Investigation into the circumstances surrounding the death of a man at HMP Wandsworth in March 2010

Report by the Prisons and Probation Ombudsman for England and Wales

January 2011

This is the report of an investigation into the death of a man at HMP Wandsworth, in March 2010. He was 51 years old. I would like to offer my condolences to his family for their loss.

His death was caused by heart failure while he was in an agitated state during acute alcohol withdrawal and also chronic alcohol abuse.

The man conducted the investigation on my behalf. The local Primary Care Trust (PCT) was commissioned to conduct a clinical review into the standard of healthcare he received while in custody. A clinical reviewer from the local PCT carried out this review for which I am grateful. I would like to thank the Governor of Wandsworth, and his staff for their co-operation and assistance.

The man came into custody on 23 March and died three days later. He suffered from type 2 diabetes and also drank alcohol heavily before coming into custody. Both facts were identified on his reception at Wandsworth, but the extent of his drinking was not investigated and no treatment for either condition was provided. He was of Sri Lankan origin and spoke little English. His behaviour deteriorated, and was described by staff and fellow prisoners as “bizarre”.

On the evening of 26 March, the man’s cell mate told staff that he wished to move cells as he was concerned about his behaviour. Staff saw the man acting in what they perceived to be a threatening manner. A period of negotiation followed, during which staff used another prisoner who spoke Tamil to speak with him and interpret, in an attempt to calm him. However, this was unsuccessful, so staff went into the cell and restrained him using Prison Service control and restraint techniques. During the restraint the staff noticed that he was unconscious. All the restraints were removed, he was placed in the recovery position and medical assistance requested. Nursing staff administered cardio pulmonary resuscitation with the assistance of a prison doctor. Unfortunately, attempts to revive him failed and at 7.32pm, the prison doctor pronounced him dead.

My investigation has found that there were a series of missed opportunities by healthcare staff to identify the cause of the man's behaviour. Most notably staff did not correctly identify and treat his alcohol detoxification. These failures denied him treatment and may well have caused his disruptive behaviour. I am however satisfied that, in these regrettable circumstances, control and restraint was appropriate and followed the approved techniques. The police investigation has found the same. Nevertheless he must have found it a distressing and uncomfortable experience and, had treatment been given, he might well be alive today.

I make eight recommendations relating to clinical matters, provision for foreign national prisoners, the induction process and cell sharing risk assessments. I am disappointed to repeat some recommendations from earlier investigations at Wandsworth. The Prison Service has accepted all the recommendations made, and their response is added to page 32.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Jane Webb
Acting Prisons and Probation Ombudsman **January 2011**

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SUMMARY

The man went into custody at HMP Wandsworth on 23 March 2010. He was 51 years old and a Sri Lankan national with limited English.

When he arrived, a nurse assessed him and completed a medical screening. During the screening process, the nurse recorded that the smell of alcohol was very noticeable and, when asked about his alcohol consumption, he said that he drank six to eight cans of lager daily. It was also recorded that he had type 2 diabetes for which he was receiving regular medication. (Type 2 diabetes is usually found in people over 40. It develops gradually over weeks and months and means the body is either not producing sufficient insulin for the body's needs or the cells in the body do not use it properly.) He was then assessed by Prison Doctor A, who commented that his community general practitioner (GP) should be asked to confirm the medication he was taking. However, the doctor made no comment on the issue of alcohol and did not refer him to other specialists.

After the reception process, the man was allocated to a shared cell in E wing. The following day he moved to C wing. It is unclear as what information was given during his induction and whether anything was provided in his own language. A fellow Sri Lankan prisoner who befriended him on C wing said that when he first arrived on the wing, he appeared confused as to what he should be doing, but physically appeared well.

The man's GP provided information about the medication by fax on 24 March. Despite confirmation that he was taking regular medication, none was prescribed to him.

On 25 March, staff and other prisoners commented that the man's behaviour had become "bizarre" and that he was shaking. There is no indication that any concerns were raised with medical staff at this time. During the early hours of 26 March, the cell mate complained that the man's behaviour was worrying him and asked staff to move the man. When the senior officer (SO) opened the cell, he saw that he was wearing a sheet and a pillowcase on his head. However, he was not being aggressive and the senior officer walked with him to E wing where he was given a single cell. He continued to behave in a "bizarre" fashion, and an officer wrote in the wing observation book that a referral to the Mental Health In-Reach Team (MHIRT) might be advisable.

Despite the concerns raised that morning by the cell mate, staff allocated the man to another shared cell on C wing just before lunchtime on 26 March. Throughout the remainder of the afternoon, both staff and fellow prisoners commented on his behaviour and a nurse was eventually asked to assess him. His blood sugar levels were checked, as it was considered his behaviour might have been caused by his diabetes, but they were normal. The senior nurse who had seen him also commented on his behaviour and spoke to Prison Doctor B who said that he would look at the medical record to see if any underlying cause could be identified. However, when the senior nurse spoke to him later he said that he had identified nothing, but said that staff should monitor the man.

At around 7.00pm on 26 March, the new cell mate also asked to be moved as the man's behaviour was causing him some concern. A member of staff asked her colleagues to help find another cell. When they returned to the cell some minutes later, the man was standing behind the cell door and shouting in Tamil. He was also holding a plastic knife and a waste paper bin. The staff immediately asked the orderly officer to come up to the cell as they were unable to communicate with him and he did not respond to their requests for him to move away from the door. (The orderly officer is in charge of the prison at night, as there is a reduced level of staff.)

The orderly officer was dealing with something else at the time and SO A attended in his place along with the Duty Governor. Staff explained the situation and the SO attempted to talk to the man. When this failed, staff asked another Sri Lankan prisoner to interpret for them. Although the prisoner attempted to calm him down, he found that he was not making any sense. The staff then decided that it was essential to take the cell mate out of the cell so that he was safe. They opened the door, but as they did so the man grabbed it and it had to be closed again.

As he was still holding the knife and bin, the SO along with two other staff took out his baton and attempted to reopen the door. He came towards them and the bin was knocked from his hand with a baton. Staff then attempted to restrain him using techniques approved by the Prison Service. He reportedly continued to struggle and was eventually brought under control and handcuffs were applied.

Once the handcuffs were placed on the man, staff noticed that he had stopped resisting and there appeared to be no response from him. They sat him up and it became clear that he was unconscious. The handcuffs were immediately removed, he was placed in the recovery position and medical assistance was summoned via the radio.

A nurse arrived within a few minutes and on checking him, immediately recognised that he was not breathing and no pulse could be detected. Staff gave cardio pulmonary resuscitation (CPR) and called the duty GP. However, after around 20 minutes, the decision was taken to stop CPR and the GP pronounced the man dead at 7.32pm.

Later that evening, a governor and the prison chaplain visited the man's family to break the news of his death. The governor remained in contact with the family and advised them about progress on the Coroner's actions as well help with press coverage of the death and financial assistance with the funeral.

Staff involved were offered the support of the care team. A debrief of the staff involved took place and other prisoners who were subject to suicide monitoring procedures were supported following the death.

THE INVESTIGATION PROCESS

1. The investigation was opened on 29 March by a colleague, on behalf of the investigator. The colleague was told that the police were treating the man's death as suspicious at that stage. He advised the investigator of this and collected the relevant documentation.

2. Notices were issued to staff and prisoners informing them of the investigation process and inviting anyone who had relevant information to come forward. No responses were received.

