

**Investigation into the circumstances surrounding the
death of a man at hospital, while a prisoner at HMP
Wandsworth, in April 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, a prisoner at HMP Wandsworth, in April 2010. He was 49 years old and had been in custody since 4 June 2008 after he had been recalled from licence.

He was in poor health before he went into custody and during previous prison sentences. In total, he had suffered five previous heart attacks and, as a result, was scheduled to undergo a quadruple heart bypass operation. The operation took place on 28 April 2010. Unfortunately, he developed complications and his condition deteriorated. He was pronounced dead by medical staff and his family were with him when he died. I would like to offer my condolences to the family and friends for their loss.

An investigator conducted the investigation. I would like to thank the Governor of Wandsworth and his staff for their co-operation and assistance with the investigation. Particular thanks go to those responsible for making the practical arrangements for the investigator.

The local Primary Care Trust (PCT) was asked to conduct a review into the standard of healthcare given to the man while in custody. A clinical reviewer was appointed to conduct the review. Like the clinical reviewer, I am satisfied that the man's clinical care was equivalent to what he would have received in the community. I particularly note the efforts made by healthcare staff to retrieve his old hospital records which helped to ensure that his treatment was followed up appropriately.

The investigation and clinical review has found that the man's care was thorough and appropriate. No issues have been identified and accordingly, I make no recommendations as a result of this investigation.

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

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SUMMARY

The man was remanded into custody at HMP Highdown on 4 June 2008, having been recalled to prison following a breach of his licence. He had previously served several periods of custody and been released from HMP Wandsworth within the last six months. He was 49 years old when he died.

When he arrived at Highdown, staff completed an initial health screen and a second screening took place the following day. It was recorded that he had experienced five previous heart attacks and undergone cardiac surgery. In addition to his heart condition, he was diagnosed with hepatitis C and had been under the care of a hospital for his liver problems and another for his cardiac treatment.

Following his reception, staff tried to obtain his previous medical notes from both hospitals, but there was no response to their initial requests. However, the prison continued to follow this up and he was eventually seen by a liver specialist in November 2008.

A couple of weeks after attending this appointment, the man transferred to HMP Wandsworth as he was attending court within that area. Wandsworth continued to pursue the medical notes from the hospital, which were eventually received together with notes from the second hospital. He began attending regular appointments at both hospitals in January 2009.

The man's heart problems meant that he would require further surgery in the form of a quadruple heart bypass operation, as well as treatment for his liver disease. Treatment for his liver condition was affected by his heart problems and it was considered that the heart operation should take place before further treatment would be given. His liver condition also increased the risks of major surgery and the two hospitals worked together to ensure that these risks were minimised. He was aware of the risks posed to him by having major surgery, but was keen for the operation to be carried out.

He was admitted to hospital on 12 April 2010 and the operation took place on 28 April. However, as initially feared, there were complications during the surgery. He had a further operation on the morning of 29 April, following which he remained heavily sedated and in a critical condition. The doctors told prison staff escorting him and his family that he was unlikely to survive. Sadly, he died with his family at his side.

Following his death, prison staff went to the hospital and spoke to his family. They maintained contact regarding the arrangements for the funeral and a memorial service, as well as the return of his property. Staff who escorted him during his stay in hospital were offered support.

I am satisfied that both prison discipline and medical staff handled his care appropriately. Neither I, nor the clinical reviewer, make any recommendations.

THE INVESTIGATION PROCESS

1. Notices informing both staff and prisoners of the investigation were issued on 29 April. They invited anyone who had information about the man's death to contact the investigator. No responses were received.
2. The investigator contacted the prison on 29 April to inform them that he had been appointed as the investigator and arrange for the necessary documentation to be made available. He followed this up by visiting Wandsworth on 5 May, where he met the Safer Custody Manager and collected the documentation relating to the man.
3. No formal interviews were conducted with staff in relation to the man's death, but the investigator did speak with a nurse who had known him and been involved in his treatment at Wandsworth.
4. The local Primary Care Trust (PCT) was commissioned to conduct a review of the medical care that the man received in custody. The PCT asked the clinical reviewer to conduct this review. He had ongoing chronic medical conditions, and as such had regular contact with healthcare while in custody. I would like to thank the clinical reviewer for his report.
5. Wandsworth provided the investigator with details of the man's next of kin. One of my family liaison officers (FLO) wrote to his sister on 12 May, to advise the family of the investigation and the role of the Ombudsman. Another FLO has since taken over the role. This report will be made available to the family.
6. The investigator contacted HM Coroner to inform him of the nature and scope of the investigation and to request a copy of the post mortem report. This was kindly provided and indicated that the cause of the man's death was a heart attack.

