. One to one observations of his mood and behaviour continued. The psychiatrist noted in the medical record that it was planned to increase his Depixol injection.
84. Again, mid April, the man was seen by the prison psychiatrist and a dual diagnosis nurse for an assessment. The session was described as difficult in that the man was adamant about being referred to an outside hospital, and was not receptive to therapeutic treatment within a prison environment. According to staff, this was the only option that he was prepared to consider. The man was also convinced that continued attempts at self-harm would support his cause to be referred to an outside hospital. The following day the man was told by healthcare staff that there was no guarantee that he would be referred to an outside hospital.
85. The same day he was seen by the prison psychiatrist who noted that the man was eating reasonably well, although he was still convinced that he was going

- to be transferred to a secure unit. The man was told of the importance of eating well and complying with his medication regime. He appeared to be calm and rational.
86. Two days later the man complained of a toothache and breathlessness. He requested and was given oxygen. Staff advised him to reduce smoking.
 87. The following day the man suffered a panic attack, stating that he was anxious about his forthcoming court appearance for sentencing. However, following his two year sentence, he believed that he could be released on licence as early as July 2005, as he had served approximately eight months on remand. In a telephone call to his mother he appeared to be upbeat about the prospect of being released on Home Detention Curfew, although there was no indication during the investigation that this process had been set in motion.
 88. At about 6.50am towards the end of April, the man complained of chest pains and appeared to lose his balance. He was given oxygen and went back to bed. He continued to complain that he was not able to sleep properly.
 89. That day the doctor sent a letter to the local Mental Health Team. The letter asked that further consideration should be given to reviewing the man's mental health condition, with a view to compulsorily detaining him under the Mental Health Act. The doctor was concerned that the man could suffer a relapse at any time and, despite the highest level of observations, he would succeed in killing himself. However, he did not receive an acknowledgement to this letter and attempts to follow up the letter proved unsuccessful.
 90. The following day the man was seen once again by the doctor, who recorded that he looked brighter and was optimistic that he might be released on an electronic tag as early as July. A decision was made to increase his Depixol injection to 60mg every two weeks. The man was told once again about the importance of eating and taking his medication. He indicated he was willing to stop smoking and therefore advised to see the prison doctor regarding cessation. However, he showed little inclination or determination to give up. This was of particular concern to staff as he only had one lung and was prone to chest infections.
 91. Towards the end of April the man complained of the side effects from the Depixol injection. The dual-diagnosis nurse suggested that the man was exaggerating the side effects. However, his concerns were noted and staff were to continue to observe and note any changes. Later that day he was examined by a nurse who suggested that he might have been experiencing anxiety, rather than the side effects of the medication.
 92. By the end of April, the medical record indicates that the man was fragile and emaciated in appearance. He was still refusing food at mealtimes, but was eating biscuits, fruit and crisps. He was also taking herbal tea. Whilst the man sometimes chose a sandwich, staff recalled that he would often only eat part of the sandwich and throw the rest away.

93. In early May, the man's weight was recorded at 51kg. This was an apparent increase of approximately 4kg since his arrival at Wandsworth in November 2004, but a decrease of 3kg since December 2004. It was evident to the investigation team that, when the man was hungry, he was given bread and herbal tea when he requested it, in an endeavour to encourage him to eat and build up his strength.
94. The following day the man was seen by the psychiatrist and claimed not to be well. He said he was not eating or sleeping well. Again, he was advised to eat properly and to continue taking his Ensure. Again, he was advised to stop smoking in an attempt to increase his appetite. The man also requested to be taken off the one to one observations for his own privacy.
95. Also that day, there was a multi-disciplinary team meeting at which the man appeared, albeit briefly. He was described as very anxious and agitated and asked once again to be taken off the one to one observations for his own privacy. Once again, he was advised to take his medication and Ensure regularly and to stop smoking in order to increase his appetite. The medical record also indicated that he should be given 40mg of Depixol every two weeks rather than the 60mg dose that was decided upon at the end of April.
96. A few days later the man was offered counselling but refused the offer. He was described as being very low in mood and continuing to eat erratically. Because he was eating, albeit small amounts of low nutritional value, he was not placed in the Food Refusal Book. Despite the man's frail, emaciated appearance, his weight was not being taken or monitored regularly. Staff confirmed at interview that when his weight was taken this was recorded in his nursing record. Wandsworth does not maintain as a matter of course a weight chart for patients where food intake is an issue. At this time, the man refused to attend to his hygiene needs and showed little interest in cleaning his cell or associating with other prisoners.
97. At 6.45am one morning in early May, the man attempted to self-harm by tying a sock and some cellophane around his neck. Staff intervened quickly. Materials that could be used to self-harm were removed from his cell. At 7.00am the man then attempted to poke his right ear with a plastic spoon. The record indicates that the man remained 'manipulative and disruptive'.
98. The following day, despite the one to one observations in place, it was noted that the man attempted to choke himself on a plastic object and attempted to set fire to newspapers in his cell using a cigarette lighter. Staff recorded that he was still requesting to go to an outside hospital.
99. The day after this the man asked for his trainer shoes to be returned to him, but was told that they had been removed for his own safety. He became verbally abusive and had to be led back to his cell. Half an hour later he apologised to staff.
100. The following day the man refused to eat breakfast and asked to be forcibly fed. The man's request was denied by staff on the basis that such treatment would

infringe his human rights. In view of his continual refusal to eat properly and his intention to self-harm, the man was seen by a member of the prison chaplaincy in an attempt to encourage him to eat. Staff also outlined to the man the consequences of not eating properly. The man appeared to acknowledge and understand the full consequences of his behaviour, but according to staff his mind was set on getting to an outside hospital. The investigation established that the man had complained that, as the last prisoner to be unlocked at mealtimes, there was limited choice of food on the servery that appealed to his taste. As a consequence, it was decided to unlock this man's cell first, so that he could be assured of a wider choice and variety at mealtimes. However, he would often eat small amounts of food and on numerous occasions would throw most of it away.