3. In accordance with the Ombudsman's terms of reference, the local PCT were commissioned to conduct a clinical review into the care and treatment of the man at Wandsworth. A clinical reviewer for the local PCT conducted the review and a copy of his report is attached. In addition to the clinical review, the investigator asked the PCT to consider commissioning a report from an expert in alcohol detoxification, but they did not deem this necessary.

4. The investigator telephoned the Governor, who was acting as the contact point, on 31 March. He introduced himself as the investigator and discussed the initial concerns surrounding the man's death. They agreed that he would arrange interviews with staff once the outcome of the police investigation was known.

5. On the same day the investigator also contacted the Detective Inspector (DI) who was leading the investigation for the Metropolitan Police. They agreed to share relevant information with each other, such as police statements and the report of the clinical review. The DI confirmed that the PPO investigation should run in tandem with that of the police. The investigator contacted the DI during the investigation, so that they could update each other on their findings. The police investigation focused on the use of restraint, and following interviews with those staff involved, concluded that there were no further actions to be taken.

6. One of my family liaison officers (FLOs) contacted the man's family and explained the role of my office in relation to the investigation. She and the investigator visited the family at their home on 11 June. The family shared their concerns and questions about his care. They are summarised below and are addressed within the body of this report:

    - He does not appear to have been given any alcohol detoxification or any medication to manage his existing health conditions while he was at Wandsworth.

    - Why his diabetes does not appear to have been considered as the reason for his strange behaviour and why no further healthcare intervention was not requested?

    - The appropriateness of using other prisoners to act as translators.

- The accuracy of information provided by Wandsworth following his death.

7. The family have also responded to the initial draft report and their response can be found on page 31 of this report.

8. The investigator wrote to HM Coroner to inform him of the nature and scope of the investigation. The initial post mortem was inconclusive and further tests were requested. Toxicology tests proved unremarkable. The tests relating to the man's heart indicated, in the absence of a toxicological explanation, that he had been suffering from "excited delirium" leading to sudden cardiac arrest. The issue of excited delirium is explained further in the issues section of this report. The official cause of death is given as:

    1A – Sudden cardiac death while in an agitated state during acute alcohol withdrawal.
    1B – Chronic alcohol abuse.

HMP WANDSWORTH

9. HMP Wandsworth is a local prison in South London. It has the capacity to hold up to 1,644 sentenced or remand adult males. The prison has two main wings, Heathfield that comprises five separate wings and Onslow which houses vulnerable prisoners. In addition, there is a healthcare unit with inpatient facilities.

10. In July 2007, Wandsworth Teaching PCT commissioned a private company, Secure Healthcare, to provide healthcare services at Wandsworth and employ the medical staff. However, the company went into liquidation in September 2009. The healthcare team is currently employed by the part of NHS Wandsworth which provides services, rather than commissions them.

11. Healthcare provision is divided between primary care (treating physical health problems), substance misuse (treating drug and alcohol users) and the Mental Health In-Reach (MHIRT) team (treating mental health problems), which is funded by South West London and St George's Hospital Mental Health NHS Trust. The MHIRT has the equivalent of one full-time consultant psychiatrist and one staff grade psychiatrist post. The team also includes three community psychiatric nurses (CPNs), one of whom acts as the team manager.

12. The Addison Unit is a 12 bed inpatient unit accommodating prisoners with severe and enduring mental health needs who are experiencing acute difficulties. The unit won an award in 2009, recognising the service it provides. There are no inpatient facilities for prisoners with physical health problems. There are two treatment rooms on the Onslow Centre. The prison pharmacy uses a number of technicians to carry out its functions.

13. HM Inspectorate of Prisons (HMIP) published a report into the the most recent inspection ofWandsworth in September 2009. The former Chief Inspector was critical of Wandsworth but much of her report focussed on issues that do not relate to this investigation. She also reflected on other areas that are relevant to the man's care.

14. Commenting on first night and induction procedures, the Chief Inspectorate said:

> " … All new arrivals were moved to the first night unit, which was next to the reception area, thus facilitating speedy movements. They were interviewed in private by a first night officer, who focused on safety issues, including completing the cell-sharing risk assessment. Prisoners were not located to a cell until this had been completed. Four prisoner Insiders, some of whom were Listeners and a Prison Advice and Care Trust (PACT) worker also worked on the first night landing. They provided a range of support, information and advice about the prison, including some induction materials. Relationships were observed to be positive and respectful and the general atmosphere relaxed and welcoming. All new prisoners received an initial health screening on the first night centre from a nurse and also had the opportunity to be seen by the GP …"

> "…Newly arrived main location prisoners were moved to C wing on the afternoon of their second day at the prison, and formal induction commenced on the next working day. Induction was comprehensive and split into four elements: an interactive computer program providing information about the prison, followed by sessions covering resettlement, skills assessment, and health and safety and the gym. The computer package used had been developed specifically for Wandsworth and contained opportunities to test out learning and receive feedback. Delivery of this element was heavily dependent on induction orderlies, who provided ongoing support to prisoners, with supervision from dedicated induction officers. Each element of induction was delivered on a different day to allow time for reflection and consolidation, but this could be spread over a two-week period. A parallel induction was run for vulnerable prisoners on Onslow unit, but there were significant delays in these prisoners receiving the health and safety and gym element. A written induction booklet was available, but some information in this and the computer program was out of date. Despite the large number of prisoners held with little or no use of English, much of the induction information specific to the establishment was not available in any other languages. An assessment of resettlement needs was completed and resulted in referrals to a range of interventions. A system had recently been introduced to ensure that all elements of the programme were complete before movement on to another wing …"

15. The man was a foreign national prisoner who had a poor grasp of English. On provision for foreign national prisoners, the Chief Inspectorate made the following comments:

> " … Wandsworth had been identified as a main centre for foreign national prisoners, and there was a large foreign national population. The full-time foreign national's coordinator had not been formally trained. A foreign nationals committee met quarterly but did not use monitoring to inform its work. A network of orderlies provided a valuable service, but insufficient attention had been given to ensuring that the specific needs of foreign nationals were reflected in all aspects of prison life. Prisoners were able to provide interpreting services, but were sometimes used inappropriately and the professional interpreting service was underused. A lack of translated documents left some prisoners feeling isolated and uninformed. Some foreign nationals were unaware of facilities for keeping in touch with families because of their poor understanding of English …"

16. The Chief Inspectorate also commented on the healthcare provision:

> " … Patients received thorough reception screening, but there were gaps in the provision of care, with only one life-long condition clinic being run and no immunisation clinics. There were a number of staff vacancies on the primary care team, resulting in an over-dependence on bank and agency staff and an inconsistency of approach to prisoners. Healthcare staff did not work as an integrated team. There were links with outside care providers, but too many external appointments were cancelled or missed. Dental services were good. There were a considerable number

of pharmacy issues requiring attention. There were no inpatient services for prisoners with physical illnesses. Mental health services appeared good and were responsive to prisoners' needs …"

17. She made a number of recommendations to the prison. It is apparent from my investigation that some of the issues remain outstanding and I make similar recommendations on the subjects of healthcare, foreign national prisoners and first night/induction procedures.

18. Every prison and immigration removal centre has an Independent Monitoring Board (IMB), comprising members of the public. IMB members are volunteers and they monitor the day-to-day life in their local prison or removal centre to ensure that proper standards of care and decency are maintained. They publish an annual report to the Secretary of State for Justice which outlines particular areas of concern or good practice at their particular prison. The IMB published a report for the period June 2008 to May 2009. They drew attention to a lack of major languages on the induction computer programme, and said some prisoners depended on others speaking their language to operate the system.

