

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Vine a prisoner at HMP Wandsworth on 11 April 2019

A report by the Prisons and Probation Ombudsman

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*



© Crown copyright 2018

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 Stephen Vine died in hospital on 11 April 2019 from pneumonia and heart disease, while a prisoner at HMP Wandsworth. He was 49 years old. I offer my condolences to those who knew him.

Mr Vine had been at Wandsworth for only eight days when he was found unresponsive in his cell and was taken to hospital, where he died the next day. During his time at Wandsworth, Mr Vine displayed very challenging behaviour and frequently refused to engage with prison healthcare staff. The clinical reviewer was satisfied that the care Mr Vine received at Wandsworth was equivalent to that which he could have expected to receive in the community.

I am concerned, however, that when Mr Vine was found unresponsive, healthcare staff did not call a medical emergency code immediately, which caused a delay in an ambulance being called. I cannot say whether the delay affected the eventual outcome for Mr Vine.

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

November 2019

Contents

Summary	1
The Investigation Process	3
Background Information	4
Key Events	5
Findings.....	8

Summary

Events

1. On 2 April 2019, Mr Stephen Vine was remanded in custody for arson and sent to HMP Wandsworth.
2. When Mr Vine arrived at Wandsworth, nurses were unable to complete a reception health screen as Mr Vine would not cooperate.
3. The following day, a prison psychiatrist went to see Mr Vine, but he still refused to cooperate. He was moved to the mental health inpatients unit within the prison for further assessment.
4. Over the next few days, Mr Vine's behaviour was very difficult. He refused to have his clinical observations taken, refused to take his medication and was often rude and abusive to staff when they went to his cell.
5. At around 9.30pm on 10 April, a nurse went to Mr Vine's cell to check on him. The nurse looked through the observation panel and saw Mr Vine lying on his back on his mattress on the floor. Mr Vine asked the nurse for a cup of tea.
6. When the nurse went back 15 minutes later, Mr Vine was still lying down and the nurse could not get a response from him. The nurse called to another nurse for help and they both looked through the observation panel and tried to get a response from Mr Vine but without success. After a few minutes, one of the nurses called a medical emergency code. An officer attended, unlocked the cell and all three of them went in. A third nurse arrived shortly after. She could not find a pulse so staff started cardiopulmonary resuscitation (CPR) until ambulance paramedics arrived and took over.
7. Mr Vine was taken to hospital but he never regained consciousness and died the next day.
8. The post-mortem report concluded that Mr Vine died from aspiration pneumonia and heart failure, caused by heart disease.

Findings

9. The clinical reviewer found that overall, Mr Vine's care was equivalent to that which he could have expected to receive in the community.
10. However, we are concerned that when the nurse realised that Mr Vine was unresponsive, he did not call a medical emergency code immediately. This resulted in a delay in calling an ambulance, though we cannot say whether this affected the outcome for Mr Vine.
11. The clinical reviewer was also concerned that when the nurses entered the cell to assess Mr Vine, they did not immediately check for a pulse or start CPR.

Recommendations

- The Head of Healthcare should ensure that all staff are familiar with the medical emergency response codes and use them appropriately.
- The Head of Healthcare should ensure that all staff are properly trained to be able to respond appropriately to emergency situations.

The Investigation Process

12. 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
13. The investigator visited and obtained copies of relevant extracts from Mr Vine's prison and medical records.
14. The investigator interviewed six members of staff at Wandsworth on 16 May 2019.
15. NHS England commissioned a clinical reviewer to review Mr Vine's clinical care at the prison. The clinical reviewer conducted joint interviews with the investigator.
16. We informed HM Coroner for Inner West London of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
17. There was no family involvement in the investigation. Mr Vine had no nominated next of kin.
18. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

HMP Wandsworth

19. 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

20. The most recent inspection of HMP Wandsworth was in March 2018. Inspectors found that most prisoners were satisfied with the quality of health provision, but waiting times for appointments were often lengthy. They considered the range of primary care services and visiting specialists was appropriate and external hospital appointments were well managed.
21. Inspectors also reported that healthcare staff were proactive in supporting smoking cessation for prisoners and their response to medical emergencies was timely and coordinated.

Independent Monitoring Board

22. 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.
23. The Board was pleased to note that Her Majesty's Inspectorate of Prisons found the mental health services in the prison adequate. The service was comparable to that which would be available in the community, and prisoners who would not meet the threshold for community mental health services were seen and assessed in the prison.

Previous deaths at HMP Wandsworth

24. Mr Vine was the eighth prisoner to die at Wandsworth since April 2017. Of the previous deaths, six were from natural causes, one was drug-related and the other is awaiting classification. There are no similarities between Mr Vine's death and previous deaths at Wandsworth.

