A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

Investigation into the death of a man in April 2010, at a local hospital, while in the custody of HMP Wandsworth

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 an investigation into the circumstances of the death of a man at a local Hospital on 26 April 2010, while in the custody of HMP Wandsworth. . The man had been diagnosed with a chronic heart and chest condition for which he was treated in prison and in the community prior to his recall to prison in October 2009. His condition deteriorated during early 2010 and a terminal prognosis was made.

I would like to offer my sincere condolences to the family of the man and to the staff and prisoners at Wandsworth who were involved in his care and affected by his death.

My colleague conducted the investigation on my behalf. A review of the man's medical care was undertaken by a doctor on behalf of Wandsworth Primary Care Teaching Trust. I am grateful to the clinical reviewer for his contribution.

I would also like to thank the Governor of Wandsworth and his staff for their cooperation. I would also like to express my appreciation and thanks to the prisoners and staff on the Onslow Unit who provided valuable information for the investigator.

My investigation has found that, overall, the man was well cared for at Wandsworth. I make three recommendations. They relate to the need to ensure that terminally ill prisoners are referred to palliative care services and that restraints are removed from terminally ill prisoners in hospital who are immobile and have a short life expectancy. A debrief for staff was not held after he died. My recommendations aside, I judge that the care the man received while at Wandsworth was appropriate, timely and equitable to that which he would have received in the community.

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 **July 2011**

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SUMMARY

The man who died was imprisoned in August 2005 and released on licence in August 2006. He was recalled to prison following a breach of his licence conditions in October 2009. He died from right sided heart failure due to lung disease (core pulmonale).

While in the community, the man's doctor referred him to hospital as an emergency because he complained of shortness of breath and chest pain. The hospital discharged him on 10 February with a diagnosis of infective chronic obstructive pulmonary disease (COPD[1]) with future treatment planned for his heart condition. His condition was managed on the Onslow Unit with oxygen in his cell, support from the disability orderly and regular visits from healthcare. (A disability orderly is a trusted prisoner who is responsible for assisting disabled prisoners with everyday tasks such as cleaning cells and collecting meals for them.)

In late October, the man was recalled to prison. He was taken to HMP Wormwood Scrubs where, following an initial routine reception healthscreen, he was immediately admitted to the healthcare inpatient unit for observation because of his poor mobility and breathing problems.

Medical and healthcare staff contacted the man's doctor and the hospital for further information on his medical history. In the meantime, he remained on the healthcare unit, took his medicine and was discharged to a residential wing on 6 November 2009. He transferred to Wandsworth on 19 November 2009.

In January 2010, the man was sent to hospital as an emergency because he complained of shortness of breath and chest pain. The hospital discharged him on in 10 February with a diagnosis of infective chronic obstructive pulmonary disease (COPD) and arranged future treatment for his heart condition. His condition was again managed on the Onslow Unit with oxygen in his cell, support from the disability orderly and regular visits from healthcare staff.

The heart procedure was carried out in early April, but other serious conditions were identified with a plan for him to attend a follow-up clinic in 12 weeks. The hospital discharge letter dated 9 April suggested that he would benefit from the help of the palliative care team in the management of end stage COPD.

The man was sent back to hospital on 16 April with breathing difficulties and discharged back to the prison on 24 April. Nursing staff were called to the wing on 26 April because he was again experiencing severe difficulty breathing. He was sent to the local hospital as an emergency. Hospital staff advised the prison to contact the man's next of kin who arrived at around 1.00pm. Sadly, despite the efforts of staff, he died later that day.

[1] Chronic obstructive pulmonary disease is lung disease such as emphysema

The clinical reviewer has judged that the man suffered from chronic lung disease for which he received appropriate treatment. The prison managed his condition and hospital referrals were made when necessary. The clinical reviewer makes one recommendation regarding the lack of a timely referral by the prison to the palliative care team which I endorse. I make two further recommendations. The first relates to removing restraints from prisoners in hospital who are immobile, have a terminal condition and a short life expectancy. The second relates to the need for a hot debrief at the first opportunity after an emergency. There is no evidence that a hot debrief was held for staff to raise any concerns with senior managers or to ask for support from the prison care team.

