

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at
hospital while in the custody of HMP
Wormwood Scrubs in August 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 report of the investigation into the death of a man, who died in hospital in August 2012, while he was a prisoner at HMP Wormwood Scrubs. He was 43 years old and died as a result of a gastrointestinal bleed, caused by the perforation of a stomach ulcer. I offer my condolences to his family and friends.

A review was undertaken of the clinical care the man received at received at Wormwood Scrubs. Wormwood Scrubs co-operated fully with the investigation.

The man was remanded into custody on 10 August 2012. He was treated for alcohol withdrawal in the substance misuse unit. He had no symptoms of an intestinal ulcer until his collapse on 14 August. The emergency response was quick and effective. He was taken to hospital by the paramedics, but died shortly after.

The investigation has not identified any concerns about the man's care. We agree with the clinical reviewer that the standard of his healthcare at the prison was good and there was an appropriate medical response to his collapse. Sadly his death was neither predictable nor preventable.

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

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SUMMARY

1. The man was born in April 1969. He suffered from alcoholism and muscular dystrophy and had served several short prison sentences. He was in custody at HMP Wormwood Scrubs from 18 to 24 July 2012, when he completed alcohol detoxification. Once he was released from prison, he started drinking heavily again and did not take his prescribed medication.
2. The man was arrested on Friday 10 August and returned to Wormwood Scrubs. The reception nurse referred him to the doctor to prescribe chlordiazepoxide for alcohol detoxification medication. The doctor prescribed appropriate medication, and did not consider that he had any further immediate health needs.
3. The man was admitted to the detoxification unit. He complained of feeling dizzy on 12 August, and nurses monitored him and encouraged him to eat and drink. Later that day he appeared better and did not complain of feeling dizzy again.
4. On Monday 13 August, the doctor carried out a routine medical assessment for those receiving substance misuse treatment. The man fell over as he left the room. He was helped back to his cell uninjured, although he complained of lower back pain. At 2.45pm the next day, officers saw him lying on the floor of his cell. A locum doctor assessed him and helped him to sit up. His blood pressure was low so the doctor decided he should be taken to hospital for further assessment, but he did not regard it as an emergency.
5. While the doctor was writing a referral letter to hospital, the man lost consciousness. Officers called the doctor back, resuscitation was attempted and an emergency ambulance was called. Paramedics arrived ten minutes later, at 3.23pm, and continued resuscitation. He was taken to hospital, but later died.
6. The post-mortem examination concluded that the man died due to the perforation of a stomach ulcer. We agree with the clinical reviewer that his clinical care was appropriate and his death was neither predictable nor preventable.

THE INVESTIGATION PROCESS

7. The Ombudsman's office was notified of the man's death on 14 August 2012. The investigator issued notices informing staff and prisoners of the investigation and asking anyone with relevant information to contact him. No responses were received.
8. The investigator was given copies of the man's medical record and relevant aspects of his prison records. NHS Hammersmith and Fulham appointed a clinical reviewer to review the clinical care he received at Wormwood Scrubs. The clinical reviewer was given a copy of his medical record.
9. The investigator visited Wormwood Scrubs on 22 August 2012 to interview one member of staff, and returned with the clinical reviewer on 27 September to interview three more staff. A final interview took place in the Primary Care Trust (PCT) offices on 10 October. The investigator wrote to the Governor with feedback after the last interview.
10. HM Coroner for the Western London District was informed of the investigation and provided the results of the post-mortem investigation. The Coroner will be provided with a copy of this report to assist with her enquiries.
11. One of the Ombudsman's family liaison officers contacted the man's brother outlining the purpose of the investigation. His brother had no concerns about the treatment.
12. The man's family were informed the draft report was available, but did not wish to receive a copy or make any comment.

HMP WORMWOOD SCRUBS

13. HMP Wormwood Scrubs is a large local prison in West London. It can accommodate more than 1,200 adult male prisoners. In addition to the five main residential units, there is an induction unit, an inpatient healthcare centre, and a dedicated drug stabilisation unit.

Independent Monitoring Board

14. All prisons have an Independent Monitoring Board (IMB) made up of volunteers from the local community who monitor standards to help ensure prisoners are treated fairly and decently. In its most recent report (2011 to 2012) the IMB were concerned that an increasing number of prisoners were entering custody with alcohol misuse problems: The IMB noted "This is a growing problem within the prison. There is now one alcoholic for every two drug addicts on Methadone." The IMB reported the positive impact additional resources for healthcare had made at the prison.

Her Majesty's Inspectorate of Prisons

15. The most recent inspection of Wormwood Scrubs was an unannounced full follow-up inspection conducted in June 2011. The Inspectorate found significant improvements in identifying prisoners' substance misuse needs and co-ordinating their care. Reception and induction was described as generally appropriate, with good arrangements to ensure drug and alcohol dependent prisoners received quick treatment.
16. Primary physical care had improved as a result of effective leadership, and there was less reliance on agency staff. The Inspectorate found that most prisoners were able to see a doctor reasonably quickly.

