Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Reader, a prisoner at HMP Wandsworth, on 29 March 2020

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 Mark Reader died in hospital from a lung infection on 29 March 2020, while released on temporary licence from HMP Wandsworth. He was 47 years old. I offer my condolences to Mr Reader's family and friends.

Mr Reader displayed very challenging behaviour during his four months in prison and would have been a challenging patient to care for in any environment. The clinical reviewer was satisfied that the standard of care Mr Reader received at Wandsworth was equivalent to that which he could have expected to receive in the community.

I am concerned, however, that there was a delay in contacting Mr Reader's family when he was taken to hospital and admitted to intensive care on 3 March. His family were not notified until the following day.

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 **September 2020**

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Summary

Events

1. On 5 November 2019, Mr Mark Reader was sentenced to six months in prison for burglary and sent to HMP Wandsworth.

2. Mr Reader had bipolar disorder, a personality disorder and a long history of drug misuse. He displayed very challenging behaviour at Wandsworth including deliberately banging his head against the wall, smearing himself in faeces, urinating on the floor, touching female staff inappropriately, and repeatedly banging on his cell door and using his emergency cell bell.

3. He underwent tests in hospital to check for any brain abnormality, but the hospital found no cause for Mr Reader's bizarre behaviour and suspected it was due to illicit drug use.

4. Mr Reader spent most of his time at Wandsworth in the mental health inpatient unit where he was regularly monitored by healthcare staff and had to be spoon-fed and helped with personal hygiene.

5. On 3 March 2020, Mr Reader's physical health began to deteriorate. A nurse noted that his heart rate and blood oxygen saturation levels were abnormal, and he was showing signs of dehydration. A doctor reviewed him and sent him to hospital. That evening, he was moved to intensive care.

6. Mr Reader continued to deteriorate and on 13 March, the prison released him on temporary licence. He died in hospital on 29 March.

7. The post-mortem report concluded that Mr Reader died from a lung infection.

Findings

8. The clinical reviewer found that overall, Mr Reader's care was of a good standard and was equivalent to that he could have expected to receive in the community.

9. However, we are concerned that the prison did not contact Mr Reader's family when he was taken to hospital and admitted to intensive care on 3 March.

10. We are also concerned that Mr Reader's next of kin has complained that some of the bedwatch staff – not all – treated her and Mr Reader's next of kin with a lack of sensitivity at times.

Recommendations

- The Governor should ensure that staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill.
- The Governor should ensure that all bedwatch staff understand the importance of treating prisoners' relatives with sensitivity.
- The Governor should share this report with the family liaison officer to note that Mr Reader's family were grateful for his help and support.

The Investigation Process

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

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

13. NHS England commissioned an independent clinical reviewer to review Mr Reader's clinical care at the prison.

14. We were unable to conduct interviews in person during the Covid-19 lockdown. The clinical reviewer conducted interviews with eight healthcare staff on the phone but was unable to make recordings.

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

16. One of the Ombudsman's family liaison officers contacted Mr Reader's next of kin to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. Mr Reader's family asked:

    - Why were the family not contacted when Mr Reader was taken to hospital on two occasions in December 2019?
    - Why did the prison say that they had no contact details for Mr Reader's next of kin when they had previously contacted his next of kin about the possibility of releasing Mr Reader to her address on Home Detention Curfew?
    - Why did the prison did not return Mr Reader's next of kin's calls?
    - Was Mr Reader's health allowed to deteriorate before he was admitted to hospital for the final time?
    - Why was Mr Reader's next of kin not informed until the following day that he had been admitted to hospital and was in intensive care in March 2020?

    These issues have been addressed in this report and in the clinical review. The family also raised other issues that were outside the remit of this investigation.

17. Mr Reader's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

18. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

19. The initial report was shared with the clinical reviewer. The clinical reviewer pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Wandsworth

20. 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.

21. There is a 6-bed inpatient unit (Jones) which caters for prisoners with a wide range of general medical, rehabilitative and health-related respite needs. There is also a 12-bed mental health unit (Addison) which is staffed by prison officers and a multi-professional team of medical, nursing and occupational therapy staff, with 24-hour nursing cover.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Wandsworth was in March 2018. Inspectors found that the demand for mental health beds in the prison remained high and there was a waiting list for admission to the Addison Unit. Delays occurred in transferring patients to mental health beds in the community. Assessment and care planning were good and inspectors saw some positive care in the unit. The environment was adequate. Patients had satisfactory access to showers and exercise. Weekly art therapy and a hearing voices group were positive initiatives, but there were still too few therapeutic activities and many patients spent too long locked in their cells.