19. On the issue of healthcare provison, the IMB highlighted that there was a dependence on only a few senior nurses, and they were concerned about incidents involving handling and issuing drugs. The Board also mentioned concern that specialist clinics had not been set up and there was no evidence of new policies or procedures being implemented. Since the publication of both the IMB and Inspectorate reports, a new management structure has been put in place at Wandsworth.

20. All prison officers are trained in basic approved control and restraint techniques as part of their initial training. All staff must take a yearly refresher course to ensure they remain competent in these techniques. In addition to the basic control and restraint, some staff are trained in advanced techniques, but this is voluntary.

21. The Prison Service Order (PSO) 1600 sets out the rules regarding the use of force. It lists four points that define the lawful use of force, these are, reasonable, proportionate, necessary and no more force than is necessary in the circumstances. These points must be adhered to by all staff involved in any restraint of a prisoner.

22. The Prison and Probation Ombudsman was tasked with investigating deaths in prison custody in 2004. Since then, there have been a total of nine deaths, prior to the man's, attributed to natural causes at Wandsworth. In some of the investigations that followed these deaths, recommendations about healthcare provision were made. I repeat recommendations relating to healthcare as a result of this investigation.

KEY FINDINGS

23. The man was 51 years old when he died. He was born in Sri Lanka. He lived there until 2000, when he came to the UK as an asylum seeker. He had not worked since arriving in the United Kingdom due to his limited English. He had received police cautions in the past for violent and alcohol related behaviour, but this was his first time in prison. He was married and is survived by his wife and three daughters.

24. He went into HMP Wandsworth on 23 March 2010. He had appeared at Magistrates Court earlier that day, where he had been sentenced to four months imprisonment. His daughters told the investigator that they had not seen their father before he went to court and a custodial sentence had never been considered likely by his family.

25. On reception at Wandsworth, the man was initially interviewed by Officer A who completed reception paperwork, including a cell sharing risk assessment (CSRA). (The purpose of the CSRA is to find out whether a prisoner is suitable to share a cell and to gauge the level of risk posed to a cell mate. A series of questions are asked to find out whether the person is either racist, prone to violent outbursts or has history of bullying etc.) He was considered suitable to share a cell. He then moved onto the first night centre where a more in-depth assessment of his medical history was completed by Nurse A.

26. Nurse A has been a general nurse at Wandsworth since April 2000, and has worked in most areas of the prison. He wrote on the medical section of the CSRA that there was "insufficient evidence to give opinion" in relation to the man's suitability for cell sharing prior to completing the health screen. The escort record that had arrived with him from court indicated that he was diabetic and had breathing problems, and the nurse confirmed that he would have been aware of the information on it. When he completed the health screen he recorded:

> "… No obvious signs of alcohol problems, 3-4 cans daily. The man states that he is type 2 diabetes but cannot remember the tablets he takes, he also drinks alcohol a lot – still smelling of alcohol. Refer to GP …"

27. At interview, the investigator asked Nurse A whether he was trained to recognise people who came into custody with alcohol or drug problems. He said that by the nature of his work, he would come across prisoners in reception with all kinds of problems, and refer them to either the doctor or substance misuse team. However, he had no specific training in substance misuse.

28. When asked about the CSRA he had completed, the nurse explained that the man would have initially been assessed by another nurse in reception who would have recorded details such as date of birth and registered him on to the Electronic Medical Information System (EMIS) before he went to the first night centre.

29. The man spoke very little English. Nurse A was asked what provision he made for this during the health screening and whether he felt the man had been able to understand the questions being asked. The nurse replied that when he had unlocked him to conduct the screening, he was in a cell with another Sri Lankan national who spoke fairly good English. He used this prisoner to explain his questions to the man. Prison staff have the use of interpreting services which can be accessed via the telephone, but it does not appear that this service was considered by the nurse.

30. During his screening of the man, the nurse said that he learned that he was type 2 diabetic, and also noticed that he smelt strongly of alcohol. In view of this he wanted to establish how much alcohol he drank and was told that it was about four to six cans of lager daily. He said that because the smell of alcohol was so strong and that he had established the man was a diabetic, he knew that he would have to be assessed by the doctor. He explained his reasoning as firstly the man took medication for diabetes, and secondly the strong smell of alcohol which led him to believe that he would require some form of detoxification.

31. Nurse A explained that, while he was not part of the substance misuse team, the nature of his work meant that he was familiar with prisoners with drug or alcohol issues. He said that it would be normal practice for such prisoners to be referred to the substance misuse nurse following his screening and that of the GP. However, the man was not referred which he could not explain, but he confirmed that it was the normal procedure at Wandsworth.

32. In relation to the man disclosure that he was type 2 diabetic, the nurse said that a verification form would be completed and faxed to his GP in the community to clarify the medication he was receiving. Prison Doctor A assessed him following the screening by the nurse. The investigator was unable to contact the doctor but his entry in the medical record said:

> "… Patient reviewed no immediate concerns. Past medical history of diabetes. Sarcoid has OPD (out patient appointment) every 6/12. Contact GP for past medical history and meds …"

33. Prison Doctor A made no reference to the concerns on the health screening about alcohol despite having access to the screening form, and no mention is made of checking the man's blood glucose levels at that time. Neither does the documentation indicate how the doctor conversed with him, given his lack of English.

34. There is documentary evidence that the verification form was completed and a response detailing all the medications was received by the healthcare department at Wandsworth on 24 March. Despite this confirmation, which included his diabetic medication, nothing was prescribed immediately by the prison. Nurse A told the investigator that he could see no reason why it would take two days for medication to be prescribed after the verification was received.

35. In addition to the list of the man's existing medication, the GP also attached letters relating to outpatient appointments that he had attended. One letter was from the Consultant in Respiratory Medicine dated 9 September 2009 that mentioned a history of alcohol excess with abnormal liver function tests. Healthcare staff do not appear to have investigated this further. None of this information was updated onto System 1 which would have provided nursing staff with more information about reasons for the later deterioration in his health. (System 1 is the electronic medical database that has recently been introduced into the prison estate.)

36. Following the reception procedures, the man went to the First Night Centre, E wing. At Wandsworth, this wing also contains the detoxification unit. (The First Night Centre accommodates prisoners when they come into custody. While on this unit, they will have a secondary health screen.) However, no further input from nursing staff or substance misuse staff is recorded. On 24 March, the day after his arrival, he moved to C wing where he took part in an induction. (During induction, prisoners are given advice on what to expect in prison, the prison routine, rules and, processes such as obtaining visits, goods and services, as well as advice on completing forms.)

37. The man had been considered as suitable to share a cell. Prisoner A who worked on the servery on C wing and spoke Tamil (one of the languages of Sri Lanka), told the investigator that he first noticed the man on 24 March when he went to collect his meal. He did not notice anything unusual about him, and he appeared to be all right. He said that they did not have a long conversation, but spoke briefly.

38. Prison staff recorded little about the man during the first couple of days that he was in custody, but on 25 March while collecting his meal, he spoke again to Prisoner A. He told him that he had mentioned his medication during the reception process, but had still not been given anything. The prisoner said that the man appeared to him to be shaking. As he was in the middle of serving meals he was unable to leave, so he told him to wait until he had finished. However, it appeared he was unable to stay and said to him "ok, I will go and speak to the doctor".

39. A short while later, the man returned to the servery and asked the prisoner if he could write his name and prison number down for him, which he did. The prisoner told him that he would go and see him in his cell later that evening, and was under the impression that at this point he had seen the doctor. Their conversations were all in Tamil. There is no evidence that suggests a doctor or any other medical staff saw him that day. We know that he asked the prisoner to write his name and prison number for him and this may have been in order to complete a request form to see a GP, however, no such form was provided for the investigator.

