

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at HMP
Wandsworth in May 2014**

Our Vision

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

This is the investigation report into the death of a man, who died from chronic obstructive pulmonary disease in May 2014, at HMP Wandsworth. He was 85 years old. I offer my condolences to his family and friends.

A clinical review of the care received by the man at Wandsworth was undertaken. The prison cooperated fully with the investigation. This investigation was suspended until we received confirmation of the cause of death and the post-mortem report. I regret that this has delayed the issuing of our report.

The man was extradited from Spain and remanded to HMP Wandsworth on 10 May 2014. His reception health screen noted he was fit and well, but staff had no previous medical records. He did not have a more detailed secondary health assessment, which usually takes place shortly after a new prisoner arrives. Late at night on Friday 16 May, he told a nurse that he had abdominal pain and constipation. She gave him laxatives and referred him to see the doctor the next day. Nurses checked him three times on Saturday 17 May, but the doctor did not see him that day as a nurse had reported no clinical concerns and there did not appear to be any urgency. His cellmate found him collapsed and unresponsive. Staff were unable to revive him and it was evident that he had died.

I do not think that staff at Wandsworth could have predicted or prevented the man's death. I also agree with the clinical reviewer that the standard of healthcare he received at Wandsworth was equivalent to that he could have expected to receive in the community: nurses examined him a number of times in the days before he died and there was little to indicate any serious concerns. However, it is unfortunate that he did not have a secondary health assessment or see a GP during his first week at the prison, which were missed opportunities to assess him fully. While it does not appear to have affected the outcome for him, I am also concerned that it took an officer about 15 minutes to respond to the cell bell when his cellmate raised the alarm, which is unacceptably long in an emergency.

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

May 2015

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SUMMARY

1. The man was extradited to the United Kingdom from Spain on 10 May 2014. He was remanded to HMP Wandsworth the same day.
2. During his initial reception health screen, the man reported no concerns about his health. He was due to have a secondary reception health screen on 12 May, but there were no officers to escort him. The appointment was rearranged for the next day but he did not attend. No reason was recorded.
3. At 11.00pm on Friday 16 May, a nurse examined the man in his cell after he reported abdominal pain. He told her he had been constipated for eight days. The nurse gave him laxatives and listed him to see the GP the next day.
4. Nurses checked the man three times on Saturday 17 May and he said he was still in pain but felt better. One of the nurses, who saw him at around midday, said she told the GP on duty that he was on the list to be seen that day, had abdominal pain due to constipation but was otherwise generally well. The GP did not see him, apparently because no one brought him to his clinic and because his symptoms did not indicate it was urgent.
5. The man's cellmate attended a service in the prison chapel at 2.00pm. When he returned to their cell at about 3.30pm, the man was not in the main cell area and he assumed he was using the toilet. After about an hour or so, he called to him several times, but he did not respond. He then went into the toilet area and found he had collapsed on the toilet.
6. The cellmate pressed the emergency cell bell at 4.51pm and again two minutes later. A prison officer did not answer the bell until sometime between 5.05pm and 5.10pm. The officer called to a nurse who was giving medication to a prisoner in the next cell. The officer radioed an emergency medical code, indicating a prisoner was unresponsive and an ambulance should be called.
7. The nurse checked the man and found no signs of life. His cellmate helped her to place him on the floor and she started cardiopulmonary resuscitation immediately. Within two minutes, two more nurses arrived at the cell and helped her. Paramedics arrived at 5.21pm. At 5.30pm, they confirmed that he had died.
8. The clinical reviewer found that the standard of healthcare the man received at Wandsworth was equivalent to that he might have expected to receive in the community. However, the investigation identified some areas for improvement. He missed two appointments for a secondary health screen and did not see a GP on Saturday 17 May, although a nurse had listed him to see one. There was a significant delay in answering the cell bell when his cellmate tried to alert staff to the emergency. Finally, nurses attempted resuscitation although there were signs of rigor mortis. We make three recommendations.