INVESTIGATION PROCESS

1. The man who is the subject of this report died on 26 April 2010 at 4.05pm. This office was notified of his death on the same day at 4.50pm. Terms of reference and notices were issued to staff and prisoners at Wandsworth telling them that an investigation would be taking place, and inviting those with relevant information to contact the investigator. The investigator requested copies of his core record, clinical record, and other records relevant to his time in custody and his death. Two prisoners wrote to my investigator.

2. The investigator also contacted HM Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. The Coroner's Officer told my investigator that the man died of:

   1a Core pulmonale[2]

3. My investigator visited Wandsworth on 25 May and 16 September. She spoke with liaison staff and the family liaison officer, the Reverend. She also spoke with prisoners and staff on the Onslow Unit who knew the deceased.

4. A clinical review of his medical care was commissioned from Wandsworth Primary Care Teaching Trust and undertaken by a doctor from the local community. The doctor focussed on the clinical care the man received at Wandsworth.

5. One of my family liaison officers spoke with the man's daughter. She explained the purpose of my investigation and provided his family with an opportunity to ask any questions about the care he received in prison. The man's daughter said that she felt her father had been well cared for at Wandsworth. He appeared to receive appropriate and timely healthcare and was taken to attend hospital appointments, as required, without hesitation. His daughter spoke regularly with her father who was always very positive about the treatment he received and told her he was being well looked after. She felt her father had adapted well to prison and enjoyed a good rapport with prisoners and officers alike. The man's daughter also spoke very positively about the support she received following her father's death, particularly from the prison chaplain.

6. The man's daughter said that her only concern was that her father remained restrained, while in outside hospital, until shortly before his death and she questioned why this was. Although she understood the need for security she felt, given her father's age and deteriorating health, that it was unnecessary and inappropriate. She said this had caused her family significant distress. I hope that my investigation addresses her concerns.

[2] Core pulmonale is right sided heart failure due to lung disease.

7. The man's daughter received a copy of my draft report as part of the consultation process. In her response, she said the most significant concern for her and her family remained the prolonged and unnecessary use of restraints prior to her father's death. She agreed with the recommendation about this and hopes this will lead to improved practice in this area for the benefit of other prisoners.

HMP WANDSWORTH

8. HMP Wandsworth is a category B[3] male prison located close to a residential area of London. It houses remand, recalled and sentenced prisoners and has a high percentage of foreign national prisoners. It is the largest prison in the United Kingdom and has the capacity for 1665 men.

9. HM Inspectorate of Prisons most recent inspection was in June 2009. The resulting report was critical of a number of aspects of Wandsworth's functions. At the time of the inspection, the prison had 217 prisoners over the age of 50 and 20 over 70 years. The prison worked with the Age Concern charity to develop services for an older population.

10. The Independent Monitoring Board for England and Wales (IMB)[4] Annual Report for the period June 2009 to May 2010 raises a variety of concerns. They include staff shortages and difficult relationships between staff and prisoners leading to an increase in incidents. There were improvements in the overall running of the Onslow Unit, but a lack of staff and an increase in older and disabled prisoners on the unit was an issue.

11. The man who is the subject of this report was accommodated on the Onslow Unit, a 360 place unit for vulnerable prisoners[5]. Older prisoners on the unit are placed on the second floor of the wing as this is nearer to the staff. There are two healthcare emergency equipment bags held in the prison and one of these is on the Onslow Unit. The other is on the A wing Heathfield Unit. There are two disability orderlies who are prisoners who help less able prisoners by cleaning their cells and collecting their meals.

12. 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.

13. My investigator spoke with Head of Healthcare. He said that inpatient mental health services were provided by South West London, and St George's NHS Trust but there was no provision for inpatient care for prisoners such as the man

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[3] Prisoners are categorised. On arrival into prison, prisoners are risk assessed and given a category based on their offence and the risk that they pose to the public should they escape. Category B prisoners are those for whom the highest security conditions are not necessary but for whom escape must be made very difficult.)

[4] The Independent Monitoring Board comprises volunteers from the community. They monitor daily life in prison to ensure that decency is maintained, deal with prisoners' complaints and submit an annual report to the Secretary of State for Justice.

