Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Milan Feri a prisoner at HMP Wandsworth on 27 August 2018

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*

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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.

Mr Milan Feri died on 27 August 2018 of heart failure due to heart disease, at HMP Wandsworth. He was 50 years old. I offer my condolences to Mr Feri's family and friends.

Mr Feri was a Slovakian national with very limited English. He also had significant physical, cognitive and communication problems as a result of a historic brain injury.

Our investigation found a number of significant shortcomings in Mr Feri's care. Although these are unlikely to have affected the outcome for Mr Feri, we cannot ignore the poor management and treatment of a man with enduring and complicated health needs. I recognise that Mr Feri's problems would have made him challenging to support in any environment. Nevertheless, I do not consider it was acceptable that this vulnerable man was left in the same clothes and a dirty bandage for six weeks because he was unable to dress himself, urinating on the cell floor and drinking his own urine.

I am concerned that when Mr Feri first arrived at Wandsworth, the reception nurse and prison staff responsible for first night induction did not use an interpreter for initial assessments.

I consider that healthcare staff should have been more proactive in assessing his needs, putting care plans in place, arranging social care and considering him under the complex case arrangements.

Mr Feri missed several health appointments but, given the lack of induction and his language difficulties, it is not clear whether he was aware of them or the healthcare processes, and the reasons for his non-attendance were not followed up.

I am concerned that Mr Feri was not referred to the equalities officer, so that consideration could be given to reasonable adjustments and how best to support him.

I am also concerned that staff did not fully complete the security risk assessment for a hospital admission, or consider the impact of Mr Feri's reduced mobility and health in decisions about the use of restraints.

After Mr Feri's death, prison managers did not debrief staff, or formally notify prisoners and they were not offered support.

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

Sue McAllister CB
Prisons and Probation Ombudsman **June 2019**

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Summary

Events

1. Mr Milan Feri was remanded to HMP Wandsworth on 16 April, on a European arrest warrant, for extradition to Slovakia. He was Slovakian with limited English.

2. At his reception and general health screens, healthcare staff noted that Mr Feri was frail, with a large skull depression from a brain injury; impaired vision, hearing and memory; reduced mobility due to right-sided weakness; and limited use of his right arm. He was considered vulnerable because of his health issues.

3. Between 19 and 23 April, Mr Feri was admitted to the Jones Unit at Wandsworth, for prisoners with special medical needs. He then returned to the vulnerable prisoners' unit.

4. Prison and healthcare staff were increasingly concerned about his physical and mental health, as he became unkempt and incontinent and drank his own urine. In May, a nurse asked the virtual ward team (which provides enhanced nursing care on wings) to consider Mr Feri, but no action was taken.

5. A psychiatrist concluded that Mr Feri's problems were due to his brain damage and consequent inability to communicate, as well as depression and social issues.

6. Mr Feri had limited contact with healthcare staff as he did not attend several appointments. On 17 July, a nurse passing his cell noticed it was squalid and smelt and that Mr Feri was in poor condition. She completed a full assessment of Mr Feri's needs and took steps to begin addressing his health and social care problems. This included formal referrals to social services and to the virtual ward team.

7. At 8.14am on 27 August, a prison officer found Mr Feri unresponsive in his cell and radioed a medical emergency. Nurses attended and found signs of rigor mortis. Paramedics confirmed Mr Feri's death at 8.27am.

8. The post-mortem found that he had died of a heart attack.

Findings

9. Mr Feri had significant physical, cognitive and communication difficulties as a result of historic brain injury. In addition, he had very limited English.

10. The investigation found numerous failings in the management of Mr Feri and we agree with the clinical reviewer that the standard of his care at Wandsworth was below that he could have expected to receive in the community. Although these failings are unlikely to have affected the outcome for Mr Feri, we cannot ignore the unacceptably poor management and treatment of a vulnerable man with enduring and complicated health needs.

11. Healthcare staff did not manage Mr Feri under the prison's complex case arrangements and there was no overall care plan to address his medical needs.

