Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Osman Hassan a prisoner at HMP Wandsworth on 10 October 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*

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 Osman Hassan died on 10 October 2018 at HMP Wandsworth. The cause of his death was cardiac tamponade (compression of the heart due to a build-up of blood around the heart muscle). He was 45 years old. I offer my condolences to Mr Hassan's family and friends.

Mr Hassan had high blood pressure, which had been diagnosed by his community GP. Prison healthcare staff re-prescribed his medication and checked his blood pressure frequently. On most occasions, it was high. The investigation found that the prison's management of high blood pressure was not consistent with national guidelines. There was no clinical pathway to manage men with this condition and no coherent plan to address Mr Hassan's consistently high blood pressure. When Mr Hassan reported chest pains, a nurse listed him for a chest X-ray, but there was no record of the outcome. I consider that Mr Hassan's clinical care was the below the standard he could have expected to receive in the community.

After Mr Hassan's collapse, healthcare staff quickly attempted to resuscitate him. However, there was an unacceptably lengthy delay in allowing the second paramedic crew access to the prison. This was particularly poor, as the crew had arrived in response to a request from the first paramedics who needed additional assistance and equipment.

I am also concerned that managers did not debrief staff involved in the emergency response to ensure that they were adequately supported.

I commend the safer custody team for the exceptional tailored support and counselling provided to prisoners affected by Mr Hassan's death. I regard this as very good practice.

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** **May 2019**

## Contents

# Summary

## Events

1. On 25 September 2017, Mr Osman Hassan was remanded to HMP Wandsworth. He was later sentenced to ten years and three months in prison.

2. Mr Hassan had a family history of cardiovascular disease and he had been diagnosed with high blood pressure by his community GP. An initial check of his blood pressure showed that it was within normal limits. However, within a few days it became elevated. Mr Hassan's blood pressure was checked many times over the following year and was usually high. A prison GP arranged for him to discuss with a nurse whether he was taking his medication as prescribed, but there is no record that this took place.

3. On 11 October 2017 and 11 March 2018, Mr Hassan was seen by emergency response nurses after reporting chest pain during the former incident and abdominal and back pain on the latter. In July, he complained of dizzy spells and blurred vision.

4. During a blood pressure check on 9 October, Mr Hassan told a nurse that he often had dizzy spells, headaches and tension in his neck. The nurse added him to the list for blood pressure monitoring and an appointment with an advanced nurse practitioner to manage his condition. That afternoon, Mr Hassan reported pain in his neck and shoulder and received painkillers.

5. At around 11.20pm the same day, Mr Hassan was on the prison landing talking to several other prisoners who were waiting to go into their cells. He suddenly collapsed. Healthcare staff were immediately on hand and began cardiopulmonary resuscitation. Paramedics attended and took over the resuscitation attempts. They were unsuccessful and a paramedic confirmed Mr Hassan's death at 12.43am on 10 October.

## Findings

6. The cause of the aortic aneurysm with led to the cardiac tamponade is unknown, but persistently raised blood pressure can increase the risk.

7. National guidelines on managing high blood pressure advocate the importance of regular monitoring and management of those with high blood pressure. Mr Hassan's blood pressure was taken 20 times during his year at Wandsworth and was consistently high. However, the prison had no clinical pathway to manage high blood pressure, so there was no structured care plan to explore his symptoms and help improve his condition. While there is no evidence that the absence of such management impacted on Mr Hassan's death, the care he received at Wandsworth was below the standard he could have expected to receive in the community.

8. After he reported chest pains on 11 October 2017, a nurse listed Mr Hassan for a chest X-ray. There is no record of whether this was followed up or completed and, if so, the outcome. The clinical reviewer considered that there was no

rationale for such an X-ray and that no direct harm was caused but, with hindsight, there is a possibility it might have detected an underlying condition.

9. The first crew of paramedics asked for additional assistance and equipment. When the second crew arrived, there was a significant and unacceptable delay of at least 16 minutes in allowing entry to the prison.