Previous deaths at Wormwood Scrubs

17. The Prisons and Probation Ombudsman has been responsible for investigating deaths in prison custody since April 2004. The office investigated four deaths in Wormwood Scrubs in 2010, and there have been a further three deaths in 2012. There were no similarities with the circumstances of the man's death.

KEY EVENTS

18. The man was remanded to HMP Wormwood Scrubs on 18 July and was prescribed chlordiazepoxide for alcohol detoxification. He was released on 24 July 2012.
19. The man was remanded to Wormwood Scrubs again on 10 August 2012. At reception he told the nurse he was an alcoholic and had muscular dystrophy. The nurse noted that he was unkempt and unsteady. He recorded that his mental state appeared stable, but he told the nurse he was in “agony”. The nurse told the investigator that he understood him to mean general pain in his whole body, not a specific pain in his abdomen.
20. The man told the nurse that he was a very heavy drinker and normally drank ten cans of strong lager a day. When he held his arms out, he had tremors due to his withdrawal from alcohol. The nurse recalled that he answered in full sentences without wincing and could speak logically and fluently without coughing. He told the nurse that he was taking codeine phosphate (an opiate-based pain killer) and temazepam (a sedative and muscle relaxant), but had borrowed medication from a friend as he had been unable to leave his house to see a doctor.
21. The nurse said that the man refused a urine screen (to test for drugs) and complained of having hiccups since he left the prison on 24 July. His blood pressure, respiration and pulse were normal. The nurse recalled that it was not possible to take his temperature as he was coughing and retching during the assessment. The nurse referred him to the reception doctor, due to his alcoholism, muscular dystrophy and epilepsy. He noted that he should be given a lower bunk if given a double cell because of the risk of seizures associated with alcohol detoxification.
22. The reception doctor told the investigator that he could not recall the details of his meeting with the man, but said that the nurse told him that he required an alcohol detoxification prescription. He did not recall the nurse or the man talking about pain. He said that he did not think that he was coughing, or hiccupping. He told the investigator that the reference to his mental state in his note (“stable, well orientated”) suggests that he had no difficulty speaking to him.
23. The reception doctor explained that he started the man on a seven day alcohol detoxification plan, and prescribed him paracetamol (for pain relief) and carbamazepine (for seizures). He said that, at that time, he did not have any particular concerns about his health.
24. The man was given a single cell in the Conibeere unit (CBU), a 51-bed detoxification unit. He was given chlordiazepoxide every morning, afternoon and night by a nurse at the treatment hatch to relieve the symptoms of alcohol withdrawal.
25. The man saw a nurse at 2.40pm the following day (11 August). The nurse noted his alcohol use and muscular dystrophy and completed a comprehensive substance misuse assessment.

26. The man told an officer at 11.50pm on 12 August that he felt dizzy. A nurse went to his cell, took basic observations and encouraged him to eat his food and drink plenty of fluids. His pulse was recorded as high at 177 beats per minute (bpm), and his blood pressure was 116/73 (within the normal range). His vital observations were taken later in the afternoon and his pulse rate had fallen to within the normal range (89bpm), although his blood pressure was slightly high (126/84). At 3.50pm, a nurse recorded in his medical record that he was chatting to other prisoners and no longer complained of dizziness.

13 August 2012

27. On the morning of 13 August 2012, the man walked to the consulting room (opposite his cell), where a doctor carried out a routine substance misuse assessment.
28. As the man left the consulting room at approximately 11.30am, he lost his balance and fell over. He told the doctor he felt weak and could not stand unaided. He was examined and found to be alert and uninjured. The doctor told the investigator that there was no suggestion that this fall was caused by a blackout or epilepsy. He said he had painful hips and the doctor increased his pain relief.
29. The doctor said that the man did not mention pain in his abdomen, any acid taste in his mouth or indigestion, and was not coughing or hiccupping. A nurse explained that he was taken back to his cell in a wheelchair. He complained of lower back pain, but the nurse said that he seemed better by the afternoon when he got his medication, although he said he was still in pain.

Day of the incident

30. An officer saw the man lying on the floor of his cell at about 2.45pm. She asked a nurse to help, and he brought blood pressure measuring equipment with him to the cell. He was lying face down, close to the cell door and said he fell and could not get up again. He had urinated on the cell floor. The nurse asked him to roll onto his back, which he did. He then asked him to bend his knees and sit up which he did with encouragement. He eventually managed to get back to the bed, but was unable to get onto it. His blood pressure was low, he looked pale but his pulse was normal (86 bpm). The nurse asked a doctor to assess him.
31. The doctor recorded that the man was pale and sluggish. He told them that he still could not move. The doctor and nurse agreed to send him to hospital for further assessment. The doctor recorded in a statement at that time:
- “It was decided that he needed to be seen urgently in accident and emergency and that I had to write a referral letter. I came to the consulting room to put an entry on the file at about 14h54, and started writing the referral letter for accident and emergency.”
32. The nurse agreed to telephone the communications room to arrange the man’s transfer to hospital. Before making the call, the nurse asked the officer for some new clothes for him and asked another nurse to help him change.

