PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Wandsworth in March 2012

Our Vision

‘*To be a leading, independent investigatory body,*
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’

This is the investigation report into the death of a man at HMP Wandsworth in March 2012. He died from hypertensive heart disease. He was 45 years old. I offer my condolences to his family.

A clinical review of the standard of healthcare the man received in prison was commissioned. Wandsworth cooperated fully with the investigation. I am sorry for the late issue of this report.

The man had spent time in prison on a number of previous occasions and had been to Wandsworth before his current sentence. He had a long history of substance misuse and had renal failure for which he received dialysis treatment. Although his health was not good, his death was sudden and unexpected.

I am satisfied that the man received an appropriate standard of healthcare in prison, equivalent to that he might have expected to receive in the community and it does not appear his death could have been predicted or prevented.

However, I am concerned that, although the man had been unwell during the night of 11 March, the nurse who saw him twice did not record his medical observations. Subsequently, no one appears to have checked on his welfare after he was seen by an officer at 6.30am on 12 March. When he was found collapsed at 11.30 am, the emergency response was not as swift as it should have been. I understand that new instructions about emergency procedures have since been issued at Wandsworth and the Governor will need to ensure that all staff understand these responsibilities.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman December 2013

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SUMMARY

1. The man was remanded to HMP Wandsworth in December 2011 on charges of theft. On 5 January 2012, he was sentenced to 14 weeks imprisonment. He was released on 14 February. During his time at Wandsworth he had received treatment for drug dependency and had been taken to hospital regularly for kidney dialysis treatment because of renal failure.

2. On 3 March, the man was convicted of a further offence of theft and sentenced to 26 weeks imprisonment. He went initially to HMP Pentonville, then to Wandsworth on 6 March.

3. The man had a long history of chronic drug addiction and habitually used heroin and crack cocaine. He was prescribed methadone in the community to treat his addiction and his methadone treatment continued in prison. He was again taken to hospital for regular kidney dialysis sessions.

4. In the early hours of 12 March, the man was found lying on the floor of his cell. He had fallen out of his bed and grazed his head. A nurse treated the graze and he went back to bed. The nurse said she checked him at 6.00am and took his medical observations which were normal, but these are not recorded in his medical record. At 6.30am on 12 March, an officer conducting a roll check saw him in his cell but he did not respond when she spoke to him and it is not clear that he was conscious at that time. His cell was unlocked by 8.15am but there is no record of who unlocked the cell or whether anyone spoke to him or saw him. He did not collect his medication that morning. Cells would normally be locked again at 9.00am but again we do not know whether anyone saw or spoke to him at that time.

5. At around 11.30am, an officer found the man unresponsive in his cell. Healthcare staff were called and attempted to resuscitate him. An emergency ambulance was not called until at least 12 minutes after he had been found. Paramedics assisted with his care, but they were unable to resuscitate him and, at 12.21pm, he was declared dead.

6. The clinical reviewer concluded that the standard of healthcare the man received at Wandsworth was equivalent to what he would have received in the community. However, we are concerned that there is no record that anyone checked his welfare that morning, that a nurse who had seen him during the night and early the next morning did not record her contact with him in his medical record and that the emergency response was too slow.

THE INVESTIGATION PROCESS

7. The original investigator issued notices to staff and prisoners at HMP Wandsworth informing them of the investigation and inviting anyone with relevant information to contact him. No responses were received.

8. The local Primary Care Trust commissioned two clinical reviewers to review the man's clinical care in prison. They visited the prison to speak to healthcare staff in June 2012.

9. The original investigator visited Wandsworth on 21 March. He met staff from the safer custody team and visited E-wing where the man had lived. He obtained copies of the man's prison and prison healthcare records.

10. HM Coroner for Inner West London was informed of the investigation. The Coroner has been sent this investigation report.

11. One of the Ombudsman's family liaison officers contacted the man's sister to explain the purpose of the investigation and invite his family to identify relevant matters they wished the investigation to consider. She said that the family had not received any information about the cause of death. She said that, when she saw her brother's body, he had cuts and bruises to his nose, face and head. The family where informed that he had fallen out of bed while in prison and would like to know what happened. She also said she would like to know if he was taken for dialysis treatment regularly while in custody and how his health care was managed.

12. The post-mortem report into the man's death was delayed for some time and we did not receive it from the Coroner's Officer until June 2013, when the investigation was re-opened. Unfortunately, the original investigator left the PPO's employment some weeks later which caused further delay. The investigation was then completed by another investigator. We are sorry for the delay this has caused in issuing this report.