23. Inspectors found that, despite efforts to tackle the supply of illicit drugs, they remained too accessible, particularly cannabis and PS. 40% of prisoners said it was easy to get illegal drugs. Inspectors noted that the strategic approach to supply reduction and addressing substance misuse was weak, although it was improving, and they made recommendations designed to bring about improvements.

Independent Monitoring Board

24. 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 2019, the IMB said they remained very concerned that the 12-bed Addison Unit was unfit for purpose. The Unit had insufficient beds and cells were frequently out of use awaiting repair.

Previous deaths at HMP Wandsworth

25. Mr Reader was the 11th prisoner to die at Wandsworth since March 2018. Of the previous deaths, six were from natural causes, two were self-inflicted, one was drug-related and the other is awaiting classification. There were no similarities between the circumstances of Mr Reader's death and previous deaths at the prison.

Key Events

26. On 5 November 2019, Mr Mark Reader was sentenced to six months in prison for burglary. He was sent to HMP Wandsworth.

27. Mr Reader had a long history of drug misuse and he tested positive for opiates, benzodiazepines and cocaine when he arrived at Wandsworth. Mr Reader told staff that he had been diagnosed with bipolar disorder and they referred him to the mental health in-reach team (MHIRT). The MHIRT assessed that Mr Reader had a personality disorder complicated by addictions, with drug-seeking, challenging behaviour.

28. On 4 December, a nurse saw Mr Reader after he deliberately hit his head on the wall. She noted that Mr Reader appeared to be confused and was speaking rapidly. He would not let her treat the gash on his head and she was unable to carry out vital signs and observations because he was uncooperative. She called an ambulance and Mr Reader was taken to hospital.

29. The hospital could not find any cause for Mr Reader's bizarre behaviour and suspected it was drug-induced. On 7 December, he was discharged and returned to prison and was located in the prison's mental health unit (the Addison Unit). Staff noted that Mr Reader appeared to be agitated, as he was banging his cell door and continually pressing his emergency cell bell.

30. On 8 December, staff noted that Mr Reader's weight was 54.8kg (about 8 stones 9 lbs), down from 60kg (about 9 stone 6 lbs) when he arrived at Wandsworth, but his weight remained in the healthy range given his height of about 5 feet 5 inches.

31. On 9 December, Mr Reader told staff that he had taken 'Spice', a psychoactive substance (PS). He was seen later that day by a specialist doctor in psychiatry, who concluded that, as there was no obvious cause for Mr Reader's behaviour, his current mental state was likely to have been triggered by PS.

32. On 12 December, staff noted that Mr Reader weighed 54.4kg, and although he was still a healthy weight, they decided to prescribe Fortisip (supplementary nutrition). By 18 December, his weight was 59.4kg, so almost back to his weight when he arrived.

33. On 22 December, Mr Reader's behaviour deteriorated further, he smeared himself with faeces and it was noted that he had touched a female member of staff inappropriately. On 23 December, Mr Reader was seen by a consultant forensic psychiatrist and the lead GP. They did not know why Mr Reader's behaviour had deteriorated and decided that he needed to be assessed further. They arranged for him to be admitted to hospital for assessment.

34. While Mr Reader was in hospital, he had several clinical investigations including a CT scan, a MRI scan and a lumbar puncture. He was also treated with antibiotics and antiviral medication in case he had a type of brain infection.

35. On 2 January 2020, Mr Reader was discharged from hospital and returned to prison. The hospital discharge summary said that, after extensive investigations,

there was no identifiable cause of Mr Reader's behaviour, and therefore, the use of PS was the most likely diagnosis.

36. On 5 January, an officer went to see Mr Reader to tell him that he could not be released on home detention curfew (HDC). Mr Reader had given the HDC clerk his next of kin's address as a release address but, when Mr Reader's next of kin was contacted she said that she was not happy for him to be released to her address. The officer asked Mr Reader if there was another address that could be considered for him to be released to. Mr Reader would not communicate with the officer so no alternative address was obtained.

37. On 6 January, Mr Reader was seen by the consultant forensic psychiatrist, and two other doctors. They noted no improvement and the prognosis was still very unclear. The consultant forensic psychiatrist wanted to speak to Mr Reader's family to inform them of Mr Reader's condition and to ask if he had ever had a similar episode in the past. A nurse emailed the Offender Management Unit (OMU) to ask for the details of Mr Reader's next of kin but was told that Mr Reader did not have any next of kin details held on record.

38. On 8 January, an address was found for Mr Reader's next of kin by the administrator of the mental health team, via his NHS central records. The consultant forensic psychiatrist wrote to Mr Reader's next of kin and asked her to contact the prison to discuss his health.

