Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Powell a prisoner at HMP Wandsworth on 31 October 2017

A report by the Prisons and Probation Ombudsman

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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*

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.

Mr John Powell died of a liver abscess and heart disease on 31 October 2017 while a prisoner at HMP Wandsworth. He was 73 years old. I offer my condolences to his family and friends.

Mr Powell died of an uncommon condition which is difficult to diagnose without specialist investigations. There was nothing in his past medical history that indicated he was at risk of a liver abscess. I am satisfied that the prison GP recognised that Mr Powell was unwell and arranged appropriate tests and investigations to find the cause.

I am concerned that the support officer who found Mr Powell unconscious did not radio a medical emergency code or open the cell door to attend to Mr Powell. This caused a delay in starting resuscitation efforts, although it is unlikely to have affected the outcome for Mr Powell.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Elizabeth Moody
Acting Prisons and Probation Ombudsman **October 2018**

Contents

Summary

Events

1. On 23 September 2014, Mr John Powell was sentenced to ten years in prison for drug trafficking and was sent to Cork Prison in the Republic of Ireland. On 27 April 2017, he was repatriated to the United Kingdom and transferred to HMP Wandsworth.

2. On 27 April, a nurse completed Mr Powell's initial health assessment and noted that he had Type 2 diabetes and had had a heart bypass operation. A prison GP noted that Mr Powell had hypertension.

3. On 7 August, Mr Powell saw a prison GP and told him that he had been feeling very unsteady and light headed for the past few weeks. The GP noted that Mr Powell looked pale and had very low blood pressure (70/40) so asked for urgent blood tests.

4. The GP saw Mr Powell the next day and noted that his blood pressure was now normal (110/68). He asked for an electrocardiogram (ECG, a test to check the heart's rhythm and electrical activity). The results of this were normal.

5. On 14 August, the GP saw Mr Powell and said that he had an irregular pulse rate. He asked for Mr Powell to have a number of further heart tests. A repeat ECG showed a potential atrial fibrillation (an irregular and often abnormally fast heart rate).

6. On 18 September, the GP saw Mr Powell and told him that he needed an endoscopy procedure (an internal examination). He referred Mr Powell under the NHS suspected cancer pathway, which requires patients with suspected cancer be seen by a specialist within two weeks.

7. On 19 October, a nurse saw Mr Powell because he was trembling uncontrollably. Mr Powell's pulse rate was very high (171 beats per minute). The nurse spoke to a prison GP, who said that he would re-prescribe his diabetes medication. No action was taken about the very high pulse rate.

8. At 11.56am on 31 October, a nurse saw Mr Powell in his cell. He was weak and unable to get up. The nurse spoke to the GP, who agreed to move Mr Powell to the Jones Unit (the prison's inpatient unit). At 4.37pm, a nurse noted that a bed was available in the unit and that he would arrange for wing staff to move Mr Powell later.

9. Mr Powell remained on the wing. Between 5 and 6pm, while Mr Powell was lying in bed, a prisoner gave him his evening meal. The officer who completed a roll check before 7.00pm said he saw Mr Powell sitting at the desk in his cell with his meal.

10. At about 9.15pm, a support officer, who was doing his evening count, saw Mr Powell sitting in his wheelchair. He said that he appeared to be asleep. He knocked on the cell door, but Mr Powell did not respond. He switched the cell light on and saw Mr Powell was unconscious. With the help of another support

officer he tried to wake Mr Powell. They did not go into his cell or radio an emergency code, but instead radioed for a custodial manager to assist.

11. At 9.33pm, an officer and a custodial manager went to the cell, knocked on the door, got no response, opened it, went in and tried to wake Mr Powell. The officer radioed a code blue (which indicates that a prisoner is unconscious or not breathing).

12. Mr Powell was cold to the touch and did not have a pulse. The custodial manager and the officer began cardiopulmonary resuscitation. Two nurses went to the cell and continued resuscitation efforts. A nurse used a defibrillator which said that there was no shockable heart rhythm.