13. The man's family received a copy of the draft report. They raised a number of issues that have not led to any factual changes in this report.

HMP WANDSWORTH

14. HMP Wandsworth is a large local prison in south London which holds up to approximately 1800 men. It serves the courts of central and south west London as well as the surrounding counties. At the time of the man's death, healthcare services at the prison were commissioned by the local Primary Care Trust. Following NHS reorganisation in April 2003, the commissioner is now NHS England London Region. There is 24 hour healthcare cover. There are a number of nurse-led clinics and doctors, dentists and other specialists run regular clinics at the prison.

HM Inspectorate of Prisons

15. HM Inspectorate of Prison's (HMIP) most recent inspection of Wandsworth was in June 2013 but the report of that inspection has not yet been published. At the inspection in June 2011, the Chief Inspector concluded that the treatment of many prisoners at Wandsworth "fell below what could be classed as decent". Inspectors were concerned that some prisoners with drug and alcohol problems were moved from the first night centre, where they could be closely monitored, before they were stabilised. They noted that emergency cell call bells took too long to be answered. Inpatient healthcare facilities were found to be very good but only a limited range of primary care services were provided and access to a GP was poor.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In their latest annual report for 2012/13, the IMB said that the prison was improving, with the regime becoming more predictable and prisoner-staff relationships were getting better. The IMB noted that most of their previous concerns about healthcare services had been addressed. The Board was concerned about the adequacy of access protocols for ambulances and had sought assurances from the prison that robust procedures were being put in place for improvement.

Previous deaths at Wandsworth

17. The man was the sixth prisoner to die at HMP Wandsworth since the beginning of 2011 and there has been one further death at the prison since this investigation started. Of these other deaths, four were also due to natural causes. We have previously made recommendations about emergency response procedures and the importance of accurate record-keeping and we do so again in this report.

KEY EVENTS

18. The man had a number of previous criminal convictions, mainly for theft, and had frequently spent time in prison.

19. On 28 December 2011, the man was remanded to Wandsworth facing charges of theft. At initial health screenings, it was noted that he had a history of substance misuse and had been using drugs for over 20 years. To help manage his drug dependency he had active prescriptions for methadone (a heroin substitute) and diazepam (to relieve anxiety). A nurse recorded that he appeared restless and agitated and was likely to be suffering from withdrawal from drugs.

20. The man had renal (kidney) failure and told a nurse that he went regularly to the hospital for kidney dialysis treatment. A nurse contacted the hospital dialysis unit and confirmed his treatment. His record shows that he attended regular dialysis appointments during his stay at Wandsworth.

21. The man had an ulcer on his right leg. The wound was cleaned with saline (a sterile solution) and re-dressed regularly by healthcare staff.

22. On the evening of 28 December, a prison GP saw the man and continued his methadone and diazepam prescription as well as prescribing tramadol (a strong pain-killer), thiamine (a form of vitamin B), omeprazole (to reduce stomach acid) and paracetamol.

23. The man was initially located on E-Wing (the first night centre and detoxification unit) in a cell on his own and monitored for 72-hours. After showing some initial drug withdrawal symptoms, his condition improved and he was recorded to be stable.

24. On 5 January 2012, the man was convicted of theft at magistrates' court and sentenced to 14 weeks imprisonment. He returned to Wandsworth and remained there until he was released on 14 February, at the halfway point of his sentence.

25. On 3 March 2012, the man was convicted of a further offence of theft and sentenced to 26 weeks imprisonment. He was sent to Pentonville. At an initial health screen, he told a healthcare assistant that he was in a lot of pain as he had missed his last dialysis appointment. The ulcer on his leg was also causing him some discomfort and he was using a walking stick. He told her that he had been punched in the left eye three days earlier. She recorded that his blood pressure was high at 157/89 mmHg. It is not clear what action was taken in respect of this.

26. The man said that he had used crack cocaine and heroin in the previous two days and a nurse recorded that he had symptoms of drug withdrawal and appeared sedated. A GP at Pentonville assessed him and, after confirming current prescriptions with his chemist in the community, prescribed

methadone and diazepam. Arrangements were made for him to go to the hospital that evening for dialysis treatment. When he returned to Pentonville, he went to F-wing (the substance misuse stabilisation unit) and told a nurse that he felt much better after dialysis.

27. On 5 March, a GP at Pentonville saw the man and recorded that he had mild drug withdrawal symptoms but was mentally well. Later that afternoon, he attended a dialysis appointment.

