Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Fallows, a prisoner at HMP Wandsworth, on 8 August 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 Anthony Fallows died in hospital on 8 August 2020 of acute pyelonephritis (a kidney infection) while a prisoner at HMP Wandsworth. Mr Fallows was 83 years old. I offer my condolences to those who knew him.

Mr Fallows had several long-term health conditions when he arrived at Wandsworth in April 2018. In 2019, Mr Fallows began refusing some elements of his care and from May 2020 onwards, he began to disengage with his care and rehabilitation, and then his medication and nutrition. His disengagement was inconsistent and unpredictable day-to-day but increased over time. In the months before his death, this was amounting to self-neglect.

The clinical reviewer found that Mr Fallows was an exceptionally difficult patient who would have been difficult to manage in any circumstances or environment. She is satisfied that, until the last few days of his life, he received a high level of care at Wandsworth equivalent to that he would have received in the community.

However, we share the clinical reviewer's concern that there was no medical management care plan to tell healthcare staff what to do if Mr Fallows became acutely unwell. As a result, when his health deteriorated, his care for the last four days of his life was not equivalent to that he could have expected in the community. Although individual staff members worked hard to help Mr Fallows, they were not able to afford him a dignified end to his life.

We also share the clinical reviewer's concern that the prison needs to clarify its approach to self-neglect as a safeguarding issue.

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 **October 2021**

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Summary

Events

1. In April 2018, Mr Anthony Fallows was sentenced to 17 years for sexual offences and was sent to HMP Wandsworth.

2. Mr Fallows had several existing health conditions including atrial fibrillation (an irregular or fast heartbeat) and high blood pressure. He had poor hearing and wore hearing aids. He was a wheelchair user and was given an adapted prison cell to meet his needs. He was prescribed appropriate medication and his conditions were regularly checked.

3. Mr Fallows was initially a co-operative patient and was compliant with his care and medication. However, during 2019, he began refusing some elements of his care (for example, refusing to attend hospital unless he was taken to the hospital of his choice, and refusing to change to a different drug for his atrial fibrillation) for no logical reason. He also behaved inappropriately to female healthcare staff on three occasions.

4. In March 2020, just as the COVID-19 lockdown began, he developed a leg wound. He was prescribed antibiotics but did not take them and his wound got worse.

5. At the end of April, Mr Fallows suffered a series of falls. Following the last fall, he was taken to hospital where he was diagnosed with sepsis and a fractured hip which required an operation. Unsuccessful attempts were made to arrange a transfer to a prison where his needs could be met better.

6. On 28 May, he was discharged back to Wandsworth and was located in the prison's inpatient unit. He was no longer mobile, but he refused to co-operate with his rehabilitation because he wanted to return to his wing where he believed other prisoners would look after him. This was wholly unrealistic.

7. Over the following two months, Mr Fallows did not fully engage with healthcare staff, and refused care, food, medication and liquids – sometimes completely, sometimes in significant part. He was often verbally and sometimes physically aggressive to staff. His behaviour amounted to self-neglect. Healthcare staff sought safeguarding advice from the local authority team but were told this was the prison's responsibility. His health deteriorated and, by early August, healthcare staff considered that Mr Fallows needed to be cared for in a nursing home.

8. In the early hours of 8 August, Mr Fallows became acutely unwell. Nursing staff called an ambulance. Paramedics arrived at the prison around 2.00am but they decided not to take Mr Fallows to hospital as they considered he only had hours to live. Although healthcare staff disagreed with this decision, they did not escalate their concerns. Healthcare staff continued to provide care to Mr Fallows in his cell.

9. Around midday, Mr Fallows was assessed by a prison GP. After discussion with the lead GP, he sent Mr Fallows to hospital.

10. An ambulance arrived at 2.47pm and took Mr Fallows to hospital. He arrived in hospital at 3.30pm and was declared dead five minutes later.

Findings

11. The clinical reviewer found that Mr Fallows was an exceptionally difficult patient who would have been difficult to manage in any circumstances or environment.

12. The clinical reviewer concluded that the clinical care Mr Fallows received at Wandsworth was generally equivalent to that he could have expected to receive in the community.