HMP WANDSWORTH

7. Wandsworth is one of the largest prisons in Western Europe. It was first opened in 1851. It has the capacity to hold over 1,400 prisoners and a recently-opened refurbished wing has added extra cells.
8. The prison has 24-hour healthcare cover. There is at least one doctor on site until 10.00pm, as well as on-call cover out of hours. However, the doctors act as general practitioners (GPs) and do not necessarily expect to respond to emergencies. Hotel Three is the radio call sign for staff to attend any emergency response in the prison and is taken on rota by medical staff. Until recently the healthcare at Wandsworth was provided by Secure Health, however their involvement has now ceased and responsibility has transferred back to Wandsworth PCT.
9. The most recent inspection of Wandsworth by HM Chief Inspector of Prisons was a full follow-up inspection in July 2006. The report published following that inspection does not touch on any of the issues raised in this investigation.
10. Each prison in England and Wales has an Independent Monitoring Board (IMB) responsible for monitoring day-to-day life in the prison and ensure that proper standards of care and decency are maintained. The last report published by the IMB at Wandsworth, before the man died, does not raise any issues of relevance to this investigation.
11. Since the Ombudsman was given responsibility for investigating deaths in Prison custody in 2004, there have been ten previous deaths at Wandsworth attributed to natural causes. Recommendations made following previous deaths have not been found to relate to this investigation.

KEY FINDINGS

12. The man was an offender who had breached his licence and was recalled to prison for a violent offence on 4 June 2008. (Once released on licence, a prisoner can be recalled to prison at any time if they breach the conditions in their licence, for example by committing a further offence.) He was 48 years old. Following his appearance at court, he was remanded to HMP Highdown. He had been in custody on a number of occasions before and had been released from HMP Wandsworth within the last six months. He was therefore familiar with the reception process.
13. While in reception, a nurse assessed him and completed a health screen. The nurse recorded previous drug and alcohol use in addition to a medical history that included five previous heart attacks. He told the nurse that he had his first heart attack aged just 31, and had also had two operations at hospital to insert coronary artery stents. (Coronary artery stents are small, self-expanding, stainless steel mesh tubes that are placed within a coronary artery to keep the vessel open.) His last heart attack had been when he was 42 years old. He told the nurse that he had missed his last appointment at hospital, scheduled for 7 May 2008. This appointment had been arranged shortly before his last release from HMP Wandsworth.
14. As well as recording his chronic conditions, the nurse also noted that he suffered from psoriasis (a skin condition). He was provided with treatment for alcohol detoxification and the nurse recorded that other medication should continue with information to be requested from both treating hospitals.
15. A well man assessment was conducted on 5 June. (A well man clinic is provided in some prisons and provides advice on various conditions, in addition to smoking cessation and other health promotion.) In addition to the information given during the initial health screen, the nurse recorded that the man was a smoker who was interested in stopping. He also said that he had a family history of heart problems and that he was hepatitis C positive. (Hepatitis C is an infectious viral disease affecting the liver.) The hospital was also contacted to obtain previous notes but no reply was received. A note was made to continue to try to obtain these.
16. The man was examined by healthcare staff in late June for an abscess on his right thigh and treatment was given. He also attended a number of follow up appointments. On 12 August, officers asked a nurse to check him, as he appeared unwell in his cell. The nurse recorded that he was unable to sit up but was aware of his surroundings. His blood pressure and pulse were normal, but the nurse referred him to the GP.
17. A prison doctor assessed the man later that day and recorded that he was "quite sluggish", but was not in pain. The doctor said that the nurse had told him that his pupils were very small when she had examined him, and he had been asked for a sample of urine, but this had yet to be provided. The doctor noted the previous history of substance misuse and cardiac problems. He recorded that he required an electrocardiogram (ECG) and a further review

when the results were available. (An ECG measures the electrical activity of the heart.) He also instructed that the previous notes from the hospital should be obtained before this review. (It is apparent that the prison had attempted to obtain previous history from both treating hospitals when he arrived at Highdown, but nothing had been received.) He gave consent for his previous medical notes to be obtained from both hospitals.