101. The following day the man complained that he had a chest infection. He had developed a persistent cough. In view of this he was referred to the prison doctor. Staff advised him to reduce the number of 'roll ups' he was smoking. The medical record also states that the man refused his Depixol injection claiming that it made him stiff. He continued to refuse to eat properly.
102. In mid May, the man was seen by the prison psychiatrist, who also acts as a GP. The doctor noted that the man had a persistent cough and was bringing up green phlegm, and diagnosed acute bronchitis. Oral antibiotics were prescribed for him and he was strongly advised to give up smoking. Later on that day, he agreed to his Depixol injection and was given 40mg. The medical record notes that no adverse reaction was noted or expressed by the man.
103. Following this event the man complained about the medication he was receiving, stating that it was rubbing him up the wrong way. Healthcare staff assured the man that the treatment was critical in treating his depression and eliminating his ideas of self-harm. The man was reminded, once again, of the importance of eating healthily particularly as he was receiving medication. Although the man claimed that he had not eaten, it was noted that he had eaten cereal that morning.
104. The man was then reviewed by the prison psychiatrist who assessed that he was suffering from bronchopneumonia and pleurisy. In light of the fact that he only had one lung the doctor referred him to St George's Hospital for treatment. By 9pm, the man had returned from St George's Hospital, having been treated with intravenous antibiotics during the course of the day. However, there was no evidence of a discharge letter from the hospital on the man's medical record. The psychiatrist also noted that the man was not happy because he had not heard about his referral to the Mental Health Trust.
105. Four days later the record indicates that the man was making himself vomit. He was given a change of clothes. His weight was taken and recorded at 48kg, a reduction of 3kg in less than one month. The man was described as weak and lethargic. He was rigid in his movements and had very dry lips. This, it later transpired, was due to the side effects of Depixol.

106. Two days after this the ACCT review indicated that the man was still contemplating self-harm. Following a case review in the Kearney Unit, the medical record shows that he was still refusing to eat properly, and refused to take any medication, including the course of antibiotics for his chest infection. The man also declined to associate with other prisoners, take exercise, clean his cell or attend to his personal hygiene needs. To staff it seemed that the man continued to pin all his hopes on a transfer to an outside hospital. However, he was again told that there was no guarantee that such a transfer would occur. The man also claimed that the Depixol injections were making him more agitated and restless. Following this review, it was decided to chase up the Mental Health Team referral. The man stated that he would try to eat hot meals as long as they were brought to him from the hot plate. This was agreed in another effort to encourage the man to eat. The medical record indicates that the man felt that he was going to die as he felt weak. The clinical record notes that physically the man was deteriorating.
107. Three days later the man refused to take any medication or food. It was also apparent that he was eating very little and was feeling weak.
108. Early on the following day, the man was observed by an agency nurse, trying to block his mouth and his nose with his hands. He was still refusing food, and his weight was recorded at 46kg. This amounted to a 2kg reduction in as many days.
109. That day the medical record states that there was another discussion in the Kearney Unit about the future of the man's care in prison. The meeting was attended by Healthcare staff, the Dual Diagnosis Nurse and the Manager of the Kearney Unit. Staff had been concerned at the man's physical deterioration during the previous week, noting that he had an emaciated and lethargic appearance and that was refusing to eat or take medication, despite persistent encouragement from staff. It was noted that the man was drinking fluids and that he had accepted some food from the night nurse. It was also noted that the man had been eating crisps and cake earlier that morning, although such intakes of food were not considered to be substantial or nutritious in content.
110. Following the discussion it was decided to refer the man to the duty doctor later that day. A Health Care Officer who had established a good rapport with the man, tried to convince him to eat properly. The man again stated that he would take food from the hotplate as long as it was brought to him. This was agreed. The man also agreed to take his Ensure. In the meantime, a member of the dual diagnosis team telephoned the Mental Health Team in order to obtain a response to the letter of late April. However, the telephone line was constantly engaged. Healthcare staff told the investigation team that they would normally have expected an acknowledgement or reply from the mental health team, but did not receive either. The investigation established that the Mental Health Team had no record of the letter being received. In any event, the team would not have been able to deal with the request as Wandsworth is outside its catchment area.

111. The prison doctor, saw the man at about 12.30pm that day. The man managed to walk unaided a distance of about 25 metres with minimal effort to see the doctor. The doctor was satisfied that the man's vital signs were satisfactory and that he did not warrant an urgent referral to hospital. The doctor also emphasised to the man the importance of eating properly and prescribed him more Ensure drinks. The man assured the doctor that he would take Ensure as well as his medication. A food and fluid balance chart was started to assess what the man was eating, drinking and losing in terms of fluid. The doctor also told healthcare staff that, as he was the duty doctor for the weekend, he would review the man the next day. If his condition deteriorated then further consideration would be given to referring him to hospital for treatment. The medical record states that at lunchtime the man ate a piece of cake.
112. At 6pm, it was noted by the observer outside his gated cell that the man took his medication and his Ensure. At about 6.30pm, it was noted that the man made a telephone call. At 7.35pm the man refused to have his weight checked and refused to eat. At 7.45pm, he stated that he was not feeling very well but was encouraged by the observer outside his cell to eat more in order to regain his strength.
113. At about 9pm, the member of staff who was observing the man noted that he was lying down and shaking all over. At around 9.30pm, the member of staff noted that the man had vomited water. The man was given a change of clothing. He was also given a change of bedding through the gate of his cell. The man threw the sheets over the bed and then went to sleep.
114. At 11pm, the man was observed by the same staff member to be sleeping. At 3am on the following day, the Special Observation Log indicates that the man had been retching intermittently with small amounts of fluid brought up. At 4am, he was observed to be sleeping.
115. At about 4.30am, the man's breathing was noted by the night nurse to be laboured. Arrangements were made through the night duty prison officers to unlock and access his cell. The supervising staff member told my investigators that the man had saliva coming out of his mouth and appeared to be very unsteady on his feet when he tried to get out of bed. He appeared to him to be getting worse.
116. At about 5.30am, the medical record states that the man's cell was unlocked for the purpose of assessing his condition. His vital signs were checked by a nurse. His blood pressure was recorded at 123/93, with an oxygen saturation level of 98%, pulse 111 and respirations 26. The nurse was not unduly worried about the man's vital signs, and in her opinion his condition did not warrant an urgent referral to the doctor or immediate transfer to hospital. The nurse also told my investigators that there was nothing out of the ordinary in respect of the man's breathing compared to other occasions. However, the medical record states that his vital signs were to be monitored closely. There is no documentary evidence that this was done. Nursing staff were aware that the man was to be seen later on in the day by the doctor. During the investigation, staff confirmed that in the event of a rapid deterioration in a patient's condition,

arrangements would be made to transfer the patient to hospital as a matter of urgency. The nurse told my investigators that, when she examined the man, she asked him if he was okay and reminded him that he could see a doctor. The man replied that he was alright.