40. The prisoner said that, after he had finished his work on the servery, he went to the man's cell and spoke to him. The cell door was closed and he appeared to be grabbing or scratching at the door. He went back around 40 minutes later when the wing was unlocked for association, but his cell mate said that the man was not there and he did not know where he had gone. (Association is when

prisoners are out of their cells and make telephone calls, take part in other activities and socialise together.) The investigation found no documentary evidence to indicate he had moved cells or had been taken to see a nurse during that time.

41. Officer B, who was working on C wing, also recalled her interaction with the man on 25 March. She said that during the serving of the evening meal he indicated to her that he required medication. She said that he could not speak English and made a gesture with his hands as though he was taking a tablet and also mentioned diabetes. When she realised what he was trying to tell her, she directed him to the treatment room on the wing. She said that he went off the landing and she assumed that he went to the room. She saw him on his return, he thanked her and he was locked back in his cell. She could not recall seeing him with any medication.

42. An entry in a wing observation book refers to the man having to be moved from his cell during the early hours of 26 March, as he was not getting along with his cell mate. Senior Officer (SO) B was the orderly officer that night and provided an account of his interaction with him. He said that he was made aware by the staff on C wing that the man's cell mate had said he "could not put up with him" any longer. The SO went to the cell to find out what the problem was and spoke with the cell mate who told him, "two days of this gov, no more, get him out". He said that at this point the man came out of the toilet wearing a sheet and had a pillow case on his head. He was smiling and appeared pleased to see the SO who considered it necessary to move him to avoid any further problems. He said that when the man left the cell he was happy. The SO felt that he was displaying either signs of mental health problems or being very elated, to the point that the SO said that it was "quite comical".

43. The SO explained that, when the man left the cell, he hurried along the landing. As he did so, he checked each cell door, before informing the SO that they were locked. He eventually followed the SO to E wing where he was given a single cell. The SO described his behaviour as not aggressive but quite "bizarre". Officer C was on duty on E wing when the man got there and he wrote in the wing observation book.

> "… From C wing not getting on with cell mate. Moved by Oscar 1. Appears to have mental health problems. At the time of writing this he has been rambling on in a foreign language for over 3 hours. It may be a good idea if in-reach spoke to him. He was presenting some strange behaviour. Has been trying to get the door open from the inside, he has tried to slide the observation glass down. If you look at him through the observation glass he tries to see you through solid metal …"

44. Officer C was asked during the investigation about his interaction with the man. He said that within five minutes of his arrival on the wing he began pressing his cell call bell. (Each cell has a bell to be used by prisoners in an emergency or if they require staff attention.) He went to the cell and asked him what he wanted. The man then tried to look through the door at him, he then began saying "it's gone, it's gone" and appeared to be searching the cell. The officer explained that there was little in the cell, but he lifted his mattress, looked in

cupboards, lifted chairs and looked in the toilet. The officer tried to ask him what he had lost, but got no response. He then sat down on his bed and, despite attempts to engage him in conversation, he did not reply. The officer was unsure whether he understood English, although he had said "it's gone", and left him alone. He added that after around 20 minutes, the man began talking in a foreign language. Again he asked what the problem was, but he continued to speak in Tamil and appeared oblivious to him.

45. The officer continued to check on him. When he returned to his cell later, the man was holding a towel and using it to try and slide the observation glass down. (Cell doors are fitted with a panel of glass to enable staff to see prisoners without opening their door. The panel on the cell could not be moved.) The officer said that when attempts to move the panel with the towel failed, he began using his hands to try and slide it down. He gripped the edge of the door and appeared to be trying to pull it open. The officer's impression was that he was in a "confused state".

46. The investigator asked whether the officer found the man confrontational during his interaction with him. The officer said that he did not have that impression and the man ignored him as though he was not there. He said that it was very strange and had prompted him to make the entry in the observation book that the man should be seen by the MHIRT. He did not make a referral himself or contact anyone from the healthcare centre, but believed that the entry in the observation book would be followed up by the day staff, who would make the necessary arrangements. He left duty at 7.00am on 26 March when the man was still talking loudly in Tamil, so he thought that the day staff would have heard him and been aware.

47. The officer was asked whether any discussion took place about the man's suitability to share a cell or whether the CSRA was reviewed. He replied that this had not been mentioned to him. Little is documented about the man's time on E wing after Officer C's entries in the wing observation book, but it is known that he moved back to C wing into another shared cell later that morning.

Events following the man's return to C wing

48. Officer D was working on C wing when the man returned. She was responsible for arranging the movements of prisoners. She said that prisoners were normally moved between wings after lunch, but she recalled that he returned just before lunch at around 11.30am. She was unaware that he had moved cells the previous evening and there was nothing to suggest that he should not be located in a shared cell. She said that there were no entries in his wing history file. According to the CSRA he was considered 'low risk' and could therefore be in shared accommodation. This was her only contact with him during that afternoon.

49. In a statement given to the police, the cell mate said that the man moved into the cell at around 12.00pm. He was quiet at first and then began to speak broken English to himself and shake the bunk beds. They left the cell to collect their lunch and, after returning to the cell, watched television. The cell mate

described him as anxious and said that he would constantly get up and press the cell call bell, but could not seem to communicate with the officer.

50. Prisoner A told the investigator that he had seen the man in his new cell whilst handing out visit slips. He spoke to him through the observation panel and asked if he was alright. He gave no indication of any problems, but the prisoner said that he was still shaking as he was when he last saw him.

51. During the afternoon, Officer B went to the man's cell as he kept pressing his cell bell. She said that his behaviour was very strange. She asked him what the problem was and he replied that he wanted to go to Wimbledon. She clarified with him what he had said and he said "yes court". The officer explained that he had already been to court, but said he was not listening at all and kept saying that he wanted to go to Wimbledon.

52. She asked him not to ring the cell bell unless it was an emergency. After leaving the cell she returned less than ten minutes later as the bell was pressed again. She said that on this occasion it was not him, but his cell mate who had pressed the bell. She asked him what the problem was and he replied "I don't know what's wrong with him but he's in the toilet and he's just up and down the cell". When she looked into the cell, she saw that he was pacing up and down in the toilet area. In his police statement the cell mate also mentioned that he was behaving strangely and putting bread down the toilet.

53. Officer B went to speak to Nurse B, the nurse working on E wing and asked her to examine the man. The officer was concerned because she recalled him saying that he was diabetic the previous evening. She thought that his blood sugar level might have dropped which would account for his behaviour. At interview, the nurse said that the officer told her about a prisoner in C wing behaving strangely who had said he was diabetic and who had not had any medication. She asked the officer to contact the nurse in charge. She then went to see him, taking the machine for measuring blood sugar levels. The nurse in charge, Nurse C, followed her.

54. Nurse C told the investigator that she was the lead nurse on 26 March and had gone to C wing to look for Nurse B. Nurse B explained that an officer had asked her to check the man as he was concerned about him. She had tested his blood sugar which was within normal limits. Nurse C said that the man was not able to converse very well, but seemed pre-occupied with moving things around in his cell.

55. On that particular afternoon, Nurse D was in the prison to conduct a weekly diabetic clinic. He said that he went to see the man as he had recently arrived into custody and had been listed as diabetic. He had not gone to see him as a result of being asked by wing staff or nurses. The nurse said that he had cell keys, but for safety reasons he would always open the observation panel to assess who he is unlocking. When he looked into the cell, he saw him acting strangely and holding his pillow. As he did not know him, the nurse returned to the healthcare wing and suggested to the senior sister that maybe they should go and see him together. However, when he returned to the cell, Nurses B and C were already there. They told him that they had checked the man's blood

sugar and that it was alright, so the nurse did not actually meet him face to face.