10. Prison managers did not comply with the requirement in national guidance to hold an immediate 'hot' debrief for staff involved in the emergency. At the critical incident debrief, seven weeks later, it was acknowledged that staff should have been better supported. Prison managers acted promptly when the investigation identified a staff member who clearly needed additional support.

## Good Practice

11. Several prisoners witnessed Mr Hassan's death. After giving immediate support, the safer custody team proactively created a comprehensive package of one to one and group counselling for the men on Mr Hassan's wing who had been affected by his death and others during the same period. This is good practice and we commend the team for their efforts to safeguard the prisoners affected.

## Recommendations

- The Head of Healthcare must develop a clear protocol for the management of prisoners with hypertension and ensure that prisoners with high blood pressure are appropriately investigated and managed, in line with NICE guidelines.
- The Head of Healthcare should ensure that all actions are recorded so that there is a clear audit trail of investigations, tests and outcomes.
- The Governor should ensure that emergency response vehicles are given prompt access to prisoners in medical emergencies.
- The Governor should ensure that, in line with national policy, a manager debriefs all the staff involved in a death or serious incident immediately after the emergency response and offers appropriate support.

# 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 Wandsworth on 12 October. She obtained copies of relevant extracts from Mr Hassan's prison and medical records.

14. NHS England commissioned a clinical reviewer to review Mr Hassan's clinical care at the prison. The investigator and clinical reviewer interviewed five members of staff at Wandsworth on 8 November and 13 December. The investigator also conducted a telephone interview on 8 January 2019.

15. 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.

16. The investigator wrote to Mr Hassan's mother, his next of kin, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Hassan's sister spoke to the investigator on her mother's behalf. She was concerned that Mr Hassan was on a low dose of medication for high blood pressure; that he had not had an electrocardiogram (ECG) test during the year; and that he had not received regular medical checks and medication reviews. We have dealt with these matters in this report.

17. Mr Hassan's mother and other family members received a copy of the initial report. They made no comments.

18. 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

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 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. 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. Between February and May, only one prison clinic had been cancelled and there were no cancelled hospital appointments as more escort staff were available.

23. Waiting times for prison clinics were still very high - two weeks for a GP clinic and a week for a nurse-led clinic. A number of prisoners had written to the Board about pain or discomfort while waiting to receive an appointment.

## Previous deaths at HMP Wandsworth

24. Mr Hassan was the fourth prisoner at Wandsworth to die from natural causes since January 2016. There have been two further deaths, apparently from natural causes. In our investigation into a death in February 2018, we expressed concern about a lengthy avoidable delay before ambulance paramedics were able to gain access.

# Key Events

25. On 25 September 2017, Mr Osman Hassan was remanded to HMP Wandsworth. He was later convicted of kidnapping, false imprisonment and blackmail and sentenced to ten years and three months in prison.

26. At an initial health screen, Mr Hassan told a nurse that he had high blood pressure, a painful left ear and had used cocaine in the past month. The nurse referred him to the prison GP and the substance misuse team. A GP then examined Mr Hassan and re-prescribed ramipril, a medication to treat high blood pressure, and painkillers for his ear.

27. Mr Hassan declined to be assessed by the substance misuse team, stating that he had occasionally used cocaine in the past, but was not dependent on illicit drugs or alcohol. (Due to an error, he was not removed from their list, so they monitored him daily. This included blood pressure checks.)

28. On 26 September, a nurse conducted a secondary health screen. Mr Hassan reported a family history of cardiovascular disease. His father had died from a heart attack and high blood pressure ran in his family. A blood pressure check was within normal range. Mr Hassan said that he wanted to stop smoking and the nurse referred him to the smoking cessation service.

29. Checks between 28 and 30 September showed Mr Hassan's blood pressure was high. On 30 September, the healthcare assistant who took his blood pressure noted that he was dizzy and had a headache. She reported this to a nurse, but there is no record of any further action.

30. At 6.15pm on 11 October, Mr Hassan reported chest pain and a code blue emergency was called. (A code blue indicates that a prisoner is unresponsive, or has breathing difficulties.) A nurse prescribed painkillers and listed Mr Hassan for a chest X-ray. There is no evidence that this X-ray took place.