18. The man was due in court the following day, 13 August, but due to receiving ongoing treatment, a nurse asked for him to be placed on “medical hold”. (Medical hold is the term used when a prisoner is receiving treatment in a particular prison and a transfer to another prison might prove detrimental to the delivery of that treatment. He was attending court outside the catchment area of Highdown and this would normally result in him being taken to another local prison following his court appearance. The medical hold would ensure that he returned to Highdown.)
19. The further request for hospital records resulted in a letter from the hospital detailing the man’s previous appointment in February 2008, while he was still at HMP Wandsworth. The letter, from a hospital doctor, informed his colleague, a cardiology consultant, that there was a high risk that the man might have cirrhosis, and requested that he see him before any treatment was started. (Cirrhosis is the scarring of the liver caused by injury or long term illness.)
20. Following receipt of this information the locum GP at Highdown wrote to the liver unit at the hospital asking if they would see the man.
21. A hospital doctor reviewed the man in the Viral Hepatitis Clinic at the hospital on 11 November. In a follow up letter, he said that the cirrhosis highlighted on the earlier biopsy made planning antiviral therapy urgent. However, his history of heart problems could pose a problem to this treatment. The doctor added that he would write to the cardiologist at the second hospital for an update on his cardiological status. Highdown had still not received any reply from that hospital to their requests for information.
22. Despite the earlier medical hold, the man eventually transferred to HMP Wandsworth on 25 November 2008. The reason for the transfer was to make it easier for him to attend court as it was within the area covered by Wandsworth. He was known to the nursing staff at Wandsworth.
23. In view of his medical history, on his reception at Wandsworth he was assessed by a prison doctor, who recorded that he had hepatitis C and was also awaiting a coronary angioplasty at hospital. (Coronary angioplasty is a procedure to treat the narrowed coronary arteries in the heart, often as a result of coronary heart disease.) The doctor recorded that he was hoping for antiviral medication to treat his hepatitis. She also checked his blood pressure, which was slightly raised and noted that it was to be checked again in two weeks. She also noted that staff would need to remind the hospital of their request and tell them that the man was now at Wandsworth.

24. The hospital doctor's letter was received by Wandsworth on 5 December 2008. The prison doctor again recorded that the hospital would need to be followed up regarding the man's cardiology appointments. He began attending appointments at both hospitals in January 2009, so that his treatment could be planned. Within the prison, he was seen regularly by nursing staff and GPs who ensured that follow up notes from the hospitals were followed up appropriately.
25. Wandsworth ensured that he attended all his hospital appointments, and only one had to be rescheduled. He wrote to the healthcare department about this missed appointment and was told that they had to re-book it as the hospital had failed to inform them in time. The delay in attending this appointment was not considered detrimental to his care.
26. Another GP at Wandsworth assessed the man on a number of occasions during 2009, and was instrumental in following up with both hospitals in relation to the perceived delays in treating his heart problems. Due to the complexities of his condition, treatment for his liver problems could not be started until the cardiologists had treated him. This appears to have been a frustration for both him and the healthcare team at Wandsworth. He was regularly reviewed by prison healthcare staff, both for his existing chronic conditions and other symptoms.
27. Following an appointment on 12 August 2009 at hospital, a prison doctor wrote to say that the man was still keen to pursue this treatment although he was aware of the risks from undergoing cardiac surgery given his liver problems. This was also supported by a nurse at Wandsworth who spoke to my investigator. She said that he was fully aware of his medical problems and how they might increase the risk of complications during or following surgery.
28. In view of the risks, a Consultant in Genito-urinary Medicine wrote to Wandsworth on 6 December. He agreed to liaise with the cardiothoracic team at the other treating hospital as well as the liver team, to see whether the man's care could be coordinated there in view of potential complications with surgery.
29. The man was taken to hospital on 12 April, under escort by prison staff, to undergo a quadruple heart bypass operation. He remained in hospital while tests were carried out and during this time he received regular visits from family and friends. The operation was due to take place on 23 April but was postponed until 28 April. While in hospital, he was handcuffed to staff using an escort chain. (An escort chain consists of two ratchet handcuffs joined by a length of chain. One end is attached to the prisoner's wrist and the other to an officer. The escort chain provides the prisoner with more freedom of movement and is less intrusive to medical staff when administering treatment.) The escort chain was removed prior to him going into the operating theatre. The restraints remained off for the remainder of his time in hospital.
30. He remained in theatre for several hours as there were complications during the procedure. He was then taken to the Coronary Care Unit (CCU). Medical staff told the prison staff on the morning of 29 April, that he was in "a bad way",

