A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in December 2014, a prisoner at 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 from pulmonary embolism of a man in December 2014 at HMP Wandsworth. He was 63 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received was undertaken. The prison cooperated fully with the investigation.

The man was remanded to Wandsworth on 7 August 2014 until the outcome of extradition proceedings to Ireland. He suffered from complex health problems, including diabetes, chest pain, bi-polar affective disorder and paranoia. At the end of August, he was detained in hospital under the provisions of the Mental Health Act. In November, the hospital discharged him and he returned to Wandsworth's healthcare unit, on 28 November. He was a difficult patient and did not always take his diabetic medication as prescribed. He had had two toes amputated in June 2014, and a third toe amputated while he had been detained in hospital. This meant his mobility was poor and he was reliant on a wheelchair.

At the beginning of December nurses were having difficulty moving the man from his wheelchair to the bed. A prison officer tried to help but he became unresponsive. The officer radioed an emergency code and he and the nurse started cardiopulmonary resuscitation. Nurses and then paramedics continued the resuscitation attempt. However, he could not be revived.

I agree with the clinical reviewer that the care the man received at Wandsworth was equivalent to that he could have expected to receive in the community. The emergency response was both timely and appropriate.

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 2015**

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SUMMARY

1. The man was remanded to HMP Wandsworth on 7 August 2014, pending an extradition hearing for alleged sexual offences in Ireland.

2. At an initial health screen, a nurse noted that the man suffered from diabetes and had a history of chest pain. On 7 and 8 August, a mental health nurse at court examined him and noted that he had been diagnosed with bi-polar affective disorder and paranoia in 2004. The nurse recorded that he had been under the care of the Community Mental Health Service in Derbyshire in 2012 and he was an insulin dependant diabetic. In June 2014, he had two toes amputated because of complications of diabetes.

3. On 13 August, a prison psychiatrist assessed the man and noted he was neglecting his foot dressings, refusing to have a shower or have his toes examined. The psychiatrist considered that he did not have capacity to make decisions about his treatment and admitted him to the Addison Unit (the mental health unit at Wandsworth).

4. On 28 August, the man attended Magistrates' Court, but was found not fit to plead. He was detained in hospital under the Mental Health Act 1983. He remained in hospital until 26 November when doctors considered him stable and well enough to attend court again. On 28 November, he appeared at Magistrates' Court and was remanded to Wandsworth again. A reception nurse noted that he appeared stable in mood and he was admitted to the prison's healthcare unit.

5. At the beginning of December, a nurse and a healthcare assistant were having difficulty moving the man back to his bed from his wheelchair. A few minutes later, an officer came to assist. He noted that the man had become unresponsive and, at 10.20am, radioed an emergency medical code to summon help. He and the nurse began to attempt resuscitation. Further healthcare staff attended and took over the resuscitation attempt. At 10.34am, paramedics attended and continued emergency treatment. At 11.19am, a paramedic pronounced that he had died.

6. The clinical reviewer noted that the man had extensive and complex medical problems that would have been challenging to manage in any healthcare environment. We are satisfied that his clinical care at Wandsworth was equivalent to that he could have expected to receive in the community. The emergency response when he collapsed in December was timely and appropriate.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at Wandsworth informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.

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

9. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. He and the clinical reviewer interviewed staff at Wandsworth on 29 January 2015. He interviewed further members of staff on 20 February.

10. 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.

11. One of the Ombudsman's family liaison officers wrote to the man's son to inform him of the investigation. We received no reply.

12. The man's son was informed the draft report was available, but did not make any comment. The prison received a copy of the draft report.

HMP WANDSWORTH

13. HMP Wandsworth is a local prison in London and holds up to 1,877 men in eight residential wings. St George's Healthcare Trust provides healthcare services at the prison.

14. There is an inpatient unit for up to six prisoners (The Jones Unit), which caters for prisoners with a wide range of general medical, rehabilitative and health-related respite needs. There is also a 12-bed mental health unit (The Addison Unit).

HM Inspectorate of Prisons

15. The report of the most recent inspection of Wandsworth, in March 2015, has not yet been published. However, inspectors told us they were impressed with the healthcare team's robust system for learning from all deaths in custody. Each death at the prison was subject to a root cause analysis and review by a clinically expert and senior panel from the Trust.