THE INVESTIGATION PROCESS

9. The investigator issued notices to staff and prisoners at HMP Wandsworth, informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.
10. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. She interviewed five members of staff and his cellmate. She gave the prison initial feedback about the preliminary findings of the investigation.
11. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison. He participated in some of the interviews with staff.
12. We informed HM Coroner for Inner West London District of the investigation, who provided the post-mortem report. We have sent the Coroner a copy of this investigation report. The investigation was suspended until we received confirmation of the cause of death and the post-mortem report on 21 January 2015. We regret the delay this caused in issuing this report.
13. One of the Ombudsman's family liaison officers contacted the man's next of kin, his sister-in-law, to explain the investigation. The family liaison officer also contacted his cousin, at the request of his next of kin. His family did not have any specific concerns for the investigation to consider.
14. The man's cousin received a copy of the draft report. She raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.
15. The man's sister-in-law received a copy of the draft report. She did not make any comments.
16. The draft report was shared with the Prison Service. There were one factual inaccuracies and the report has been amended accordingly. The action plan has been added to the end of the report.

HMP WANDSWORTH

17. HMP Wandsworth is a local prison in London which holds up to 1,665 men in eight residential wings. St George's Healthcare Trust provides healthcare services at the prison. There is an inpatient unit for up to six prisoners. Nurses are on duty at all times.

HM Inspectorate of Prisons

18. The most recent inspection of Wandsworth was in June 2013. The Inspectorate noted that healthcare services had improved since their last inspection. Primary care services had developed well, as had inpatient care. A clinic had been introduced to provide health and social care for older prisoners. Inspectors noted that advanced nurse practitioners were experienced in delivering care to prisoners with long term illnesses, including chronic obstructive pulmonary disease.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that all prisoners are treated fairly and decently. In its report for the year ending May 2014, the IMB found a highly committed team of managers, doctors and nurses and good rapport with both prisoners and prison staff. The IMB noted that the healthcare department continued to provide a good service although sometimes target times for appointments with GPs and advanced nurse practitioners were not met. The IMB believed that a reduction in the number of prison officers had seriously impaired prisoners' access to healthcare services.

Previous deaths at HMP Wandsworth

20. The man's death was the third of five deaths from natural causes at Wandsworth since 2013 and the second from chronic obstructive pulmonary disease. There were no other significant similarities between the previous deaths and that of his.

KEY EVENTS

21. A European arrest warrant for the man was issued on 19 February 2014. He was extradited to the United Kingdom from Spain on 10 May and appeared at Magistrates' Court the same day. He was remanded into custody and sent to HMP Wandsworth.
22. During his reception health screen, the man told a nurse that he had no existing health conditions or concerns about his health and had not been prescribed any medication. She noted that he looked well for his age and told the investigator, that he had showed no signs of chronic obstructive pulmonary disease (COPD) such as breathlessness or difficulty walking. Healthcare staff had no access to his previous medical records, as he had lived in Spain for a number of years and could not recall the address of his GP surgery.
23. The man did not have a secondary health assessment which had been scheduled for Monday 12 May as no officers were available to escort him. Healthcare staff re-booked it for the next day, 13 May, but he did not attend. The reason was not recorded.
24. A nurse saw the man in his cell at 11.00pm on Friday 16 May after he had reported upper abdominal pain. He told her that he had not opened his bowels for eight days and she gave him senna tablets (a laxative) to help relieve his constipation. She advised him to ask for help if his symptoms got worse and noted that he should be reviewed the next morning.
25. The man's cellmate said that the man had told him that he was in pain that day. He had smoked up to that point, but began coughing badly and did not smoke again.
26. At 7.30am on 17 May, another nurse checked the man while she was on the landing giving medication to other prisoners. He told her that he was still in pain but felt better than he had the previous night. She noted there was no visible swelling in his abdomen and no symptoms of nausea or vomiting. She added his name to the Saturday GP ledger and noted "Pls review. Bowels not opened for 8 days". She told the investigator that the ledger was used to handover to staff on the next shift and nurses noted in the ledger any concerns about a patient, including those to be assessed by the GP.
27. A nurse examined the man in his cell at 11.27am the same day. His abdomen was not distended, but he said it was still painful. He told her that he usually had an enema when he became constipated. She gave him lactulose, another laxative.
28. The same nurse went back to see the man about 30 minutes later, but he was attempting to open his bowels at the time. There were indications that the laxative was working. She went back to the healthcare centre and told a prison GP that he was generally well but had abdominal pain due to constipation. She mentioned that he was on the list to see him that day. However, the GP did not review the list in the ledger or examine him. In a statement the GP explained that the nurse had told him that the man's

observations were within normal limits and he was clinically well. He said that prisoners who need to be seen on a Saturday would normally be brought to his clinic in the healthcare centre, based on priority, or a nurse would specifically ask him to go and see someone in their cell if that was not possible. There was no indication that he was a priority case and no one brought him to the healthcare centre.