and this information was passed on to the prison. He had another operation later that day as there were further complications. A nurse at Wandsworth contacted the hospital after hearing that he had been taken back into theatre. She was told by a Sister at the hospital that during the complicated surgery the previous day his main stem had been dissected resulting in the need for further emergency surgery. At the time of her call, the nurse was told that he was in the Intensive Treatment Unit (ITU), heavily sedated and that his family had been informed by the hospital.

31. A surgeon told the escort staff at 11.20am that he did not expect the man to live very long and they reported this to the duty governor at Wandsworth. The escort staff also arranged for his son to be informed of his father's critical condition. Sadly at 12.25pm, he was pronounced dead. His family were with him when he died.

Following the man's death

32. A prison family liaison officer was appointed. Along with members from the prison chaplaincy team, he went to the hospital at 1.15pm, where they met the man's family. He spoke briefly to the man's sister, who told him that she would act as the initial point of contact, and he agreed to contact her again on Tuesday 4 May, to give the family some time to come to terms with their loss.
33. As arranged, he contacted the man's sister on 4 May. They discussed with her the large amount of property that he had at the prison. He also said that he would let them know the date of a memorial service to be held at the prison and confirmed that the prison would contribute towards funeral costs. He next contacted the family on 11 May, and arranged for the man's sister to visit the prison in order to collect his property. She told him that the funeral was to take place on 20 May, and she was happy for the memorial service at the prison to be held on the same day. At the family's request there were no representatives from Wandsworth at the funeral.
34. Where appropriate staff and prisoners who had known the man or been involved in his care were offered support by the chaplaincy and staff care teams.

Clinical care

35. The clinical reviewer conducted a review of the care the man received in custody. He listed his medical conditions as hepatitis C and cirrhosis, severe ischaemic heart disease, including five myocardial infarctions (heart attacks) and hypertension. He added that his medical history was very complex and during his time in custody he had received care from specialist cardiology and hepatology teams in addition to the prison healthcare team. He concludes that this care had been both thorough and appropriate. He makes no recommendations as a result of his review. I concur with his view and I have identified no issues or shortcomings on the part of prison discipline or healthcare staff which impacted adversely on his management or clinical care.

36. I particularly note the efforts made by healthcare staff at Highdown and Wandsworth to obtain the medical records for the man's previous stays in hospital. Continuity of treatment is essential and the staff went to considerable trouble to get the records. They were eventually successful which contributed to the decisions and preparations for his hospital treatment.

CONCLUSION

37. The man had been diagnosed with chronic health problems prior to his imprisonment. I have found that they were treated appropriately from the time of his initial reception and he appears to have been fully aware of his conditions and the treatment he would receive. The severity of his cardiac condition meant that he required a quadruple heart bypass operation that in its nature carries risks. These risks were increased due to his liver problems and he was aware of these when he agreed to have the operation.
38. The investigation and the clinical review have found that the care given to him was equal to that which he would have expected in the wider community. Again I would like to express my condolences to his family for their loss.