

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of a man, a prisoner at HMP Wandsworth, in October 2014

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

**We are:**

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

This man died from coronary heart disease at HMP Wandsworth in October 2014. He was 32 years old. I offer my condolences to his family and friends.

He was sentenced to 16 weeks in prison on 25 August 2014. He had an appropriate initial health screen when he arrived at the prison and, while he did not receive a secondary screen, staff monitored him for symptoms of alcohol withdrawal. I am satisfied that his healthcare was equivalent to that which he could have expected in the community and that staff at Wandsworth could not have predicted his sudden and unexpected death.

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**

**December 2015**

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# Summary

## Events

1. On 25 August 2014, the man was sentenced to 16 weeks in prison for burglary and taken to HMP Wandsworth. At an initial health screen, a nurse identified no significant health concerns but referred him to a GP because of his reported level of alcohol consumption. The GP saw no signs that he was experiencing withdrawal symptoms, but offered him medication to relieve symptoms, which he declined. Over the next days, staff monitored him and had no concerns. His clinical observations including blood pressure, pulse and temperature were all normal. He had no further contact with healthcare staff during his time at Wandsworth and reported no concerns.
2. During the early hours of a Saturday in October, the man's cellmate was woken by loud snoring and gurgling sounds. He asked the man if he was okay, but got no response. The noise stopped and he went back to sleep. The next morning, his cellmate woke up just before 9.00am and tried not to disturb him. When an officer unlocked the cell at 11.40am, his cellmate looked at the man, realised something was wrong and alerted the officer. He was unresponsive and his body was cold and stiff. The officer radioed for help but was hesitant about using the standard medical emergency code as he was certain the man had died. A nurse attended and asked for the duty doctor and an ambulance. The nurse began to try to resuscitate the man, as he was not certain about rigor mortis. The doctor arrived very shortly afterwards and pronounced the man dead. A post-mortem examination found that he died from coronary heart disease.

## Findings

3. The clinical reviewer found that the man's clinical care was broadly equivalent to that he could have expected to receive in the community. We are satisfied that there was nothing staff at Wandsworth could have done to prevent the man's sudden and unexpected death. The officer who found the man had no doubt that he had been dead for some time, so was unsure whether to call an emergency medical code, which would have prompted the control room to call an ambulance immediately. We understand his hesitation. It is usually better for officers to act with caution and radio an emergency code, but in the circumstances we make no recommendation.

## The Investigation Process

4. The investigator issued notices to staff and prisoners at HMP Wandsworth informing them of the investigation, asking anyone with relevant information to contact her. No one responded.
5. The investigator visited Wandsworth on 17 October 2014. She went to D Wing, where the man had lived, spoke to some staff and prisoners and collected relevant records. She later interviewed staff. The police shared copies of their interview statements.
6. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.
7. We informed HM Coroner for Inner West London of the investigation, who gave us the preliminary results of toxicology tests. We did not receive the post-mortem report until 23 September 2015 and had to suspend the investigation until the cause of death was confirmed. We regret the consequent delay this caused in issuing this report, a copy of which we have sent to the coroner.
8. The prison did not have any direct contact details for the man's next of kin. The coroner gave one of the Ombudsman's family liaison officers contact details for a member of staff at the Algerian Embassy. Despite several attempts, the Embassy did not respond. Unfortunately, this means we have been unable to contact any of the man's family.

# Background Information

## HMP Wandsworth

9. HMP Wandsworth is a local prison in south west London that holds over 1,250 men and primarily serves the courts in south London. St George's Healthcare Trust provides healthcare services at the prison.

## HM Inspectorate of Prisons

10. The most recent inspection of Wandsworth was in March 2015. The report found outcomes for prisoners had fallen from the last inspection and that it was facing severe problems. The prison held over 700 foreign national prisoners, about 40% of its population. More than 100 could not speak English and provision for them was inadequate. The prison had severe staffing shortages and the budget had been cut by a quarter. Inspectors judged substance misuse services to be adequate. Healthcare services had deteriorated since the last inspection, and the quality of nursing from some nurses was poor.

## Independent Monitoring Board

11. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its annual report for the year ending May 2015, the IMB said that low staffing levels continued to be a problem and restricted regime opportunities.

## Previous deaths at HMP Wandsworth

12. This man was the fifth prisoner to die from natural causes at Wandsworth since 2012. There have been two subsequent deaths from apparent natural causes. We have previously made recommendations about emergency response arrangements and the circumstances in which resuscitation is appropriate, issues which are touched on in this investigation.