When they reached the cell they found him gasping for breath and his eyes were rolling. He stopped breathing and had no pulse, so the nurse started cardiopulmonary resuscitation (CPR). He asked the other nurse to collect the bag of emergency equipment. At the nurses' request an officer radioed an emergency alert and asked the control room to request an ambulance. A Senior Officer wrote in his statement that the emergency alert was made at 3.11pm. The London Ambulance Service records show that the emergency telephone call was answered at 3.12pm.

33. The nurse ran to get the doctor, who was writing the referral letter to the hospital. When the doctor arrived at the cell, the nurse was continuing CPR. The doctor took over chest compressions so the nurse could attach a face mask to him to administer oxygen. A defibrillator was attached to him but it stated that no shock should be applied and staff continued CPR.
34. The ambulance crew arrived at 3.17pm and paramedics took over resuscitation. The paramedics decided to take the man to hospital at approximately 4.00pm. An officer escorted him to hospital in the ambulance. He was not restrained. The ambulance arrived at the hospital at 4.05pm and he was taken into a resuscitation ward. The officer was told by hospital staff that he died at 4.28pm.
35. An officer was appointed as the prison's family liaison officer. The man had not given any next of kin details, so the officer contacted his solicitor, who provided his social worker's details. The investigator was told that the local authority paid for the funeral. Eventually, the prison traced and contacted his brother several weeks after he died.
36. A member of the care team went to the hospital to collect the officer. The Samaritans and Listeners (prisoners trained by the Samaritans to provide emotional support to other prisoners) were informed of the man's death and two Listeners were sent to the CBU to support any prisoners who needed it. Officers reviewed those subject to suicide and self-harm monitoring procedures.

Post-mortem examination

37. A post-mortem examination was held on 17 August 2012 and concluded that the man's provisional cause of death was a gastrointestinal haemorrhage caused by a perforated duodenal (intestinal) ulcer. He also had bronchopneumonia when he died.

ISSUES

The man's presentation in August 2012

38. The man was very likely to have had the ulcer that caused his death when he entered prison on 10 August. The clinical reviewer writes:

“He did not complain of any of the classic symptoms of a duodenal ulcer; a history of periodic epigastric pain, that often wakes the patient during the night and is relieved by food, milk or alkalis. There may be black stool, nausea, loss of weight, loss of appetite and bloating of the abdomen. Alcohol is a precipitating factor in the formation of a duodenal ulcer by increasing the acid production in the stomach. Smoking is also a risk factor. In a small proportion of cases of duodenal ulcer perforation, the ulcer has been ‘silent’, meaning that it has not produced any previous symptoms. In his case the perforation of the ulcer unfortunately produced a sudden and catastrophic gastrointestinal haemorrhage.”

39. Due to the lack of symptoms, the clinical reviewer concludes that the man's fatal gastrointestinal bleed was neither predictable nor preventable:

“In conclusion the opinion of the clinical reviewer the presence of duodenal ulceration would not have been detectable unless symptoms were apparent. Therefore the fatal gastrointestinal bleed was not predictable or preventable.”

Overall clinical care

40. The man saw healthcare staff every day he was in custody. The clinical reviewer writes of the care provided:

“The clinical care concerning his physical and substance misuse needs was appropriate and the clinical decision-making and record keeping was coherent and clear. In addition the records suggest that there was compliance with all prison policies, procedures and practices.”

We agree with the clinical reviewer that his medical care at Wormwood Scrubs was appropriate.

Emergency response

41. When the doctor first examined the man, he agreed with the nurse that he needed to go to hospital. The transfer was urgent, but it was not an emergency, so an ambulance was not requested while he wrote a referral letter.
42. As soon as the man became non-responsive, an officer radioed for an ambulance. His cell was opposite the office where the emergency equipment was kept, and healthcare staff responded immediately. The clinical reviewer writes of the efforts made by the staff: “The attempted resuscitation of the man by the nurse and doctor was immediate and followed the correct guidelines of the Resuscitation Council”.

Conclusion

43. The clinical reviewer was satisfied with the man's care at Wormwood Scrubs and we agree. We do not consider the prison could have been expected to predict or prevent his death. He concluded:

“The clinical care of the man whilst he was in HMP Wormwood Scrubs was equitable with that in the wider community and in the opinion of the clinical reviewer was good.”