29. The man's cellmate said that the man appeared more active than he had been, and had collected his own lunch from the servery. The cellmate went to a service in the prison chapel at 2.00pm and came back at around 3.30pm. The man was not in the main cell area and he assumed he was in the toilet where it was not unusual for him to spend some time. He said that after about an hour he called out to him, but he did not reply.
30. After calling several times for about ten minutes, the cellmate went into the toilet area and found the man sitting on the toilet, leaning to his left side. He nudged him, but he did not respond. He immediately pressed the cell bell, at 4.51pm, to call for help. He pressed it again two minutes later. (Prison records show that the bell was pressed at 3.51pm, but the prison later explained that the clock was one hour behind, as it had not been changed to reflect British Summer Time.)
31. The man's cell was on the ground floor. When the cellmate pressed the cell bell, an officer was on the floor above. The officer said that a nurse had asked if she would take her to give medication to a prisoner on the ground floor, as there were no other officers around. (The prisoner who needed medication was in the cell next door to him.) When she went down, she unlocked the cell so the nurse could go in and give the prisoner his medication. She then went to the man's cell as his cell bell was ringing. This was at about 5.05pm.
32. The officer said the cellmate pointed to the toilet area and she went in. She found the man unresponsive and left the cell to shout to the nurse next door for help. There are slightly differing accounts of the sequence of events. The officer told the investigator that, at the same time, she radioed the first of three calls, a code one (an emergency response code indicating that a person is unconscious or had breathing problems and an ambulance is needed). She made two further radio calls – to request an emergency bag and to give an update for the ambulance crew. Prison records show a code one was called at 5.10pm and the ambulance document indicates the call was received at 5.11pm.
33. The nurse went into the cell and found the man unconscious with no signs of life. She said that his cellmate helped her lift him from the toilet area and move him to the cell floor. She put him in the recovery position and then asked the officer to radio the emergency code, request the healthcare emergency bag, oxygen and an ambulance.
34. At 5.11pm, the nurse started cardiopulmonary resuscitation. Two more nurses attended within minutes and attached defibrillator pads to the man's chest. His jaw and neck were stiff, so they supported his head with a pillow as it could not lay flat. The defibrillator did not find a shockable heart rhythm so the nurse continued to attempt resuscitation. Paramedics arrived at

5.21pm. They were unable to revive him and pronounced his death at 5.30pm.

Liaison with the man's family

35. The prison's family liaison officer and a chaplain left the prison at 6.10pm to travel to the home of the man's sister-in-law, his next of kin. They arrived at 8.10pm. The family liaison officer informed her of his death and offered condolences. He explained his role as family liaison officer and offered support. They discussed arrangements for the funeral.
36. The man was cremated on 18 June 2014. In line with national policy, the prison contributed towards the funeral costs.

Support for staff and prisoners

37. A Governor's notice informed staff and prisoners of the man's death. A senior manager debriefed staff involved in the emergency response and offered them the support of the prison's care team. Staff offered prisoners on his wing support and access to Listeners (prisoners trained by the Samaritans to provide emotional support to fellow prisoners). They also checked prisoners considered at risk of suicide and self-harm, in case they had been affected by his death.

Post-mortem

38. A post-mortem examination concluded that the man died from an infective exacerbation of chronic obstructive pulmonary disease with pulmonary hypertension.

ISSUES

Clinical care

39. The man died from chronic obstructive pulmonary disease (COPD), with pulmonary hypertension. The clinical reviewer commented that the main contributory cause for both conditions is smoking. As he smoked cigarettes, he was predisposed to COPD.
40. At his reception health screen, the man did not disclose any existing health conditions and said that he did not take any prescribed medication. He had no UK health records. Three nurses all saw him and said that he appeared well for his age. Although his cellmate said that, on Friday 16 May, he had been coughing quite badly, he did not smoke after that day and none of the nurses saw any signs or symptoms to suggest that he suffered from COPD. A nurse took his clinical observations on Friday 16 May and his blood pressure and oxygen saturation levels were normal. The clinical reviewer concluded that his clinical care at Wandsworth was equivalent to that he could have expected to receive in the community and that his sudden death was not foreseeable or preventable.