13. However, she concluded that the care he received between 4 and 8 August 2021 was not equivalent.

14. She found that in early August there was a failure to create a clear, medically-led care plan which told healthcare staff what to do if Mr Fallows became seriously unwell. The absence of the care plan contributed to delay and confusion when Mr Fallows became acutely unwell on 8 August.

15. As a result, he was not taken to hospital until it was too late to be of any benefit to him and he was declared dead within minutes of arriving at the hospital. The clinical reviewer considered that this did not afford him a dignified end to his life.

Recommendations

- The Head of Healthcare should ensure that the checklist for the regular review of vulnerable patients includes assessment of all aspects of their sleep environment.

- The Governor, the Head of Healthcare and the Local Authority Safeguarding Team should meet to discuss how to manage and support a prisoner who is self-neglecting, with a view to establishing best practice and improving local policy awareness.

- The Head of Healthcare and the lead GP should establish clear parameters around leadership and planned action in unusual or complex cases and ensure that there are clear written care plans with instructions to direct staff specifically on what action to take.

- The Head of Healthcare should ensure that there is a system for clear handover of patients whose care might become complex to the emergency response nurses. The increased use of “Co-ordinate my Care” should be considered to share information with other providers if possible and as appropriate.

- The Head of Healthcare should ensure this report is shared with LAS with a view to considering what joint learning has emerged. The level at which the report is shared is a matter for Oxleas and NHSE.

- Oxleas, as the provider of care at Wandsworth, and NHSE, as the commissioner, should jointly articulate what out of hours medical support is available to HMP Wandsworth. This should then be turned into an operational policy which is shared with all staff to allow lead nurses working at a time when there is no GP on site to gain appropriate medical advice.

- The Head of Healthcare and the Regional Manager for Oxleas should review and relaunch the guidance on escalation of concerns out of hours and ensure that lead nurses working out of hours know how and who to contact if they find themselves in a situation where they require specific support.
- The Head of Healthcare and the lead GP should produce guidance for staff on the difference between DNACPR and ADRT, and joint training events should be offered.
- The Head of Healthcare should obtain assurance that all staff are aware of the revised guidelines on end-of-life care.
- The Head of Healthcare and the lead GP should share this report with all clinical staff involved in Mr Fallows care and offer a reflective discussion on its findings. This should be extended to staff who no longer work at HMP Wandsworth.

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 him. No one responded.

17. Due to restrictions during the COVID-19 pandemic, the investigator was unable to visit Wandsworth. He obtained copies of relevant extracts from Mr Fallows' prison and medical records.

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

19. The investigator and clinical reviewer jointly interviewed twelve members of staff on 22 and 30 October, 2 and 4 November and 15 December 2020. The interviews were conducted by telephone because of the restrictions imposed in response to the COVID-19 pandemic. The investigator also interviewed one member of staff on 27 October. In addition, a statement was received from one member of staff. The audio recording with a prison GP was of poor quality and transcription proved difficult. It has not been included in the transcripts. We note that the GP has provided a statement to the Coroner in relation to Mr Fallows' death.

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

21. HMP Wandsworth made efforts to identify Mr Fallows' next of kin but were unable to do so.

22. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies and their action plan is attached separately.

Background Information

HMP Wandsworth

23. HMP Wandsworth is a medium security prison in south west London which holds up to 1,432 men. It is operated by HM Prison Service. As part of its role, it serves the courts of London and the Thames Valley area.

24. Healthcare is provided by Oxleas NHS Foundation Trust. The prison has a six-bed physical care inpatient healthcare unit (the Jones Unit) and 24-hour nursing provision.

HM Inspectorate of Prisons

25. The most recent full inspection of HMP Wandsworth was in February/March 2018. Inspectors found that, despite shortcomings in some elements of health care, including social care, health services were reasonably good. The two inpatient units, one for physical and one for mental health care, provided reasonable support for patients with very complex health needs. Secondary mental health services (which were provided by South London and Maudsley NHS Trust) were very good but there were some gaps in the range of primary mental health services.

26. Inspectors reported that a social care support worker usually provided good support for the small number of men with high level needs. There was now a nominated adult safeguarding manager and contact with the local safeguarding adults board. The prison had reviewed safeguarding functions and had produced a document explaining the procedure if staff had safeguarding concerns. However, staff awareness of safeguarding adults at risk was poor and, despite a memorandum of understanding, joint working between the prison, local authority and health services was underdeveloped.