117. At about 7.26am, the man was observed by a member of the nursing staff to be asleep on his back in his bed. During the course of the previous night, the man had not interacted at all with the observers outside his cell, despite the fact that a reasonable rapport had developed between the man and the team of one to one observers.
118. At about 7.38am, the man awoke and sat up on his bed. He was asked by the supervising member of staff "What do you want?" The man did not reply. His eyes appeared to roll back in his head and he slumped back unconscious on his bed. The member of staff was concerned that the man was not breathing, but he did not have keys to the cell. He ran down the corridor to the nurses' office to tell staff what he had seen. When he arrived at the nurses' office, the night staff were preparing to handover to the day staff. Staff immediately attended the man's cell.
119. The cell was opened and two nurses attended the man's cell with oxygen. The man was unconscious and unresponsive. His vital signs were checked using a digital monitor and an oxygen saturation probe that had been brought by one of the healthcare staff from the treatment room. As there was no sign of life, cardio-pulmonary resuscitation (CPR) was started. A further Nurse also entered the cell and assisted with the resuscitation efforts. All the staff who worked on the man had attended first aid training. The Control Room was informed and an ambulance was called at 7.50am. However, there was some confusion in that first reports to the Control Room suggested that the man had attempted to self-harm by stabbing himself. An accurate picture of what was happening was quickly established and the ambulance crew was duly informed by telephone. The prison doctor was called at 8am, and arrived in the cell at 8.15am.
120. Oxygen was administered to the man via a mask whilst another nurse undertook chest compressions. CPR continued until the arrival of the paramedic team who then took over the resuscitation effort. The man failed to respond to these efforts which included advanced resuscitation treatment. Resuscitation efforts continued until 8.24am when the doctor pronounced the man dead.

EVENTS AFTER THE MAN'S DEATH

121. In light of the sensitivities surrounding the man's previous experience with the police, it was decided that the prison would take responsibility for telling the man's next of kin of his death. The deputy governor, accompanied by a member of the prison chaplaincy, visited the family home later that morning and told them of their son's death.
122. While the deputy governor and the chaplain were at the home address, other members of the man's family arrived. They were devastated at the news. Family emotions, principally of anger, were directed to the deputy governor who felt threatened. It was decided that in this highly charged atmosphere he should leave. Support to the family continued to be given by the prison chaplain.
123. The man's funeral took place in June. The family asked the prison for financial support in respect of the funeral expenses. In normal circumstances, the prison would pay up to £2,000 for such expenses. The newly appointed Governor authorised payment of £3,200 towards the cost of the funeral. The family have asked that further consideration should be given by the prison to paying towards a headstone. I am aware that such payment is entirely at the discretion of the Governor and does not fall within the scope of prison Service Policy. This is the second occasion that a request for a suitable memorial has been brought to my attention and as such I feel that any additional commemorative costs will need to be considered across the Prison Service. The family were also given the opportunity to visit Wandsworth and the cell where the man had died. The family was surprised and suspicious at the informality of Kearney Unit, perceiving that this was an elaborate public relations exercise.
124. The man's personal possessions were given to his mother. However, this included soiled bandages that had been used by the man, which caused the family great upset. The man was a known MRSA carrier and there were therefore concerns in respect of hygiene. The Governor apologised very quickly by letter to the family. The family remain very concerned that there appears to have been very little thought or consideration given to returning the man's property and that the prison should have consulted them before items of personal property were returned.
125. In July, my Family Liaison Officer and the investigating officer met with the man's family. The focus of family concern and anger was directed primarily at the Prison Service for failing to provide what the family perceive as the level of care and treatment to which the man was entitled, as a man with mental health as well as unique physical health problems. It was apparent that the man's family were very supportive of him, and that they had made huge efforts on his behalf to ensure that he was receiving adequate care whilst in prison. It was also evident that the family felt that he should not have been in prison and that he would have received more effective and compassionate care and treatment had he been dealt with under the Mental Health Act. Indeed, the man's family are critical of the psychiatric assessments that were carried out on him, stating

that his varied, dramatic and repeated attempts at self-harm were indicative of his volatile, deteriorating state of mind.

126. In respect of the man's mental health, the family were also very critical and highly suspicious of the anti-psychotic drug, Depixol, that the man was prescribed. On visits to the man, his family had noticed a dramatic change in his physical appearance that included rigidity and drooling. These, it later transpired, were side effects of the drug. In a subsequent call to my investigator, the family also claimed that Depixol was freely prescribed at Wandsworth with scant regard to the consequences. The Prison Service have said that Depixol is rarely prescribed and is normally classified as a major tranquilliser/anti-psychotic rather than a mood stabiliser. Along with other older tranquillisers it also has anti-emetic and appetite inducing effects and can be administered by long acting injection. These may have been the reasons for prescribing it to him. The family said they were aware of another prisoner who was at Wandsworth, who was also prescribed Depixol. They said that on release from prison, the man died of pneumonia. This particular prisoner is not subject of an Ombudsman's investigation. In essence, however, the family believes that there could be a link between Depixol and the man's death. The man's family has maintained that he was doing reasonably well on the medication that he had been prescribed before he went to prison. The family is concerned that the change in his medication may have been a contributory factor in his death.
127. Family concerns have been most directed at the failure of healthcare staff to send the man to hospital during the last week of his life when his physical condition had deteriorated significantly. The man was subject to the highest level of observations, albeit to prevent direct attempts at self-harm, but his physical condition was allowed to deteriorate. The family accuse healthcare staff of not doing enough for him during this critical period. The family are also highly critical of the fact that the man's varied, and in some instances unique, physical disposition was not fully understood and dealt with effectively. In terms of the man's refusal to eat and his significant reduction in weight, the family claims that he was allowed to die without dignity and that the prison should have done more to make him eat.
128. It was apparent during the investigation that healthcare staff who dealt with the man were surprised and upset about his death. The man had spent a relatively long period of time in Kearney Unit and staff had got to know him quite well. The man was a complex patient in terms of his mental and physical problems, and staff considered that the multi-disciplinary approach to his healthcare was a model for good practice. Much effort and resource had been spent on attempting to treat and care for him, and there followed a sense of frustration, disappointment and shock at the outcome.