28. The next day, 6 March, the man transferred from Pentonville to Wandsworth. The prisoner transfer form noted that it was not possible for him to remain at Pentonville, as the prison was already holding two other prisoners undergoing dialysis treatment. He was again given a cell on his own on E-wing. At a health screen assessment, he told a nurse about his ongoing treatments and medication. He said he was feeling low because of being in prison again, but he was not regarded as being at risk of suicide and self-harm. He declined a second health assessment later that evening.

29. On 7 March, a nurse noted that the man's blood pressure was normal. A prison GP saw him and recorded that he had no drug withdrawal symptoms. The doctor prescribed methadone and diazepam, as well as omeprazole and paracetamol. He noted that his dialysis appointments should be arranged and that the wound caused by his ulcer should continue to be treated and dressed. After seeing the doctor, he went for dialysis treatment that day.

30. For the next three days, the man was monitored as required for a newly arrived prisoner dependent on drugs. He complained of pain caused by his leg ulcer, but nurses recorded that he had slept well. On 9 March, he went to hospital for dialysis treatment. The next day, it is recorded that an officer gave him a warning for attempting to hide medication when it was dispensed to him.

31. At approximately 00.45am on 12 March, an operational support grade (OSG), the night patrol officer on E wing, heard the man calling for help. Night officers opened his cell and found him lying on the floor with a small graze on his head. He said he had fallen out of bed. He was helped back to bed. According to the night orderly officer, a nurse took his medical observations (blood pressure, blood and oxygen levels) and put a plaster over his graze. She made him a cup of tea and then he was left in his cell. The night orderly officer described him as "calm and talkative" while the nurse was treating him. He said that the nurse saw the man again at around 6.00 am, and took his observations which were normal. The nurse made no entry in his medical records to note the observations.

32. At 6.30am, an officer said he had taken over responsibility for E wing from night staff. He said he had been warned that the man 'had been on his bell' all night so, as he was doing a check of the wing, he went to see him and opened his cell door. There is no record of him using his bell during the night. The officer said that he was lying on his bed with his left leg on the floor with his eyes open. He did not respond when he spoke to him. The officer said

that he had known him for six years and thought that he was in his "usual unhappy mood", so he continued with the wing check.

33. At around 8.15am, an officer said he began to unlock prisoners who needed medication. He noted that the man's cell and two others next to it were already unlocked. He did not check the cells and assumed that they had gone to collect their medication. There is no record that he collected his medication that morning.

34. At around 11.30am, an officer was unlocking prisoners from their cells for lunch. He discovered the man lying on his bed and unresponsive. He said that, after calling out to him twice, he went up to him but was unable to find any sign that he was breathing. He called a Senior Officer (SO) to the cell. The SO said in the incident report that he also called out to him and checked for a pulse but he was unable to find one. He radioed for healthcare staff to attend at 11.33am. The officer locked the prisoners in their cells and he said that by the time he had done this healthcare staff had arrived.

35. A nurse attended and began cardiopulmonary resuscitation (CPR – a mixture of rescue breaths and chest compressions to circulate oxygen around the body). Another nurse had brought a defibrillator. (An automated external defibrillator analyses heart rhythm and delivers electric shocks to victims of cardiac arrest to restore a heart beat when it determines there is a rhythm that is likely to respond.) Two more nurses and a doctor were also present. A nurse used the defibrillator but the machine did not detect a shockable rhythm, so she and another nurse continued with CPR. The doctor wrote later in the medical record that the man had been seen earlier that morning but it was not known how long he had been lying unconscious in his cell. He could see no significant trauma on his body, which was still warm to touch.

36. At 11.44am, the SO asked another SO to call the control room for an ambulance, after being asked by a nurse to do so. The ambulance arrived at the gate at 11.50am and the paramedics were escorted to the wing. An incident log notes that the paramedics were present from 12.01pm and assisted prison staff with CPR from 12.04pm. During the attempt to resuscitate him, he was given adrenaline, glucose and naloxone (an opiate blocker). The doctor wrote that he remained asystolic (without a heartbeat) throughout the attempts to resuscitate him and he was pronounced dead at 12.21pm.

37. After the man's death, an operational manager at Wandsworth held a debrief for all staff who were present and involved in the response to offer support. The prison chaplain was designated as the care team contact for staff.

38. Shortly after the man's death, an operational manager was appointed as the prison's family liaison officer (FLO). He was initially unable to find details of the man's next of kin, but found out from enquiries with healthcare and the dialysis unit that his partner was a prisoner at Holloway. He contacted the duty governor at Holloway and arranged for the news of his death to be passed on to her by prison staff. The FLO visited the man's partner at

Holloway the next day to explain what had happened. (His core record shows that he had originally nominated a friend as his next of kin but the details had not been added to his electronic record.)