Between June and August, Mr Feri missed eight healthcare appointments. The reasons were not recorded or followed up, and most were not rearranged.

12. Although Mr Feri was disabled, with reduced mobility and impaired communication skills, he was not referred to the equalities officer, as he should have been; there is no evidence that reasonable adjustments were made to reduce the disadvantage arising from his health problems; and no social care was provided.

13. The Governor had previously taken steps to make telephone interpreters more accessible and most healthcare staff used them. However, the nurse who conducted Mr Feri's initial health screen did not use this facility and prison staff did not conduct a first night interview due to Mr Feri's lack of English.

14. Mr Feri was in hospital for two days from 7.30pm on 17 April, yet a nurse noted in his medical records that she had a conversation with him after 10.00pm and made three further entries that she had observed him asleep in the early hours of 18 April. The prison should investigate the reasons for this inaccuracy.

15. The security risk assessment for Mr Feri's journey and admission to hospital was incomplete, with no medical input; no justification for either the level of risk, or the use of handcuffs on a man with reduced mobility; and no confirmation that the arrangements for restraints had taken account of a medical assessment.

Recommendations

- The Head of Healthcare should ensure that there is a coordinated multidisciplinary approach to meeting the needs of prisoners with complex health needs, including clear personalised care plans; prompt action on referrals; and appropriate standards of care.

- The Head of Healthcare should ensure that prisoners are appropriately notified of GP or clinic appointments; missed appointments are followed up and the reasons recorded; and appointments are rebooked, if necessary.

- The Governor and Head of Healthcare should ensure that all prisoners with disabilities are referred to the equalities officer and reasonable adjustments are made, if necessary, in line with PSI 2011/32.

- The Governor and Head of Healthcare should ensure that prisoners' social care needs are promptly assessed; that they receive appropriate and structured support, where necessary; and that there is a process in place to review their needs if their condition changes.

- The Governor and Head of Healthcare should ensure that staff use interpreting services for interviewing and assessing prisoners who do not understand English well.

- The Head of Healthcare should investigate the reason for the inaccuracies in Mr Feri's record on 17 April 2018 and consider whether disciplinary proceedings are appropriate.

- The Governor and Head of Healthcare 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 Governor should ensure that all relevant sections of the risk assessment are completed, including medical information on how the prisoner's current state of health has an impact on his mobility; and confirmation that prison staff have taken this information into account in assessing the prisoner's current level of risk.
- The Governor should ensure that, in line with national policy, prison staff, healthcare staff and prisoners are offered appropriate and timely support after a death in custody.

The Investigation Process

16. 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.

17. The investigator visited Wandsworth on 11 September. She obtained copies of relevant extracts from Mr Feri's prison and medical records and interviewed a prisoner.

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

19. The investigator and clinical reviewer interviewed 15 members of staff at Wandsworth on 9 and 12 October and 8 November.

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

21. The investigator wrote to Mr Feri's sister in Slovakia to explain the investigation and to ask if she had any matters they wanted the investigation to consider. She also sent a copy of the letter via the Slovakian Embassy contact who had initially located Mr Feri's sister. She did not reply to our letter and we understand that Mr Feri's family told the prison and the Slovakian Embassy that they did not want to be involved.

22. We shared the initial report with HM Prison and Probation Service (HMPPS) and they found no factual inaccuracies. The HMPPS action plan has been annexed to this report.

Background Information

HMP Wandsworth

23. 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) for prisoners with a wide range of general medical, rehabilitative and health-related respite needs.

HM Inspectorate of Prisons

24. 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 waiting times for appointments were often lengthy and there were high rates of non-attendance. The range of primary care services and visiting specialists was appropriate. However, there was concern about the arrangements for social care.

25. Inspectors reported that the strategic management of equality and diversity had improved, but was still underdeveloped and under-resourced. Prisoners' protected characteristics were not routinely identified and there was no disability data on around half of them. A third told the inspection team they had a disability, but inspectors found that prisoners with disabilities received little targeted support. Thirty-eight per cent of prisoners were foreign nationals. Again, there was little specific provision for them and the telephone interpreting service was used almost exclusively by healthcare staff. There were inadequacies in the first night and induction process.

