

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr David Cope a prisoner at HMP Wandsworth on 25 April 2018

**A report by the Prisons and Probation Ombudsman**

PO Box 70769  
London, SE1P 4XY

Email: [mail@ppo.gsi.gov.uk](mailto:mail@ppo.gsi.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T | 020 7633 4100  
F | 020 7633 4141

## 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 I oversee can improve their work in the future.

Mr David Cope died on 25 April 2018 of pancreatic cancer and bronchopneumonia while a prisoner at HMP Wandsworth. He was 71 years old. I offer my condolences to Cope's family and friends.

I am satisfied that Mr Cope received a good standard of care at Wandsworth.

However, I am concerned that Mr Cope was left alone in his cell after it had been identified that an ambulance was required to take him to hospital, and that an ambulance was not called sooner. I consider the use of restraints at hospital to have been excessive, an issue that I have previously raised with Wandsworth which I now bring to the attention of the Governor's manager. I also consider that Mr Cope's partner should have been informed when he was taken to hospital.

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**  
**Deputy Prisons and Probation Ombudsman**

**November 2018**

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# Summary

## Events

1. On 12 April 2018, Mr Cope was remanded to HMP Wandsworth on a charge of common assault committed within the context of domestic violence. He had long term alcohol dependence, liver disease and chronic obstructive pulmonary disease (COPD). He began an alcohol withdrawal programme and was located in a cell to allow regular monitoring of his withdrawal to take place.
2. Mr Cope was monitored regularly during his first five days in prison by healthcare staff and no concerns were raised. On the morning of 18 April, an officer asked healthcare for an assessment of Mr Cope because he was unkempt. A psychiatrist saw him in his cell because he was not well enough to attend the drug and alcohol clinic, and considered he might have a chest infection. An appointment with a doctor was requested.
3. A nurse saw Mr Cope in his cell at 4.30pm and noted he was coughing and felt unwell. He went back and checked on him at 7.30pm and found his condition had deteriorated. He discussed his presentation with a doctor and they agreed that Mr Cope should go to hospital. The nurse discussed Mr Cope at a handover at the end of his shift and the nurse taking over found that no ambulance had been called. She requested one immediately. Mr Cope was taken to hospital, placed under restraint with double cuffs.
4. Mr Cope was initially treated for a chest infection but a scan showed he had pancreatic cancer which had spread. On 21 April, his condition deteriorated and he was placed in intensive care. His restraints were removed. He moved back to a ward on 24 April and his restraints were reapplied. Escort staff were informed that he was receiving palliative care and gained permission for his restraints to be removed. On 25 April, Mr Cope died.

## Findings

5. We agree with the clinical reviewer that the care Mr Cope received was equivalent to that which he could have expected to receive in the community. The management of his alcohol dependence and detoxification was satisfactory.
6. We are, however, concerned that Mr Cope was left alone in his cell after a nurse had identified that he needed an emergency ambulance and consider that an ambulance should have been called sooner. We also consider the use of restraints to have been excessive when Mr Cope was taken to hospital on 18 April, an issue we have previously raised with Wandsworth. We think that Mr Cope's partner should have been informed when he was seriously unwell in hospital.

## Recommendations

- The Head of Healthcare should ensure that when an ambulance is called for an unwell prisoner he is accompanied by a member of healthcare staff while waiting.

- The Head of Healthcare should ensure that all staff understand their responsibilities in relation to calling an ambulance for an unwell prisoner.
- The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints 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.
- The Prison Group Director, London, should assure herself that meaningful action is taken to address this recommendation.
- The Governor should ensure that when a prisoner is taken to hospital and is very unwell the prison should inform the prisoner's next of kin or spouse.

## The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Wandsworth informing them of the investigation and asking anyone with relevant information to contact her. No one responded
8. The investigator obtained copies of relevant extracts from Mr Cope's prison and medical records.
9. NHS England commissioned a clinical reviewer to review Mr Cope's clinical care at the prison.
10. We informed HM Coroner for Inner West London of the investigation. She gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.
11. The investigator wrote to Mr Cope's partner to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She did not respond to our letter.
12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

# Background Information

## HMP Wandsworth

13. 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

14. The most recent reported inspection of HMP Wandsworth was conducted in March 2018. Inspectors found that most prisoners were satisfied with the quality of health provision, but lengthy waiting times for appointments were a recurring theme. They considered the range of primary care services and visiting specialists was appropriate and external hospital appointments were well managed. They were concerned that systems were weak to address prisoners' social care needs and prisoner carers were used for inappropriate lifting.