13. At 9.42pm, two ambulances arrived at the prison and, at 9.50pm, paramedics reached Mr Powell. Together with healthcare and prison staff they continued cardiopulmonary resuscitation and treatment. They stopped at 10.15pm, and pronounced that Mr Powell had died.

Findings

Clinical care

14. The clinical care that Mr Powell received at Wandsworth was equivalent to that which he could have expected to receive in the community. Mr Powell died of a liver abscess, an uncommon condition which is difficult to diagnose without specialist investigations.

15. Even though it was not directly related to Mr Powell's death, his high pulse rate (recorded on 19 October) should have prompted staff to take immediate further action, including a discussion with a prison GP and continued monitoring of Mr Powell.

Emergency response

16. The support officer who found Mr Powell did not open the cell door because he said that he did not believe it was an emergency. However, he said that Mr Powell was unconscious and he should, therefore, have called a medical emergency code. This caused a delay in starting the resuscitation efforts.

17. A medical emergency was called as soon as it was apparent that Mr Powell was not breathing and the control room promptly called for an ambulance. Healthcare staff arrived promptly, and supported by prison staff, appropriately used a defibrillator and started cardiopulmonary resuscitation.

Recommendations

- The Head of Healthcare should ensure that healthcare staff take appropriate action when clinical observations are outside the normal range and might indicate deterioration in a prisoner's condition.

- The Governor should ensure that staff are given clear guidance about the circumstances in which they should go into a cell during night patrol duty and radio a medical emergency code.

The Investigation Process

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

19. The investigator obtained copies of relevant extracts from Mr Powell's prison and medical records.

20. NHS England commissioned a clinical reviewer to review Mr Powell's clinical care at the prison.

21. The investigator interviewed five members of staff at Wandsworth on 18 December, including three jointly with the clinical reviewer.

22. We informed HM Coroner for Inner West London of the investigation who gave us a copy of the post-mortem examination. We have sent the Coroner a copy of this report.

23. One of the Ombudsman's family liaison officers contacted Mr Powell's daughter to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She was concerned that Mr Powell waited alone in his cell for a hospital bed to be prepared for him. She understood that he had complained of feeling unwell earlier in the day but was still alone in his cell when prison staff found him unconscious at 9.30pm. She said that this seemed very late in the day to wait to be moved to a hospital bed.

24. We shared the initial report with the Prison Service. They pointed out one factual inaccuracy, this report has been amended accordingly.

25. Mr Powell's daughter received a copy of the initial report. She did not make any comments.

Background Information

HMP Wandsworth

26. HMP Wandsworth is a local prison in London and holds up to 1,628 men in eight residential wings. St George's University Hospital NHS Foundation Trust provides physical healthcare services at the prison. Mental health services are provided by South London and Maudsley NHS Foundation Trust. 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.

HM Inspectorate of Prisons

27. The most recent reported inspection of HMP Wandsworth was in March 2015. Inspectors noted that primary care services had deteriorated due to staffing pressures. They found that the management of long-term conditions was reasonable but health promotion was weak. They noted that the management of medicines was adequate but that the regime in the Jones Unit was unnecessarily restrictive and not individualised. Inspectors identified that there was no regular review of the needs of prisoners with disabilities and that there were insufficient activities for older prisoners, many of whom spent a lot of time locked in their cells.

28. A further inspection was undertaken by the HMIP in February 2018, and a report, which is expected to report on progress since the 2015 inspection, is expected.

Independent Monitoring Board

29. 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 latest annual report for the year to May 2017, the IMB reported that the four main problems facing the primary healthcare service were the lack of officers to escort prisoners to clinics and hospitals and the consequent knock-on effects, nurse vacancy levels, poor healthcare facilities and delays in carrying out repairs to medical facilities and cells. They noted that there had been a significant recruitment programme to attract more nurses which had had some success despite the national challenges of recruiting registered nurses.

Previous deaths at HMP Wandsworth

30. No prisoners died from natural causes at Wandsworth in the 12 months before Mr Powell died, and there have been no such deaths since Mr Powell's death.