[5] Vulnerable prisoners are those who ask to be segregated for their own protection, for example, if they fear for their safety because they have committed an offence of which other prisoners might disapprove or have accumulated debts.

with physical illness. In addition to nursing staff, there is one full-time prison doctor. General practitioner (GP) sessions are run regularly on each wing, with an out of hours service by the local community service provider.

14. The Inspectorate found that a number of vacancies had led to the overuse of agency and bank staff with a number of outside hospital appointments being cancelled. The Head of Healthcare said that the prison was actively recruiting medical staff but there were difficulties in recruiting and retaining staff. This had led to the high dependency on agency staff. Regular clinics such as dentistry, podiatry and an optician were also held. He also said that the prison had not addressed the issue of caring for elderly prisoners, however they were currently developing an end of life policy with the local hospital and a monthly liaison meeting was already in place.

15. The Prisons and Probation Ombudsman was tasked with investigating deaths in prison custody in 2004. Since then, there have been ten 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.

KEY EVENTS

16. The man was sentenced in August 2005. He received a two year prison sentence, plus a two year extended licence[6] on release. He was released from HMP Littlehey on licence in August 2006.

17. In October 2009, while living in the community, he was referred to a hospital in his local area by his general practitioner.. At the hospital appointment, he told a consultant at the General Medicine and Care of the Elderly Unit, that he had experienced shortness of breath for the past two years and could only walk 20 yards without stopping. He had been in hospital for about six weeks in 2008 and given inhalers on the assumption that he was asthmatic. The consultant concluded that the man's breathlessness was related to atrial fibrillation[7], possible heart failure and high blood pressure. He felt that an electrocardiogram[8] (ECG) should be carried out and that he would benefit from oxygen therapy. He was given a follow-up appointment for two to three weeks later.

18. Later in October the registrar to the consultant, referred the man to a doctor. . She asked the doctor to see the deceased urgently because of his longstanding breathing problems and possible heart condition. She also asked for guidance as to further investigations, managing his condition and his suitability for home oxygen.

19. On 29 October, the man breached the terms of his licence. He was immediately recalled to prison and taken to HMP Wormwood Scrubs. This meant he was unable to attend his doctor or go to hospital appointments in the community.

HMP Wormwood Scrubs

20. When he arrived at Wormwood Scrubs, he was seen by healthcare staff in the early evening on 29 October as part of the reception process. The investigator noted good quality completion of the First Reception Healthcare Screen with a clear care plan.

21. As part of the reception process, a Cell Sharing Risk Assessment form (CSRA) was completed the same evening. (This assesses a prisoner's suitability and potential risk of harm to another prisoner when sharing a cell.) The man was assessed as a medium risk of harm to others. However, the situation would be regularly reviewed. He was assessed as suitable to share a cell as long as he was on the ground floor of a wing (because of difficulty with the stairs) and not

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[6] An extended licence is given to those who are considered to pose a higher risk than most offenders and need a lengthier period of supervision by Probation Trusts to complete work with Offender Managers to reduce risk of harm to others and of re-offending. This is particularly important if offenders do not undertake offending behaviour courses in prison for whatever reason.

[7] Atrial fibrillation is a particular type of very fast heartbeat.

[8] An electrocardiogram is a test that measures the electrical activity of the heart.

sleeping on the top bunk bed. However, the man identified a prisoner who he was happy to share with and in those circumstances he accepted the top bunk.

22. The First Reception Healthscreen document evidences that the man told the healthcare worker that he had seen a doctor a month earlier because of a breathing problem. He had also undergone an ECG at the hospital he previously attended in his local area because of heart problems the day before his recall to prison and was awaiting a further appointment. His medication at that time included bendroflumethiazide[9], warfarin (to prevent blood clots) and digoxin (to treat heart conditions). He did not have any physical injuries, however, he was concerned about his health as he was breathless and blue (cyanosed). The healthworker observed that generally that he was unfit, with poor mobility and laboured breathing. He was referred to the doctor.

23. Staff assessed the man as requiring admission to the inpatient healthcare unit from reception. This was for a medical assessment because of his history of chronic obstructive pulmonary disease (COPD) and the medication he was taking. An Inpatient Admission Sheet to the prison healthcare unit was completed. The man's clinical observations at the time included pulse, blood pressure, height and weight and respiration. His mood was described as "depressed". He was able to care for himself and walked with the aid of a stick.