27. HMIP also conducted a Short Scrutiny Visit of Wandsworth in April 2020 to report on the treatment and conditions of prisoners during the COVID-19 pandemic. They found that the prison had adopted clear plans to manage the pandemic at the start of the lockdown, identifying those who were most vulnerable so they could protect them and limit the spread of the virus. Health and safety protocols were in place and the prison remained calm, well ordered and safe. Most healthcare clinics had been suspended but managers had implemented a triage system to ensure that urgent cases were dealt with appropriately.

Independent Monitoring Board

28. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to May 2020, the Board noted that the carers who provided social care for prisoners on the wings stopped coming into the prison in the second half of March 2020 because of the pandemic. Prisoners needing high levels of social care were moved, whenever possible, to the Jones Unit, where nurses took over the carers' duties.

Previous deaths at HMP Wandsworth

29. Mr Fallows was the eleventh prisoner to die at Wandsworth since August 2018. Of the ten previous deaths, six were from natural causes, two were self-inflicted, one was drug-related, and one is awaiting classification.

30. There are no similarities between our findings in the investigation into Mr Fallows' death and our investigation findings for the previous deaths.

Key Events

31. On 10 April 2018, Mr Anthony Fallows received an Extended Determinate Sentence of 17 years for sexual offences. He was sent to HMP Wandsworth.

32. Mr Fallows had several existing health conditions, notably hypertension (high blood pressure) and atrial fibrillation (an irregular or fast heartbeat). He had previously had kidney problems. He had poor hearing and wore hearing aids. He was a wheelchair user and was given an adapted prison cell on a standard residential wing to meet his needs.

2018

33. Mr Fallows was prescribed medication for his atrial fibrillation and high blood pressure. He was seen regularly by healthcare staff and was referred to social services, ophthalmology and audiology (as his hearing was getting worse). He was a co-operative patient and was compliant with his care and medication.

34. As a former member of the armed services, he was referred to SSAFA, the armed forces charity, and in October he was seen by a nurse from the veterans' mental health transition and liaison service (TILS). The nurse found Mr Fallows to be cheerful and talkative and continued to see him regularly throughout his time at Wandsworth.

35. In November, Mr Fallows received a new wheelchair. He was not happy with it as he would have preferred an electric one, but it was explained to him that he was not eligible for an NHS-funded electric wheelchair because he had full range of movement and strength in his arms and hands. He continued to press for an electric wheelchair, and this appears to have been his main concern for the next year.

36. In December, he was referred to Wandsworth Social Services with a view to receiving help with daily activities. Mr Fallows said he preferred to receive informal care from friends on the wing.

2019

37. In March 2019, Mr Fallows was diagnosed with a hernia and a prison GP planned to send him to St George's Hospital. However, Mr Fallows said he would not go to hospital unless he was taken to University Hospital Lewisham (UHL). When he was told this was not possible, he signed a disclaimer refusing treatment.

38. The management of Mr Fallows' medication continued as before. It would have been logical to prescribe him a different medication for his atrial fibrillation, but he refused to accept any change of medication. His medical records show that he had very clear views on what he was willing to accept. For example, he was willing to miss appointments for routine medical reviews which are available at any district general hospital if he could not be seen at UHL.

39. He behaved inappropriately to female healthcare staff on three occasions during the year. The nurse from TILS continued to see Mr Fallows and identified no treatable mental health condition, although he observed that change made Mr

Fallows feel stressed. In general, however, staff described Mr Fallows as engaged and chatty. His main focus remained his wish for an electric wheelchair.

2020

40. During the first few months of 2020, Mr Fallows' medical records show that he had become incontinent of urine. Staff continued to describe him as chatty and he appears to have been generally compliant with his medication, although he continued to refuse to change his medication for atrial fibrillation. His main issue continued to be his wish for an electric wheelchair.

41. In March, restrictions began to be imposed in response to the COVID-19 pandemic. On 23 March, the UK COVID-19 lockdown began. This led to changes to the prison regime, and a reduction in face-to-face clinical care.