Secondary health assessment and GP review

41. Prison Service Order (PSO) 3050 Continuity of Healthcare for Prisoners, gives guidance on the clinical management of prisoners from reception through to discharge, with a focus on those with ongoing health needs. A mandatory requirement of the PSO is that:

“In the week following first reception, every prisoner must be offered a general health assessment. This assessment is equivalent to a primary care assessment when registering with a new practice in the community...”

The secondary screen is an opportunity to gather and provide further information. The man did not receive a secondary health screen.

42. The Head of Healthcare said that most new prisoners go to E Wing, the first night and induction wing, which is very close to the healthcare centre and are less likely to miss assessments. As a vulnerable prisoner (VP), the man went to C Wing. (VPs are those who might be vulnerable to threats and bullying from other prisoners, because of the nature of their offence or other reasons.) Staff shortages on C Wing had prevented him being escorted to the first secondary health screen appointment. There is no record to explain why he did not attend the rescheduled appointment the next day, but it seems likely that the same staffing difficulties applied.
43. On the morning of Saturday 17 May, a nurse listed the man to be seen by the GP. Another nurse told the duty GP that day that he was constipated but otherwise appeared well. The GP explained in a statement that he had understood the man’s clinical observations were within normal limits and that he was clinically well. He said that, on Saturdays, he would review, according to priority, newly- arrived prisoners, those requiring urgent medical attention or essential medications, and prisoners with substance misuse problems. We

note that again no one took him to the healthcare centre for the appointment. The clinical reviewer commented that he was not acutely unwell, therefore the delay was acceptable, but the reason should have been recorded.

44. Nurses saw the man on three days in the week he was at the prison. Apart from suffering from constipation, he showed no signs of ill health. The clinical reviewer considered that because of his age (he was 85) the secondary health screen should have been prioritised. We agree that the lack of a more in-depth health assessment of GP review is a concerning for someone of his age, who had just arrived in prison. It is also concerning that prisoners living in the vulnerable prisoners unit on C Wing, who are likely to be older than average, seem more likely to miss healthcare appointments. Healthcare staff made prompt appointments to see him, but shortage of officers meant they did not see him. We make the following recommendation:

The Governor and Head of Healthcare should ensure that secondary health screens and GP appointments for 'at risk' prisoners, including the elderly, are prioritised, that there are sufficient staff to take prisoners to healthcare appointments and that staff record the reasons when prisoners do not attend.

Emergency response

45. A nurse said that when she went into the man's cell, she asked an officer to call a code one. Prison records show that this was done at 5.10pm. The officer's account slightly differs. She said that she called the code one immediately and shouted to the nurse at the same time. She believed that the only instruction the nurse gave her was to ask healthcare staff to bring the emergency bag. While we have been unable to resolve the conflicting accounts, we are satisfied that once staff found the man unresponsive, an emergency medical code was called quickly and the control room called an ambulance promptly in response.
46. However, we are concerned about the length of time it took to answer the cell bell on 18 May. The man pressed the cell bell at 4.51pm. The officer said that she answered the bell at 5.05pm, but the cell bell records show that it was reset at 5.10pm. (Officers are expected to reset bells as they answer them.) A custodial manager confirmed that cell bells can only be reset outside the cell itself, so it is likely that the officer went into the cell nearer to 5.10pm. This indicates that there was a delay of between 14 and 19 minutes in answering the cell bell. The officer was the landing officer for the first floor landing that day (known as "the twos" landing). She told the investigation that the nurse had told her that there were no officers about on the ground floor ("the ones").
47. While it does not appear that the delay affected the outcome for the man, cell bells are supposed to be used in an emergency and it is vital that staff respond to them quickly. In other circumstances such a delayed response could have made the difference between life and death. It is also unacceptable to leave another prisoner in a cell with someone who needs emergency attention for such a length of time, before responding. We make the following recommendation:

The Governor should ensure that prison staff respond quickly when a prisoner uses an emergency cell bell and that managers monitor response times frequently.