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16. The previous published inspection of Wandsworth was in June 2013. At that time, inspectors found that primary care services were developing well, and the advanced nurse practitioner role was very impressive. Inpatient and mental health services were good.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In its most recent published report for the year to May 2014, the IMB commented the improvements in healthcare noted in the previous year's report had continued, with an increase in funding. However, there had been too much reliance on bank and agency nurses, unfamiliar with the prison. The rate of non-attendance at healthcare appointments remained high.

Previous deaths at HMP Wandsworth

18. The man was the fifth prisoner to die of natural causes at Wandsworth since 2013. There were no significant similarities with the circumstances of the previous deaths.

KEY EVENTS

19. The man was remanded to HMP Wandsworth on 7 August 2014, pending the outcome of extradition proceedings for alleged sexual offences in Ireland. The proceedings were taking place at Magistrates' Court.

20. At an initial health screen, a nurse noted that the man suffered from diabetes and had recently had toes amputated. He took insulin for diabetes and ramipril for high blood pressure and aspirin. A prison GP examined him and did not record any additional information. He prescribed insulin but did not prescribe ramipril or aspirin.

21. On 7 and 8 August, a nurse from the court diversion team examined the man. (Court diversion teams aim to ensure that people who come into the criminal justice system with mental health conditions and other vulnerabilities are identified and referred to health and other services to get the treatment and support they need.) She noted that he had been diagnosed with bi-polar affective disorder and paranoia in 2004. For several months in 2004 he had been detained at a hospital under the Mental Health Act. She recorded that he had been under the care of the Community Mental Health Services in Derbyshire since 2012 and he was an insulin dependant diabetic. She noted he had had two toes of his right foot amputated and had been admitted to the hospital in June 2014 to dress and clean his toes. The nurse concluded that he was a risk to himself through neglect and referred him to the prison's mental health and medical services.

22. On 11 August, a mental health nurse assessed the man and referred him to the Addison Unit, the prison's mental health unit. On 13 August, a psychiatrist admitted him to the unit. She noted that he continued to be unwell. His physical state was a concern, as he appeared to have been neglecting his foot dressings. He refused to have a shower or have his toes examined. She considered that he appeared not to fully understand information, and did not have the mental capacity to make decisions about his treatment. She referred him to the GP to review his physical condition.

23. On 14 August 2014, a prison GP examined the man, who did not cooperate. The doctor noted that he monitored his blood glucose levels himself and decided his dose of insulin. The doctor suspected he had a foot infection because he not changed his foot dressing. He recorded that he was at risk of developing sepsis (a potentially life-threatening condition). The doctor sent him to hospital, where doctors treated his foot. He returned to the prison on the same day. The GP wrote to Magistrates' Court and advised that he was not fit to attend court for a hearing.

24. On 16 August, a nurse reviewed the man at the diabetic clinic, noted he had a family history of diabetes and advised him to continue taking insulin three times a day. Healthcare staff regularly monitored his diabetes. However, he remained uncooperative and did not always take his medication.

25. On 18 August, a prison GP assessed that the man did not have the mental capacity to manage his diabetes properly. She arranged for nurses to test his

blood sugar levels three times a day and administer his insulin. The psychiatrist considered that it would be appropriate to transfer him to hospital under the Mental Health Act.

26. On 19 August, health professionals of the court diversion team assessed the man. They considered that he was unable to instruct a solicitor and was not fit to take part in the court process or plead. They thought he was still unwell and possibly suffering from a relapse of bipolar disorder. The court diversion team asked the court to remand him until 28 August, to allow a full Mental Health Act assessment.

27. On 21 August, a psychiatrist completed a medical report for the purpose of the man's transfer to hospital. He considered that the man's mental disorder made it appropriate for him to be detained in hospital for medical treatment.

28. On 28 August, the man attended Magistrates' Court and then was taken to hospital to be detained under the Mental Health Act 1983. During his stay in hospital, he developed sepsis and doctors amputated the third toe in his left foot. The hospital's safeguarding and capacity team assessed that he now had the capacity to manage his diabetes. Doctors treated his mental illness with medication and the psychiatric team reviewed him regularly.

29. On 26 November, doctors considered the man was medically stable for discharge and fit enough to attend court. The hospital discharged him into police custody. That day he appeared at Magistrates' Court and was remanded to HMP Nottingham. Healthcare staff at the prison noted his bipolar disorder and diabetes. A blood test showed he was anaemic and had chronic kidney disease.