39. The psychiatrist spoke to Mr Reader's next of kin on the phone on 13 January and explained how ill he was and that he did not know if he would ever recover. He recorded that Mr Reader's next of kin said he had been diagnosed with a range of conditions, including bi-polar disorder, and that he had become confused after previous uses of illicit drugs and each time he took longer to recover. He invited her to visit but she said she did not think she could cope with seeing him in his present state and that she was due to have an operation.

40. Over the next few weeks, Mr Reader's behaviour remained the same. He was reviewed regularly by the MHIRT and closely monitored by healthcare staff. It was noted that Mr Reader still needed help with eating and needed supervision when showering and help with personal hygiene. Staff spoon-fed Mr Reader in his cell or, if he became agitated, through the hatch in the cell door.

41. On 21 January he was seen and assessed by a GP who examined him and prescribed a combination steroid and antibiotic cream for a large number of small scabs on his face and body.

42. On 3 February, Mr Reader was seen by a prison GP, who noted that Mr Reader's physical observations were normal and he was not in any physical distress. The GP also noted that Mr Reader was incoherent, and had lost weight. He noted that Mr Reader's weight was 49kg (about 7 stone 10 lbs), which made him underweight, and he queried the accuracy of the previous weights. He said that nurses should use a food chart to record Mr Reader's food intake and continue Fortisip. The prison GP also said that Mr Reader needed to have a blood test.

43. On 5 February, Mr Reader had a blood sample taken. The following day the results were reviewed by a prison GP. Not all the tests were performed as the

sample was insufficient for the full blood count. The prison GP noted that Mr Reader's urea, potassium and calcium levels were slightly outside the reference range, but the remainder of the tests were normal except for one liver enzyme which is known to be raised due to alcohol and drug misuse.

44. The consultant forensic psychiatrist saw Mr Reader on 10 February. Mr Reader's weight was now 48.7kg and he increased Fortisip to four times a day. He noted that staff reported that Mr Reader had a good dietary intake but he was awake and active for up to 22 hours a day.

45. On 17 February, a psychiatrist, saw Mr Reader. He noted that Mr Reader was naked from the waist down and did not engage during the interview, although he did not appear to be distressed or in any pain. His weight had increased to 52.2kg. On the same day, it was also noted that Mr Reader had made little progress. He was restless and agitated and had smeared faeces on himself and the walls and had grabbed the breast of a female member of staff who was helping him with his evening meal.

46. A GP saw Mr Reader on 24 February, as staff were concerned about his swollen ankles. She noted that the swelling was to his feet rather than his ankles and that he was difficult to examine because he was agitated. She noted he had no shortness of breath, no obvious infection and from a brief examination, his chest was clear and there was no evidence of heart failure.

47. On 27 February, Mr Reader was discussed at the ward round. Nursing staff reported that Mr Reader was eating more, but, overall, remained much the same. He was reported to be awake all night on 29 February/1 March and to have been restless and pacing his cell overnight on 1/2 March. On 2 March, Mr Reader was unable to feed himself and had to be fed by an officer, his weight was 53.5kg just back within the normal healthy weight range.

48. On 3 March, Mr Reader's physical health began to deteriorate. A nurse noted that Mr Reader's heart rate was raised and his blood oxygen saturation was low, and that Mr Reader had signs of dehydration. She called a speciality psychiatric doctor, to see Mr Reader. She said that Mr Reader needed to be taken to hospital. At 11.11am, a non-emergency ambulance was called.

49. Mr Reader was escorted to hospital by three officers, using the single cuffing method (when the prisoner's wrist is attached to a prison officer's wrist by a set of handcuffs). At 12.27pm, the ambulance arrived at the hospital. That evening Mr Reader was taken to intensive care. All restraints were removed.

50. On 4 March, the psychiatric doctor, rang Mr Reader's next of kin at 9.00am to let her know about Mr Reader's condition.

51. On 5 March, a hospital doctor told the psychiatric doctor, that Mr Reader was being treated for empyema (a lung infection) and that, although recovery should not normally be difficult, complications may arise because of Mr Reader's generally poor state of health, and that his prognosis was unclear.

52. Also on 5 March, the consultant forensic psychiatrist, rang Mr Reader's next of kin, he also left a text message. She called him back on 6 March. She was very upset and said that she thought Mr Reader had been neglected in prison. They

had a discussion about his care and he texted her a summary of the conversation and offered to meet her.

53. Mr Reader's health deteriorated rapidly in hospital. On 13 March, the prison released him on temporary licence.

54. Mr Reader did not regain consciousness and died on 29 March.

Contact with Mr Reader's family

55. On 4 March, the prison appointed a Supervising Officer as the prison's family liaison officer (FLO). The FLO met Mr Reader's next of kin at the hospital and introduced himself as the prison FLO.