Management and security of nights

31. Prison Service Order (PSO) 24/2911 on the management and security of nights says that under normal circumstances, authority to unlock a cell at night must be given by the night orderly officer (NOO) and that no cell will be opened unless a minimum of two or three members of staff are present, one of whom should be the NOO. The order says that the preservation of life must take precedence. Where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the NOO and an individual member of staff may

enter the cell on their own. However, night staff should not take action that they feel would put themselves or others in unnecessary danger.

32. The order says that, before going into a cell, every effort should be made to gain a verbal response from the prisoner. This, together with what the member of staff can observe through the panel and any knowledge of the occupant, should inform a rapid dynamic risk assessment of the situation and a decision on whether to enter immediately or wait for assistance.

33. Wandsworth's local instruction for opening cells at night is the same as the PSO.

Key Events

Clinical care

34. On 23 September 2014, Mr John Powell was sentenced to ten years in prison for drug trafficking and was sent to Cork Prison in the Republic of Ireland. On 27 April 2017, he was repatriated to the United Kingdom and transferred to HMP Wandsworth.

35. On 27 April, a nurse completed Mr Powell's initial health assessment. Mr Powell said he had Type 2 diabetes, had had a heart by-pass operation and had arthritis in his knees so used crutches. A prison GP saw Mr Powell and noted that he had hypertension (high blood pressure).

36. On 28 April, a locum prison GP received details of Mr Powell's long-term medication and prescribed allopurinol to treat his gout, amlodipine for his high blood pressure, atorvastatin for his high cholesterol, and gliclazide and metformin for his diabetes.

37. On 2 May, when healthcare staff received the details of Mr Powell's prescription from Cork Prison, a locum prison GP also prescribed ramipril for high blood pressure and heart failure.

38. On 22 May, a nurse saw Mr Powell to review his diabetes and take blood tests. On 30 May, she discussed the blood test results with Mr Powell. She told him that because his blood sugar level was high, he should reduce the sugar in his diet and increase the metformin dose.

39. On 14 July, a nurse saw Mr Powell in his cell because he was shivering. He had a raised temperature (38.3 C). She gave him paracetamol and his condition improved.

40. On 7 August, Mr Powell saw a prison GP and told him that he had felt very unsteady and light headed for the past few weeks. The GP noted that Mr Powell looked pale and had very low blood pressure (70/40). The GP asked for urgent blood tests and told him to stop taking the anti-hypertensive medication.

41. A prison GP saw Mr Powell the next day and noted that his blood pressure was normal (110/68). The GP asked for an ECG. On 9 August, a locum prison GP reviewed the results and noted them as normal, no further action. He instructed that Mr Powell have a GP appointment.

42. Later that day, a nurse saw Mr Powell to take blood tests and an ECG. Mr Powell was shivering but was fully alert and breathing normally. He checked Mr Powell's temperature, which was normal. The blood test results showed a raised white cell count (which could be the sign of an infection). A locum prison GP considered the results as normal in the circumstances.

43. On 14 August, a prison GP saw Mr Powell and noted that he had an irregular pulse rate. He noted that Mr Powell should have an echocardiogram, a cardiac monitor test and repeat the ECG. He noted that he would discuss Mr Powell at the complex cases' meeting where staff discuss patients with complex medical

problems. A locum prison GP reviewed the ECG which showed a potential atrial fibrillation.

44. On 11 September, a prison GP saw Mr Powell, who used a wheelchair to go to the appointment because he said he got short of breath and had periods of shivering. The GP discussed Mr Powell at the complex cases' meeting and planned to repeat blood tests and refer him for the cardiac monitor test.

45. On 18 September, a prison GP saw Mr Powell, who had again used a wheelchair to get to the clinic. The GP said that his low blood test results for kidney and liver function could be due to poor nutrition and weight loss. Mr Powell said that he felt sick when he ate so he had stopped eating, had milk and biscuits but no meals. The GP prescribed lansoprazole for indigestion.

46. A week later, Mr Powell saw the GP again and told him that the lansoprazole allowed him to eat much better. The GP told him that he needed to have an endoscopy procedure. He referred Mr Powell under the NHS pathway, which requires patients with suspected cancer be seen by a specialist within two weeks.