31. On 14 October, Mr Hassan went to the medication hatch and asked a nurse for additional ramipril tablets. The nurse asked why he needed them before his next batch was due. He said that he had been taking 10mg instead of the 5mg dose prescribed, as his blood pressure was high. The nurse added him to the GP list, for a medication review.

32. A GP reviewed Mr Hassan on 26 October. His blood pressure was high and she increased the dosage of ramipril to 10mg.

33. Over the next two months, Mr Hassan's blood pressure was taken several times. Each time, it was elevated. On 7 December, a GP reviewed the blood pressure readings and noted that Mr Hassan had not collected the ramipril prescription due on 24 November. She booked a nurse clinic appointment to discuss compliance with his medication. When Mr Hassan's blood pressure was checked on 12 December, it was still high, but the nurse recorded nothing about compliance.

34. On 19 and 21 December, Mr Hassan missed clinic appointments with a healthcare assistant and a GP, respectively.

35. On 21 December, a GP noted Mr Hassan's high blood pressure. He wondered whether he was compliant with his medication and booked an appointment for him to have a further check and discussion with the nurse. There is no evidence of such a discussion and no further blood pressure readings were recorded until March 2018.

36. Mr Hassan missed a smokers' cessation group appointment on 7 March 2018. (It was later noted that he smoked between 10 and 19 cigarettes a day and he received nicotine patches.)

37. On 11 March, a nurse attended a code blue emergency called for Mr Hassan. He told the nurse that he had pains across his abdomen and the centre of his back after lifting a heavy object in the kitchen and felt discomfort while breathing. After examining him, she concluded it might be musculoskeletal pain, as his breathing was normal and there were no signs of sweating or clamminess. His blood pressure was high. The nurse gave Mr Hassan painkillers. She noted that he was smoking before and after his examination. Mr Hassan's back pain continued and he was reviewed by healthcare staff over the following weeks.

38. At the beginning of April, the prison became smoke free. On 20 May, an officer found Mr Hassan smoking with two other prisoners. He noted that it was the second time that he had smelt smoke in a cell visited by Mr Hassan.

39. Mr Hassan's blood pressure readings taken between April and June were high. On 22 May, a GP noted that Mr Hassan was banned from the gym until his blood pressure was controlled. On 6 June, Mr Hassan asked for his blood pressure to be checked, but no reason was recorded.

40. On 10 July, a nurse reviewed Mr Hassan, who had complained of dizzy spells and intermittent blurred vision. At interview, the nurse said that Mr Hassan was concerned about his blood pressure, but had said that the dizzy spells and blurred vision were normal for him. The nurse checked his blood pressure, which was within acceptable limits on that day, but he noted it should be monitored. On the same day, Mr Hassan had blood tests, which had been requested by a GP and the results were normal. There were no further blood pressure readings or significant entries in the medical records until October.

41. On 1 and 7 October, Mr Hassan requested paracetamol, but the reason and the specific pain were not recorded.

42. At a blood pressure check on 9 October, Mr Hassan told a nurse that he regularly felt rushes to his head and had dizzy spells, headaches and tension in his neck. He said that he was fully compliant with his medication. The nurse took his blood pressure, which was high. She added him to the daily ledger for blood pressure monitoring and arranged an appointment with the advanced nurse practitioner to manage his condition.

43. In the afternoon, Mr Hassan received ibuprofen (an anti-inflammatory painkiller), for pain in his neck and shoulder. He also had a visit from his mother and sister.

44. During the evening, Mr Hassan completed a shift as a first night and induction assistant, helping with newly-arrived prisoners. He and a few other assistants were out on the wing, waiting to go to their cells. The group were sitting at a

table talking when Mr Hassan started gasping and collapsed to the floor. The other prisoners put him in the recovery position and tried to ensure his tongue was clear. They noticed that he had turned blue and was not breathing.