56. The prison contributed to Mr Reader's funeral in line with national guidelines.

Post-mortem report

57. The post-mortem report concluded that Mr Reader died from empyema (pus-filled pockets in the space between the outside of the lungs and the inside of the chest cavity), lower respiratory tract infection and pericarditis (inflammation of the pericardium, the fluid-filled sac around the heart).

Findings

Clinical Care

58. The clinical reviewer concluded that the clinical care Mr Reader received at Wandsworth was equivalent to that which he could have expected to receive in the community. She noted that Mr Reader was a very challenging patient and would have been extremely difficult to manage in any setting.

59. The clinical reviewer found that Mr Reader was placed in the most appropriate location within the prison to meet his needs and that there was evidence of a clear approach to managing his hydration and nutrition.

60. She noted that prior to 3 March, Mr Reader did not show signs of the symptoms of empyema - difficulty in breathing, a raised body temperature, a productive cough or lack of energy. She also noted that there is nothing in Mr Reader's medical notes to suggest he had symptoms of pericarditis - chest, neck, arm or shoulder pain or fever – in the days before he was admitted to hospital. She said that when Mr Reader became suddenly unwell on 3 March, prison healthcare staff quickly sent him to hospital.

Contact with Mr Reader's family

61. Prison Rule 22 states that prisons should inform the next of kin immediately if a prisoner becomes seriously ill. Prison Service Instruction 64/2011, on safer custody, says that if a prisoner suffers an unpredicted or rapid deterioration in their physical health an appropriate member of prison staff should engage with their next of kin to provide information and support. If a prisoner's health deteriorates, a family liaison officer should be appointed immediately and next of kin should be contacted.

62. Mr Reader's family are concerned that they were not contacted in December when Mr Reader was taken to hospital twice. It is not a requirement for the prison to notify the next of kin if a prisoner is taken out to hospital, unless the prisoner is seriously ill. In December, when Mr Reader was taken to hospital, he was not seriously ill.

63. Mr Reader's family also asked why the prison psychiatrist was told that there were no next of kin details held on file, when in December, Mr Reader's next of kin was contacted to ask if Mr Reader could be released to her address on home detention curfew (HDC).

64. There were no next of kin details held on Mr Reader's prison record because when he arrived at Wandsworth, he told officers that he had no next of kin. (It is not a requirement for prisoners to provide next of kin details if they choose not to.) Although Mr Reader had given his next of kin's address as a potential release address, he did not give her details as his next of kin. He, therefore, remained on the system as having no next of kin.

65. On 8 January, Mr Reader's next of kin's contact details were obtained from NHS central records. The consultant forensic psychiatrist wrote to Mr Reader's next of kin to explain that Mr Reader was unwell.

66. On the morning of 3 March, Mr Reader was taken to hospital. That evening, he was moved to intensive care. We consider that, at this point, Mr Reader was critically unwell and the prison should have notified his mother (although we note that she was informed at 9.00am the following morning). We therefore make the following recommendation:

The Governor should ensure that staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill.

67. We note that the consultant forensic psychiatrist, demonstrated good practice in ringing Mr Reader's next of kin to discuss his condition on 13 January and also in inviting her to visit him. Mr Reader's sister has complained that her mother subsequently rang the Addison Unit on "numerous occasions" to ask how Mr Reader was and was told each time that someone would ring her back, but no one did. There are no records to confirm or refute this. Clearly if Mr Reader's next of kin rang the Unit and was told that someone would ring her back, someone should have done so as a matter of basic courtesy and good practice.

68. We are also concerned that Mr Reader's sister has complained that the family were treated with a lack of sensitivity by some of the bedwatch staff (for example, having their ID checked repeatedly and being told that they could not stay in the hospital's family room overnight), although she praised the prison's FLO, and some other staff. She also said that the family appreciated the prison's decision to release Mr Reader on temporary licence for the last 16 days of his life.

69. Although security is important, it needs to be handled sensitively and proportionately in the case of critically ill prisoners and their families. Mr Reader was in a coma in intensive care and was not restrained as he was not considered to be an escape risk. In addition, the Governor had authorised visiting by his mother and sister. Bedwatch staff should have been advised to take account of this in their dealings with Mr Reader's next of kin and sister. In these circumstances, we do not consider that it would have been appropriate for bedwatch staff to say that Mr Reader's next of kin and sister could not spend the night in the family room while he was in the Intensive Care Unit.

70. There is no record that Mr Reader's family raised their concerns with the FLO at the time. If they had done so, he would have been able to speak to the bedwatch staff or prison managers to resolve any problems.

71. We recommend:

The Governor should ensure that all bedwatch staff understand the importance of treating prisoners' relatives with sensitivity.

The Governor should share this report with the family liaison officer to note that Mr Reader's family were grateful for his help and support.

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