## Independent Monitoring Board

15. 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 at Wandsworth 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

16. Including Mr Cope, we have investigated 10 deaths at Wandsworth since 2015. Of the other deaths, one prisoner was murdered, three prisoners died of natural causes and five deaths were self-inflicted. We have raised the issue of excessive use of restraints with the Governor following previous investigations.

## Key Events

17. On 12 April 2018, Mr Cope was remanded to HMP Wandsworth on a charge of common assault within the context of domestic violence. He reported that he had been in prison before. Mr Cope had long term alcohol dependence, liver disease and chronic obstructive pulmonary disease (COPD). In September 2017, a community GP had visited Mr Cope at home and recommended a hospital admission to investigate his liver disease but Mr Cope had refused to go.
18. A nurse completed Mr Cope's initial health screening and referred him to a prison GP on account of his alcohol dependence. The prison GP assessed Mr Cope as undergoing acute alcohol withdrawal and prescribed a reducing dose of librium (a sedative) supplemented with vitamins to manage his withdrawal symptoms.
19. Mr Cope was allocated a cell for prisoners detoxifying from drugs and alcohol for overnight observation. At his second day health screening, a nurse found Mr Cope to be experiencing a mild withdrawal from alcohol. He had several contacts with healthcare staff during the next five days but no concerns were noted.
20. On 17 April, Mr Cope attended court and no concerns were raised about his health. On the morning of 18 April, an officer noticed that Mr Cope was walking very slowly on the wing. He had faeces on his clothes so was given a shower and fresh clothing. The officer asked healthcare to assess Mr Cope.
21. A consultant psychiatrist saw Mr Cope in his cell at around 3.30pm because he was too unwell to attend a clinic to review his alcohol withdrawal. She found him to have laboured breathing and to be slightly blue in colour. She thought that he might have a chest infection and requested that he be seen by a doctor.
22. At 4.30pm, nurse A saw Mr Cope in his cell and noted that he felt unwell and was coughing. He was avoiding lying down as this made his breathing worse. Nurse A contacted the Jones Unit for a possible admission but no bed was available.
23. At 7.30pm, Nurse A returned to review Mr Cope and found that his condition had deteriorated. He discussed his condition with a prison GP and they agreed that Mr Cope should be taken to hospital as an emergency. Nurse A said in a statement, that he informed the control room and the custodial manager in charge of running the prison that an ambulance was required. There is no record of this or of an ambulance being called.
24. Nurse B began her night shift at 8pm. In a handover meeting, Nurse A explained Mr Cope's condition. Nurse B said in a statement to the investigator that she was initially under the impression that Mr Cope had been taken to hospital. When she found out that Mr Cope was still in his cell she asked control for an update on when the ambulance would arrive and discovered that no ambulance had been called. She rectified this immediately and at 8.23pm the control room requested an ambulance.
25. Nurse B went straight to Mr Cope's cell and told the nurses ending their shift that Mr Cope should not have been left alone. After ten minutes, an ambulance arrived and Mr Cope was taken to the hospital. Mr Cope was restrained with

double cuffs. This entails the prisoner having his hands handcuffed in front of him and then having one wrist attached to a prison officer by an additional set of handcuffs.

26. Hospital doctors initially treated Mr Cope for a possible lung infection linked to his COPD. A CT scan revealed he had pancreatic cancer which had spread to his liver, abdominal cavity and possibly his lungs. On 21 April, Mr Cope's condition deteriorated and he was taken to intensive care. Permission was given by Custodial Manager for his restraints to be removed. On 24 April, Mr Cope was moved to back to a ward and was put back in restraints. He had difficulty breathing and a doctor asked for his next of kin details.
27. On 25 April, a nurse told escort staff in the early hours of the morning that Mr Cope was receiving palliative care and he would not be given any medication or have his observations taken. Staff gained permission for his restraints to be removed. At 6.41pm, a doctor certified that Mr Cope had died.