Independent Monitoring Board

26. 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 31 May 2018, the IMB reported that, owing to successful recruitment of healthcare staff, there had been improvements in some of the problems identified in their previous annual report. Waiting times for prison clinics were still very high.

27. The prison held weekly private surgeries for foreign national prisoners. Staff sometimes used prisoners to assist with interpreting and they also had access to a telephone interpreting service. The Board was concerned that staffing problems had reduced the effectiveness of the equalities team. This was evident in the poor accuracy of equalities information from the first night in custody form.

Previous deaths at HMP Wandsworth

28. Mr Feri was the third prisoner to die from natural causes at Wandsworth since January 2016. There have been two further deaths. We have made previous recommendations to Wandsworth about risk assessments and the use of restraints; and the need to use translation services for prisoners with limited English.

Key Events

Mr Feri's arrest and detention

29. On 13 April 2018, Mr Milan Feri was arrested on a European arrest warrant, for extradition to Slovakia. Once extradited, he was expected to serve three years in prison for 'legacy' child neglect.

30. Mr Feri was a Slovakian national, with limited English. The police used an interpreter to speak to him. A small quantity of cocaine was found on him and it was noted that he had an obvious skull depression from a craniotomy (surgery to open the skull and access the brain). The police concluded he was a vulnerable adult at risk of serious harm and he was refused bail for his own protection. While in police custody, Mr Feri complained of hunger and hearing problems.

Arrival at HMP Wandsworth

31. On 16 April, Mr Feri was remanded to HMP Wandsworth. An officer began the Assessment Care in Custody and Teamwork (ACCT) suicide and self-harm prevention procedures due to concerns about Mr Feri's mental health, unusual behaviour and vulnerability. She also noted in Mr Feri's personal record that his first night in custody assessment was not completed due to "… no English spoken and mental health issues". (The ACCT process was closed on 20 April.)

32. A nurse carried out an initial health screen. She, incorrectly, noted Mr Feri's language as Slovenian and that an interpreter was not needed. She noted Mr Feri's previous craniotomy and "right arm visibly disabled, reasons not known, shoulder slumped and a lack of movement is noted throughout the arm". She described him as frail, with an unsteady gait and extremely underweight and he presented as mildly anxious, moderately agitated, restless and fidgety. Mr Feri also had impaired vision and hearing and he was unable to focus or concentrate. The nurse completed a drug and alcohol assessment, concluding that Mr Feri was a heavy drinker, but needed no medication to manage his symptoms. She referred him to the mental health team, drug treatment service and smoking cessation service. In view of his difficulties and vulnerability, he was allocated to the vulnerable prisoners' unit.

33. A prison GP then reviewed Mr Feri. He noted that his history was "all very unclear" and that he had epilepsy following a head injury. He prescribed diazepam (a drug used to treat anxiety and seizures).

34. On 17 April, at a secondary health screen, a nurse noted the indentation to Mr Feri's skull and that Mr Feri appeared to have right-sided weakness. He was unable to understand simple questions and said he could not understand the Slovakian interpreter. His cellmate said that Mr Feri was able to dress and feed himself and go to the toilet. On the strength of this information, the nurse concluded that he did not need social care support.

35. Shortly afterwards, a prison GP assessed Mr Feri, using a telephone interpreting service. Mr Feri said that his right arm had been painful following an accident. He appeared to be hard of hearing on the same side as his craniotomy. A fax from Mr Feri's GP confirmed that he had no current medication and his brain

injury had been caused by a subdural haemorrhage (bleeding between the skull and the surface of the brain) after being hit by a car as a pedestrian in 2008. This had also impaired his memory. The GP prescribed Fortisip, a nutritional supplement.