24. Handwritten notes in the clinical record confirm that he went to the inpatient centre directly from reception. An entry dated 30 October (the following day), said that the man told staff that he and his doctor had discussed having oxygen supplied to him at home because of his breathing problems. He had smoked around 60 cigarettes a day in the past but had given up smoking.

25. A care plan showed that his breathing was to be monitored. Nursing action would be to establish a good patient/nurse relationship with a review on 6 November. The man would be encouraged to sit or lie down to allow him to breathe properly and tight clothing was not encouraged. He was to be monitored daily until he was judged to be stable in respect of his medication and heart problem.

26. On 30 October, a prison doctor assessed the man. The doctor noted that he was cyanosed, there was "clubbing"[10] and his face was grey. The doctor rang his community doctor for further information about whether he had been hypoxic[11] in the past. The doctor confirmed this. The doctor rang the hospital previously attended in his local community the same day for further information. He spoke with a member of the medical staff who had agreed to respond to him within the hour once he had read the clinical notes. However, the hospital did not call back.

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[9] Bendroflumethiazide is used to treat high blood pressure.
[10] Clubbing is a condition in which the ends of toes and fingers become wide and thick; a symptom of heart or lung disease.
[11] Hypoxic means inadequate oxygen reaching the body's tissues.

The prison doctor spoke with the man who told him that his condition had not deteriorated in the last few months.

27. Throughout his stay in the healthcare centre, the man was considered by staff to be pleasant, he ate well and took his medication. His international normalised ratio[12] (INR) was checked on 2 November. Staff continued to monitor him throughout his stay.

28. On 6 November, the man's condition was assessed as stable and he was fit to be discharged to the wing. A Cell Sharing Risk Review was carried out the same day by a wing officer. He was assessed as a medium risk of harm to a cellmate. He told staff that he felt vulnerable due to his offence but was willing to share with trusted prisoners. Although he had a single cell while in healthcare, this could be reviewed after he had settled on to the wing. He transferred from the healthcare centre to the First Night Centre on 8 November when his bed was needed for another prisoner who had to be placed on overnight observation.

29. A week later, on 13 November, the man made an application to be segregated from other prisoners because of the nature of his offences. He asked to be located in a vulnerable prisoner unit as he feared for his safety if placed in a cell on a normal wing. Documentation authorising that he could be held in the segregation unit was completed and showed that he was held there pending a space in the healthcare centre. He was to remain in the segregation unit until 16 November when a review would be held to decide whether segregation would continue. Records show that he transferred to HMP Wandsworth on 19 November.

30. The computerised clinical record held at Wandsworth shows that the man was assessed as suitable for sharing a cell. No immediate medical action was necessary but he was referred to another prison doctor.

31. On 25 November, the Parole Board reviewed his case and were unable to recommend release. The National Offender Management Service (NOMS) emailed the prison and the London Probation Trust asking for information to help the Recall Team in the Public Protection Casework Section consider whether his risk of harm and of re-offending had reduced sufficiently to allow release again into the community. This information was needed by 11 June 2010 which was when he was next due to be reviewed.

32. The man's personal officer made an entry on his wing history sheet on 11 December confirming that he was sharing a cell with another prisoner. The officer said there were no problems and that he had settled in well to the wing routine.

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[12] International normalised ratio is used to assess the clotting ability of blood. This is particularly relevant in the case of those patients who are taking Warfarin, a drug to thin the blood.

33. In speaking with the investigator, the man's personal officer recalled that he generally stayed in his cell or sat outside it in the corridor so that he could socialise with others. She remarked that he had obvious breathing difficulties but she never heard him complain and, in her opinion, he was resigned to his illness.

34. On 20 January, the man was awaiting an urgent appointment for the chest clinic at the hospital. He had asked for oxygen and healthcare staff told him that he would need an assessment at the chest clinic to determine whether he met the criteria for having oxygen in his cell. The healthcare worker said that he would pursue the urgent appointment with the healthcare administration staff. The man went to the local hospital for an appointment on 26 January.