Key Events

25. On 2 April 2019, Mr Stephen Vine was remanded in prison custody charged with arson. He was sent to HMP Wandsworth.
26. Mr Vine had been diagnosed with left ventricular dysfunction (a problem with the heart's main pumping chamber which can often lead to heart disease) in 2017 and with high blood pressure in 2018. When he was arrested, he complained of chest pain and was admitted to hospital for five days. Tests showed that he had high troponin levels, which can indicate a heart attack. However, Mr Vine refused further treatment and declined medication while he was a hospital inpatient.
27. When he arrived at Wandsworth, a nurse completed an assessment of Mr Vine's alcohol intake. She recorded that Mr Vine had been a heavy drinker before coming into prison. She referred him to alcohol intervention services.
28. Later that evening, a nurse attempted to complete a reception health screen. Mr Vine was uncooperative so the assessment was very limited. Healthcare staff planned to see him again the following day to try to gather further information.
29. On 3 April, Mr Vine did not attend for his secondary screening. A psychiatric doctor from the mental health in-reach team, tried to assess Mr Vine but he would not cooperate. He sat on the floor swearing at the doctor and muttering to himself. The doctor decided that Mr Vine should be moved to the Addison Unit (the inpatient mental health unit in the prison) so that he could be assessed further. That afternoon, Mr Vine refused to be moved to the Addison Unit, so he was moved under restraint. He prescribed him with Lorazepam (a benzodiazepine drug with sedating properties).
30. That night, Mr Vine slept poorly and did not allow staff to carry out vital observations on him.
31. On 4 April, a prison GP went to Mr Vine's cell to try to carry out an assessment. Mr Vine was racially abusive and aggressive to her, so it was not possible for her to complete an assessment.
32. Later that day, Mr Vine was discussed on the ward round. A psychiatric doctor contacted Mr Vine's solicitor to say that they were considering transferring Mr Vine to a secure unit.
33. Over the next few days, Mr Vine declined to be assessed and refused to take his medication. When staff went to his cell he was rude and abusive.

Events of 10 April

34. On 10 April, a psychiatric doctor went to Mr Vine's cell. He was lying on the floor and would not engage in any assessment. Mr Vine was again racially abusive to the doctor, he refused to have his observations taken and refused to take any medication. Later that day a nurse created a hygiene care plan for Mr Vine.
35. At 9.30pm, a nurse who was on night duty went to Mr Vine's cell to check on him. He said that Mr Vine was lying on his back on his mattress on the floor and

asked for a cup of tea. When he went back to the cell 15 minutes later, Mr Vine had moved position but was not responding. Because of Mr Vine's previous behaviour, he did not think that it was strange for Mr Vine to not respond, but asked his colleague to go with him to the cell to assess the situation.

36. At 9.51pm, both nurses looked through the cell hatch and tried to get a response from Mr Vine. The other nurse thought that he could see Mr Vine breathing. He noted that the cell was very messy, food and faecal matter could be seen on his body and on the floor, and Mr Vine's trousers were covered in urine. Mr Vine still did not respond.
37. At approximately 9.58pm, the nurse called a code blue (a medical emergency code used to indicate that a prisoner is unconscious or having breathing difficulties). The nurses did not have a cell key so could not open the door until an officer attended with keys. A few moments later an officer arrived, opened the cell door and entered the cell with both nurses. A nurse heard the code blue over the radio and went to the cell. She saw that Mr Vine was not breathing and his skin had turned grey. The cell was very cramped so she moved him to the landing to start cardiopulmonary resuscitation (CPR). Other prison staff responded and assisted in CPR until the ambulance arrived and took over at 10.20pm.
38. At 11.40pm, the ambulance left the prison to take Mr Vine to the hospital. When Mr Vine got to hospital he was taken to intensive care. He was put on a ventilator and had a scan of his brain and his chest. The scan showed that he had a collapsed lung and brain damage.
39. On 11 April, brain stem testing showed no effective responses, treatment was stopped and Mr Vine's ventilator was turned off. At 3.10pm, Mr Vine was pronounced dead.

Contact with Mr Vine's family

40. On 11 April, shortly after Mr Vine had died, the prison appointed a Senior Officer (SO) as the family liaison officer (FLO). Mr Vine did not have a named next of kin but the SO tried to find out if Mr Vine had any family by contacting the mental health service and Leicestershire police. After lengthy searches no next of kin was identified.
41. The prison paid for Mr Vine's funeral in line with national guidelines.

Support for prisoners and staff

42. After Mr Vine's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
43. The prison posted notices informing other prisoners of Mr Vine's death, and offered support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Vine's death.

Post-mortem report

44. The post-mortem report concluded that Mr Vine died of aspiration pneumonia and heart failure, caused by heart disease.

Findings

Clinical Care

45. The clinical reviewer considered that the care Mr Vine received at Wandsworth was equivalent to that which he could have expected to receive in the community.

Emergency Response

46. Prison Service Instruction (PSI) 03/2013 'Medical Emergency Response Codes', issued in February 2013, contains a mandatory instruction that prisons should have a local protocol which gives guidance on efficiently communicating the nature of any medical emergency. It directs that staff should use a code blue (or code one) for any emergency where a prisoner has symptoms including unconsciousness and fitting.
47. We consider that when a nurse did not get a response from Mr Vine he should have called a code blue. The code blue was not called until several minutes later, which caused a delay in an ambulance being called. We are unable to say if this delay affected the overall outcome for Mr Vine but we know that in an emergency situation, a delay of a few minutes may be critical. We make the following recommendation:

The Head of Healthcare should ensure that all staff are familiar with the medical emergency response codes and use them appropriately.

48. We are also concerned that when two nurses entered the cell they did not start CPR or take the necessary actions that would be expected of a nurse, particularly checking for a pulse. We make the following recommendation:

The Head of Healthcare should ensure that all staff are properly trained to be able to respond appropriately to emergency situations.

**Prisons &
Probation**

Ombudsman
Independent Investigations