## Key Events

13. On 25 August 2014, the man was sentenced to 16 weeks in prison for burglary with intent to steal and was taken to HMP Wandsworth. He had not been in prison in England before, but told his cellmate he had served a sentence in France. He was using his brother's identity when he was arrested and gave these details to the prison. His real name was identified and he was Algerian, but this was not established until further enquiries, after his death.
14. At an initial health screen, a nurse noted that the man had no physical health concerns, except that he had metal in his foot from an operation six years previously. He was not taking any prescribed medication, had normal blood pressure and no chest pain. He said he had not been in prison before. He had no thoughts of suicide or self-harm and said he had never received psychiatric treatment.
15. The nurse completed a standard alcohol screening questionnaire. The man said he drank alcohol four or more times a week, and drank ten units or more on each occasion. The nurse referred him to the GP and the substance misuse team, as she considered that this level of alcohol intake suggested that he might need alcohol detoxification.
16. The man moved to the first night centre. An officer noted he was a smoker and could share a cell. A nurse assessed the man's substance use. She recorded that the man said that he used cocaine regularly at weekends and also drank alcohol. He said he did not have any withdrawal symptoms. The nurse completed a different alcohol screening questionnaire. The man's overall score was 19 (out of 40), which the nurse told us is a moderate score. The man said he drank two or three times a week, drinking seven to nine drinks each session.
17. The nurse completed an alcohol withdrawal screen to identify symptoms such as nausea or vomiting, tremors, sweating, anxiousness, itching, hearing noises, feeling dizzy or experiencing visual disturbances. The man said he only had one symptom – he felt mildly 'dizzy or lightheaded'. Although the nurse did not observe any particular signs of drug or alcohol withdrawal she decided to refer him to the GP and substance misuse service. He was allocated to an observation cell so that staff could monitor any withdrawal symptoms over the next 72 hours.
18. A doctor saw the man that evening. The man could speak and understand English but they spoke in Arabic. He thought that the man was unsure about his alcohol consumption but said he drank a bottle of spirits each week. The doctor did not see any evidence that the man was withdrawing from drugs or alcohol. The man declined a precautionary low dose alcohol detoxification to relieve possible symptoms. Staff checked him during the night but he showed no signs of withdrawal. He did not attend a second health screen the next day and no reasons were recorded.
19. On 28 August, a healthcare assistant saw the man and completed a "Severity of Alcohol Dependence" questionnaire. He scored two on the questionnaire – one for mild sensitivity to light and one for a very mild feeling of his head being different. His blood pressure, pulse and temperature were all normal. The

healthcare assistant told the investigator that a score of five to ten is reported to a nurse and over ten to the GP. She took no further action.

20. On 29 August, a doctor saw the man again for a five day review. The man repeated that he was a social drinker and did not have an alcohol problem. His observations were all normal and staff did not monitor him for withdrawal symptoms any longer.
21. On 4 September, the man applied to have four telephone numbers added to his account. He listed four numbers – Shelter, Housing Advice, his solicitors, and a French number which he said was a girlfriend's. (This number appears to have been entered incorrectly. He tried to ring it twice when the wing telephones were not available and again on 25 September, when he was unable to get through.)
22. On 8 September the man moved to D Wing where he shared a cell with one prisoner. The man's cellmate said that he was quiet, but always seemed to be okay and coped well with his time in prison. He said the man looked fit and healthy, ate all his meals and bought fruit and chocolate bars from the canteen. They sometimes did exercises, such as press ups, in their cell. His cellmate said that he had never seen the man taking drugs.
23. The man attended English as a Second Language (ESOL) classes from 15 September to 6 October. The tutor said he was quiet and pleasant in class.
24. The man completed a second telephone form on 7 October, listing a different number for his girlfriend. This was not processed before the man died.
25. His cellmate said that during the evening of 10 October 2014, the man seemed the same as usual. They did some exercises together for a while before settling down. The man told him that he intended to get up the next morning to spend some time in the exercise yard because the scheduled period was an hour later than usual on Saturdays. His cellmate thought they had last spoken at about 10.30pm, while they were watching a film. After an hour or so, the cellmate heard the man snoring, so he turned the TV volume down so as not to disturb him.
26. The cellmate fell asleep shortly afterwards and said he slept until about 1.30am, when he was woken by loud snoring and gurgling sounds. The man slept on the lower bunk and his cellmate leant over from the top bunk, where he slept, and asked him if he was okay. He did not respond and the cellmate assumed he was asleep. The cellmate went to the toilet and had a cigarette before getting back into bed. He said that by then, the man had stopped snoring.
27. In the early morning of Saturday 11 October, the night officer did a roll check (count) of all the prisoners on D Wing. He pressed the "pegging" point outside the man's cell at 5.41am. (The electronic pegging system requires night patrol staff to register a device at various points on the wing.) The roll check is a security check to establish that all prisoners are present. Officers are not required to check on prisoners' welfare or wake them up, but are expected to be vigilant for any obvious concerns. The night patrol did not record any concerns about the man.