36. The same day, the community learning disabilities nurse recorded that the in-reach multidisciplinary team had decided that Mr Feri should be managed under the ACCT procedures and the substance misuse strategy. (A later entry noted there was no evidence of substance misuse.)

37. During the evening, Mr Feri collapsed in his cell, with breathing difficulties and was sent to hospital. He became unconscious and was admitted to the intensive care unit. Doctors removed a large mass of food from his throat.

38. On 19 April, Mr Feri returned to Wandsworth. A nurse examined him and noted that he appeared frail and his left arm was bandaged. Mr Feri was admitted to the Jones Unit and observed four-hourly. A nurse noted a plan to request a soft diet from the kitchen; maintain a food chart; weigh Mr Feri twice a week; and refer him to a speech and language therapist (to assess his swallowing reflex, given the choking which had led to his hospital admission). In an entry the following day, the nurse repeated the need for this referral, but there is no evidence that it was made.

39. Mobility and epilepsy care plans were created. Staff monitored Mr Feri closely and noted every day that he was constantly hungry and frequently asked for food. (Frequent complaints of hunger persisted throughout his time at Wandsworth.) Mr Feri was discharged from the Jones Unit on 23 April and returned to the vulnerable prisoners' unit.

40. On 14 May, a supervising officer told a nurse that he was concerned about Mr Feri, as he remained in his cell all day, was incontinent of urine and faeces and had been drinking his urine. The nurse referred him to the mental health in-reach team. (Further mental health referrals were made by concerned staff.)

41. On 20 May, a nurse sent a task to the virtual ward team, requesting help for Mr Feri. (A virtual ward is an enhanced package of care overseen by a GP. It is a pathway for those who do not need acute medical inpatient support, but require ongoing intensive therapy and/or nursing care.)

42. An Associate Specialist Psychiatrist assessed Mr Feri on 29 May, with an interpreter. He found that Mr Feri was not oriented to person, time or place and was unaware of his physical health needs, although he mentioned some of his struggles with daily living activities. The psychiatrist diagnosed dysphasia (difficulties with spoken language, understanding, reading and writing due to brain damage or disease) and noted that the interpreter found it difficult to understand his speech. At times during the consultation, Mr Feri became angry and tearful due to the difficulties in finding words to describe his needs.

43. The psychiatrist found no thought disorder and concluded that Mr Feri's presentation was due to a combination of his severe brain injury, moderate depression, and social issues due to isolation and not seeing his family. He

prescribed mirtazapine (an antidepressant) for sleep and to treat Mr Feri's depression.

44. The psychiatrist also referred Mr Feri to the in-reach psychology service for a neuropsychology assessment and anger management, as his frustration and difficulty in controlling his emotions, due to his head injury, was complicating his physical health issues. Mr Feri was not seen by this service.

45. Between June and August, Mr Feri failed to attend eight healthcare appointments, including several booked by the virtual ward team for the unit nurse, prison GP and an optician. There is no evidence that the appointments were followed up.

46. On 10 July, a nurse from the primary care mental health team went to see Mr Feri in his cell, due to continuing concerns. He refused to engage with her. The smell of urine in the cell was very strong and he was unkempt. A supervising officer and a prisoner told the nurse that Mr Feri's brother-in-law had helped to care for him in prison, but he was no longer there. Since then, Mr Feri would not allow nurses or officers to clean him. He urinated around his cell and drank his urine. He was again discussed at the multidisciplinary in-reach team meeting and referrals were made to the GP, to check if he had a urinary tract infection and to the specialist learning disabilities nurse. Mr Feri's urine was not tested and he was not seen by the learning disabilities nurse.

47. On 17 July, a nurse was passing Mr Feri's cell and was concerned about the smell. She went in and saw that Mr Feri was extremely soiled, lying on his bed with no bed linen and multiple discarded Fortisip bottles. She removed the bandage from his left arm, as it was very dirty and appeared not to have been changed since April. The nurse noted safeguarding and vulnerable adult concerns and planned to discuss with a manager the possibility of readmission to the Jones Unit for a comprehensive assessment of Mr Feri's needs. She made an urgent referral to social services (which had not been done before) and requested an infection screen, urine analysis and a GP review.