56. Nurse D noted that the man had not been given any medication for his diabetes since his arrival and thought this strange. He said that if the verification had been received by the prison healthcare department he would have expected it to have been prescribed. He took the prescription chart to the duty GP and asked him to write it up, before taking the prescription to the pharmacy. He then spoke to Nurse C, who was responsible for administering medications that evening and asked her to ensure that he received his.

57. Nurse C told the investigator that when she saw the man it had only been a "snapshot" of a minute or so. There was something about him that bothered her and she shared her concerns with Prison Doctor B. She was carrying out the role of duty nurse and she said that it was a particularly busy day, as she had been called to numerous medical emergencies. However, she took the time to discuss with the doctor whether she should carry out a mental health assessment or refer him for a specialist MHIRT assessment and make sure that nothing was missed from the mental health perspective.

58. During nurse's conversation with the doctor she was again called away and when she returned the doctor said that he had checked the man's medical history. The doctor said that he could not see anything that would have given rise to the bizarre behaviour, but they would monitor and carry out blood tests on the Monday. She said that her normal practice, if she had concerns about a patient, is to read back through the medical history from when the person came into prison to see if anything had been missed. On that day, she did not have time to do this because of various emergencies, such as patients harming themselves which was why she discussed it with the GP.

59. Nurse C said that she was not aware at any time that there had been mention of alcohol on the man's reception assessment. She said that, given that his medical notes were relatively short, she would have expected the doctor to have identified this when he explored his history.

60. In interview after the man's death, his cell mate described another person visiting the cell shortly after the nurses had left, who he thought was a Samaritan. However, it is likely that it was actually Nurse D. When interviewed, the nurse said that he did not actually see the man 'face to face' but had observed him through the observation panel, and that he thought he was acting strangely.

61. Prisoner A said that he did not see the man while on exercise. When he returned to the wing he saw him on the ground floor and he appeared to be trying to get out of the door. He saw an officer standing in front of him, trying to talk to him. As he knew that the man spoke little English, he went across to see if he could help. He asked him what was wrong and he replied, "I just bought two kilos of mutton and I left it in the road, I just want to give it to my wife and come back quickly". The prisoner tried to explain that he was in prison, but he did not appear to listen. He kept repeating, "I only live next door, next road, let me go and give that mutton because some visitors are coming to my house, let

me go and give that mutton and come back to the room again, please tell the officer". The prisoner told him to return to his cell. He walked him to the gate and he believed that he returned to his cell. He told the officer that he believed the man required the doctor's help.

62. The cell mate said that the man returned about 15 to 20 minutes after being unlocked, which he thought was strange as exercise usually lasted longer. When returned to the cell, he began to panic and continually press the call bell. The cell mate thought something needed to be done and that the man was going mad. He asked a prison officer who passed the cell if he could be moved as the man's behaviour was becoming worse.

63. The man later went to collect his evening meal along with his cell mate. Prisoner A recalled seeing him and said that he appeared to be sweating. He asked for chicken curry and, although it was not what he had ordered, the prisoner ensured that he was given that meal. His cell mate said that when they returned to the cell, initially the man was calm and resting on his bed. All of a sudden, he began panicking again, talking incoherently non-stop and shaking the bed. His cell mate said that he was not violent but appeared confused. He described him as becoming more erratic. The man collected their food bowls and wrapped them in paper. He was shouting and began banging on the cell door and pressing the bell.

64. Officer B said that she answered the man's cell bell again at around 7.00pm. His cell mate asked her if he could be relocated as the man's behaviour was scaring him. She saw him pacing up and down the cell and shouting, but she could not understand what he was saying. She told the cell mate to start packing his belongings while she went to see if another cell was available. The cell mate said that, while she was gone, the man began placing the items he had wrapped in the waste paper bin and seemed confused.

65. The officer returned to the cell a short while later with her colleagues, Officers D and E who were to help her relocate the cell mate. When they got there, the man was holding the waste paper bin and stabbing at the cell door with a plastic knife. On seeing this, they decided to contact the orderly officer.

66. Senior Officer (SO) A was on duty as Oscar 2 on 26 March, and, as Oscar 1 was elsewhere in the prison, he went to C wing at the request of staff. (Oscar 1 is the night orderly officer and Oscar 2, the assistant.) He said that when he was asked to go to the wing, he was not aware of what the problem was. He got to the landing at around the same time as the duty governor, who had also been contacted. The SO said that as he walked towards the cell he could hear raised voices and saw three members of staff outside the cell gesturing to the occupant to calm down. He tried to speak to the man, who he had not met before. He was unable to communicate with him, and asked staff what was happening. Officer E told the SO that the man was agitated and had a plastic knife that he had been attempting to sharpen. The SO could see no marks on the knife, but the man was striking it back and forth across the observation panel and continuing to shout.

67. The staff also told the SO that the man's cell mate had raised concerns and said that he was afraid of him, as he had been behaving erratically for sometime. He asked the staff whether anyone on the wing who could communicate with him in his own language and was told about Prisoner A. Officer D went to ask the prisoner if he would come and try to speak with the man. The prisoner said that, when he arrived at the cell, staff asked him to tell him to move back from the door, so that they could go inside. He said that the man kept repeating "I want to park my car and I am going to come quickly". He told him that he was in prison and again told him to move back from the door, but he continued to repeat that he had keys and needed to move his car. The investigator asked the prisoner whether he could recall anything that the man was holding, and he replied that he was holding his bin under his arm. He explained that the man had placed his belongings inside, which was typical of how people in Sri Lanka would move items from one place to another. He did not see anything in his other hand.

68. The SO told the investigator that, when he asked the prisoner what the man was saying, he was told that the prisoner could not understand him, and no mention was made of moving his car. The SO said that it became apparent that he needed to remove the cell mate for his own safety. Although there was no indication that the man had threatened the cell mate, his safety was the first priority for staff. The duty governor said that at the same time as staff tried to calm the man and move the cell mate, he received a radio call that there was a fire elsewhere in the prison. At this point the SO thought that it became more urgent to bring the problems with the man to a safe conclusion, so that he and the SO could deal with the fire.

69. The SO said that he indicated to the man's cell mate to be ready to leave the cell when the door was opened. When they opened it, the man attempted to grab at the door and it was pulled shut again. The SO said that as the man was still holding something which he thought could be a weapon, all the staff drew their batons to protect themselves. (Prison staff are provided with extendable batons as part of their uniform. They are trained to use them in self defence.) The SO said that the man was again instructed to move back from the door before it was opened a second time. It was about 7.15pm by this time. As the door was opened, the man came forward holding the bin which both the SO and Officer E knocked from his hand by striking it with their batons simutaneously. He was holding the knife which was aimed upwards towards what the SO presumed to be his chest or throat. The SO took hold of his right hand, which was holding the knife, and pulled it past him and then other staff helped to restrain him.

70. The SO explained the efforts to restrain the man in some detail. He described it as a "very protracted and somewhat impractical" control and restraint (C&R) incident. This was because, as the man came out of the cell, all the staff including the duty governor responded to try and control him. (The use of C&R is closely monitored and PSO 1600 sets out the requirements that must be followed. It is the only method approved for prison staff to restrain violent prisoners by force.)