47. On 2 October, a locum prison GP reviewed Mr Powell at the complex cases' meeting and asked for more blood tests. The next day, a prison GP reviewed the blood test results, which showed that Mr Powell had anaemia, but a normal white cell count, and that his liver function was normal.

48. On 5 October, Mr Powell went to hospital for the endoscopy procedure. A prison GP said that despite chasing the hospital, he did not receive Mr Powell's results until 1 November.

49. On 13 October, Mr Powell had more blood tests which a prison GP reviewed. The results showed that Mr Powell was still anaemic and had a raised white blood cell count. The GP noted that he needed to speak to another doctor because the results were abnormal. There is no evidence that this happened.

50. On 19 October, a nurse saw Mr Powell because he was shaking uncontrollably. Mr Powell's blood pressure and blood oxygen saturation were normal but his pulse rate was very high (171 beats per minute). The nurse spoke to a prison GP, who said that she would re-prescribe Mr Powell's diabetes medication. He asked the nurse to book an appointment for Mr Powell at the clinic. No action was taken about the very high pulse rate.

51. On 30 October, a prison GP saw Mr Powell. Mr Powell said that he was weak and did not have the strength to sit up, walk or lift a cup. The GP noted that Mr Powell had a normal but irregular pulse rate. He said that he would discuss Mr Powell at the complex cases' meeting and chase the results of the endoscopy procedure and the cardiac monitor appointment.

52. At 11.56am on 31 October, a nurse saw Mr Powell in his cell. He said that he was weak and unable to get up. He said that he was struggling to use the toilet and have a shower. He said that he was not eating and had no appetite. The nurse noted that she would refer him to social services. She spoke to a prison GP, who agreed to move Mr Powell to the Jones Unit. The nurse noted that unit was full but that she would arrange for Mr Powell to move there when a bed became available. At 4.37pm, a nurse noted that a bed was available and that

he would arrange for wing staff to move Mr Powell later. There is no evidence to say what happened after this.

Emergency response

53. Between 5.00pm and 6.00pm, a prisoner gave Mr Powell his evening meal in his cell. He saw that Mr Powell was lying in bed and asked him for extra milk.

54. An officer did a roll check, which he said he usually completed before 7.00pm. He said that he saw Mr Powell sitting at the desk in his cell with his meal.

55. At about 9.15pm, an operational support grade (OSG) was carrying out his evening count on Trinity Wing. He saw Mr Powell sitting in his wheelchair, and said that he appeared to be asleep. He knocked on the cell door, but got no response. He called another OSG and they both tried to wake Mr Powell. They did not enter the cell.

56. The OSG said that he understood the local instructions for opening cells at night and had a night pouch, which contains a 'fish knife' (a cut-down tool), general keys and a sealed cell key. He said that he could use a cell key on his own to open a cell door in an emergency such as if a prisoner hanged himself. He said that when he turned on the cell light he saw that Mr Powell was unconscious but did not believe the situation was an emergency.

57. The other OSG telephoned the night state prison office. A custodial manager went to Trinity Wing and arrived with an officer. At 9.33pm, the officer knocked on the cell door, got no response, opened it and with the custodial manager tried to wake Mr Powell. The officer radioed a code blue.

58. The custodial manager saw that Mr Powell was cold to the touch and did not have a pulse. With the officer, they lifted Mr Powell out of his wheelchair and placed him on the floor. The manager began cardiopulmonary resuscitation. When he got tired an officer took over.

59. Two nurses went to the cell with an emergency bag. The officer removed Mr Powell's upper clothing with his fish knife. One nurse inserted a tube into the airway, and tried to resuscitate him. The other nurse used a defibrillator, which advised no shock.

60. At 9.42pm, two ambulances arrived at the prison, and at 9.50pm, paramedics were with Mr Powell. With the help of healthcare and prison staff, they continued cardiopulmonary resuscitation and treatment. At 10.15pm, they pronounced that Mr Powell had died.