### **Contact with Cope's family**

28. An offender manager was appointed as family liaison officer on the day that Mr Cope died. She sought advice on how to contact Mr Cope's partner to break the news of his death because she had been the victim of his alleged offence. The police visited his partner at home the next day to tell her that Mr Cope had died.
29. The offender manager contacted Mr Cope's partner and went to visit her at home on 21 May, to discuss funeral arrangements. The funeral took place on 5 June and the prison contributed towards the funeral costs, in line with national policy.

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

30. After Mr Cope's death, the staff that were involved his hospital escort were offered the support of the care team. No debrief took place.
31. The prison posted notices informing other prisoners of Mr Cope's death, and offering support.

### **Post-mortem report**

32. The post-mortem report found that Mr Cope died of pancreatic cancer and bronchopneumonia.

# Findings

## Clinical care

33. Mr Cope entered custody suffering from COPD and was withdrawing from alcohol. We agree with the clinical reviewer that the care Mr Cope received at Wandsworth was equivalent to that which he could have expected to receive in the community.

## Calling an ambulance

34. On 18 April, when Nurse A assessed Mr Cope at 7.30pm and found him to be unwell, he discussed his presentation with a doctor. They agreed that he should be taken to hospital. Nurse A said in a statement that he informed the control room and the custodial manager in charge of running the prison that an ambulance was required. There is no record of this or of an ambulance being called.
35. Nurse A went on to discuss Mr Cope at the handover of his shift with Nurse B at 8pm. Nurse B checked why an ambulance had not arrived and found that one had not been requested and called for one immediately. She was concerned that Mr Cope had been left alone in his cell and ensured that he was supervised until an ambulance arrived.
36. Mr Cope should not have been left unaccompanied in his cell while waiting for an ambulance. We also consider that an ambulance should have been called sooner and make the following recommendations:

**The Head of Healthcare should ensure that when an ambulance is called for an unwell prisoner he is accompanied by a member of healthcare staff while waiting.**

**The Head of Healthcare should ensure that all staff understand their responsibilities in relation to calling an ambulance for an unwell prisoner.**

## Use of restraints

37. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. 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 takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.
38. On 18 April, Mr Cope was taken to hospital restrained with double cuffs. This is usually required for moving category A or category B prisoners in good health. There was limited information in the medical section of the risk assessment about Mr Cope's condition, contrary to the requirements set out in the High Court

judgement. There is no evidence to support the decision to use double cuffs and we can see no reason why it would be justified given the nature of Mr Cope's offence, his age and his poor and deteriorating physical condition.

39. When Mr Cope's condition deteriorated and he was taken into intensive care permission was sought to remove his restraints, which was agreed. When he was taken back to a ward, restraints were reapplied, before being removed for a final time a few hours later.
40. The Safer Custody Manager told the investigator that when a prisoner is admitted to hospital an escort chain would be used. This is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer. This appeared to be a general approach to the use of restraints and not the required individualised risk assessment.
41. We are also concerned that there is no evidence in the records of when the double cuffs were changed to an escort chain. When restraints were reapplied after being removed, we accept that it is likely that an escort chain was applied (rather than double cuffs) but this was not documented.
42. We previously made a recommendation to Wandsworth in 2016 about the inappropriate use of double cuffs. This was accepted and an action plan to address it was produced. The investigator asked Wandsworth for evidence of the actions that had been taken to implement our recommendation but they were unable to provide this. We therefore repeat our previous recommendation and draw this unsatisfactory state of affairs to the attention of the Director for London prisons.

**Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints 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.**

**The Prison Group Director, London, should assure herself that meaningful action is taken to address this recommendation.**

### Notifying families of serious illness

43. When Mr Cope became unwell and was taken to hospital his partner was not informed. Prison Rule 22(1) states: 'Notification of illness or death. '22 – (1) If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed.'
44. Although Mr Cope's partner was also the victim of his alleged offence, she was his long-term partner and may have wanted to know that he had been taken to hospital and was very unwell. Her details were listed on Mr Cope's prison file and there was no restraining order in place, so we consider that the prison should have contacted her when he went to hospital and make the following recommendation:

**The Governor should ensure that when a prisoner is taken to hospital and is very unwell the prison should inform the prisoners next of kin or spouse.**

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