48. Later that day, the nurse persuaded Mr Feri to go to the clinic room. With the help of the equalities orderly, she helped him out of the clothes he had been wearing constantly for the last six weeks and helped him to put on clean clothes. She said his aggression was more frustration than anger and he was easily calmed. In spite of using a Slovakian interpreter, it was a very difficult consultation. Mr Feri did not know where he was or what country he was in.

49. The nurse completed a full assessment of Mr Feri's needs. She concluded that he could not cope with daily living tasks and listed the following: he could not wash or dress himself without help, due to weakness on his right side and an inability to use his right hand; he was always hungry, but unable to open packaged food and relied on others to collect his meals; he had difficulty chewing because of poor teeth and oral care, so had a mainly liquid diet; he was unable to use the toilet properly and urinated on the floor, probably due to a lack of dexterity; he could walk short distances, but was unsteady and needed a walking stick; and one of the lenses from his glasses was missing, so he squinted. The nurse planned for Mr Feri to be monitored at least twice weekly by the virtual ward and referred him to the optician. She considered him unsuitable for the Jones Unit at that time, as he would become disorientated, agitated and stressed.

50. On 18 July, a prison GP reviewed blood test results. He noted abnormalities and that Mr Feri should see a GP. Two appointments were booked, but Mr Feri did not attend and this was not followed up.

51. On 24 July, a nurse made a formal referral to the virtual ward and noted that they were still waiting for a social services assessment. Mr Feri missed a GP appointment the next day and an appointment with a consultant psychiatrist on 16 August.

52. On 19 August, an entry in the prison's intelligence system noted several concerns about Mr Feri's physical and mental health and that managers should do a welfare check. The information was supposed to be disseminated to the security manager, wing manager, in-reach team and safer custody.

53. Mr Feri did not attend a virtual ward appointment on 21 August, so a nurse went to see him. She planned to discuss whether he met the criteria for the Jones Unit.

54. In May and again in July and August, there are numerous entries in Mr Feri's prison record about him constantly misusing the emergency cell bell. When staff answered he either could not say what he wanted or asked for food or medication which he had already received, and staff recorded that he shouted, grunted or swore at them. On 22 May he was described as being "a drain on staff resources". He was given warnings under the Incentives and Earned privileges (IEP) policy on 6 May and 11, 12 and 25 August for misusing his cell bell.

Events of 26/27 August

55. An equalities representative (a paid prisoner role) helped Mr Feri informally by collecting his meals and changing his bedding. He said that Mr Feri was a little quieter on 26 August, but was otherwise his normal self.

56. An operational support grade (OSG) counted the prisoners on C wing at around 9.00pm. She said Mr Feri was sitting on his bed and looked up at her. Unusually, he did not ring his cell bell at all that night. Just after 5.00am on 27 August, the OSG carried out the early morning count of prisoners, but she could not remember Mr Feri's position in the cell, or anything specific about him.

57. Just after 8.00am, an officer began unlocking prisoners who needed to collect their medication. At 8.14am, he went to Mr Feri's cell and saw him slumped on the floor against his bed. The officer called out to Mr Feri three times, but he did not respond. He then tapped Mr Feri's shoulder, felt his hand and noticed he was cold. The officer called a code blue (a medical emergency code which indicates a prisoner is unresponsive, or has difficulty breathing).

58. Five nurses attended in response to the code blue. The two emergency response nurses took the lead. They moved Mr Feri to the landing and applied the defibrillator, which advised no shock. The nurses performed one cycle of cardiopulmonary resuscitation, then stopped as there were signs of rigor mortis.

59. An ambulance arrived at the prison at 8.18am and the paramedics reached the cell at 8.24am. The paramedics noted the rigor mortis and confirmed Mr Feri's death at 8.27am.