30. On 28 November, the man appeared at Magistrates' Court and was remanded to Wandsworth again, until an extradition hearing on 10 December. When he arrived at the prison a nurse noted that he appeared stable in mood and said he had no thoughts of self-harm. A prison GP reviewed him, continued his medication and admitted him to the prison's healthcare unit. On 30 November, a nurse noted that he appeared frail and shaken. She changed the dressings on his feet, assisted him to shower and created a care plan for him.

31. At 1.00am on 1 December, a nurse responded to the man's cell bell. He said he felt suicidal and the nurse comforted and supported him. The nurse began Prison Service suicide and self-harm prevention procedures, known as ACCT (Assessment, Care in Custody and Teamwork). He was placed under the care of the mental health team. A psychiatric nurse examined him and noted he appeared much more frail than in August and had tremor of the hands and head. The nurse noted that there was no record that he had had any previous suicidal thoughts or actions.

32. A prison GP examined the man the same day and noted he was immobile and unsteady on his feet. He had good circulation and his wounds were healing. However, he had a loss of sensation in his legs, due to diabetes. The GP referred him to a diabetic nurse.

33. Nurses regularly reviewed the man and recorded their observations in the ACCT plan. The nurses helped him eat and take his medication. They comforted him when necessary.

34. One morning at the beginning of December, a nurse and a healthcare assistant went to the man's cell and moved him from the bed into a wheelchair. The nurse gave him his breakfast and medication, including insulin. She then left to attend another patient.

35. At around 9.55am, the nurse went back to the man's cell and found that the healthcare assistant was having difficulties keeping him in the wheelchair, as he kept slipping out. They tried to move him back to the bed but were unable to do so. The nurse recorded that his airway, breathing and circulation were fine but he said he could not stand up. At 10.10am, the healthcare assistant asked an officer to help.

36. The officer noted that the man was sitting in an awkward position and had become unresponsive. At 10.20am, he radioed a medical emergency code and he and the nurse started cardiopulmonary resuscitation. Further healthcare staff arrived at approximately 10.24am and took over the resuscitation attempt. Paramedics arrived at 10.34am, and continued emergency treatment, but he did not respond. At 11.19am, a paramedic pronounced his death.

Family liaison

37. A prison family liaison officer was appointed. He noted that the address for the man's son, his listed next of kin, was in Kettering. He considered this was too far for anyone from Wandsworth to visit to allow them to inform him quickly, and asked the local police to do this. (Contrary to national Prison Service policy, which expects prisons to use staff from nearby prisons if possible.) However, the police discovered that he was no longer living at the address.

38. Over the following days, the prison and police made a number of enquires to locate the man's son and, on 10 December, the police provided up to date contact details. A custodial manager telephoned him the same day, informed him of his father's death and offered support. On 19 December, the family liaison officer contacted him and offered support. Subsequently, he was unable to contact him again and he has not been in contact with the coroner or the prison since.

Support for staff and prisoners

39. The prison issued notices informing staff and prisoners of the man's death and the support available. A prison manager debriefed the staff involved in the emergency response and offered appropriate support. The prison reviewed prisoners identified as at risk of suicide and self-harm, in case the news of his death had adversely affected them.

Post-mortem

40. A post-mortem examination established that the cause of the man's death was pulmonary thromboembolism (a blockage in the artery that transports blood to the lungs).

ISSUES

Clinical Care

41. The clinical reviewer noted that the man had extensive and complex medical problems, which were very challenging for prison and healthcare staff. He concluded that, despite these difficult challenges, the clinical care provided to him, was equivalent to that he could have expected to receive in the community.

42. The man developed major complications in the management of his diabetes leading to foot ulcers and amputation of toes on both feet. The clinical reviewer noted that there was little doubt that his chronic self-neglect contributed to this. He was generally uncooperative with healthcare staff and often mismanaged his insulin medication.

43. The clinical reviewer considered that healthcare staff at Wandsworth managed the man’s diabetes and mental health well in the circumstances. However, he noted that when he first arrived at Wandsworth the doctor did not re-prescribe him ramipril or aspirin. Although this did not contribute to his death, the clinical reviewer considered this was an oversight for someone with severe complications due to diabetes, and has made a recommendation in the clinical review, which the Head of Healthcare will need to address.

44. The clinical reviewer noted that on the second occasion the man returned from hospital to Wandsworth, healthcare staff adequately assessed him and created a suitable care plan. He considered that his collapse in December could not have been foreseen or prevented, and found that the emergency response was timely and appropriate.