A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

Investigation into the death of a man at HMP Wormwood Scrubs in November 2013

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 from coronary artery disease of a man in November 2013, at HMP Wormwood Scrubs. He was 44 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. The clinical reviewer reviewed the clinical care the man received at Wormwood Scrubs.

The man was sentenced to six months imprisonment in August 2013 and sent to HMP Wormwood Scrubs. His reception health screen did not identify any long term medical conditions and he had no further contact with healthcare staff during his time at the prison.

On the morning of 23 November 2013, an officer found the man unresponsive in his cell. Resuscitation was attempted, but it became apparent he had been dead for some time.

I am satisfied that the man's sudden death could not have been foreseen or prevented. While it would not have changed the outcome for the man, the investigation has identified a need for improvements in unlock and emergency response procedures at the prison.

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 **August 2014**

CONTENTS

Summary	5
The investigation process	6
HMP Wormwood Scrubs	7
Key events	8
Issues	10
Recommendations	13

SUMMARY

1. The man was sentenced to six months imprisonment on 2 August 2013 and sent to HMP Wormwood Scrubs.

2. The man was a German citizen who was homeless at the time of his arrest. He had previously served a number of short sentences for minor offences.

3. Healthcare staff in reception noted that the man had no identified physical or mental health needs. He was not registered with a GP, had no outstanding medical appointments and was not taking any prescribed medication.

4. During his initial health screen, healthcare staff asked a number of standard questions about the man's medical history, including whether he had ever had any chest pains or heart problems. He denied any previous health problems and his pulse and blood pressure were recorded as normal. The man had no further contact with healthcare staff while he was at the prison.

5. The man's sentence ended on 1 November 2013. However, he remained in Wormwood Scrubs pending a review by the Home Office for deportation to Germany.

6. At 11.48am on 23 November, an officer was locking prisoners in their cells after lunch had been served. He arrived at the man's cell and noticed he was still in bed. He called to him, but the man did not respond. He went into the cell and tried to rouse the man by shaking the bed but again he did not respond. The officer radioed for assistance, but did not use an emergency code.

7. Other officers responded quickly and arrived to assist the officer. At 11.50am, a nurse arrived at the cell with an oxygen bottle and a defibrillator. She found no vital signs and began to attempt resuscitation. The defibrillator pads were missing so it could not be used.

8. At 11.54am, another nurse arrived at the cell with a doctor. The doctor examined the man and concluded that he had been dead for some time. However, she requested a second defibrillator to check for any output from his heart. This indicated that there was no heart activity. At 12.01pm, paramedics arrived and, after a brief discussion, the doctor confirmed the man's death.

9. We agree with the clinical reviewer that the man's death was not foreseeable. Although it would not have affected the outcome in the man's case, as he had apparently been dead for some time when he was found, we are concerned about unlock procedures and the emergency response. We make two recommendations.

THE INVESTIGATION PROCESS

10. The investigator issued notices to staff and prisoners at HMP Wormwood Scrubs informing them of the investigation and inviting anyone who had relevant information to contact him. No one responded.

11. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. He visited Wormwood Scrubs on 2 December 2013 and met the manager, staff and prisoners on the wing where the man had lived.

12. The investigator interviewed three members of staff on 21 January 2014 at the prison. He gave the Governor initial feedback about the investigation and followed this up in writing.

13. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.

14. We informed HM Coroner for West London District of the investigation, who provided a copy of the post-mortem report. We have sent the Coroner a copy of this investigation report.

15. The man family received a copy of the draft report. They did not make any comments.

HMP WORMWOOD SCRUBS

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

Her Majesty's Inspectorate of Prisons

17. The most recent inspection of HMP Wormwood Scrubs was in June 2011. The Inspectorate noted that primary healthcare had improved as a result of effective leadership, and there was less reliance on agency staff. Inspectors found that most prisoners were able to see a doctor reasonably quickly. All nurses held lead roles for more specialised clinics, such as diabetes or the older prisoner. Prisoners were consulted about the delivery of healthcare services.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recently published report for the year to May 2013, the IMB reported that their concerns about the safety of both staff and prisoners had increased during the year. The IMB noted some positive improvements in healthcare, but were concerned about the number of missed healthcare appointments.