35. He was admitted as an inpatient and a nurse spoke with the hospital who said they would telephone back to confirm the diagnosis. The investigator spoke with the nurse who said that the man's condition had raised some concerns at the hospital and so doctors decided to admit him. He returned to the prison later that day but without a discharge letter. A doctor typed in the clinical record that he would telephone the hospital the following day because he had been treated in the resuscitation unit.

36. The man was admitted to the local hospital, two days later on 28 January suffering from shortness of breath and chest pain on exertion. He was diagnosed with infective COPD. He would need a left heart catheterisation in the future and a Professor's team would perform a right heart catheterisation. The man was to attend the Professor's clinic in 4 weeks. His daily medication comprised:

- warfarin
- digoxin[13]
- paracetamol
- omeprazole[14]
- irbesartan[15]
- diltiazem[16]
- Gaviscon
- tiotropium inhaler[17];
- simvastatin
- aspirin; prednisolone[18]
- co-amoxiclav[19]
- amoxicillin

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[13] Digoxin is for heart failure.
[14] Omeprazole is for excess stomach acid.
[15] Irbesartan is for the treatment of hypertension.
[16] Ditiazem is for hypertension, angina or heart failure.
[17] Tiotropium is for COPD
[18] Prednisolone is for allergies.
[19] Co-amoxiclav is an antibiotic.

He was discharged from hospital on 10 February and returned to the Onslow Unit.

37. On 19 February, a list of medical recommendations included a bed board and an extra pillow to help with the man's breathing. An entry in the wing history sheet by his personal officer showed that he was allocated in a single cell because he had an oxygen machine and it was in constant use. Wing staff also recorded that he was polite and spent his time in the day room.

38. Cell sharing risk assessment (CSRA) reviews were carried out on 26 February and 16 March in order to assess whether he posed a risk of harm to his cellmate while using oxygen, as he was now sharing a cell. A note was made on the CSRA review on 16 March that healthcare staff should update the assessment.

39. The wing observation book showed that the man's cell door should remain unlocked between 8.00am and 8.00pm to allow the disability orderly access to the man and because of healthcare concerns. On 2 April, the nurse checked on the man and found his condition "stable". She advised him to press his cell bell immediately if he felt unwell.

40. The man went to court on 15 March for a hearing regarding a Sexual Offences Prevention Order. The Application for Production of Prisoner form completed by the prison on 5 February highlights that wheelchair access was needed and this had been arranged with the court manager by the prison. (This was sensitive to the man's needs and good practice.)

41. A prisoner friend of the man, recollected that he went blue when he went out to court. In an earlier letter to the investigator, the prisoner friend said he believed that Wandsworth did all it could for the man and he appreciated their help.

42. The prisoner friend was allocated in the cell next door to the man's and would speak to him for about half an hour a day. He said that he felt a certain amount of respect for him as he had been in the armed forces. He described the man as "in a state" and said that he "went blue" on two occasions and the prisoner friend went for help. He said he helped the man where he could. He praised the nursing staff and confirmed that he never complained.

43. On 2 April, a healthcare worker went to the man's cell to help him with his personal care. He did not want help to wash and dress but needed someone to help him to remove and then replace the oxygen after he had washed himself. He was embarrassed at having help with his personal care from female staff. While encouraging him to keep his independence, the healthcare worker made it clear that help was available if he needed it.

44. The investigator spoke to a prisoner and the wing disability orderly. The prisoner and wing disability orderly said there were two orderlies available on the Onslow

Unit. They had completed an approved cleaning course and help with cell cleaning. Prisoners such as the man who need help, complete a self-referral form. the prisoner and wing disability orderly said that, while encouraging prisoners to do as much as they can, the orderlies help with tasks such as collecting meals and cleaning cells. They do not collect medication and are not allowed to help with personal care.

45. An entry in the clinical record on 8 April showed that the man had returned from hospital and mentioned the contents of the discharge summary. However, there is no record to show when he had been taken to hospital. The following day, the oxygen concentrator arrived and after initial problems using it, the man did not appear to have contact with healthcare until 16 April when he was sent to hospital again with breathing difficulties. The nurse spoke with a nurse on Amyand Ward the same day. The nurse said that the man was very unwell and had been diagnosed with end stage COPD. The hospital had referred him to the palliative care service.