42. On 24 March, Mr Fallows was seen by a nurse as he had developed a leg wound and cellulitis (an infection of layers of the skin). He was prescribed antibiotics but did not take them as he said they made him feel 'funny'. A different antibiotic was prescribed, but it is not clear if he took it.

43. The limitations placed on staff and prisoner movement after the national lockdown meant that it became more difficult for healthcare staff to see prisoners face to face. Mr Fallows was largely self-isolating and the personal care support he had previously received from his friends on the wing was not available. He was not managing his personal care effectively; his cell was untidy and he was described as "unkempt" and "malodorous".

Events of 29 and 30 April – admission to hospital

44. During the early hours of 29 April, the night officer on Mr Fallow's wing called healthcare staff after Mr Fallows fell in his cell. Mr Fallows told a nurse that he had been sleeping in his wheelchair since arriving at Wandsworth, some two years previously.

45. That evening and night, Mr Fallows suffered three further falls in his cell. He also began vomiting. Prison and nursing staff agreed that an Operational Support Grade (OSG) would check on Mr Fallows hourly for the rest of the night and his care and location would be escalated to management in the morning. A nurse noted that that care could no longer be provided safely for him on the wing and planned to discuss moving him to the healthcare unit with prison managers and senior nursing staff.

46. In the early hours of 30 April, the OSG carrying out the hourly checks on Mr Fallows, saw him on the floor of his cell. A nurse was called and assessed him. Mr Fallows was very pale and was in pain. She completed a NEWS-2 assessment (NEWS-2 is a tool to measure clinical deterioration). Mr Fallows scored 9 which indicated he needed an emergency response. She asked the prison Control Room to call an ambulance.

47. Mr Fallows was taken by emergency ambulance to St George's Hospital, where he was diagnosed with sepsis and a fractured hip. On 1 May, Mr Fallows had an operation on his hip.

48. Mr Fallows did not consistently cooperate with his care in hospital. On 3 May, hospital staff reported that Mr Fallows was reluctant to engage with occupational therapy and physiotherapy to help him become mobile again. On 11 May, hospital staff reported that Mr Fallows was due to have a psychiatric assessment to see if there were reasons for his non-compliance with his care. On 24 May, hospital staff reported that he was not compliant with his medication.

49. While Mr Fallows was in hospital, senior healthcare staff at Wandsworth tried hard to find a prison that would be able to support his complex health needs better when he was discharged. However, they were not able to find an alternative location for him. Emails were also sent to Oxleas, St George's Hospital and Wandsworth Council requesting equipment to manage Mr Fallows safely (such as a hoist and air mattress) if he had to remain at Wandsworth.

28 May onwards – return to Wandsworth

50. On 28 May, Mr Fallows returned to Wandsworth and was placed in the healthcare unit. This was the only location in the prison that could meet his physical care needs. He was now incontinent of both urine and faeces and required pads. He also needed to be turned in bed regularly by healthcare staff to prevent him developing pressure sores. A GP prescribed him medication, including buprenorphine patches (a strong opioid painkiller).

51. Although healthcare staff had made a referral to Wandsworth Adult Social Care on 11 May, the funding for carers had not been allocated by the time Mr Fallows was discharged from hospital. His social care was approved on 8 June.

52. When he returned to prison, Mr Fallows often refused to allow healthcare staff to re-position him or to give him medication and did not eat meals given to him. For example, on 30 and 31 May, he declined food and pain medication but drank water offered to him. Mr Fallows told staff he wanted to return to his previous wing and be looked after by his friends again. This would have been wholly impractical as it required three healthcare staff to move him.

53. On 2 June, a sessional GP saw Mr Fallows. They discussed his care and his reasons for not cooperating with his rehabilitation. Mr Fallows told her that he would not engage with his care and rehabilitation until he was moved back to his old wing. She explained that he could not move back until he was physically well enough to do so, and she told him in some detail the likely consequences if he did not engage in treatment.

54. The sessional GP assessed his mental state. She concluded he had capacity to make decisions even though these decisions posed a real risk to his health. They discussed a Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) and Mr Fallows agreed to having one. This meant that he agreed that he did not want to be resuscitated in the event of a heart attack or if he stopped breathing.