Previous deaths at Wormwood Scrubs

19. The man was the third prisoner to have died of natural causes at Wormwood Scrubs since the start of 2012. There were no significant similarities with the circumstances of previous cases.

KEY EVENTS

20. On 2 August 2013, the man was sentenced to six months in prison and taken to HMP Wormwood Scrubs. He was 43 years old and had served a number of short prison sentences before.

21. A nurse carried out an initial health screen and noted that the man had been homeless before his arrival at the prison and that he was not registered with a GP. He checked his heartbeat, breathing rate, temperature and blood pressure and recorded normal results. The man did not report any significant medical history and was not taking any prescribed medication. He smoked, but declined smoking cessation advice.

22. The next day, another nurse carried out a substance misuse screen. The man told the nurse that he never drank alcohol and had not taken any illicit drugs within the previous month. His blood pressure and pulse rate were noted as normal. The man had no further contact with healthcare staff in the following months.

23. The man's sentence ended on 1 November and he was due to be deported back to Germany, pending a review of his case by the Home Office. He remained in Wormwood Scrubs while awaiting this decision.

24. At 11.46am on 23 November, an officer was locking cells after prisoners had collected their lunch. He arrived at the man's single cell at 11.48am and noticed that he was still in bed and had not collected his lunch. The officer called to the man, but he did not respond. He went into the cell and tried to rouse the man by shaking the bed. He then noted that the man's eyes were open, but he did not appear to be breathing.

25. The officer radioed for the emergency response nurse. He did not use an emergency radio code to indicate a life threatening situation. The emergency nurse, the nurse did not respond to the initial call, but answered a subsequent radio call a few seconds later to say he was on his way. At this point, the control room called for an emergency ambulance.

26. The officer called to another officer for assistance. She went to the man's cell and also alerted another officer to the emergency. One of the officers checked the man's neck for a pulse, but could not find one.

27. At 11.50am, a nurse arrived at the man's cell with a defibrillator and oxygen cylinder. She had been working in the treatment room on D wing when she heard a call for assistance. She noticed that the man was unconscious and appeared to cyanosed (a bluish discolouration to the skin indicating a deficiency of oxygen to the blood). Officers moved him onto the floor and the nurse began

to attempt resuscitation. An officer repeated the request for the emergency response nurse to attend, but again did not use an emergency code.

28. An ambulance arrived at the prison gates at 11.51am, but it took a further six minutes to find an escort to accompany the paramedics to the man's cell.

29. At 11.53am, the nurse asked the officer to set up the defibrillator. However, he found that the pads required to attach the defibrillator to the man's chest were missing, which meant it could not be used.

30. At 11:54am, the nurse and a doctor arrived at the man's cell. The doctor examined the man and noted he was very cold and showed no signs of life. To be sure that there was no cardiac output before confirming his death, she asked for a second defibrillator to be brought. This was attached to the man, but indicated no heart activity.

31. Paramedics arrived at the cell at 12.01pm and noted that the man was cyanosed, had no heart sounds and his pupils were fixed and dilated. The paramedics and the doctor discussed the man's condition and, at 12.01pm, the doctor confirmed his death.

32. An operational manager contacted the German Embassy, who arranged for the local police to inform his mother at her home in Germany. She was told of her son's death later that afternoon.

33. The man's funeral was held on 12 December at East London Crematorium. The prison arranged and paid for the funeral.

34. A post-mortem examination established that the cause of the man's death was coronary heart disease, due to a severe blockage in one of his coronary arteries.

ISSUES

Clinical care

35. The clinical reviewer concluded that the standard of healthcare the man's received at the prison was equivalent to that he could have expected in the community. While he had little contact with healthcare staff, a good health screen was carried out when he arrived at Wormwood Scrubs.

36. The clinical reviewer noted that the presence of the man's coronary artery disease would not have been detectable unless specific symptoms were apparent. In his opinion, the man's sudden and fatal cardiac arrest was not predictable or preventable.

Unlock procedures

37. At 11.48am on the morning of Saturday 23 November, the officer went to the man's cell to check if he had collected his lunch. He was unable to gain a response from the man.