71. The SO said that the man took the staff about seven to ten feet down the landing, by pushing backwards. The SO still had hold of his right hand and was carried by the momentum. He wanted to take him into a situation where staff could control him, so they used his own momentum to get him to lie on the floor.

72. The SO was conscious of the need to protect the man's head so, because of the speed, he kept his arm underneath him. Officer D had control of his left arm and Officer E had his head. The duty governor was between the man and the rail, and tried to communicate with him. The SO said that these actions all happened in seconds and the man was brought under control within a maximum of two to three minutes. As soon as he was controlled, staff put handcuffs on and he continued to shout a lot.

73. The SO again asked Prisoner A to tell the man that, if he calmed down, staff would sit him up and find out about his problems. The SO said that he wanted to put the man back in the cell and move his cell mate. He did not want to take him to the Care and Separation Unit (CSU), but that became increasingly likely and was the reason for using handcuffs. (The CSU provides temporary accommodation for prisoners who have become violent or disruptive, committed offences against prison rules or require protection if they are under threat from other prisoners.) The prisoner spoke again in Tamil, but gestured to the SO that he did not know what the man was saying.

74. All the staff said that when the handcuffs were applied, the man went from struggling, being loud, screaming and shouting to complete silence which was very noticeable. He stopped resisting and did not appear to respond to staff. The SO said that, although not medically trained, he thought that he had a pulse. He was put in an upright seating position and staff noticed that he had passed urine. The staff thought that he was unconscious and so the handcuffs were immediately removed and he was placed in the recovery position. Nurse C was called, via the radio.

75. The nurse recalled that she had been contacted at 7.11pm. She was the duty nurse and had been treating a prisoner with chest pain when she was told about the fire. She left the prisoner with an officer and made her way to E2 landing, with her emergency bag and an oxygen cylinder. She began treating a prisoner for smoke inhalation and had been there for around three minutes when she received the radio call about the man. The prisoner with smoke inhalation was well enough to leave so she took her equipment and went to C wing. Her emergency bag contained cannulation equipment (for inserting a tube into the body), as well as observation equipment such as a blood pressure monitor and a defibrillator.

76. She said that it only took her about two minutes to get to C4 landing. As she approached the staff she called out and asked what the problem was. When she got up to the staff she saw that the prisoner was the man and the SO explained to her what had happened. She asked the staff to place him on his back so that she could assess his airway and circulation. She said there were no signs of breath, no rise and fall of the chest and no carotid (neck) pulse either. She then told the other staff that he was in cardiac arrest. She asked

them to start cardio pulmonary resuscitation (CPR) and notify the London Ambulance Service. She also asked staff to get the GP, who was in the first night centre. Officer E started CPR, but was replaced by the SO, while the nurse put the defibrillator onto him to see if there was any heart rhythm. (A defibrillator monitors heart rhythm and where necessary will deliver an electric shock to put the heart back into a regular rhythm. A defibrillator cannot restart a heart that has no heartbeat.) Once the defibrillator was in place it advised that no shock was advisable and there was no cardiac output. As the nurse's oxygen was still with the prisoner in the fire, she used a protective mask to give mouth-to-mouth breaths to him until another oxygen cylinder arrived.

77. Nurse C told the staff to carry on with the CPR while she continued to give oxygen. At various times the defibrillator was checked, and it still showed no output. The duty GP had arrived and the nurse asked him to try to cannulate the man to insert the medication used in cardiac arrest. The doctor tried to do so on a couple of occasions while staff continued the resuscitation process. The nurse gave him all the information that she had about the man and they attempted to revive him for around 20 minutes.

78. Another nurse who had accompanied the duty GP asked if the staff agreed that they should stop the resuscitation attempts. The GP pronounced the man's death at 7.36pm.

Events after the man's death

79. Following the man's death, staff contacted the Governor and the prison initiated their contingency plans. The Deputy Governor returned to the prison along with another governor who took on the role of the prison's family liaison officer. The chaplain also attended and offered support to the staff as well as assisting the family liaison officer to notify the man's family. Due to the circumstances of the death, the police were notified and attended the prison to interview the staff before they left the prison.

80. The prison's family liaison officer and the chaplain left the prison at about 10.45pm, to visit the man's family and tell them of his death. They told the family of the circumstances of his death as known at the time and stayed until other family members arrived to offer support. The family liaison officer also told the family about the role of the Ombudsman's office and the Coroner, and that an investigation would take place. They left the family home at 1.20am and arrived back at Wandsworth at 3.20am.

81. Later on 27 March, the prison's family liaison officer contacted the man's family and spoke to them about the special post mortem notified by the Coroner's officer and that a press release was to be issued. During the conversation, the family asked him about the man's death and he told them again what he knew at that time. They were concerned about when they would be allowed to arrange the funeral and he agreed to contact them again on 29 March.

82. Later that evening, the family liaison officer learnt that a news channel was running the story of the man's death and stating that it was linked to a hostage

incident. After establishing that it had not originated from the Prison Service press office, he telephoned the family and told them of the coverage. The man's daughter told him later that her father's name was on the BBC website and asked whether it could be removed. However, the press office told the family liaison officer that this was standard practice and it could not be removed.

83. Later on 27 March, the Governor contacted all the staff involved at their homes. He offered the support of the staff care and welfare team and their colleagues at Wandsworth.

84. The prison's family liaison officer remained in regular contact with the man's family. He kept them updated on progress with the Coroner's office and also arranged for funeral costs to be met by the prison. The family told the Ombudsman's investigator and family liaison officer that they appreciated the support which he had given, particularly his help with the press coverage.

85. The family were however concerned about the accuracy of the information they were initially given. The investigator explained that any information immediately following a death in custody can be subject to change as more facts emerge. He made the prison's family liaison officer aware of the family's concerns and suggested that it might be advisable in future to restrict information to that which has been substantiated to avoid confusion later. He agreed to adopt this approach in future.

86. A debrief of the staff involved was carried out by the prison immediately after the man's death. In addition the prisoners who were subject to suicide monitoring were reviewed, as is standard practice following any death in custody.

ISSUES

Initial health screen and clinical care

87. When the man arrived at Wandsworth, Nurse A completed the reception health screening process. In his notes of the assessment, he recorded that the man had a strong smell of alcohol about him. The nurse confirmed to the investigator that he was concerned and that the normal procedure would be for him to refer the man to the Substance Misuse Team. He could not explain why he did not refer him for specialist support.

88. During the investigation, all the healthcare staff interviewed were shown two documents, 'Clinical Management of Drug Dependence in the Adult Prison Setting' published by the Department of Health in November 2006 and Prison Service Order (PSO) 3550 Clinical Services for Substance Misusers, issued in December 2000. None were aware of either publication. The documents set out the procedures to be followed for prisoners arriving into custody with identified or suspected drug or alcohol problems. Although the staff were unaware of the publications, they were familiar with the procedures in place at Wandsworth to treat such prisoners. A member of the Substance Misuse Team is available on the first night centre so that referrals can be made directly.

89. Following Nurse A's assessment, Prison Doctor A assessed the man, but he did not refer to the comments about smelling of alcohol or make any other reference to alcohol.

The Governor and Head of Healthcare should conduct an immediate review of the reception screening processes for identifying and following up those prisoners arriving in custody at Wandsworth with possible drug or alcohol problems. This should include a system for ensuring that such prisoners are automatically referred to the Substance Misuse Team and that the requirements of PSO 3550 are met.

The Governor should ensure that all relevant documentation and PSOs relating to healthcare requirements for prisoners with alcohol or drug dependency are made available to nursing staff. Consideration should be given to allowing access to such documents via the prison intranet.