Clinical Review and Post Mortem Report

129. The post mortem was carried out by a pathologist. It revealed that the man died as a result of bronchopneumonia. The examination also established the cause of death was attributable to emaciation and previous left pneumonectomy for a gunshot wound. The Coroner requested a toxicology report from the University of London in respect of the levels of the anti-psychotic drug Depixol associated with therapy. That report appears to be inconclusive.
130. The independent clinical review concludes that the man presented an unusual and complex challenge to the healthcare team. Throughout his time at Wandsworth, The man was insistent on being sent to an outside hospital for psychiatric treatment, despite the fact that two psychiatric assessments had determined he did not meet the criteria for compulsory detention under the Mental Health Act.
131. The clinical review also suggests that the intentions of the team in treating the man were appropriate, considered and well thought out. The man was advised on numerous occasions what the implications of his food refusal would be, particularly after he had told staff, on his return from the Chelsea and Westminster Hospital, that he was going to starve himself to death.
132. However, the independent clinical review does highlight a number of operational and administrative issues in relation to the care and treatment of the man.
133. The clinical review makes a number of recommendations. The main thrust of these relate to the monitoring of weight, vital observations, fluid balance and food intake in relation to patients with erratic eating patterns or refusal to eat. In the case of this man, who entered prison in a frail condition and who experienced erratic eating patterns and then refused to eat properly, consideration could have been given to commencing him on the Food Refusal Regime as well as a prompt referral to a dietician for nutritional advice and support.
134. The review also recommends that referrals to other healthcare agencies should be followed up quickly, particularly in the event of an unsatisfactory or nil response. In addition, medical/nursing notes should be completed thoroughly, legibly and in chronological order. Hospital discharge notes should be placed in the medical record to enable healthcare staff to have a complete and comprehensive picture of a patient's condition and continuity of care.
135. The independent review also suggests that, in light of the man's frail physical condition, compounded by his refusal to eat properly or take his medication for chest infection, consideration should have been given to referring him back to hospital, particularly when his condition appeared to deteriorate after his discharge from hospital in May. By mid May, the medical record refers to the man being emaciated. The clinical review suggests that his deterioration could have prompted healthcare staff to consider referring him back to hospital. The review says that readmission to hospital at this time would have certainly benefited him and could have had a direct effect on the final outcome. It notes

that there were several subsequent occasions when the man's condition could have warranted referral to outside hospital. However, the reviewer says that, given the man's physical and clinical presentation to the clinicians and the occasions on which he was returned to Wandsworth from the local hospital having received little or no treatment, it was a difficult judgement call for the clinical team at Wandsworth to make.

136. The clinical review by the Wandsworth Primary Care Trust also indicates that the man's condition continued to deteriorate after discharge from hospital in May. It concludes that the medical record showed limited evidence of physical examination, findings or management planning, and it was not clear from the notes whether the man could have benefited from being reviewed or physically examined more frequently or re-admitted to hospital. In respect of his mental status, the reviewer concludes that the assessment and review process was thorough and reasonable.

Consideration of issues

Treatment of mental health and desire to be sectioned

137. The man entered prison with complex mental health problems that included bouts of depression and a history of self-harm, particularly since he was shot by police. In the Summer of 2004, he tried to kill himself following the death of his fiancée earlier in the year.
138. The man's mental health was assessed when he first entered Wandsworth. In December, the Dual Diagnosis Psychiatrist who deals with both mental health and substance misuse, carried out a full assessment of the man's condition and, according to the independent clinical review, an appropriate care plan was drawn up. The prison psychiatrist and the dual diagnosis team carried out numerous assessments and reviews over the subsequent months.
139. In March, a psychiatric pre-sentence report concluded that the man did not suffer from a mental illness within the meaning of the Mental Health Act 1983, therefore not justifying compulsory hospitalisation. The psychiatrist diagnosed that the man was suffering from moderate depression with some psychotic features. Treatment with medication was considered to have been effective, and his mental state was said to have improved considerably. He remained anxious, but otherwise his mental state was reasonably stable. The report suggested that the man could have benefited from bereavement counselling, although this does not appear to have taken place. The clinical review has suggested that referrals should be followed up quickly by prison staff.
140. In March, following two serious self-harm attempts the man was assessed again under the Mental Health Act 1983. This assessment also concluded that he was not suffering from a mental disorder of a nature or a degree that warranted admission to hospital under the Mental Health Act. The evidence from the assessment was that he suffered from psychological and personality problems. The report suggested that, if he was willing to participate, the man should be offered some form of psychotherapy to help him with his self-harming behaviour and psychological distress. It does not appear that the prison subsequently offered the man any psychotherapy.
141. It is clear that, by April, staff were finding it increasingly difficult to manage the man, and one element of the care plan agreed that day was to obtain advice from a doctor who used to care for the man. Although a letter was sent requesting advice, a response to the request does not appear to have been chased up or a reply received.
142. At the end of April, the prison psychiatrist wrote a letter of referral to the local Mental Health Trust asking them to consider a further mental health assessment of the man. In light of his previous attempts at self-harm and refusal to eat, the psychiatrist felt that he might succeed in killing himself. The man was aware of the referral, and was told that he should not pin all his hopes on a transfer to hospital. A response to the letter was not received and attempts to chase it up proved unsuccessful. It transpired during the

investigation that the Mental Health Trust had not received the letter and in any event would not have been able to deal with the man. The clinical review has highlighted the need for the prison to follow up such referrals quickly and ensure that an appropriate and timely response is received.

143. It is clear from the above that the prison was aware of the man's mental health problems, and took a number of steps to try and help him with these. He was assessed and reviewed regularly, and a care plan was in place. He was twice assessed to see whether there were grounds for compulsory admission to hospital under the Mental Health Act, and the conclusion was that there were not. There were failures by the prison to follow up on counselling and therapeutic support for the man, but it is far from certain that he would have taken these opportunities had they been presented to him. The referral at the end of April 2005 to the Mental Health Trust was, however, misplaced, and not properly pursued. The professional view at the time was that a further assessment was required. I cannot say what would have been the outcome had this referral been made to the appropriate team.

Depixol

144. In April, following another self-harm attempt by setting himself alight, it was decided by the prison psychiatrist in consultation with the man to prescribe the anti-psychotic drug Depixol. The medication was used in small dosage to suppress any further ideas of self-harm. The man was made aware of the side effects of the medication. The man started on one 20mg dose of Depixol and this was increased to 40mg in May.
145. The man complained that the medication was making him feel more suicidal and rubbing him up the wrong way, although nursing staff felt that he was exaggerating. He was reviewed regularly by the prison psychiatrist who had no concerns about the medication or the effect it was having on the man.
146. During the investigation it transpired that Depixol has some physical side effects in the form of stiff limbs and drooling. On visits to the man, his family found this most distressing. These features were also the subject to comment by staff and another prisoner.

Weight loss

147. The man had been losing weight before he entered Wandsworth and was described as a slight man with an erratic appetite. In light of his weight loss he had been prescribed Ensure by his GP as a supplement to meals. In November 2004, his weight was recorded as 47.7kg. The man was also prescribed Ensure whilst in prison and was encouraged to take this, particularly when he was not eating nutritious food. In December, the man's weight was recorded at 54kg which indicated a 6kg weight gain since entering prison. In May 2005, his weight was recorded at 51kg which was a loss of 3kg over a period of five months but still equated to an increase of 3.3kg since entering Wandsworth. However, later in May, the man's weight was noted as 48kg, a loss of 3kg over a 10 day period, albeit that this still represented a slight increase since entering

prison. When the man died, his weight was recorded at 47.7kg, the same as when he entered Wandsworth. The family were concerned at the man's weight loss and the fact that, because of his pneumonectomy, he was unable to ingest food properly. Despite the man's variable weight, the clinical review found little recorded evidence that his weight was taken or monitored on a regular basis. It was only one day before his death, following a referral to the prison doctor by staff because of his physical appearance, that the man was placed on a food and fluid balance chart. The clinical review suggests that this should have been started at an earlier stage.