Contact with Mr Powell's family

61. On 31 October, the duty governor and Head of Security appointed two officers as family liaison officers. At 6.40am on 1 November, they went to Mr Powell's daughter's home. Although they remained at the address for 25 minutes and telephoned her, she did not answer the door.

62. At 7.30am, Mr Powell's daughter telephoned one of the family liaison officers and apologised for not answering the door. Because the officers were on the

motorway returning to London, the family liaison officer told her over the phone that Mr Powell had died and offered her condolences.

63. Mr Powell's funeral was held on 21 December. The prison contributed towards its cost in line with national policy.

Support for prisoners and staff

64. After Mr Powell's death, a senior manager debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

65. The prison posted notices informing other prisoners of Mr Powell's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Powell's death.

Post-mortem report

66. A post-mortem examination found that the cause of Mr Powell's death was a liver (hepatic) abscess. He also had heart disease.

Findings

Clinical care

67. The clinical reviewer concluded that the care that Mr Powell received at Wandsworth was equivalent to that which he could have expected to receive in the community. At his initial health screen, healthcare staff identified that he had long-term conditions, which they managed appropriately with a multi-disciplinary approach.

68. The clinical reviewer said that Mr Powell's cause of death - a hepatic (liver) abscess - was uncommon and difficult to diagnose without specialist investigations. He said that severe infections could present similar symptoms, including fever and a high pulse rate. Mr Powell had some of these symptoms but these were infrequent. Mr Powell's liver function blood tests were consistently normal and there was nothing in his past medical history which indicated he was at risk of a liver abscess.

69. A prison GP saw Mr Powell in early August, and frequently until his death. The GP realised that Mr Powell was unwell and arranged tests and investigations to find the cause. He also referred Mr Powell to the complex cases' meeting.

70. In September, the GP appropriately referred Mr Powell under the two-week wait rule for an endoscopy because he thought Mr Powell may have cancer of the stomach and oesophagus. His anaemia suggested to the GP that Mr Powell might have a gastrointestinal tract cancer. The healthcare team did not get the result of the endoscopy until after Mr Powell's death. We are satisfied that the GP tried to get the results of the endoscopy from the hospital before Mr Powell died, but they were not made available to him.

71. When a nurse saw Mr Powell on 19 October, his blood pressure and blood oxygen saturation were normal but his pulse rate was high. The clinical reviewer said that this should have prompted immediate further action, including a discussion with a prison GP and continued monitoring of Mr Powell. The nurse spoke to a prison GP about Mr Powell's medication, but took no action about the very high pulse rate.

72. Mr Powell's pulse rate was not checked again until 30 October when it was normal (68 beats per minute). The clinical reviewer concluded that Mr Powell's high pulse rate was not directly related to his death but we are concerned it did not prompt immediate further action. We make the following recommendation:

    The Head of Healthcare should ensure that healthcare staff take appropriate action when clinical observations are outside the normal range and might indicate deterioration in a prisoner's condition.

73. Because Mr Powell was weak and unable to look after himself, a nurse spoke to a prison GP about transferring him to the Jones Unit, which they arranged. Although a bed became available at 4.37pm, Mr Powell died before he could be moved to the unit. There is nothing to suggest that an earlier move would have prevented Mr Powell's death.

Emergency response

74. An OSG carrying out a roll check saw Mr Powell sitting in his wheelchair, apparently sleeping. He tried to wake him by calling his name, rattling the lock and kicking the cell door. He then called for another OSG to help him to try to wake Mr Powell.

75. The OSG, who was not trained in first aid, did not open and go into the cell and did not radio a medical emergency code blue, even though it was apparent to him that Mr Powell was unconscious. This delayed resuscitation efforts. He considered it necessary to radio for a custodial manager and a prison officer to go the wing before the door could be opened. While it is unlikely that the delay in opening the cell door would have changed the outcome for Mr Powell, this should not have happened. We make the following recommendation:

The Governor should ensure that staff are given clear guidance about the circumstances in which they should go into a cell during night patrol duty and radio a medical emergency code.

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