55. The sessional GP also created nursing care plans for Mr Fallows' skin care and mouth care. She added oral morphine to his prescriptions for when he needed to be repositioned and created charts so nursing staff could measure what he was eating and drinking and knew how often to re-position him. She noted in his records:

> "He should be regarded as terminally ill because, unless he starts to cooperate with his own rehabilitation, he has a massively high chance of dying - from combined effects of wasting, pressure sore infection, malnutrition, PE [pulmonary embolism], etc."

56. Also, on 2 June, healthcare staff wrote to the NHSE Health and Justice Commissioner about a possible alternative placement for Mr Fallows. This was followed up on the following day with additional information from the Head of Healthcare saying that Mr Fallows' needs could not be met in Wandsworth as the cramped environment meant that the equipment required to manage his care could not be used effectively. Social services had not yet assessed Mr Fallows for NHS-funded continuing health care funding (CHC, a package of care for adults aged 18 or over which is arranged and funded solely by the NHS.).

57. Healthcare staff, including the nurse from TILS, continued to explain to Mr Fallows why it was not practical for him to return to his wing, but Mr Fallows did not agree with the decision to keep him in the healthcare unit.

58. Through June and July, Mr Fallows engagement with his medication, eating and care plans became increasingly inconsistent. Staff tried to offer food he specifically asked for, but he would often ignore it or eat small amounts. He frequently refused to allow healthcare staff to move him. On 6 July, Mr Fallows was discharged from physiotherapy as he was not cooperating with his rehabilitation. Healthcare staff regularly monitored his vital signs for any sign of deterioration in his health.

59. During the weekend of 18 and 19 July, Mr Fallows displayed hostility to nursing staff, refusing all care. He shouted and threatened staff. On 20 July, the lead prison GP went to see Mr Fallows. Although Mr Fallows' hearing aids were working, he refused to turn them on, and this made communication hard. The GP had to write questions down to conduct his assessment.

60. On 27 July, after a week when Mr Fallows ate and drank little and accepted medication less frequently, the lead prison GP saw Mr Fallows again. Mr Fallows refused to talk to him. He assessed Mr Fallows as best he could in the circumstances.

61. On 29 July, healthcare staff held a meeting about Mr Fallows. They considered that Mr Fallows was self-neglecting. This was a safeguarding concern. It was agreed this should be raised with prison managers. In addition, they sought advice from Wandsworth Adult Social Care.

62. The following day, Wandsworth Adult Social Care wrote to the healthcare team saying that safeguarding in prisons was the responsibility of the Governor and that Wandsworth Local Authority had no role in such cases. There is no evidence that healthcare staff raised the safeguarding issue with prison managers prior to Mr Fallows' death.

63. On 31 July, a mental health nurse went to see Mr Fallows to assess his mental state. Mr Fallows refused to engage with her.

64. On 2 August, Mr Fallows told a nurse that he wanted to die. This was the only recorded time Mr Fallows expressed an active wish to die. There is no record that this information was shared with prison staff.

65. On 4 August, the sessional GP saw Mr Fallows. He noted Mr Fallows' deteriorating health and considered that he needed to be transferred to a nursing home. It was agreed that the lead prison GP would complete the necessary paperwork for compassionate release (although Mr Fallows was not terminally ill and was therefore unlikely to qualify). No care plan was created setting out what to do if Mr Fallows' health deteriorated significantly.

66. On 5 and 6 August, Mr Fallows refused to allow staff to complete vital signs observations. By this point Mr Fallows was getting weaker and was increasingly uncooperative with his care.

Events of 7 and 8 August

67. On 7 August, a nurse saw Mr Fallows. Mr Fallows refused all food and drink and refused personal care. That evening, the nurse noted that Mr Fallows' breathing appeared to have changed: it was faster than usual, and Mr Fallows was using his abdominal muscles to help him breathe. He called another nurse to help assess Mr Fallows.

68. At around 1.00am on 8 August, a nurse went to the healthcare unit. He and another nurse completed a NEWS-2 assessment. Mr Fallows scored 6 which indicated he needed medical assessment. He was struggling to breathe, and his chest movement was abnormal.

69. At around 1.20am, a nurse called the senior nurse on duty and explained Mr Fallows' condition. She told him to call an ambulance immediately. The nurse called the prison Control Room at 1.25am and asked them to call an ambulance. He did not use a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). A 999 call was made immediately to the London Ambulance Service (LAS) who dispatched a first responder vehicle.