148. In March, the man stated that it was his intention to starve himself to death and in effect initiate another form of self-harm. However, staff had noted that he was eating small amounts of food such as cake and crisps. Because he was eating, albeit food of little nutritional value, the man was not placed in the Food Refusal Book and his weight was not monitored or recorded regularly. On one occasion, when he claimed that the prison food was poisoned, the prison psychiatrist reassured him that it was not by tasting the food in front of him. It was also arranged for the man to be unlocked first so that he could have a greater choice of food on the server. It was also apparent during the investigation that staff encouraged the man to eat properly in a bid to build up his strength and assist with his physical recovery. However, he continued to refuse meals and this was noted in the medical record and other documentation. Although the man asked to be force fed, this was denied as it would have infringed his human rights. The man was made aware by staff on numerous occasions of the consequences if he did not eat properly. The clinical review suggests that, in light of the man's refusal to eat properly, he might have benefited from a referral to a dietician.
149. I judge, that the prison did not take sufficient steps to monitor the man's weight and food intake. Although he did eat some food, and sometimes ate quite well, it is clear that there were problems with his food intake on which a closer eye should have been kept. I agree with the clinical reviewer that the man's weight could have been monitored more effectively, and that an early referral to a dietician might have helped him to eat properly and maintain his weight and his strength.

Self-harm attempts and ACCT

150. When the man entered Wandsworth in November 2004, he was placed on the Assessment Care in Custody (ACCT) procedures because of his low mood and previous history of self-harm. The ACCT remained open until the man's death.
151. During his time at Wandsworth, the man made numerous attempts at self-harm. After the first attempt in January while in Kearney Unit, when he tried to strangle himself with a bedsheet, he was placed in a safer cell under constant observation. He was discharged back to a residential wing and an appropriate care plan was drawn up for him.
152. Later in January, he seems to have attempted to set himself alight, although there were no apparent injuries. He was placed on one to one observations.

He made further self-harm attempts later in January. He was transferred back to Kearney Unit and placed in a gated cell for better observation of his behaviour.

153. At the end of January, there were further self-harm attempts which resulted in him being taken to hospital, although he was discharged the same day. On return from hospital, his property was removed from his cell and a safe blanket given to him. However, the clinical review has highlighted that the man once again attempted self-harm by removing the venflon from his arm. He was placed on one to one observation. By mid February, his condition was considered to be more stable and the level of observations reduced to every 15 minutes. It would have been good practice to ensure that documented individual assessments are made on prisoners returning with a venflon in situ, including security risks and risk of self-harm.
154. The man's next self-harm attempt was at the end of February, when he attempted to hang himself. He was again taken to hospital but discharged. It seems that the hospital advised that the man should be put on constant watch, but the prison said it did not have sufficient staff to do this. The next day, the man was transferred to a safer cell and put on constant observations.
155. In March, the man swallowed a plastic article on two occasions in order to induce vomiting and bleeding. On both occasions he was taken to outside hospital and returned the same day. A case conference decided to discharge him back to an ordinary residential location, subject to constant observations.
156. Late in March, the man set light to himself, and was again taken to hospital, where he was kept until the end of March. The self-harm attempt prompted a mental health assessment on. Following this the prison drew up a care plan that included placing the man in a gated cell in Kearney Unit, together with one to one observations by a dedicated team of agency nurses to monitor his mood and behaviour. In view of the man's attempts at self-harm and behaviour, the Healthcare Manager decided that it was in the man's interests to locate him in Kearney Unit which afforded better observation and treatment by the dual diagnosis team. His physical condition could also be reviewed more frequently. It transpired during the investigation that residential wings were unable and unwilling to cope with the man's high level of self-harm and medical demands.
157. During April, the man made further self-harm attempts, but staff intervened quickly. He made yet further attempts in May.
158. Throughout the period from end of March until his death, the man remained in the gated cell on Kearney Unit, with an observer constantly outside his cell. The observations were carried out by a team of mental health agency nurses at significant cost to the prison. The purpose of the observations was to monitor the man's behaviour and prevent further attempts at direct self-harm by building up a rapport with him. His mood and behaviour were recorded at 15 minute intervals in Special Observation Logs and, although he had complained of intrusive observation, they did at least prevent further serious attempts at self-harm. However, these staff were not responsible for physical checks on the

man, but alerted nursing staff if they were concerned. In the last days of his life, the man did not interact with his observers.

159. It is clear, that the man was prolific in his attempts at self-harm and that steps were taken to try and keep him safe. However, the clinical reviewer notes that the records of what was done were kept in a variety of places in Special Observation Logs, the medical record and the ACCT document. The case conferences that took place are also recorded in a variety of places, and not necessarily in the ACCT format. Despite the man's continual self-harm attempts, he often managed to find ligatures or implements to cut himself and lighters or matches with which to burn himself. However, the ACCT document makes no reference to these finds or any of his self-harm attempts. The ACCT document in fact contains no available documentation to support the initial six case reviews having occurred.
160. In relation to his numerous attempts at self-harm, I believe the prison took all reasonable steps to protect the man. Indeed, for the last few weeks of his life, the man was placed on constant watch to try and keep him safe. I concur with the clinical reviewer that it would have been better to keep a multi-disciplinary record of what steps were taken, rather than to have piecemeal records.

Physical health and chest infection

161. The man entered Wandsworth with challenging physical conditions that included the removal of his left lung as a result of being shot. The clinical review says there does not appear to be a set of baseline figures for him that would have been useful in monitoring and measuring his vital signs. Indeed, the independent clinical review has identified a discrepancy between the man's height on entering Wandsworth and his recorded height at post mortem. The review also indicates that it might have been useful to have regularly recorded the man's vital signs during times of infection, and particularly after his admission to hospital for burns.
162. The man often complained of neuropathic pain following his pneumonectomy, as well as shortness of breath. Appropriate analgesia was given and he also used inhalers and oxygen. The man was also referred to a Chronic Pain Consultant in January, although there is no documented evidence that this was ever pursued.
163. The man was particularly susceptible to chest infections. In December 2004, he was taken to hospital after collapsing. He was diagnosed with a chest infection and was discharged from hospital a few days later. He also developed a chest infection in January 2005 that was dealt with by a course of oral antibiotics. In May 2005, the man developed another chest infection and was initially treated in healthcare with oral antibiotics. However, the man's refusal to eat properly, his failure to comply with his medication regime and the fact that he continued to smoke, despite staff advice, meant that he did not respond effectively to treatment. Because he only had one lung, he was considered to be very vulnerable and it was decided to send him to hospital for treatment in May. After receiving a course of intravenous antibiotics, he was discharged from St

George's Hospital later that day, although a copy of the discharge letter was not attached to his medical record.