39. On 14 March, the FLO spoke to one of the man's sisters to inform her of his death. He had been unable to contact her the day before. He also spoke to another sister and offered to visit his family at their home to explain the circumstances. In line with national guidance, Wandsworth contributed to the cost of the funeral.

40. The funeral took place on 11 April. The next day, the FLO spoke to the man's sisters, who had cancelled a visit to Wandsworth scheduled for 13 April. He asked them to contact him if they would like to visit the prison in the future. The family had no further contact with the prison and the FLO did not contact them again.

Post-mortem

41. On 15 March 2012, a Home Office registered consultant forensic pathologist completed a post-mortem examination of the man. The report was not completed until 24 April 2013, and gave the cause of death as hypertensive heart disease. Toxicology tests had shown a moderately high level of methadone in his body, but this was not inconsistent with his participation in a methadone maintenance programme which meant his tolerance levels were likely to be high.

42. In the post-mortem report, the pathologist noted a cut above the man's eye, which he stated was consistent with his fall from bed on 12 March. He concluded that the head injury was not relevant to his death and there was no evidence of any third party restraint that could have caused or contributed to his death.

ISSUES

Clinical Care

43. The man arrived at Wandsworth on 6 March and had timely health assessments. His prescriptions for medication were checked and updated and his welfare and withdrawal symptoms were monitored regularly through a 72-hour observation, in line with Prison Service guidance for newly arrived prisoners dependent on drugs. The prison gave him guidance on treating and dressing his leg ulcer but the clinical reviewers noted that he did not always comply.

44. The clinical reviewers concluded that the man's standard of health care in prison was equivalent to that he could have expected to receive in the community. They noted the medical records showed that his blood pressure had been checked many times while in prison and that it often fluctuated. The reviewers said that, because of his complicated medical history of renal dialysis and fluctuating blood pressure, they would expect any medication required to regulate his blood pressure to be prescribed and managed by the renal specialists who were responsible for his dialysis treatment rather than GPs in the prison.

45. The clinical reviewers said it was essential that the man attended dialysis treatment three times per week because of his renal problems. We are satisfied that all necessary dialysis appointments were arranged and kept and that the Prison Service managed this treatment correctly while he was in its care.

46. While we agree with the clinical reviewer's assessment of the standard of the man's health care in prison, we are concerned that treatment he received on the morning of his death was not recorded in the medical record. After he fell from his bed, he was seen twice by a nurse but the only record of this contact is in the night orderly officer's statement. While his observations were said to be normal, there is no record of this at the time. As this was his last known contact with healthcare staff, we are left without a documented account of his health before his death.

47. It is important that that any treatment given and medical observations taken are recorded on the medical record as close to the actual time as possible to provide an accurate record of a prisoner's health. We make the following recommendation:

    The Head of Healthcare should ensure that healthcare staff accurately record actions, in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

Unlock procedures

48. An officer said he went to check the man at 6.30am. He did not respond when the officer spoke to him and it is possible that he was not well at that

time as he made no further check and assumed he had just chosen not to reply. Another officer went to unlock his cell at 8.15 on 12 March to allow him to collect his medication but found another unknown member of staff had already unlocked his cell and those of two nearby prisoners. The officer did not therefore check whether he was in his cell and presumed he had gone to collect his medication. There is no record that he had collected his medication that morning. If he had been seen alive and well at unlock time we would have expected that officer to have come forward to say so. The presumption has to be that no one checked his welfare at unlock time or when he did not appear on the wing to collect his medication. His cell must have been locked at around 9.00am but it does not appear that the officer who locked the cell saw or spoke to him.

49. The Prison Officer Entry Level Training (POELT) manual states that "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead".

50. We consider that these were missed opportunities to check on the man's wellbeing. We cannot know when he became ill but at the very least there should have been some check on him when he was unlocked and there is no evidence this was done.

The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

Emergency response

51. The man was discovered unconscious by staff at around 11.30am and healthcare staff were called via the radio at 11.33am. Although they attended quickly, the officers who found him did not start CPR immediately. The prison told the investigator that the staff were not first aid trained. We are concerned that wing staff did not have the necessary training to start potentially life-saving treatment before healthcare staff arrived and make the following recommendation:

The Governor should ensure that there are sufficient up to date emergency first aid trained staff on duty to cover all wings, at all times, to provide a quick and effective response in an emergency.

52. An emergency ambulance was not called for a further 11 minutes which was an unacceptable delay. The ambulance is recorded as arriving at 11.50am, but paramedics are not recorded as on the scene until 12.01pm which is longer than we would have expected.