28. An officer began work at 7.30am on Saturday 11 October and took over from the night officer. The routine at weekends is different from weekdays because there are no work or education classes. From 8.45am to 9.45am, prisoners can go outside to spend time in the open air in the exercise yard. If they are asleep or do not want to go out, they are left locked in their cell.
29. The man's cellmate thought he woke around 8.45am. He heard prisoners in the exercise yard below. He said he sat on his bed for about half an hour before putting the kettle on and making porridge. He half opened the curtain but said he did not look at the man directly. He said the man did not usually get up until about 10.00am, so it was not unusual for him still to be sleeping. The cellmate said he read a newspaper and listened to music.
30. At 11.40am, officers began unlocking prisoners to go to the servery to collect their lunch. Two officers began unlocking the cells on landing four. One of the officers unlocked the men's cell. The cellmate bent down to get his trainers from under the bunk beds, before going to get his lunch. As he did this, he looked at the man's face and knew something was wrong. His hand was out of the bed and starting to go black. The cellmate left the cell and told an officer, who was on the landing, that the man did not look well.
31. The officer went into the cell. The man was lying in the bottom bunk with the covers over him. His body was blue and cold and one arm was hanging out over the side of the bed. The officer told the investigator that it was obvious he was dead. He felt the man's wrist and said he was cold and stiff. At 11.45am, the officer radioed a "possible code one". The operational support grade in the control room interpreted the radio message to mean that it might not be a code one situation, which would require him to call an ambulance immediately. He therefore waited for healthcare staff to tell him whether to call an ambulance or not. The officer left the cell and waited outside for the medical response nurse.
32. An officer arrived and a supervising officer (SO) ran upstairs from the wing servery. The SO could find no pulse and described the man's body as cold and hard. He could see no sign that he had harmed himself. The officer said the man's skin was very discoloured and looked bluey grey. A custodial manager, who was the orderly officer in charge of the operation of the prison that day, arrived at the cell with a defibrillator.
33. The healthcare responder arrived at the man's cell three minutes after the radio message, bringing emergency medical equipment with him. A substance misuse nurse on D Wing also went to the cell. The nurse asked the control room to get the duty doctor and to ring for an ambulance. The ambulance service timed the call at 11.49am.
34. The healthcare responder nurse said the man's body felt stiff, but because he was not sure that rigor mortis was present, he began chest compressions. However, a doctor arrived very shortly afterwards and the nurse told the doctor he thought the man had died. The doctor could not find any signs of life and confirmed that rigor mortis was present. (Rigor mortis usually starts to appear two hours or more after someone has died and takes some hours to spread throughout the body.) The doctor pronounced the man's death at 11.50am. Paramedics arrived at the prison shortly after.

### **Support for prisoners and staff**

35. At 2.30pm, the duty governor debriefed the staff involved in the emergency response and offered them support. Staff spoke about what had happened with the man's cellmate and offered him individual support.

### **Contact with the man's family**

36. The prison appointed a family liaison officer. The man had not given any next of kin information when he arrived at Wandsworth. The family liaison officer explored a number of avenues to try and identify the man's family, including ringing the numbers he had given for his girlfriend and got no reply. The coroner's office managed to contact the man's uncle who lived in France, through the French and Algerian authorities, who confirmed that he had been using his brother's identity and that he was Algerian. All contact was through the Algerian embassy who did not reply to the family liaison officer's request for information about the man's family and so he was unable to contact them directly. The man's body was repatriated to Algeria.

### **Post-mortem report**

37. The post-mortem examination found that the man died of coronary heart disease. The pathologist commented that cocaine use can accelerate the development of the disease and said the deep snoring noises might indicate left ventricular failure (the left ventricle of the heart pumps blood around the body). Toxicology tests found no alcohol or drugs in the man's body.

# Findings

## Clinical care

38. The clinical reviewer considered that the clinical care provided at Wandsworth was equivalent to that the man might have expected to receive in the community. However, he noted that the man did not attend a second health screen on 26 August and that the nurse who attended the emergency should not have attempted resuscitation when rigor mortis had set in. The clinical reviewer has made recommendations about these matters in his clinical review, which the Head of Healthcare will need to address. We do not repeat them in this report as they would not have altered the outcome for the man.
39. The clinical reviewer found that the healthcare team appropriately investigated and assessed the man's potential substance misuse issues with a short period of observation. The man showed no significant effects of alcohol withdrawal. Although he did not attend a second day health screen, healthcare staff monitored him and the GP reviewed him on 29 August and had no concerns about him. We are satisfied that the man's death was not foreseeable and staff at Wandsworth could not have prevented it.

## Emergency response

40. Wandsworth operate a code one and code two radio call system for emergency responses. Governor's Information Notice 204/2013 gives guidance to staff on communicating the nature of a medical emergency. A code one is to be used when a prisoner is having problems breathing, chest pain or is unconscious. The instruction states it is better to act with caution and call a coded response to trigger an ambulance being called (which can be cancelled later if it is not required) if there is any uncertainty.
41. An officer radioed a "possible code one" emergency. Although healthcare staff responded quickly the message confused control room staff because of its equivocal nature and they did not call an ambulance immediately. Although a nurse initially began to try to resuscitate the man for a short period, the officer and the other staff who arrived did not begin any first aid as they rightly concluded that it was apparent that the man had been dead for some time. This was an appropriate decision. In most circumstances, where a prisoner is unresponsive we would advocate calling an emergency code and an ambulance immediately, but in this situation, we understand the officer's hesitation, as he had no doubt that the man was dead. We understand his hesitation about using an emergency code and calling an ambulance immediately and therefore make no recommendation.

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