164. On being discharged from hospital, the man continued to refuse to eat properly or comply with his medication. As a result, his physical condition, compounded by his chest infection, deteriorated, and he was weak and lethargic. The independent clinical review suggests that, by mid May the man's deterioration should have prompted healthcare staff to consider referring him back to hospital. The review says that readmission to hospital in May, would certainly have benefited him and may have had a direct effect on the final outcome. The review says that there were also several times after this point in May when the man's condition warranted referral to an outside hospital.
165. When the prison doctor saw the man after staff had raised concerns about his physical appearance the doctor examined him. In his opinion, the man's clinical presentation at that time gave him no immediate cause for concern and did not warrant a referral back to hospital. However, in light of the man's continued refusal to eat properly, he was given Ensure drinks and took some under supervision. The man had assured the doctor that he would take his Ensure. The doctor who examined him was content to review the man the following day as he was the duty doctor. The doctor told the healthcare staff that, if the man was not taking his Ensure, he would give further consideration to sending him to hospital. At this stage, the doctor decided to put the man on a food and fluid balance chart.
166. At 4.45am the following day, the observer stationed outside the man's cell noticed that his breathing was laboured and alerted the night nurse. At 5.30am, the man's vital signs were checked, but these did not give undue cause for concern to the nursing staff and did not warrant an urgent referral to the doctor or transfer to hospital. However, the medical record states that the man's vital signs were to be monitored closely. There is no documented record that this was done. Nursing staff were also aware that the man was to be seen later on in the day by the prison doctor and appeared content to have waited until then for him to be reviewed.
167. At about 7.38am the man was observed sitting upright on his bed. His observer asked him a question, but did not receive a response. He appeared to slump back on his bed unconscious. Healthcare staff were immediately alerted and established that the man had stopped breathing. Cardio-Pulmonary Resuscitation commenced immediately. An ambulance was called, although it was initially reported that the man might have stabbed himself. An accurate picture of the situation was obtained quickly and conveyed to the ambulance crew. Despite the efforts of the healthcare staff and paramedics, the man was pronounced dead in his cell soon after.
168. The independent clinical review has stated that healthcare staff should be reminded that the health and welfare of the patient is paramount, and that it is their individual responsibility to ensure that a referral to outside hospital is made if the patient's condition gives cause for concern. This may be made as an emergency referral by calling the emergency services.

Conclusions and recommendations

169. There is no doubt that the man entered prison with mental and physical health problems that were both challenging and demanding to manage. From the moment he entered Wandsworth, the man was focussed on getting to an outside hospital and it was clear that he was not amenable to any form of treatment in prison. Psychiatric assessments concluded that there was no justification for him to be compulsorily detained under the Mental Health Act.
170. It is clear that much effort and resources were put in place to try to support the man and to prevent him from self-harming. Indeed, after the end of March, he was in a gated cell in the Kearney Unit, on one to one observations, and throughout his time in custody he was frequently assessed and supported through a multi-disciplinary approach. The clinical review concludes that, on the whole the man received reasonable care and attention.
171. However, whilst much of the prison's focus appears to have been on preventing the man from further attempts at self-harm, this may have diverted some attention away from his physical wellbeing. There appear to have been shortcomings in managing the man's diet and weight. The clinical review states that, whilst it was difficult to draw a firm conclusion, re-admission to hospital in mid May would have benefited the man and may have had a direct effect on the final outcome. There were also subsequent occasions when the man's condition could have warranted referral to outside hospital. However, the review states that balancing the man's physical and clinical presentation to the clinicians, and the occasions on which the man was returned to Wandsworth from the local hospital, having received little or no treatment it was a difficult judgement call for the clinical team at Wandsworth to make.

Documentation

172. It is clear that the man was prolific in his attempts at self-harm and that steps were taken to try and keep him safe. However, the clinical reviewer notes that the records of what was done were kept in a variety of places in Special Observation Logs, the medical record and the ACCT document. The case conferences that took place are also recorded in a variety of places, and not necessarily in the ACCT format. The independent clinical reviewer has suggested that, because of the multi-disciplinary approach to the man's care, notes of each individual group should be combined to provide a comprehensive, chronological and complete record.

Healthcare staff should be reminded about their duty of care and responsibility to record information and observations accurately. First Reception Health Screens and ACCT documentation should be thoroughly and accurately completed and include a full set of baseline observations where appropriate.

Clear records should be made regarding the admission and discharge details for prisoners to outside hospitals. The discharge summary should be filed in the clinical records, along with feedback regarding the findings

and treatment prescribed by the medical and nursing staff in Accident and Emergency.

Medical/Nursing notes should be completed thoroughly, legibly and in chronological order. All members of the healthcare multi-disciplinary team should file notes in the medical record including observation logs and those from the outside (e.g. Counsellors' notes). This will enable other members of the healthcare team to have a complete picture of a patient's condition.

The clinical notes of the multi-disciplinary healthcare team should be filed in the central record, in order that a chronological and complete record of care is readily available and immediate cross referencing of patient care is possible.

Care Planning

173. In early March, a psychiatric pre-sentence report concluded that the man did not suffer from a mental illness justifying compulsory treatment within the meaning of the Mental Health Act 1983. The psychiatrist diagnosed that the man was suffering from moderate depression with some psychotic features. Treatment with medication was considered to have been effective, and his mental state was said to have improved considerably. He remained anxious, but otherwise his mental state was reasonably stable. The report suggested that the man could have benefited from bereavement counselling although this does not appear to have taken place. The clinical review has suggested that referrals should be followed up quickly by prison staff.
174. At the end of March, following two serious self-harm attempts the man was assessed again under the Mental Health Act 1983. The assessment concluded that the man was not suffering from a mental disorder of a nature or a degree that warranted admission to hospital under the Mental Health Act 1983. The evidence from the assessment was that the man suffered from psychological and personality problems. The report suggested that, if he was willing to participate, the man should be offered some form of psychotherapy to help him with his self-harming behaviour and psychological distress. It does not appear that the prison subsequently offered to arrange the man any psychological support or interventions. The Prison Service responded to my draft report by saying that "at the time in question, counselling psychology services were only just beginning to be established at Wandsworth. It should be noted that patients with the man's diagnosis of personality disorder, have been very difficult to manage, both in the NHS and custodial mental health, due to the intractability of their condition. In this man's case this also meant that the Prison In-Reach team was not able to care for him". I disagree with this in that arrangements could have been made if sufficient priority had been given to them.
175. On reviewing the man's ACCT document it is not apparent what level of frequency of observations he was subject to. Furthermore his care plan was drawn up in early March 2005 and not reviewed before his death in May. The

case review just before his death makes no reference to consideration of the appropriateness of the care map from early March.