46. A cardiothoracic operation note also dated 8 April, explained that he had undergone cardiac catheterisation. There would be a follow up clinic with the Professor in chest clinic in 12 weeks. Other serious conditions identified were a previous stroke (paralysis affecting one side of the body) and COPD.

47. The discharge summary letter dated 9 April from Registrar in Respiratory Medicine confirmed that the man had undergone a catheterisation procedure to the right side of his heart. The Registrar in Respiratory Medicine observed that it seemed he did not have the same levels of oxygen available to him in prison as he did in hospital and this should be corrected. They said that the palliative care team could help manage the end stage COPD. There is no evidence that a referral was made to the palliative care team.

48. On 8 April, a respiratory nurse at the prison wrote to the hospital formally asking for an increase in the oxygen to five litres, with a plan to increase this to six litres when the hospital could arrange for the oxygen company to deliver another container.

49. The man was discharged back to the prison on 24 April, and a humidifier[20] was in place in his cell. The hospital said they would contact the prison with a discharge plan once the medical team had been consulted. The doctor on duty saw the man at the prison on the same day. He noted that he was to attend a chest clinic at the hospital in four weeks.

50. On 26 April, at around 7.00am, the nurse received an emergency call from the prison control room to go to the Onslow Unit. The nurse told the investigator that she had met the man on two or three occasions previously and knew that he was physically frail with chest problems. She arrived at his cell to find that he was

[20] A humidifier is a device for increasing humidity in a room.

very blue. He had oxygen in place but was having extreme difficulty breathing. She carried out clinical observations and he responded to her at times but she was unable to take his blood pressure. She said that it was obvious by looking at him that he needed to go to hospital for intensive treatment. She asked the officers to call for an ambulance. The telephone log shows that control room staff called an ambulance at 7.20am. They gave an update to the ambulance crew at 7.27am on the man's breathing, heart rate and colour. The ambulance crew arrived and administered Atrovent[21] and a salbutamol nebuliser.

51. The nurse told the paramedics that the man had experienced a bout of diarrhoea. Nursing staff at the hospital telephoned the prison and asked how long he had been suffering from this because he had told them he had had it for a while. She explained that he had only been back in the prison for the past 48 hours and nothing relating to that had been observed.

52. Prisoners are normally searched before they leave the prison to go to hospital. However, the Person Escort Record (PER) shows that the man was not searched before he went into the ambulance at 7.50am because he was very ill and unable to respond. However, he was placed in a single cuff restraint and accompanied by two prison officers. The ambulance left the prison at 7.59am arriving at the local hospital at 8.06am.

53. The PER shows that at 8.25am, nursing staff suggested that the prison contact the man's family to tell them that he was poorly. However, by 11.30am, he was responding to treatment. The man was wearing restraints at the hospital which were removed for treatment at the request of the hospital staff. They were reapplied following treatment and he was moved to Amyand ward.

54. An operational manager gave permission for the man's daughter to visit him in hospital. The Reverend was appointed as family liaison officer and she contacted his daughter to tell her that he had been re-admitted to the local hospital, and medical staff had asked her to contact his next of kin. The Reverend gave her the hospital telephone number so that she could contact them directly.

55. The PER shows that the family visited at 1.00pm. Escort staff contacted the prison and asked for permission for the restraints to be removed at 3.40pm because his condition had deteriorated and the doctors needed to attempt resuscitation. Despite their efforts to resuscitate him, he was pronounced dead at 4.03pm that day. His family were with him at this time.

56. The Reverend met the man's daughter at the hospital at 4.55pm. She offered support and help to answer any questions the family had about what would happen next. The man's daughter spoke very positively about the support she received following her father's death, particularly from the Reverend.

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[21] Atrovert is used with an inhaler.

57. Prisoners told the investigator that they had felt supported by staff. There is no evidence of a hot debrief. This would have given those involved in the emergency and the escort officers the opportunity to raise any concerns about the man's death and seek support from the prison care team if they needed it.

ISSUES

Clinical care

58. The clinical review was undertaken for Wandsworth Teaching Primary Care Trust. This would review the clinical management of the man's chronic lung condition and has judged that, overall, his condition was managed appropriately and he received the correct medication.

