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A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man on 12 February  
2014, 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 investigation report into the death of a man, who died on 12 February 2014, while in the custody of HMP Wandsworth. He died of chronic obstructive pulmonary disease (COPD). He was 70 years old. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. A doctor reviewed the clinical care the man received at Wandsworth. The prison cooperated fully with the investigation.

The man was remanded into custody in 2012 and sentenced to four years in prison in 2013. He was diagnosed with COPD in 2007 for which he received medication. The man frequently experienced periods of ill health related to COPD and received care from both prison healthcare and hospital staff.

On 9 February 2014, the man was taken to hospital with breathing difficulties. He remained in hospital and his condition deteriorated rapidly. He died three days later.

I agree with the clinical reviewer that the man received a good standard of care at the prison. However, I am concerned that the man missed some hospital appointments due to the lack of suitable transport to accommodate his wheelchair. The man's condition was not fully taken into account when restraints were used when he attended hospital, and it is unacceptable that it took over five hours, after a request by hospital staff, before restraints were removed at the end of the man's life.

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**September 2014**

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## SUMMARY

1. The man was remanded to HMP Wandsworth on 11 July 2012 charged with sexual offences. He was sentenced to four years in prison on 4 January 2013.
2. The man had poor health and suffered from a number of pre-existing medical conditions including chronic obstructive pulmonary disease (COPD - a term used to describe a range of lung conditions including emphysema), osteoarthritis of the hip and a benign enlarged prostate. He took a number of prescribed medications. The man had been a heavy smoker of cigarettes from the age of 17 and declined advice about giving up.
3. Healthcare staff frequently saw and reviewed the man. His COPD was severe and appropriately treated with medication. He was referred to hospital when required.
4. On 8 February 2014 a nurse examined the man who reported having difficulty breathing. The nurse found his vital signs were normal and he gave him a nebuliser and his breathing improved.
5. On 9 February 2014, a nurse administered oxygen when the man had difficulty breathing but his condition did not improve. An emergency ambulance was called and the man was admitted to Saint George's Hospital, where his condition deteriorated.
6. The prison informed the man's family of his admission to hospital on 11 February who visited him later that day. The man's condition continued to deteriorate and he died on 12 February.
7. We agree with the clinical reviewer that the standard of healthcare the man received at HMP Wandsworth was equivalent to that he could have expected to receive in the community. However, we are concerned that the man missed two hospital appointments and his wheelchair was not appropriately secured on another occasion, as suitable transport could not be provided. The man was restrained by an escort chain without any healthcare input about how his medical condition impacted on his risk of escape and it took over five hours after hospital staff requested this before restraints were removed at the end of his life. We make two recommendations.

## **THE INVESTIGATION PROCESS**

8. The investigator issued notices to staff and prisoners at HMP Wandsworth informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.
9. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. He interviewed four members of staff at Wandsworth on 3 April 2014. He gave the Head of Operations initial feedback on the preliminary findings of the investigation, and followed this up in writing.
10. NHS England commissioned a doctor to review the man's clinical care at the prison.
11. We informed HM Coroner for Inner 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.
12. The man's family received a copy of the draft report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

## **HMP WANDSWORTH**

13. HMP Wandsworth is a local prison in London which holds up to 1,665 men in eight residential wings.
14. Saint Georges Healthcare Trust provides healthcare services at the prison. There is an inpatient unit for up to six prisoners which caters for prisoners with a wide range of mental health, general medical, rehabilitative and health-related respite needs.

## **HM Inspectorate of Prisons**

15. 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 COPD. However, some prisoners had missed hospital appointments due to staff shortages.

## **Independent Monitoring Board**

16. Each prison in England and Wales 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 noted that healthcare provision at Wandsworth was much improved. The use of advanced nurse practitioners to provide care through specialist clinics to prisoners suffering with long term illnesses was noted as of a high standard. Clinics treating conditions such as diabetes and COPD used a quality outcome framework similar to that used in the wider community.
17. The IMB noted that there was a problem of prisoners not turning up for healthcare appointments and hoped that the planned introduction of prisoner healthcare representatives on each wing would improve this.

## **Previous deaths at HMP Wandsworth**

18. The man was the third prisoner to die from natural causes in the last two years at HMP Wandsworth. We have raised the issue of the unjustified use of restraints before.