Contact with Mr Feri's family

60. A supervising officer (SO) was assigned as the prison's family liaison officer (FLO). She asked West Yorkshire Police to notify Mr Feri's family of his death. On the day of Mr Feri's death, the police went to five addresses, but were told each time that the family were either unknown, or had moved on.

61. The FLO made extensive enquiries through social services departments in the West Midlands and West Yorkshire to try to trace Mr Feri's family. She found that they had returned to Slovakia. She obtained telephone numbers and an address for several members of Mr Feri's family, but all attempts to contact them, using a telephone interpreting service, were unsuccessful. The FLO contacted the Slovakian Embassy, who then located Mr Feri's sister and further communication was conducted through the Embassy.

62. The prison arranged Mr Feri's funeral, as his family were unable to do so. In line with national policy, the prison paid the funeral expenses, in full.

Support for prisoners and staff

63. A senior nurse debriefed the nurses involved in the emergency while they were together preparing their notes of the incident. No debrief was held by prison managers.

64. The prison posted a notice informing staff of Mr Feri's death and reminding them of the support available. No notice was posted for prisoners. An officer told the equalities representative who helped Mr Feri about his death. The equalities representative said he struggled to come to terms with it and, although one of the supervising officers had been supportive, he had received no formal offer of support.

Post-mortem report

65. The post-mortem examination found that the cause of Mr Feri's death was heart failure due to heart disease.

Findings

Clinical care

Physical health

66. The clinical reviewer found that Mr Feri's care at Wandsworth was not equivalent to that he could have expected to receive in the community. However, she noted that it would have been challenging to support him in any environment.

67. Reception assessments and subsequent medical reviews identified Mr Feri's longstanding health problems arising from a brain injury and his vulnerability as a result of this. Although he was reviewed from time to time, his significant and continuing health issues were not considered under the prison's primary care complex case arrangements and there was no overall plan to manage his care.

68. A task to the virtual ward on 20 May, which might have led to a GP overseeing a package of care, was not actioned and a formal referral was not made until 24 July. The absence of a coordinated approach to Mr Feri's care meant that plans in his medical record, such as monitoring his weight and diet, were not carried out and referrals to the speech and language therapist and the learning disability nurse were not actioned.

69. There was a suggestion that some of Mr Feri's behaviour might have been due to a urine infection, but no tests were carried out to investigate this. The equalities representative who assisted Mr Feri said that nurses attempted to obtain urine samples, but Mr Feri had refused as he was embarrassed to provide the samples in the presence of a woman.

70. A further consequence of the lack of a clearly defined management plan was that there was no agreed approach to managing Mr Feri's behaviours (such as repeatedly pressing his cell bell) which could be shared with prison staff to ensure there was shared understanding and a consistent approach.

71. While the deficiencies identified did not directly impact on Mr Feri's death and staff could not have prevented Mr Feri's death, we cannot ignore the unacceptably poor management and treatment of a vulnerable man with enduring and complicated health needs. We make the following recommendations:

    The Head of Healthcare should ensure that there is a coordinated multidisciplinary approach to meeting the needs of prisoners with complex health needs, including clear personalised care plans; prompt action on referrals; and appropriate standards of care.

Missed appointments

72. Mr Feri missed several healthcare appointments. No reasons were recorded and most were not followed up. It is unclear whether any special measures were put in place to notify and remind Mr Feri of these appointments, given his language and cognitive difficulties. It is also possible that Mr Feri's mobility problems might have made it difficult to get to clinics.

73. Wandsworth's equality policy says that all areas of healthcare should be easily accessible for every prisoner and arrangements will be made for the nurse to see a prisoner in their cell if they are unable to make their own way to the clinic. The investigator was told that if an appointment is missed, it is rebooked by an administrator, but there was no structured way of finding out why the prisoner did not attend.

74. We are concerned that Mr Feri missed so many appointments, without explanation and most appear not to have been rearranged. We make the following recommendation:

The Head of Healthcare should ensure that prisoners are appropriately notified of GP or clinic appointments; missed appointments are followed up and the reasons recorded; and appointments are rebooked, if necessary.