90. A verification fax was sent to the man's community GP to confirm the medication that he was taking. The GP responded the following day, attaching letters regarding his previous treatment at hospital. The GP confirmed that the man was taking a number of medications for diabetes and other conditions. The letters also referred to previous excessive alcohol use and poor liver function. There is no evidence to suggest that this information formed any part of subsequent clinical investigations. Despite the fax arriving at the prison on 24 March, no medication was prescribed for him until the diabetic nurse became involved on 26 March and there is no evidence that any was administered during the three days before he died. The clinical reviewer describes the omission as "not ideal" but "unlikely to have contributed to his death".

The Head of Healthcare should a review the procedures for recording information received from community doctors, to ensure that all relevant information is updated on System 1.

The Head of Healthcare should review the process for prescribing and dispensing medication to new prisoners to ensure that is carried out in a timely manner.

91. The man's disturbed behaviour began notably on 25 March. It resulted in him moving to another cell during the early hours of 26 March, after concerns were raised by his cell mate. The SO who arranged the move said that he appeared "bizarre" and was wearing a pillow case on his head. The officer patrolling the wing where he was moved to, also said that he continued to behave in a "bizarre" manner after moving to the single cell. No nursing staff were asked to see him at this time, despite this behaviour. The officer on E wing wrote in the wing observation book that a referral to the MHIRT might be advisable. However, he did not make the referral himself, his comments were not followed up at any other time and there is no evidence of any action resulting from his observation.

92. The man moved back to C wing on 26 March and, throughout the remainder of the morning and early afternoon, continued to display the odd behaviour described by staff. Officer B was concerned enough to ask Nurse B to assess him as she felt that his behaviour could be linked to his diabetes. The nurse, along with Nurse C, assessed him and his blood sugar was considered normal. However, Nurse C recorded that he was behaving strangely and, although he did not appear distressed, he was acting "bizarrely".

93. Nurse C had not seen the man's medical notes and was not aware of any alcohol issues. However, she expressed her concerns about his behaviour to the duty GP. The GP offered to check his history to see if there was anything that could be contributing to this. He had access to all the man's medical notes which, given his brief time in custody, were not extensive. They included the initial health screen, where concerns about alcohol were raised by Nurse A. He would also have had sight of the faxed letters from the community GP. He later told Nurse C that he had been unable to find any other possible cause for the man's behaviour, but recommended that he should be monitored. He did not ask to see him and did not make a physical assessment.

The Head of Healthcare should review the system for medical assessments of prisoners who appear to be acutely confused and ensure that prison doctors conduct face-to-face assessments in such cases.

94. Nurse C made a referral to the MHIRT. The medication that he required for his diabetes was finally prescribed on the afternoon of 26 March, following the visit by Nurse D, but was not taken before his death.

95. The clinical reviewer, who completed the clinical review, concluded:

" … In summary it appears that the man was suffering from acute alcohol withdrawal, resulting in the acute confusional state of delirium tremens. This condition has a 15% mortality rate and had it been recognised the usual treatment would have been an acute hospital admission under the physicians. There was a three day delay in starting his medication after arriving in prison and although not ideal I note that his blood sugar was checked on at least two occasions so I think this delay was unlikely to have contributed to his death.

"Alcohol intake is often under reported by patients but I note that he reported drinking three to four cans of lager to the reception nurse. This may well have been an underestimate but I note the recognition of the smell of alcohol on his breath at reception.

"It appears that the diagnosis of acute alcohol withdrawal was missed and although this can be a difficult diagnosis it seems unfortunate that the diagnosis was not suspected given the available past history, reception findings and developing bizarre behaviour …"

96. I believe that there were a series of missed opportunities to investigate the possible causes for the man's behaviour. Given the cause of death as "sudden cardiac death while in a state of acute alcohol withdrawal", my recommendations should be acted upon immediately by both the prison and the PCT responsible for the delivery of healthcare at Wandsworth.

Translation facilities and the induction of prisoners with limited English

97. Prisons have at their disposal the use of interpreting services such as 'Language Line' and 'The Big Word'. During the reception process it would be expected that the 'Language Line' service would be used when dealing with a prisoner with limited or no understanding of English. However, during the man's health screen, Nurse A did not use this service. Instead, he sought the help of another prisoner who he thought spoke "the same language" and happened to be in the reception at the same time. The health screen is a confidential medical assessment. I question whether it is appropriate to use another prisoner who was not even known to the man to relay questions about his previous medical history. The most recent prison inspection by HM Chief Inspector of Prisons also criticises the limited use of such services.

The Governor should ensure that the use of other prisoners as translators during confidential processes such as health screens should be stopped with immediate effect. In addition, the importance of using services such as 'Language Line' and 'The Big Word' must be communicated to all staff, and facilities for access to these services should be put in place.

98. As well it is not clear how effective the reception process could be given the man's poor command of English. The cell sharing risk assessment (CSRA) indicates that he answered no to every question, including questions about alcohol dependency.

The Governor should review the induction process and the documentation provided to ensure that it meets the needs of foreign national prisoners, in accordance with the requirements of PSO 2800 Race Equality. In particular, consideration should be given to the development of an information sheet in various languages. This should include information that a prisoner might need within the first 72 hours, such as how to contact their families, make a request and access healthcare.

99. In contrast, when the man began exhibiting challenging behaviour, wing staff asked for another Sri Lankan prisoner, Prisoner A, to try to communicate. On such an occasion the use of another prisoner was clearly the most effective means for staff to try and find out his problems and communicate their instructions.

100. In the documentation supplied to the investigator following the man's death, there was no evidence that induction documents were given to him in his native language. It is also not clear what took place or what he was told during his induction. Prisoner A said that the man appeared confused about what to do and was not sure how to see the doctor or even his own prison number. Again, the Inspectorate comments on the lack of information in other languages, which left some prisoners for whom English was not a first language, feeling isolated. PSO 2800 Race Equality requires information to be provided in appropriate languages and formats.

Prisoner safety / Cell Sharing Risk Assessment (CSRA)

101. On his reception into custody, staff completed a CSRA and the man was considered suitable to share a cell. He moved from E wing to a shared cell on C wing the day after he arrived. On 25 March, his cell mate complained to staff that his behaviour was worrying him and asked for him to be moved. He then moved back to E wing during the early hours of 26 March, and was given a single cell, where his behaviour continued to cause concern.

102. Despite his behaviour continuing to cause concern, the man returned to a shared cell in C wing later that day without reviewing his CSRA. The CSRA is designed to ensure that prisoners are not put into shared cells if they might pose a risk to a cell mate. A previous cell mate had already raised concern about his unpredictable behaviour, yet the man was taken back into shared accommodation. The second cell mate also raised concerns about him and told staff that he was afraid.

103. If the correct procedures had been followed in relation to the CSRA review, I doubt that the man would have been deemed suitable to share a cell. The investigator was told by the SO who led the C&R removal that, if he had been in a single cell, staff would have had more time but their priority was the safety of the cell mate. The failure to properly review the CSRA after the move to E wing potentially placed both the man and his cell mate at risk. By being in a shared cell staff were faced with having to consider the safety of the cell mate and intervene quicker than would otherwise have been necessary, had it been

a single cell. This is supported by the statement provided by the senior officer in charge.

104. Wandsworth has a CSRA Management Booklet that is attached to the wing history files of all prisoners. This booklet is used whenever a CSRA review takes place. It describes situations which may necessitate a review and one of the examples given is acute mental illness. Although, the reasons for the man's behaviour had not been established at the time, staff had commented that a referral to the MHIRT would be advisable.