## KEY EVENTS

19. On 11 July 2012, the man was remanded into custody for sexual offences and sent to HMP Wandsworth. He was sentenced to four years in prison on 4 January 2013.
20. A nurse (Nurse A) carried out a reception health screen and noted the man was in a poor physical condition and had difficulty mobilising, because of osteoarthritis and shortness of breath. Nurse A noted he had been diagnosed with COPD five years earlier and had benign prostate enlargement, both of which had been monitored and treated in the community. A doctor (Doctor A) saw him the same evening and re-prescribed the man's ongoing medications. The man's community medical records were requested shortly after he arrived.
21. The man had been a heavy smoker of cigarettes from the age of 17, and despite advice about giving up he continued to smoke up to 30 cigarettes a day.
22. The man was in very poor health and frequently suffered exacerbations of his COPD, where the condition becomes considerably worse. These were treated with prednisolone (steroid medication), salbutamol (a medication to open the airways and ease breathing) and antibiotics. Healthcare staff frequently reviewed and treated the man in line with the National Institute for Health and Clinical Excellence (NICE) guidelines. He also had an annual anti-influenza vaccination.
23. On 17 September 2012, the advanced nurse practitioner for respiratory conditions, Nurse B assessed the man after an exacerbation of his COPD. She prescribed prednisolone and antibiotics. After this she remained involved in the man's care and frequently reviewed his condition.
24. The man needed assistance from healthcare staff on a number of occasions because of breathing difficulties. He was increasingly dependent on the use of a wheelchair to mobilise.
25. Nurse C examined the man on 26 October and checked his oxygen saturation level (a measure of the concentration of oxygen in his blood). He told her that he frequently coughed up yellow sputum and Nurse C referred him to the respiratory team at St George's Hospital for further examination.
26. On 28 October, the man was taken to Saint George's Hospital, London, by emergency ambulance after he reported shortness of breath and chest pain. He was treated for an exacerbation of his COPD and returned to the prison later that day.
27. On 13 December, the man experienced further breathing difficulties and was admitted to the prison's inpatient unit for observation. Healthcare staff noted that the man could not walk more than five yards without stopping to rest. On

17 January 2013, the man was moved to a cell on C wing especially adapted for wheelchair users.

28. On 15 March, a healthcare administrator chased the referral from October with the hospital. As the hospital could not find it a second referral was faxed. An administrator followed up with a telephone call to the hospital on 19 March, and was again told the referral could not be found and sent one again. On 22 March the hospital confirmed that the referral had been received and they would be in touch in due course.
29. On 27 March, Nurse B reviewed the man. She noted that although he appeared frail, he was cheerful and told her he felt well. She noted that he appeared to have lost weight and continued to smoke heavily. The man said he was not prepared to try to stop smoking.
30. On 5 April, an administrator contacted the hospital to check the progress of the man's referral. An appointment with the respiratory clinic was confirmed for 3 May.
31. On 17 April, the man went to Saint George's Hospital for observation after reporting breathing difficulties. He returned to Wandsworth later that day. A follow up appointment was made with the acute medicine consultant at Saint George's Hospital for 19 April. The man was unable to attend this appointment as the prison was unable to provide an escort. The hospital advised healthcare staff to monitor him until his next appointment. A prison GP, Doctor B, reviewed the man on 26 April.
32. The man was unable to attend his appointment at the respiratory clinic on 3 May because the taxi company the prison used was unable to supply a vehicle adapted for wheelchair use. The appointment was rescheduled to 16 May, but this was also cancelled because there was no suitable adapted vehicle to carry wheelchairs. The appointment was rescheduled for 8 August.
33. On 18 July, Nurse B reviewed the man. She noted he was reluctant to mobilise without his wheelchair and told him that his lack of mobility had an adverse affect on his arthritis and COPD. She recorded that the man had not attended scheduled physiotherapist appointments and the man refused to engage with the physiotherapy team despite healthcare staff encouraging him. There were no concerns about the man's mental capacity.
34. On 8 August, a doctor (Doctor C) saw the man at the chest clinic at Saint George's Hospital. He carried out a spirometric test to measure the amount of air exhaled from the lungs. This indicated that the man's lung capacity was severely reduced. Doctor C noted that the man had symptoms of over-inflated lungs (over-inflation is caused by trapped air in the lungs due to blockages in the airways). He confirmed that the man had severe COPD and referred him for further investigation of his heart and lungs.
35. On 9 September, the man attended Saint George's Hospital for a CT pulmonary angiogram which showed that the man had emphysema (a

condition which gradually damages the air sacs in the lungs, causing progressive shortness of breath). There was evidence of nodules in the upper lobe of the left lung. A follow up scan was arranged for three months later, which the man refused to attend and signed a disclaimer to that effect.