75. The clinical reviewer made additional recommendations about Mr Feri's clinical care unrelated to the cause of death, which the Head of Healthcare should consider.

Mr Feri's disability

76. Prison Service Instruction (PSI) 2011/32, *Ensuring Equality*, indicates that Governors must ensure that reasonable adjustments are made for disabled prisoners to avoid them being at a disadvantage and to enable them to take a full part in the normal life of the establishment.

77. A large number of the clinicians who saw Mr Feri noted that he had a number of physical, cognitive and communication problems as a result of his brain injury. This should have led to a conclusion that he had an enduring disability for which a detailed plan of care was required. It is difficult to understand why this did not happen.

78. The equalities manager at Wandsworth was supposed to have the resource of an officer daily, but this did not happen very often (an issue also noted in the most recent inspection of Wandsworth). She expected to be made aware of any men with complex needs, but referrals to her were largely dependent on the accuracy of the information collated by first night staff. (The IMB had concerns about the accurate recording of information on the first night.)

79. The equalities manager was unaware of Mr Feri before his death. She accepted that given he was a foreign national with physical disabilities, a very limited understanding of English and limited ability to express himself, he should have been referred to her through various routes. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all prisoners with disabilities are referred to the equalities officer and reasonable adjustments are made, if necessary, in line with PSI 2011/32.

Social care

80. In the most recent inspection of Wandsworth, HM Inspectorate of Prisons found weaknesses in the process for addressing prisoners' social care needs. The

equalities manager said that social care needs should be assessed during a prisoner's secondary health screen and social services would normally see the prisoner within a week of a referral.

81. The nurse who conducted Mr Feri's secondary health screen decided that he did not need social care at that time, as his cellmate had reported that he was able to care for himself. However, within weeks, staff repeatedly reported concerns about Mr Feri's poor level of hygiene, including wearing the same clothes for several weeks and urinating around his cell. In spite of this, there was no immediate review of his social care needs and he was not formally referred for a social services assessment until 17 July. Wandsworth Council's Department for Adult Social Care said that they had no record of a referral, or an assessment of Mr Feri.

82. An equalities representative helped informally with some tasks, such as fetching Mr Feri's meals and changing his bedding. He said that Mr Feri needed a lot of help due to the incapacity caused by his weakness and pain. He and another prisoner and friend of Mr Feri, felt that he had been ignored at Wandsworth.

83. Although Mr Feri received informal help, there is strong evidence that he should have been referred for a social services assessment sooner than 17 July. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prisoners' social care needs are promptly assessed; that they receive appropriate and structured support, where necessary; and that there is a process in place to review their needs if their condition changes.

Use of interpreters and translation services

84. PSI 64/2011, *Safer Custody*, states, "All members of staff must consider the use of translation services when dealing with prisoners whose first language is not English and, in particular, when conducting assessments of risk and/or during the risk management process."

85. In addition, PSI 07/2015, *Early Days in Custody*, sets out mandatory reception and induction procedures. It states:

> "All prisoners undergoing induction must be treated decently, with full regard to equality, and any special needs … Particular care should be taken to ensure that prisoners with special needs in relation to communication or understanding receive the support and information they need to overcome immediate issues that arise. The immediate needs of prisoners with disabilities or learning difficulties must be addressed…"

The instruction also emphasises that, "safer custody, decency and equality must be treated as high priority issues at all times". At interview, the equalities manager said she expected interpreting services to be used for first night induction where necessary. To make the service more accessible for staff, the Governor had approved the use of a single access code, instead of individual PIN numbers.

86. There are varying accounts of Mr Feri's understanding and use of English. Staff did not conduct a first night interview, apparently due to his inability to speak English and his perceived mental health issues. There is no evidence that he received an induction at any other time to ensure that he fully understood the prison regime, rules and procedures. The equalities representative said that Mr Feri only had a few words of English and they communicated mainly by sign language. He had seen nurses using interpreters when speaking to him, but no wing staff.