Resuscitation

48. European Resuscitation Council Guidelines 2010 state that “Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile...” The guidelines define examples of futility as including the presence of rigor mortis. More recently, the British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued guidance in October 2014 about making appropriate decisions about resuscitation. The guidance says that every decision should be made on the basis of a careful assessment of each individual’s situation. These decisions should never be dictated by ‘blanket’ policies.
49. When a nurse arrived at the man’s cell, she noticed that he had a stiff jaw and neck, and his pupils were fixed and dilated. The nurses used a pillow to support his head as they were unable to lay him flat on the floor. Ambulance records confirm the onset of rigor mortis. Another nurse explained that her first thought was preservation of life and she had instinctively started cardiopulmonary resuscitation. We do not criticise that decision or the efforts of all the nurses to resuscitate him.
50. Healthcare staff at Wandsworth use the St George’s Healthcare NHS Trust cardiopulmonary resuscitation policy. This policy does not cover the issue of rigor mortis and when it would be unnecessary to attempt to resuscitate. The St George’s University Hospital NHS Foundation Trust resuscitation officer considered that it was outside the scope of nurses to identify the presence of rigor mortis and therefore they should always begin cardiopulmonary resuscitation in such circumstances. While we welcome the focus on preservation of life, and consider that resuscitation should always be attempted if there is any doubt, we do not consider that Wandsworth’s position is in line with current guidance. Attempting resuscitation when someone is clearly dead can be distressing for staff and undignified for the deceased. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff are given clear guidance and training, in line with established professional guidelines, about the circumstances in which resuscitation is inappropriate.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should ensure that secondary health screens and GP appointments for 'at risk' prisoners, including the elderly, are prioritised, that there are sufficient staff to take prisoners to healthcare appointments and that staff record the reasons when prisoners do not attend.
2. The Governor should ensure that prison staff respond quickly when a prisoner uses an emergency cell bell and that managers monitor response times frequently.
3. The Head of Healthcare should ensure that healthcare staff are given clear guidance and training, in line with established professional guidelines, about the circumstances in which resuscitation is inappropriate.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible
1	The Governor and Head of Healthcare should ensure that secondary health screens and GP appointments for 'at risk' prisoners, including the elderly, are prioritised, that there are sufficient staff to take prisoners to healthcare appointments and that staff record the reasons when prisoners do not attend.	Accepted	<p>The offender healthcare service will review the secondary screening processes and develop patient priority guidelines for staff to adhere to.</p> <p>Non-attendance at secondary screens will be managed in the same way as 'did not attends' (DNAs) for other clinic appointments. A nurse will review DNAs and patients will be rebooked for appointments based on their clinical need.</p>	<p>1 July 2015</p> <p>Heads of Residential / Head of Healthcare Centre</p>
2	The Governor should ensure that prison staff respond quickly when a prisoner uses an emergency cell bell and that managers monitor response times frequently.	Accepted	<p>Staff have been reminded of the importance of answering emergency cell bells quickly via Governor's notice 51/2015 (issued on 5 March 2015).</p> <p>Weekly management checks of response times have also been reintroduced to ensure compliance.</p>	<p>Complete</p> <p>Head of Safety / Heads of Residential / Head of Trinity Unit</p>
3	The Head of Healthcare should ensure that healthcare staff are given clear guidance and training, in line with established professional guidelines, about the circumstances in which resuscitation is inappropriate.	Accepted	<p>In October 2014, the British Medical Association, RCN and Resuscitation Council issued new guidance on making decisions about attempting cardiopulmonary resuscitation (CPR). NOMS Equality, Rights and Decency Group met with NHS England in February 2015 to discuss this guidance, and work is currently ongoing to agree the content of a note to issue to prison staff later this year.</p> <p>The healthcare provider adheres to current guidance regarding resuscitation. However, healthcare staff will review existing policies to ensure parity with the new guidance once it is rolled out to prison staff.</p>	<p>31 December 2015</p> <p>NOMS Equality, Rights and Decency Group/Governor/ Head of Healthcare Centre</p>