Referral to the palliative care services

59. The Clinical Reviewer makes one recommendation. This refers to the prison's apparent failure to refer the man to a palliative care team when he was released from hospital on 8 April 2010. The discharge letter from the hospital dated 9 April said that he would benefit from the support of the team. However, no referral was made and the man did not receive their help and advice.

60. An entry in the clinical record dated 16 April, some eight days later, suggests that he was re-admitted to hospital and a telephone conversation took place between a member of the healthcare staff and the hospital. The hospital had diagnosed the man with end stage COPD and they referred him to the palliative care service as there were no plans for him to be discharged back to the prison at that stage.

The Head of Healthcare should ensure that healthcare staff take responsibility for referring prisoners diagnosed with end stage illness to palliative care services in an appropriate and timely manner.

Use of restraints

61. The use of restraints is a judgement made by the prison based upon a risk assessment. However, in the man's case, the decision appears to me to have been risk averse. He had severe mobility problems and was extremely limited in his ability to care for himself. I question whether he was physically capable of escaping and consequently whether the use of restraints at the hospital was appropriate. I am pleased to note that escort officers initiated the process for the removal of restraints on two occasions on the day he was admitted to hospital and subsequently died. However, I am disappointed that they were reapplied and were still in place when his family arrived. They were only removed later that afternoon for medical treatment.

62. The hospital discharge letter of 9 April and an entry in the clinical record on 16 April shows that his condition was terminal and that he was dying. I am conscious that protection of the public is paramount, nevertheless, I judge that on 16 April, when his prognosis was certain, restraints should not have been used.

The Governor should ensure that restraints are removed at the earliest opportunity, particularly following a diagnosis of terminal illness when the prisoner is immobile and has a very short life expectancy.

Hot debrief

63. There is no evidence that a hot debrief for staff was held after the man died. Prison Service Order (PSO) 2710 paragraph 5.3 instructs that there must always be a hot debrief immediately after this type of incident and provision should be made in local contingency plans. This is not optional. A senior member of staff must act as debriefer and a duty care team member must also attend.

The Governor should ensure that a hot debrief is held in accordance with PSO 2710, at the first opportunity after a death in custody.

CONCLUSION

64. When the man was recalled to prison in October 2009, he was in poor health with a chronic lung condition and heart problems. He died six months later and his death, although sudden, was not unexpected.

65. The clinical reviewer has judged that, overall, the care he received was appropriate. However, we have made a recommendation about palliative care. Further recommendations relate to the absence of a hot debrief to support staff and to see if lessons could be learned from the management of the emergency which preceded his departure to hospital and eventual death and the use of restraints in hospital.

66. My recommendations aside, I judge that the care the man received was comparable to that which he would have received in the community.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that healthcare staff take responsibility for referring prisoners diagnosed with end stage illness to palliative care services in an appropriate and timely manner.

   "Partially accepted. The service is normally provided by main stream NHS facilities when a patient is identified in the outside hospital setting as requiring palliative care.
   Healthcare in the prison will however, if required, make a direct referral to this service. Robust links have been made with prison healthcare and both the palliative care teams to ensure appropriate and seamless service delivery. It is unclear why the consultant did not refer the man to a palliative care service directly in this instance; patients who are referred to this service do occasionally return to the prison environment. In the past, the palliative care team have contacted the prison directly to maintain contact."

2. The Governor should ensure that restraints are removed at the earliest opportunity, particularly following a diagnosis of terminal illness when the prisoner is immobile and has a very short life expectancy.

   "Partially accepted. I accept in principle with this recommendation. Each case is individually assessed accordingly but in this specific instance a risk assessment was conducted and initial application of restraints was based on a number of factors, not least of these was that the man was charged with a serious sexual offence against a minor. Our duty to protect the public (and especially children) in a public ward of a busy hospital has primacy over other considerations. The subsequent removal of the restraints was reflective of the consideration given to his final hours of life."

3. The Governor should ensure that a hot debrief is held in accordance with PSO 2710, at the first opportunity after a death in custody.

   "Partially accepted. A hot debrief was held with a duty manager however, there was no attendance from PICT (due to it being late in the evening when staff returned and them wanting to go home). The officers were informed who to contact/ speak to if they needed any further support. In future we would ensure that in the situation where it is not feasible for PICT to attend, that this should be chased up via the PICT team the following day."