53. In February 2011, the Chief Executive Officer of the National Offender Management Service (NOMS, the organisation responsible for the Prison and

Probation Services in England and Wales) wrote a letter to Governors. He said that: "It should not be a requirement in every case for a member of the prison healthcare team to attend the scene before emergency services are called … The most important aspect of emergency care is that an ambulance is called in all cases where there are grave concerns about the immediate health of a prisoner". Prison Service Instruction (PSI) 03/2013 has now formalised this guidance. The instruction says that a 'Code Red' radio call should be used on discovery of blood or burn injuries and a 'Code Blue' call for respiratory issues. It directs that there should be no delay in summoning an ambulance when there are serious concerns about the health of a prisoner and an ambulance should be called by the control room as soon as an emergency medical code is called.

54. At the time of the man's death, Wandsworth operated a code 1 and code 2 call system for emergency responses. Under this system, healthcare staff would be called to a medical emergency with a full set of emergency equipment and an ambulance would be called if deemed necessary following a clinical assessment. This was contrary to the instructions in the Chief Executive Officer's letter. As the staff who found him were unable to find signs of breathing, this demonstrated, without the need for any further clinical assessment, that his health was in immediate danger. An ambulance should have been called immediately.

55. We have made recommendations to Wandsworth in previous reports that local guidance for emergency response should be updated to reflect the Chief Executive Officer's guidance and these recommendations have been accepted. After the recent instructions set out in PSI 03/2013, the prison issued updated guidance to staff on responding to emergencies in March 2013. This stated that an ambulance should be called by the control room immediately following a code 1 (now all medical emergencies) call. We are pleased that the prison is now highlighting the correct procedure for an emergency response, in line with national instructions. Nevertheless, in view of a number of concerns about emergency response arrangements at Wandsworth we believe it is important that all staff understand their responsibilities. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including:

- **Efficiently communicating the nature of a medical emergency;**
- **Bringing the relevant equipment to the scene; and**
- **Ensuring there are no delays in calling, directing or discharging ambulances.**

RECOMMENDATIONS

1. The Head of Healthcare should ensure that healthcare staff accurately record actions, in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

2. The Governor should ensure that there are sufficient up to date emergency first aid trained staff on duty to cover all wings, at all times, to provide a quick and effective response in an emergency.

3. The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

4. The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including:

    - Efficiently communicating the nature of a medical emergency
    - Brining the relevant equipment to the scene: and
    - Ensuring there are no delays in calling, directing or discharging ambulances.

ACTION PLAN: The Man – HMP Wandsworth

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that healthcare staff accurately record actions, in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.	Accepted	All healthcare staff will be reminded of the importance of accurate record keeping through the Offender Healthcare service (OHS) team email and all staff / nursing team meetings. A memo will also be sent to all healthcare staff from Head of Healthcare reminding them to record actions, in line with professional standards. This will be quality assured by the Head of Healthcare on a regular basis	November 2013 Ongoing	
2	The Governor should ensure that there are sufficient up to date emergency first aid trained staff on duty to cover all wings, at all times, to provide a quick and effective response in an emergency.	Accepted	A training programme has been established to ensure the number of staff trained in emergency aid remains above the health & safety levels for the establishment. Current numbers exceed the required minimum and ongoing training is in place. The establishment also has in place a full time trained nurse medical emergency response on duty and is on site 24/7.	Completed and ongoing	
3	The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention	Accepted.	Staff have been reminded of this responsibility via a formal Governor's Information Notice and staff briefings.	Completed	

4	The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including: • Efficiently communicating the nature of a medical emergency • Bringing the relevant equipment to the scene: and • Ensuring there are no delays in calling, directing or discharging ambulances.	Accepted	New arrangements were put in place at HMP Wandsworth which took effect from 1st April 2013. The changes were notified to all prison staff via briefings and the publication of a formal Governor's Information Notice (copy attached) which has just been re-published as a further reminder. The new arrangements were in accordance with Prison Service Instruction 03/2013 (national instruction) and covered the need to communicate an emergency situation to the control centre using a nationally agreed code system and onwards to the ambulance service without delay. Information regarding immediate access/discharging of ambulances from the establishment was also included. The code system has become quite established and is now a routine part of procedures. Ambulances are frequently called on receipt of the code being used and then stood down when not required following in-house medical assessment. The healthcare provider NHS southwest London invited a specialist medical advisory team into the establishment to review the number and location of medical emergency response equipment. Following recommendations by the team, ten emergency grab bags have been purchased and secure cabinets are now being purchased to house grab bags and site appropriately.	Completed 1 December 2013	