36. On 10 September, a nurse (Nurse D) noted the man's wrist and elbows were bruised. He told her that the bruising on his wrist was from the restraints used when he had been taken to hospital. The man said his wheelchair had not been properly secured in the taxi and when the taxi braked the officers had to grab him suddenly, which had caused the bruising to his elbows.
37. Nurse D saw the man on 24 September after he had refused to attend a hospital appointment with a physiotherapist. He told Nurse D that he did not want to be escorted by officers after the incident on 9 September and he refused to attend an appointment at Saint George's chest clinic the next day, for the same reason.
38. On 20 October, a nurse (Nurse E) examined the man after he had complained of shortness of breath and an increased heart rate. She sent him to Saint George's Hospital where an X-ray showed he had a right pneumothorax (a pocket of air that has become trapped in the lung). He returned to the prison later that day. Two days later, the man went to the hospital for treatment of the pneumothorax, but hospital staff found the condition had resolved itself and no further intervention was necessary.
39. Between October 2013 and January 2014, healthcare staff saw the man frequently to monitor his COPD and other conditions. On 10 January 2014, Nurse E administered a salbutamol nebuliser when the man was short of breath. When he showed no signs of improvement he was taken to Saint George's Hospital by emergency ambulance. The man returned to the prison the same day with adjustments to his medication. Healthcare staff continued to monitor him frequently.
40. At 4.36pm on 8 February, a nurse (Nurse F) responded to an emergency call and found the man was having difficulty breathing. His oxygen saturation level was low. The nurse administered oxygen and the man showed signs of improvement. Healthcare staff monitored his condition throughout the night.
41. At 10.05am on 9 February, Nurse E saw the man in his cell when he was again having difficulty breathing. The nurse told Nurse E that he had used his salbutamol nebuliser but it had had no effect. She monitored his oxygen saturation level and found it to be low. She gave the man oxygen, but his condition did not improve, so at 10.15am Nurse E requested an emergency ambulance. Paramedics arrived at the man's cell 11 minutes later and took the man to Saint George's Hospital. As with all previous hospital visits, the man was restrained by an escort chain and escorted by two officers. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer).

42. The man remained in hospital where his condition continued to deteriorate. At 8.30am on 11 February, a hospital nurse informed one of the escort staff, Officer A, that the man did not have long to live and that restraints were not necessary. Officer A telephoned the prison control room at 8.50am and requested permission to remove the restraints and was told the prison would contact him when a decision had been made.
43. At 9.15am, a custodial manager, Mr A attended the hospital for a routine security check. An officer (Officer B) asked if a decision had been made about the removal of the man's restraints but Mr A contacted the prison for an update however there is no record of the response to his enquiry and he did not take the decision himself.
44. At 12.50pm, Officer B telephoned the prison and spoke to another custodial manager, Mr B to ask whether restraints could be removed. Mr B said that the head of operations, Mr C had asked another custodial manager, Mr D to attend the hospital and assess the man's condition. Just before 2.00pm, Mr D arrived at the hospital and said that Mr C had authorised the removal of the man's restraints. The escort chain was removed at 2.00pm.

#### **Liaison with the man's next of kin**

45. The man did not give his next of kin details when he arrived at Wandsworth, so prison staff searched the man's telephone records and found contact details for his ex-wife.
46. At 1.30pm on 11 February, a prison family liaison officer, Mr A, telephoned the man's ex-wife to inform her of his deteriorating condition. The man's ex-wife and daughters visited him later that day.
47. The man died at 6.08am on 12 February. Hospital staff attempted to telephone the man's family to inform them of his death, but did not get a response. At 9.15am, Mr A contacted the man's ex-wife by telephone (which had been agreed beforehand) to inform her of his death. He remained in contact with the man's family.
48. The man's funeral was held on 14 March 2014 and the prison offered financial assistance in line with national guidance.