70. The senior nurse went to see Mr Fallows. He was pale and had difficulty breathing and his hands and feet were cold. Mr Fallows was conscious and told staff to leave him alone. At 1.40am, the nurse radioed the prison Control Room and asked they ring 999 again as his condition was now critical. She said it was a code blue. The Control Room called LAS again and a second ambulance was dispatched to the prison.

71. The ambulances arrived at Wandsworth at 1.54am and 1.58am respectively and the first paramedics were at Mr Fallows' bedside at 2.00am. The nurses gave the paramedics Mr Fallows' clinical history and condition and told them about his DNACPR.

72. The prison nurses then withdrew from the cell as there was not enough room for them as well as the ambulance crew. The paramedics assessed Mr Fallows and told the prison nurses that they would not take Mr Fallows to hospital because he was dying and refusing care. They advised the nurses to keep Mr Fallows comfortable. The paramedics left the prison shortly after 2.30am.

73. Prison staff arranged for Mr Fallows' cell door to be left open so nurses could access him easily. A nurse and a prison officer stayed with Mr Fallows through the rest of the night.

74. At around 6.00am, the nurse came back to see Mr Fallows. She noted that there were now large gaps in his breathing. He was conscious and at one point told her to go away. She arranged for Mr Fallows to be seen by the prison doctor when he arrived.

75. At around 7.30am, the senior nurse handed over to another nurse. They discussed Mr Fallows' care and the need for him to be assessed by a prison doctor. The nurse also spoke to the Orderly Officer - a Custodial Manager (CM) - and told him that the doctor would see Mr Fallows when he got in and prison officers might be needed to escort him to hospital.

76. Nursing staff also called the duty chaplain. He went to see Mr Fallows in his cell at about 10.00am. He stayed for about half an hour, holding Mr Fallows' hand and comforting him. He noted that Mr Fallows' breathing was strong but irregular.

77. When a prison GP arrived at the prison around midday, he assessed Mr Fallows. Mr Fallows did not respond or engage with him. He noted Mr Fallows was breathing normally but he was concerned about his condition and what had happened when LAS had attended in the early morning. He rang the prison's lead GP for advice.

78. The lead GP advised that Mr Fallows needed to go to hospital. The prison GP then rang St George's Hospital. He spoke to a doctor in the hospital's A&E department, who advised Mr Fallows should be sent to hospital.

79. At 1.53pm, a nurse rang the Control Room to ask for an urgent, rather than an emergency, ambulance. Shortly afterwards, she spoke with the CM to arrange for prison officers to escort Mr Fallows to hospital. At around 2.00pm, the chaplain returned to visit Mr Fallows. Mr Fallows was now unconscious, and the chaplain held his hand again.

80. The ambulance arrived at Wandsworth at 2.20pm. It was a Non-Emergency Transport Service (NETS) ambulance used when no medical intervention is needed. The ambulance crew tried to communicate with Mr Fallows, but noted he was unconscious and had indicators of sepsis. They requested support.

81. At 2.47pm, a second ambulance with a paramedic arrived at Wandsworth. Paramedics treated Mr Fallows in his cell and gave him oxygen to assist his breathing. At 3.22pm, the ambulance left the prison with Mr Fallows, escorted by two prison officers.

82. At 3.30pm, the ambulance arrived at St George's Hospital and Mr Fallows was taken to A&E. He was declared dead at 3.35pm.

Contact with Mr Fallows' family

83. Despite the efforts of staff at Wandsworth, no next of kin could be traced. Mr Fallows' funeral was held on 4 November 2020. In line with HMPPS policy, the prison paid for the costs of the funeral. A prison chaplain and another staff member from Wandsworth attended the funeral.

Support for prisoners and staff

84. After Mr Fallows' 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.

85. The prison posted notices informing other prisoners of Mr Fallows' death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Fallows' death.

Post-mortem report

86. The post-mortem found that Mr Fallows died from acute pyelonephritis (a kidney infection) caused by kidney stones. Atrial fibrillation and hypertension contributed to but did not cause Mr Fallows' death.