45. An operational support grade (OSG) was in an office on the landing completing paperwork. At 11.21pm, one of the prisoners appeared, shouting for help and stating that Mr Hassan had collapsed. The OSG immediately called a code blue emergency (which indicates that a prisoner is unconscious, or has breathing difficulties).

46. A nurse and healthcare assistant, who were in another office on the landing, arrived within a few seconds. The healthcare assistant then collected the nearest emergency and oxygen bags. They began chest compressions and gave Mr Hassan oxygen. They also attached a defibrillator (a device that can give an electric shock to the heart of someone who is in cardiac arrest). During one of the cycles, the defibrillator advised them to give a shock. Additional healthcare and prison staff arrived and assisted with the resuscitation attempt in rotation.

47. The prison's control room called an ambulance immediately, in response to the code blue. The first ambulance arrived at 11.29pm. The crew reached the landing at 11.36pm and took over the resuscitation. Two further response teams arrived at the prison at 11.30pm and 11.40pm and one of the crews reported a delay in gaining access to the prison.

48. The resuscitation efforts were unsuccessful and a paramedic confirmed Mr Hassan's death at 12.43am on 10 October.

### Contact with Mr Hassan's family

49. The prison assigned two supervising officers as the family liaison officers. They went to Mr Hassan's family home that morning and broke the news of his death to his mother, sister and brother. They explained the processes to be followed and offered to provide transport for the family to visit the morgue. They also offered the opportunity for the family to visit the prison and speak to the prisoners who were with Mr Hassan on the night of his death.

50. Prison staff later held a memorial service for Mr Hassan. In line with national policy, the prison contributed to the costs of his funeral.

### Support for prisoners and staff

51. There was no debrief immediately after Mr Hassan's death. However, a prison manager held a critical incident debrief (also known as a cold debrief) on 29 November. Four prison officers and a member of the safer custody team attended. No healthcare staff were present.

52. The prison told some prisoners personally about Mr Hassan's death and later posted notices informing others and offering support. Staff covered Mr Hassan's body and put up screens to ensure his dignity until the police and coroner's officer arrived. They also conducted frequent welfare checks for prisoners whose cells were in the vicinity of the incident.

53. In addition to the standard support procedures, a member of the safer custody team carried out in depth reviews with 20 of the men on E wing affected by Mr Hassan's and other recent deaths. The prison set up a support group, led by a trained counsellor, who provided four sessions of bereavement counselling. The member of the safer custody team then facilitated additional group support work, assisted by other members of the safer custody team.

### Post-mortem report

54. The post-mortem examination found that Mr Hassan's death was due to: 1a cardiac tamponade; 1b haemopericardium; 1c ruptured dissecting aortic aneurysm; and 2 hypertension.

55. Cardiac tamponade is a serious condition in which an abnormally high level of blood builds up between the heart and the sac that surrounds it (the pericardium). This puts pressure on the heart and affects its ability to pump blood around the body properly. In Mr Hassan's case, it was caused by a ruptured aortic aneurysm (a bulge in the wall of the aorta, the main blood vessel from the heart), with hypertension (high blood pressure) as a contributing factor.

# Findings

## Clinical care

*Management of Mr Hassan's high blood pressure*

56. The National Institute for Health and Clinical Excellence (NICE) guidelines on the management of hypertension indicate the importance of regular monitoring and recording of blood pressure in patients with high blood pressure. The clinical reviewer noted that healthcare staff should follow the NICE guidance until high blood pressure is adequately controlled. Measures would include increasing the dosage of drugs, adding additional medication and offering lifestyle advice about smoking and exercise.

57. Mr Hassan's high blood pressure had been diagnosed by his community GP before his imprisonment. When he arrived at Wandsworth in September 2017, reception healthcare staff noted this diagnosis and a prison GP re-prescribed his medication at the previous dosage, 5mg. Another prison GP increased this to 10mg, on 26 October 2017. During his time at Wandsworth, Mr Hassan's blood pressure was taken over 20 times. Except for three readings, it was elevated each time.