Care plans should be drawn up which take into consideration all problems being experienced by the prisoner and documents clearly the measures to be taken to relieve and treat these problems. The level of observations for prisoners on open ACCTs should be clearly documented in the care plan. Care plans should be followed, relevant and reviewed regularly to ensure they continue to meet all the patient's requirements.

ACCT

176. In relation to the man's numerous attempts at self-harm, I believe the prison took all reasonable steps to protect the man. I concur with the clinical reviewer that it would have been better to keep a multi-disciplinary record of what steps were taken, rather than to have piecemeal records, in, for example the medical record and the ACCT.

Continuity of staff taking part in reviews should be arranged if at all possible to ensure that changes in the prisoner's condition are noted, and the effectiveness of prescribed care assessed and changed if required.

Clear documentation and instructions as to which level of observation is required by a prisoner should be in the clinical records and care plan to ensure that all members of the multi-disciplinary team are clear about the prisoner's requirements.

177. Despite the man's numerous attempts at self-harm there are no entries in the record of daily interventions log in the ACCT document. Additionally, there is no documentary evidence in the ACCT document to support all but the last two case reviews having occurred.

Observations should be carried out in line with the recommendations in the prisoner's ACCT reviews and documented on the Special Observation record.

ACCT reviews should take place as planned and records should be filed in the notes.

Reviews should be conducted by relevant members of the multi-disciplinary team at the specified time. Thorough records of the review meeting, along with the future plan of care, should be documented.

178. It would have been good practice to ensure documented individual assessments are made on prisoners returning with a venflon in situ including security risk and risk of self-harm. It may be advisable to consider a constant watch. By mid February, his condition was considered to be more stable and the level of observations reduced to every 15 minutes.

179. Following an attempted hanging the man was admitted to St George's Hospital. A thorough assessment of the man's psychiatric condition was carried out. On telephoning a prison officer to advise that the man be given one to one observation, the psychiatrist was told that there was not enough staff available to give this.

If one to one observations for a prisoner with serious suicidal tendencies are not possible due to staffing levels, alternative arrangements should be implemented.

Past medical history

Information regarding a prisoner's previous medical history and treatment should be shared by members of the multi-disciplinary team to ensure the highest standard of care delivery is possible.

The medication that a prisoner is taking on admission should be documented and prescribed if appropriate and regular medication reviews conducted to ensure prescribed treatment meets the prisoner's medical requirements.

Recording observations

180. The man entered Wandsworth with significant physical problems. The clinical review says there did not appear to be a set of baseline figures for him that would have been useful in monitoring and measuring his vital signs. The review also indicates that it might have been useful to have regularly recorded the man's vital signs during times of infection and particularly after his admission to hospital for burns.

Weight, vital observation, fluid balance and food intake charts should be commenced immediately if any concerns are identified. Checks should be carried out and documented regularly.

Vital signs (temperature, pulse and blood pressure) charts should be maintained for those patients identified with a potentially life threatening infection or serious injury which could potentially result in infection. The frequency of observation should be documented in the Nursing Care Plan.

Routine referrals to outside agencies

181. The prison was aware of the man's mental health problems, and took a number of steps to try and help him. He was assessed and reviewed regularly, and a care plan was in place. He was twice assessed under the Mental Health Act 1983 to see whether there were grounds for compulsory admission to hospital. There were some failures by the prison to follow up on counselling and therapeutic support for the man. The referral at the end of April 2005 to the Mental Health Trust was misplaced, and not properly pursued.

182. By early April, staff were finding it increasingly difficult to manage the man, and one element of the care plan agreed was to obtain advice from a doctor at the Psychiatric hospital the man had previously been treated. Although a letter was sent requesting advice, a response to the request does not appear to have been chased up or a reply received.

Referral to healthcare agencies and other professionals should be followed up quickly by prison staff. A member of prison staff should be identified as being responsible for following up referrals to ensure they are actioned.

Under-nutrition/food refusal

183. I conclude that the prison did not take sufficient steps to monitor the man's weight and food intake. Although he did eat some food, and sometimes ate quite well, it is clear that there were problems with his food intake on which a closer eye should have been kept. The man's weight could have been monitored better. An early referral to a dietician might have helped him to eat properly and maintain his weight and his strength. There are no existing arrangements with the Primary Care Trust for dietetic referrals from Wandsworth. Special diets are normally authorised by GPs and overseen by the Catering Principal Officer.

In partnership with the Primary Care Trust a clear policy should be developed regarding patients who are taking inadequate quantities of nutrition to maintain a healthy existence. The policy should include assessment of the requirement for weekly weight checks, fluid input/output charts and prompt referral to a dietician for nutritional advice.

The advice given by the dietician should then be followed and encouraged by healthcare staff. If the inadequate intake is due to refusal to eat by a prisoner (as opposed to inability due to medical condition), consideration should also be given to commencing a Food Refusal regime.

Referral to outside hospital

184. While the clinical review states that it was difficult to draw a firm conclusion, I believe that re-admission to hospital on the days just before the man died would have benefited him and could have had a direct effect on the final outcome. There were also subsequent occasions when the man's condition could have warranted referral to outside hospital

Referral to outside hospital should be made if a prisoner's condition gives serious cause for concern or if a prisoner's condition fails to improve or deteriorates further and requires more intervention than is possible in the prison healthcare system.

Healthcare staff should be reminded that the health and welfare of the prisoner is paramount and that it is their individual responsibility to ensure that referral to the on-call doctor or outside hospital is made if the

patient's condition gives serious clinical cause for concern. All referrals must be made in accordance with local policy.

Communication in emergency situations

185. An ambulance was called, although it was initially reported that the man might have stabbed himself. An accurate picture of the situation was obtained quickly and conveyed to the ambulance crew

Staff should be reminded of the importance of relaying accurate information to the emergency services.

Recommendations

Healthcare staff should be reminded about their duty of care and responsibility to record information and observations accurately. First Reception Health Screens and ACCT documentation should be thoroughly and accurately completed and include a full set of baseline observations where appropriate

This has been brought to the attention of all healthcare staff and forms part of the agenda for the clinical governance committee's work on documentation.