Findings

Clinical Care

87. The clinical reviewer said that Mr Fallows was an exceptionally difficult and capricious patient, who would have been difficult to manage in any circumstances or environment.

88. She concluded that the care Mr Fallows received at Wandsworth was generally equivalent to that which he could have expected to receive in the community. However, she concluded that the care he received between 4 and 8 August 2020 was not equivalent and that he was not afforded a dignified death.

April 2018 to end of July 2020

89. The clinical reviewer found that from April 2018, when he arrived at Wandsworth, to the end of July 2020, Mr Fallows received a high level of care equivalent to that he would have received in the community. She said that, as he was within a contained environment, prison healthcare staff persisted in delivering care when his behaviour was unacceptable, and that in the wider community care might have been withdrawn.

90. She found that there was good continuity of care from the TILS nurse, who listened to Mr Fallows' repeated requests for equipment and financial help that was unattainable and managed his demands effectively. She also commended the sessional GP's highly detailed assessments of 2 and 11 June, and she noted that the primary care healthcare management team worked hard in challenging circumstances to reach out to colleagues for assistance and advice in the placement of Mr Fallows.

91. The clinical reviewer did, however, identify some shortcomings during this period.

92. She said that there were areas where care assessment and planning may have been better codified, such as by using the falls assessment system, but they did not lead to omissions in care.

93. She considered that the referral for a CHC assessment could and probably should have been undertaken more promptly, but she concluded that it was unlikely, given the pandemic, that it would have led to a more rapid transfer to a nursing home, even if a suitable placement could have been found.

94. She was concerned that Mr Fallows told a nurse at the end of April that he had been sleeping in his wheelchair for the past two years. If so, this should have been identified via the routine monthly checks and appropriate action should have been taken to assess and reduce the risks. (However, we cannot be sure that what Mr Fallows said was true as we would have expected prison staff to have reported concerns to healthcare staff if he had been sleeping in his wheelchair for two years.) We recommend:

The Head of Healthcare should ensure that the checklist for the regular review of vulnerable patients includes assessment of all aspects of their sleep environment.

Safeguarding

95. The clinical reviewer found that Mr Fallows' inconsistent and capricious behaviour amounted to self-neglect. She said there was no known physical diagnosis for his reluctance to regain mobility or to eat and drink after he returned from hospital, and that, if he had chosen to co-operate with physical rehabilitation, taking medication and eating, many of his ongoing needs would have resolved and he would have returned to his previous level of health.

96. By late July, healthcare staff sought safeguarding advice from the local authority team as Mr Fallows' behaviour was putting his life at risk. They responded that this was a matter for prison healthcare and the Governor. There is no evidence that healthcare staff ever had a discussion with the prison safeguarding manager about Mr Fallows, although healthcare staff identified this as an action. The clinical reviewer was concerned that the approach to self-neglect as a safeguarding issue within the prison was unclear. We note that HMIP reported in 2018 that staff awareness of safeguarding adults at risk was poor at Wandsworth.

97. We make the following recommendation:

The Governor, the Head of Healthcare and the Local Authority Safeguarding Team should meet to discuss how to manage and support a prisoner who is self-neglecting, with a view to establishing best practice and improving local policy awareness.

4 to 8 August 2020 - Lack of a care plan

98. The clinical reviewer's principal concern was that there was no clear medically-led care plan which told healthcare staff what they should do if Mr Fallows became acutely unwell. She considered that a care plan (including end of life care) should have been created on 4 August when Mr Fallows' health was clearly deteriorating.

99. The clinical reviewer recognised that nuanced discussion with Mr Fallows was impossible, but she considered that a discussion should have been held about which treatments and medications he was and was not willing to accept. This should have then been formalised into an Advance Decision to Refuse Treatment (ADRT). She also considered that, given Mr Fallows' behaviour, he should have been assessed by mental health specialists. She noted that although the sessional GP left Wandsworth in June 2020, her assessments and medical management plans offered an outline not just to manage Mr Fallows' immediate needs, but that could also have been used as a springboard for discussions around decisions on ADRT. However, this was not done.