The Governor should review the way in which the CSRA process is managed to ensure that the safety of prisoners is maintained.

Use of control and restraint

105. As previously mentioned, the need for staff to intervene and go into the man's cell on the evening of 26 March, was more urgent because of the presence of hiscell mate who had already told staff that he was afraid. I am satisfied from the information in staff statements and their subsequent interviews, that they made considerable efforts to bring the situation to a conclusion without using force. However, they were faced with a prisoner who was not communicating clearly, and, from their perspective, was armed with weapons. Although, it is unlikely that he was holding the bin and knife to use as weapons, the staff had to respond to what they saw and his mental state made him unpredictable.

106. When the staff finally went into the cell, they realised that they would have to use control and restraint techniques to restrain him. There is no suggestion in the police investigation of his death, that he was subjected to any unnecessary force. My investigation reaches a similar conclusion. Having carefully considered all the documentation relating to the use of force and interviewed the staff involved, my investigator has found that the staff acted professionally. They ensured that he was monitored throughout and was not subject to unnecessary force. All the documentation relating to the use of force was correctly completed and detailed each individual's involvement.

CONCLUSION

107. When the man was taken into custody, the initial health screen identified that he was type 2 diabetic, and concerns were raised about his alcohol intake. However, following the screening there was limited involvement of healthcare staff and a series of missed opportunities to identify the cause of his escalating challenging behaviour. Had he been seen by the Substance Misuse Team, as he should have been, then it is possible that a more in-depth history of his alcohol consumption would have been made. At the very least, their involvement would have been highlighted within his medical record and signposted other staff to possible causes of his deteriorating condition.

108. However, the doctor who then reviewed him failed to comment on the concerns raised by the nurse, or refer him to the Substance Misuse Team. In addition, the doctor who saw him on 26 March did not conduct a face to face assessment, despite the concerns expressed by a nurse.

109. While the prison staff interviewed during the course of this investigation were able to explain the systems in place for dealing with prisoners with a known or suspected medical condition, the correct processes were not followed in respect of the man. As someone with limited ability to communicate his worries and needs, it must have been very isolating and distressing for him.

110. I am unable to comment on whether the man's death was avoidable. The evidence suggests that the healthcare given to him at Wandsworth was not of a standard to address his alcohol use even if the absence of diabetic medicine was not significant. However, had his health been properly looked after, circumstances might well have been different and he might well have been alive today.

RESPONSE FROM FAMILY TO DRAFT REPORT

111. The man's daughters said that they were concerned to learn of the apparent failure by both Prison Doctors A and B in their duty of care towards their father. They feel that both doctors missed opportunities to correctly identify and treat his alcohol withdrawal. The family have noted that the subsequent post mortem has given alcohol withdrawal to be a contributing factor in his death and therefore feel it is likely this could have been prevented if he was provided with appropriate medication.

112. The family also said that they were disappointed that Prison Doctor A was not able to be traced, despite being registered with the GMC, so that he could be asked about the treatment he provided. The family does not wish to penalise individuals, but they are concerned those involved are able to learn from mistakes in order to ensure the same things are prevented from happening again.

113. The family feel that the clinical reviewer has been non-committal in his conclusions and are concerned this may also lead to lessons not being learnt. They also called into question the independence of the review, as it was completed by an employee of Wandsworth PCT, who at the time of the man's death was responsible for the provision of healthcare services at the prison.

114. In respect of the man being restrained by prison staff, the family feel that this may have been avoided if he had been located in a single cell. They note from the report that he had been moved earlier due to his behaviour and cannot understand why he was then located back into a shared cell when his 'bizarre' behaviour continued to escalate.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should conduct an immediate review of the reception screening processes for identifying and following up those prisoners arriving in custody at Wandsworth with possible drug or alcohol problems. This should include a system for ensuring that such prisoners are automatically referred to the Substance Misuse Team and that the requirements of PSO 3550 are met.

   Following the draft report the Prison Service responded by accepting this recommendation and said:

   Healthcare is reviewing its procedures in reception with the implementation of System 1. Consideration is being given to the use of finger prick liver function screening as part of the alcohol screening process. The alcohol screening template on System 1 is a national agreed tool. This implementation is ongoing and will be overseen by the Substance Misuse Team Leader & Substance Misuse Nurse.

   In addition, Reception, First Night and Induction have now been grouped under one function. The functional head will be reviewing the admission/induction process in liaison with Healthcare. Target for this is February 2011.

2. The Governor should ensure that all relevant documentation and PSOs relating to healthcare requirements for prisoners with alcohol or drug dependency are made available to all nursing staff and consideration should be given to allowing access to such documents via the prison intranet

   Following the draft report the Prison Service responded by accepting this recommendation and said:

   We are currently collating all PSO's and other relevant policies relating to healthcare, and in particular substance misuse. This will be made available to all healthcare staff. Target for this is January 2011.

3. The Head of Healthcare should a review the procedures for recording information received from community doctors, to ensure that all relevant information is updated onto System 1.

   Following the draft report the Prison Service responded by accepting this recommendation and said:

   This information will be scanned directly on to System 1 on the day of arrival by the admin team. A hard copy will also be delivered to the pharmacy department and the duty GP on the day the verification is received. The implementation is ongoing and will be overseen by Head of Administration and Practice & Governance Manager

4. The Head of Healthcare should review the process for prescribing and dispensing medication to new prisoners to ensure that is carried out in a timely manner.

Following the draft report the Prison Service responded by accepting this recommendation and said:

As part of the introduction of System 1, healthcare is also reviewing first night medication dispensing. A protocol and worksheet will be produced. Target for this is January 2011.

5. The Head of Healthcare should review the system for medical assessments of prisoners who appear to be acutely confused and ensure that prison doctors conduct face-to-face assessments in such cases.

Following the draft report the Prison Service responded by accepting this recommendation and said:

Healthcare is currently reviewing the availability of primary mental health services. This will include a protocol and care pathway for patients acutely confused. Target for this is January 2011.

6. The Governor should ensure that the use of other prisoners to translate during confidential processes such as health screens should be stopped with immediate effect. In addition, the importance of using services such as 'Language Line' and 'The Big Word' must be communicated to all staff, and facilities for access to these services should be put in place.

Following the draft report the Prison Service responded by accepting this recommendation and said:

Reissue Governors Information Notice regarding use of 'The Big Word' – specifying situations where this or an appropriate interpreter must be used e.g. health screens. Healthcare will ensure that this is communicated to all healthcare staff. Target for this is December 2010.

In addition, a review of the current facilities for using translation services will be conducted to ensure the relevant staff have easy access. Target for this is January 2011.

7. The Governor should review the induction process and the documentation provided to ensure that it meets the needs of foreign national prisoners, in accordance with the requirements of PSO 2800 Race Equality. In particular, consideration should be given to the development of an information sheet in various languages. This should include information that a prisoner might need within the first 72 hours, such as how to contact their families, make a request and access healthcare.

Following the draft report the Prison Service responded by accepting this recommendation and said:

Reception, First Night and Induction has now been grouped under one function. The functional head will be reviewing the entire admission/induction process and will liaise with the Diversity Advisor to ensure that the process is meeting the requirements of PSO 2800. Target for this is February 2011.

8. The Governor should review the way in which the CSRA process is managed to ensure that the safety of prisoners is maintained.

Following the draft report the Prison Service responded by accepting this recommendation and said:

There is currently a review being conducted locally on the CSRA process intending to improve the current system. Target for this is January 2011.

In addition, all staff will be formally reminded of the events which should trigger a CSRA review. Target for this is December 2010.