38. The man's cell had been unlocked for lunch at approximately 11.40am. This was the first time his cell had been unlocked that day. Despite repeated requests to the prison, the investigator has been unable to establish which officer unlocked the cell. However, it is clear that this officer did not obtain a response from the man. There is no CCTV coverage of the area and, at that time, staff from other areas of the prison assisted in the serving lunch. Despite attempts by the investigator, it was not possible to determine an exact, or even approximate, time that the man was last seen alive.

39. For their own safety, officers are supposed to make contact with a prisoner through the observation hatch before opening a locked cell door. When unlocking a cell they should take active steps to check on a prisoner's wellbeing. 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."

40. In addition, Prison Service Instruction 10/2011 states that:

    > "Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process."

    We make the following recommendation:

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

Emergency response

41. It is apparent from the log of events kept by the prison control room and interviews with staff that the emergency code system was not used in this case.

42. The officer did not call an emergency medical code when he first found the man unresponsive. Instead, he requested the emergency duty nurse should attend. Another officer make a subsequent radio call, but again did not use an emergency response code.

43. Although the officer's did not call an emergency code, staff in the prison control room very quickly rang for an emergency ambulance. The log of events kept by staff notes that the emergency ambulance arrived at the prison at 11.51am.

44. However, it then took a further six minutes to find a member of staff to escort the ambulance to the area of the man' cell. The paramedics eventually arrived at the cell at 12.01pm, ten minutes after they had arrived at the prison. This was an unacceptable and avoidable delay.

45. Prison Service Instruction (PSI) 03/2013 requires governors to have a medical emergency response code protocol based on the instruction. This should instruct staff how to communicate the nature of a medical emergency using agreed emergency codes. Mandatory contingency responses include that an ambulance should be called immediately, the emergency duty nurse should respond with the necessary equipment and the gate should be prepared to receive the ambulance.

46. The PSI requires prisons to have local protocols which clearly define the nature of the medical emergency with the use of a two level code system that differentiates between a blood injury and all other injuries. Wormwood Scrubs does not have such a system, but uses a code one for all life threatening incidents and code two for non-life threatening incidents. This is not in line with the PSI.

47. There is no clear reason why the prison staff involved did not use an emergency code. Although all the staff we interviewed said they were aware of the emergency code system we are not satisfied that system at Wormwood Scrubs is in line with mandatory requirements. Although this did not affect the outcome for the man, in other circumstances such a delay could be crucial. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Wormwood Scrubs has a Medical Emergency Response Code protocol which:

- **Provides guidance to staff on efficiently communicating the nature of a medical emergency with appropriate codes which differentiate between blood injuries and other injuries;**
- **Ensures staff called to the scene bring the relevant equipment; and**
- **Ensures there are no delays in calling, directing or discharging ambulances.**

Defective emergency equipment

48. The first defibrillator brought to the man's cell did not have any pads and it was therefore not possible to use it. In this case it did not affect the outcome, but faulty emergency equipment is a serious issue which could have a significant impact. This issue was raised with the Governor and Head of Healthcare during the investigation. As a result a review was carried out and procedures introduced to ensure any defective emergency equipment is reported immediately and appropriate action taken. All bags containing emergency equipment are now sealed using numbered tags. By doing so it is clear when a bag has been opened and that its contents may need replenishing. We are satisfied that appropriate action has been taken and therefore do not make a recommendation.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible
1	The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.	Accepted	A wellbeing check will be conducted as staff unlock each prisoner. A Governor's order will be published to instruct staff to undertake these checks. The Governor is also looking at the provision of a further roll check for day staff arriving on duty to ensure that all prisoners are checked at the earliest opportunity each day.	30/11/2014 The Governor

2	The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Wormwood Scrubs has a Medical Emergency Response Code protocol which: • Provides guidance to staff on efficiently communicating the nature of a medical emergency with appropriate codes which differentiate between blood injuries and other injuries; • Ensures staff called to the scene bring the relevant equipment; and • Ensures there are no delays in calling, directing or discharging ambulances.	Accepted	A Governor's order was published on 03/05/14 which highlights appropriate emergency codes and actions required following their use. Healthcare staff have been trained in responding to emergencies and will bring the correct equipment to each incident that they attend. An audit procedure is also now in place to ensure that emergency grab bags are fully stocked and the correct equipment is present.	Completed The Governor and Head of Healthcare