100. The clinical reviewer said that, as none of this had been done, it was even more important for there to be a clear care plan which could have been shared with prison and ambulance staff. A nurse might then have called a code blue (meaning a request for an emergency ambulance) and so avoided the short delay before an emergency ambulance was requested. The clinical reviewer also found that without a plan, although healthcare staff were unhappy when LAS paramedics declined to take Mr Fallows to hospital in the early hours of 8 April,

they did not know what to do. They also lacked the clinical assertiveness to either insist Mr Fallows was taken to hospital or to gain support out of hours from more experienced clinical and managerial colleagues.

101. She also found that the absence of a plan resulted in a troubling level of delay and confusion about Mr Fallows' treatment later that day.

102. After the LAS paramedics left at 2.30am, Mr Fallows remained in his cell being cared for by nursing staff and was not reviewed by a doctor until around midday (nearly 10 hours later). Following consultation with the lead GP, a prison GP decided to send Mr Fallows to hospital. The lead GP recalled that this was done with the aim of establishing why Mr Fallows had deteriorated. However, the clinical reviewer said that the decision to send him to hospital was taken around twelve hours after staff first observed abnormal vital sign observations and breathing difficulties, and by then it was almost certainly too late to make any difference and did not support a dignified death for Mr Fallows.

103. There was also confusion about how quickly Mr Fallows needed to be taken to hospital. Although the GPs agreed around midday that he needed to go to hospital, an ambulance was not called until 1.53pm and then a nurse requested an urgent rather than an emergency ambulance.

104. At interview, the nurse said her rationale for this was that Mr Fallows' condition had remained essentially stable during this period and she wanted to ensure that prison staff had time to arrange hospital escorts. However, in his statement the CM said that he was told by healthcare staff at around 2.00pm that an ambulance had been called for Mr Fallows, and he said that the escorting officers were ready and available before the ambulance arrived at around 2.20pm. The chaplain also said that when he returned to see Mr Fallows at around 2.00pm, he found there was a lack of clarity about whether Mr Fallows was going to go to hospital and who was making this decision. The prison GP should have given clear instructions.

105. The decision not to call an emergency ambulance caused a significant delay in transferring Mr Fallows to hospital. The ambulance that arrived at Wandsworth at 2.20pm was not equipped to take someone as acutely ill as Mr Fallows and the crew had to request support. A second ambulance arrived at 2.47pm, and left at 3.22pm, after paramedics had had to give Mr Fallows oxygen. Mr Fallows appears to have taken his last breath as he was being taken out of the ambulance and was declared dead within five minutes of arriving at the hospital.

106. The clinical reviewer found that the absence of a clear care plan, meant that Mr Fallows' care from 4 to 8 August was not equivalent to that he might have expected in the community. She said that individual staff members worked hard to help Mr Fallows and were distressed that they were unable to afford him a more dignified end to his life.

107. We make the following recommendations:

The Head of Healthcare and the lead GP should establish clear parameters around leadership and planned action in unusual or complex cases and

ensure that there are clear written care plans with instructions to direct staff specifically on what action to take.

The Head of Healthcare should ensure that there is a system for clear handover of patients whose care might become complex to the emergency response nurses. The increased use of "Co-ordinate my Care" should be considered to share information with other providers if possible and as appropriate.

The Head of Healthcare should ensure this report is shared with LAS with a view to considering what joint learning has emerged. The level at which the report is shared is a matter for Oxleas and NHSE.

Oxleas, as the provider of care at Wandsworth, and NHSE, as the commissioner, should jointly articulate what out of hours medical support is available to HMP Wandsworth. This should then be turned into an operational policy which is shared with all staff to allow lead nurses working at a time when there is no GP on site to gain appropriate medical advice.

The Head of Healthcare and the Regional Manager for Oxleas should review and relaunch the guidance on escalation of concerns out of hours and ensure that lead nurses working out of hours know how and who to contact if they find themselves in a situation where they require specific support.

The Head of Healthcare and the lead GP should produce guidance for staff on the difference between DNACPR and ADRT, and joint training events should be offered.

The Head of Healthcare should obtain assurance that all staff are aware of the revised guidelines on end-of-life care.

The Head of Healthcare and the lead GP should share this report with all clinical staff named in it and offer a reflective discussion on its findings. This should be extended to staff who no longer work at HMP Wandsworth.

Other clinical matters

108. The clinical reviewer also made recommendations about record keeping which the Head of Healthcare will need to address.

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