87. Most healthcare staff regarded Mr Feri's English as poor and used translation services for key meetings and assessments. However, the nurse who conducted Mr Feri's initial health screen had considered it unnecessary. In a statement, she said he was confused, so it was difficult to understand the extent of his medical needs. The nurse had recorded his language as Slovenian. At interview, she acknowledged that Mr Feri was Slovakian, but maintained that he had said he spoke Slovenian.

88. The weight of evidence suggests that due to Mr Feri's limited knowledge of English (together with likely comprehension difficulties arising from his brain injury) an interpreter was needed for formal discussions with staff. This did not happen for at least two key assessments and wing staff reportedly did not use telephone or prison interpreters at any time during their interactions with Mr Feri. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff use interpreting services for interviewing and assessing prisoners who do not understand English well.

Record keeping

89. Mr Feri was taken to hospital at around 7.30pm on 17 April (and returned to the prison on 19 April). At 10.19pm on 17 April, a nurse noted in Mr Feri's medical record, "Patient stated he's fine." She later made entries at 2.30am, 5.11am and 7.00am on 18 April recording, "Patient appears asleep."

90. We do not know the reason for these significant errors. The nurse might have mistaken someone else for Mr Feri, or recorded the entries in the wrong record. However, there is also the possibility that she updated the records without making the checks. Although this had no impact on Mr Feri's death, failure to complete the prescribed checks of vulnerable prisoners can have serious consequences. We make the following recommendation:

The Head of Healthcare should investigate the reason for the inaccuracies in Mr Feri's record on 17 April 2018, and consider whether disciplinary procedures are appropriate.

Security risk assessment and use of restraints

91. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. 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.

92. 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.

93. The escort risk assessment for Mr Feri's journey and admission to hospital on 17 April stated that he was a medium risk of escape, medium risk to the public and a low risk on all the other security factors. It was noted that there was no previous history of escape or abscond, but there was no comment to explain why he was considered a medium risk on this aspect.

94. There was no medical input on the form, which explicitly requires a clinician to comment on medical conditions that might affect handcuffing arrangements, such as disability, a serious medical condition, frailty or a lower arm injury. There is also a requirement for the duty manager (or operational manager in their absence) to complete a section of the form, before the risk assessment is signed, to confirm that the handcuffing arrangements have taken account of the medical assessment and operational needs. This section was blank. The risk assessment concluded that Mr Feri was standard risk and should be escorted by two prison officers, using single handcuffs. They could only be removed with the prior approval of the duty manager and when his condition improved, he was expected to be double-cuffed.

95. The Prison Service has a duty to protect the public when escorting prisoners outside prison. It also has a responsibility to balance this by treating prisoners with humanity. We recognise that Mr Feri was verbally challenging at times, through frustration at his inability to communicate, but there is no evidence that he was physically aggressive. He had limited mobility, with right-sided weakness and no movement of his right arm. He could only walk short distances, leaning on the wall to steady himself. In spite of this and an escort of two officers, the prison concluded that he should be handcuffed (and when better, double handcuffed) with no justification as to why this was considered necessary. We make the following recommendation:

The Governor and Head of Healthcare 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 Governor should ensure that all relevant sections of the risk assessment are completed, including medical information on how the prisoner's current state of health has an impact on his mobility; and confirmation that prison staff have taken this information into account in assessing the prisoner's current level of risk.

Support for staff and prisoners

96. PSI 64/2011 requires prisons to hold a 'hot debrief' after all deaths in custody. This should be led by a senior manager and all staff directly involved in the

incident, including healthcare staff, should be invited. The instruction also sets out the expectation that prisoners should be offered support.

97. Prison managers did not hold a debrief for staff, although a senior nurse debriefed the nurses. The prison did not issue a notice to inform prisoners of Mr Feri's death and the equalities representative who assisted with his care felt inadequately supported after he learned of Mr Feri's death. We make the following recommendation:

The Governor should ensure that, in line with national policy, prison staff, healthcare staff and prisoners are offered appropriate and timely support after a death in custody.

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