#### **Post-mortem**

49. A post-mortem examination established that the cause of the man's death was chronic obstructive pulmonary disease and pulmonary artery hypertension.

## ISSUES

### Clinical care

50. The clinical reviewer found that the clinical care the man received at Wandsworth was equivalent to that he could have expected in the community. The man had very severe COPD and the overall management of his condition was good and included preventative elements such as referral to the hospital chest clinic, reviews by an advanced nurse practitioner and influenza vaccinations. The man was advised to stop smoking, but unfortunately continued. The clinical reviewer was satisfied that the management of his frequent and acute exacerbations was consistent with current good practice and included the appropriate use of steroids, antibiotics and oxygen. The man received a good level of continuity of care, and the same nurses saw him regularly and were sensitive to his needs.

### Attending hospital appointments

51. On 3 May 2013, the man was unable to attend an appointment at the respiratory clinic, because the taxi company used by the prison was unable to supply a vehicle adapted for wheelchair use. The appointment was rescheduled to 16 May, but the man again missed the rescheduled appointment as the taxi company could not supply a suitably adapted vehicle.
52. On 9 September, when the man attended Saint George's Hospital for tests he had sustained bruising to his wrist and both of his elbows which he said happened as his wheelchair was not properly secured in the taxi. We are concerned that the man missed hospital appointments because of appropriate transport was not arranged, and that he was not secured properly on another occasion which resulted in minor injuries. We make the following recommendation:

**The Governor should ensure that prisoners do not miss scheduled hospital appointments and that appropriate vehicles are provided to transport prisoners in wheelchairs.**

### Restraints, security and escorts

53. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital, and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion about the prisoner's ability to

escape must be considered as part of the assessment process. It also deemed that restraining by handcuffs of a prisoner receiving chemotherapy (and by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.

54. The man attended hospital a number of times in 2013 and the beginning of 2014 as an inpatient and for appointments. On all risk assessments he was shown as medium risk of escape and a medium risk to staff and the public but there was never any healthcare assessment of his condition or how this impacted on his risk of escape as required by the 2007 High Court judgement. Despite being frail, in poor health and dependent upon a wheelchair, he was restrained by an escort chain everytime.
55. On 9 February 2014, the man was taken to hospital by emergency ambulance, he was again assessed as a medium risk of escape with no healthcare assessment. The head of security, Mr E, authorised a two person escort and that the man was restrained by an escort chain. The man remained restrained by an escort chain in hospital. On 11 February, nurses said that the man did not have long to live and restraints were unnecessary. However, it was over five hours before the restraints were removed even though an operational manager had attended shortly afterwards.
64. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances which must be fully considered, taken into account and balanced against the security risks. The man was frail, not very mobile and extremely ill for most of the time he was in prison. We are not satisfied that restraints were justified by fully considered risk assessments that took into account the man's risk and condition at the time. Despite repeated requests from escort officers, it took over five hours to reach a decision to remove the man's restraints at the end of his life. We are not satisfied that the request was expedited reasonably or in line with the 2007 High Court judgement. We make the following recommendations:

**The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time. Decisions about removing restraints for dying prisoners should be taken quickly.**

**ACTION PLAN: The man – HMP Wandsworth**

<b>No</b>	<b>Recommendation</b>	<b>Accepted /Not accepted</b>	<b>Response</b>	<b>Target date for completion and Function Responsible</b>
1	The Governor should ensure that prisoners do not miss scheduled hospital appointments and that appropriate vehicles are provided to transport prisoners in wheelchairs.	Accepted	The Governor will take all reasonable steps to ensure that appropriate transport is arranged for prisoners attending outside hospital and scheduled appointments are not missed.	Completed  Governor and Head of Healthcare
2	The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time. Decisions about removing restraints for dying prisoners should be taken quickly.	Accepted	The Local Security Strategy has been updated to give clearer guidance about the use of restraints for seriously ill prisoners. The physical condition of each prisoner is now taken into account and considered alongside their risk of escape and risk to the public should they do so.	Completed  Head of Security