Clear records should be made regarding the admission and discharge details for prisoners to outside hospitals. The discharge summary should be filed in the clinical records, along with feedback regarding the findings and treatment prescribed by the medical and nursing staff in Accident and Emergency.

The relevant clinical information should be recorded in the clinical record on transfer to hospital. We are dependent on good practice from the discharging hospital in order to record any feedback. This is always requested.

Medical/Nursing notes should be completed thoroughly, legibly and in chronological order. All members of the healthcare multi-disciplinary team should file notes in the medical record including observation logs and those from the outside (e.g. Counsellors' notes). This will enable other members of the healthcare team to have a complete picture of a patient's condition.

It is accepted that medical and nursing notes should be recorded legibly and in order.

The purpose of the clinical record is to store information of a clinical nature and is for the use of clinical staff and other professionals who have a legitimate need to access this. The patient needs to understand who will be accessing this information in order for consent to be presumed or granted.

The clinical notes of the multi-disciplinary healthcare team should be filed in the central record, in order that a chronological and complete record of care is readily available and immediate cross referencing of patient care is possible.

Care plans should be drawn up which take into consideration all problems being experienced by the prisoner and documents clearly the measures to be taken to relieve and treat these problems. The level of observations for prisoners on open ACCTs should be clearly documented in the care plan. Care plans should be followed, relevant and reviewed regularly to ensure they continue to meet all the patient's requirements.

All ACCT documents are subject to thorough audit procedures where quality, accountability and onward referral procedures are checked. Any gaps are fed back directly to wing managers and via the Safer Prisons Meetings.

Training on ACCT procedures have become a mandatory requirement so that all staff are aware of their responsibilities. Training figures have increased to 180 staff on Awareness and 21 on ACCT assessors.

Timetabled reviews now take place where named individuals are given responsibility of actioning specific aspects of the care plan.

Continuity of staff taking part in reviews should be arranged if at all possible to ensure that changes in the prisoner's condition are noted, and the effectiveness of prescribed care assessed and changed if required.

This is the aim of the individualised care. Shift patterns and leave obligations do not always facilitate this. Good team work, record keeping and handover briefings help to address this.

Clear documentation and instructions as to which level of observation is required by a prisoner should be in the clinical records and care plan to ensure that all members of the multi-disciplinary team are clear about the prisoner's requirements.

The level of observations should be clearly displayed on the front of the ACCT document.

Observations should be carried out in line with the recommendations in the prisoner's ACCT reviews and documented on the Special Observation record.

SPC makes regular checks to correlate information and recommendations from the ACCT document into the Wing Observation Book. Further management checks are made to ensure the quality of these processes. Any gaps are fed back directly to wing managers and via the Safer Prisons Meetings.

ACCT reviews should take place as planned and records should be filed in the notes.

Timetabled reviews now take place where named individuals are given responsibility of actioning specific aspects of the care plan. Any gaps are fed back directly to wing managers and via the Safer Prisons Meetings.

Reviews should be conducted by relevant members of the multi-disciplinary team at the specified time. Thorough records of the review meeting, along with the future plan of care, should be documented.

All ACCT documents are subject to thorough audit procedures where quality, accountability and onward referral procedures are checked. Any gaps are fed back directly to wing managers and via the Safer Prisons Meetings. Personal notes/records are not required to be 'documented'. The Case Manager is required to record a summary of the case review.

Inmate Medical Records are brought to the reviews by Healthcare staff – these are updated so that information on the ACCT review is replicated in the IMR.

If one to one observations for a prisoner with serious suicidal tendencies are not possible due to staffing levels, alternative arrangements should be implemented.

There is now a protocol for admitting a prisoner into a Gated Cell. This protocol examines the need for 1:1 observations. The decision to initiate 1:1 observations is taken by a MDT. If a qualified member of a Nursing team is required and are unavailable then and there, an OSG or Officer will start the observation until this can commence.

Information regarding a prisoner's previous medical history and treatment should be shared by members of the multi-disciplinary team to ensure the highest standard of care delivery is possible.

The information is subject to medical confidentiality and should only be shared when required to protect the welfare of an individual, other prisoners or members of the public.

The medication that a prisoner is taking on admission should be documented and prescribed if appropriate and regular medication reviews conducted to ensure prescribed treatment meets the prisoner's medical requirements.

This is the current accepted practice. It is monitored through the work of the Pharmacy team and in the records auditing of the clinical governance team. In addition, the patient's prescription is reviewed by the prescriber at least monthly.

Weight, vital observation, fluid balance and food intake charts should be commenced immediately if any concerns are identified. Checks should be carried out and documented regularly.

This is the standard expected and the monitoring is the responsibility of the team leaders. All staff to be reminded of their professional responsibility in this matter.

Vital signs (temperature, pulse and blood pressure) charts should be maintained for those patients identified with a potentially life threatening infection or serious injury which could potentially result in infection. The frequency of observation should be documented in the Nursing Care Plan.

Our patients should be treated in the same manner as any person in our local community. Where a person is actively in our care for infections or injuries that might lead to confinement in bed then such observations are appropriate. Beyond that, normal community standards should operate.

Referral to healthcare agencies and other professionals should be followed up quickly by prison staff. A member of prison staff should be identified as being responsible for following up referrals to ensure they are actioned.

All referrals should be followed up in a timely manner. The Case Manager, as part of the care map, should follow up any referrals.

A clear policy should be developed regarding patients who are taking inadequate quantities of nutrition to maintain a healthy existence. The policy should include assessment of the requirement for weekly weight checks, fluid input/output charts and prompt referral to a dietician for nutritional advice.

A clear policy will be drafted.

The advice given by the dietician should then be followed and encouraged by healthcare staff. If the inadequate intake is due to refusal to eat by a prisoner (as opposed to inability due to medical condition), consideration should also be given to commencing a Food Refusal regime.

To be included in the above policy when drafted.

Referral to outside hospital should be made if a prisoner's condition gives serious cause for concern or if a prisoner's condition fails to improve or deteriorates further and requires more intervention than is possible in the prison healthcare system.

This is current practice and is always subject to clinical judgement.

Healthcare staff should be reminded that the health and welfare of the prisoner is paramount and that it is their individual responsibility to ensure that referral to the on-call doctor or outside hospital is made if the patient's condition gives serious clinical cause for concern. All referrals must be made in accordance with local policy.

Referral to hospital will only be carried out by the clinician leading the care of the patient at any time. In the absence of the clinician the duty / on-call doctor or the Head of Health Services should be consulted.

In emergencies the Ambulance Service will be summoned in co-ordinations by Control, in accordance with laid down policies.

Staff will be reminded of this.

Staff should be reminded of the importance of relaying accurate information to the emergency services.

Staff will be reminded of this.