58. Mr Hassan occasionally complained of dizziness and headaches. After his death, other prisoners reported that he had felt dizzy all week and that he had complained of headaches and pain in his neck and shoulders during the previous three days.

59. Mr Hassan's family questioned the frequency of his reviews and whether he had been given the right dosage of medication.

60. The clinical reviewer explained that the cause of the ruptured aortic aneurysm which had resulted in the cardiac tamponade was unknown, but persistently raised blood pressure is considered to increase the risk.

61. At the time of Mr Hassan's death, Wandsworth had no pathway to manage men with high blood pressure. Although his blood pressure was checked many times (possibly more frequently than it would have been in the community), no structured plan was in place to manage and help improve his condition.

62. We agree with the clinical reviewer's conclusion that there was insufficient exploration of Mr Hassan's symptoms and a lack of coherence in managing his consistently high blood pressure. We also agree that this aspect of Mr Hassan's care was below the standard he could have expected to receive in the community. We make the following recommendation:

    **The Head of Healthcare must develop a clear protocol for the management of prisoners with hypertension and ensure that prisoners with high blood pressure are appropriately investigated and managed, in line with NICE guidelines.**

*Record keeping for chest X-ray requested on 11 October 2017*

63. After Mr Hassan reported chest pains on 11 October 2017, he was listed for a chest X-ray. There is no record that this request was processed; no evidence that the X-ray was taken, or an outcome; and no indication that anyone had reviewed or followed up the request to check that it had been completed.

64. The clinical reviewer considered there was no clear rationale for a chest X-ray and nothing to show that an X-ray was ordered. She said that the omission of the X-ray did not cause any direct harm but, with hindsight, it might have been useful to detect any underlying condition. She added, "… while it is not possible to be certain in retrospect that a diagnosis of an aneurysm could have been made earlier, there is a possibility it could have been detected on a chest X-ray."

65. We consider that there should have been a better audit trail to reflect whether the chest X-ray was followed up and the outcome. If it was not pursued, the reason should have been recorded. We make the following recommendation:

**The Head of Healthcare should ensure that all actions are recorded so that there is a clear audit trail of investigations, tests and outcomes.**

### Access for emergency response vehicles

66. In response to the emergency call on 9 October, the control room requested an ambulance quickly and the first crew reached the landing within 14 minutes of the call. The paramedics asked for additional assistance and suction equipment and two further crews were despatched. At 11.46am, the second crew, who had arrived at 11.30pm, reported that they had been waiting in the courtyard between the gates for ten minutes.

67. Effective emergency response arrangements include ensuring quick access for ambulance crews. There should be no unnecessary delay in allowing paramedics to reach a prisoner.

68. We expressed similar concerns in our report into an investigation into another death at Wandsworth in February 2018, although the prison has not yet had the opportunity to respond to that report. We make the following recommendation:

**The Governor should ensure that emergency response vehicles are given prompt access to prisoners in medical emergencies.**

### Support for staff

69. Prison Service Instruction (PSI) 64/2011, *Safer Custody*, 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.

70. No debrief was held immediately after the emergency, although staff were still on duty to complete the night shift. At the critical incident debrief on 29 November, it was acknowledged that there had been a delay in debriefing staff and that managers could have been more supportive. We make the following recommendation:

**The Governor should ensure that, in line with national policy, a manager debriefs all the staff involved in a death or serious incident immediately after the emergency response and offers appropriate support.**

71. The safer custody team was responsive and took immediate action when the investigator later identified a member of staff who still appeared to be troubled by the events and required additional support.

### Good practice - support for prisoners

72. Mr Hassan was a very popular prisoner, who had many friends. Several prisoners witnessed his collapse and others on his wing were shaken by his death. They had also been affected by other prisoners' deaths at around the same time.

73. We are pleased to note that in addition to immediate support, the safer custody team also provided a package of longer term one to one and group counselling sessions for prisoners on E wing, where Mr Hassan had lived. We regard this as good practice and commend the team for their efforts to safeguard the wellbeing of prisoners affected by this traumatic event.

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