

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr William Heagren, a prisoner at HMP Wormwood Scrubs, on 14 December 2019

A report by the Prisons and Probation Ombudsman

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr William Heagren died on 14 December 2019 of heart disease while in the custody of HMP Wormwood Scrubs. He was 87 years old. I offer my condolences to Mr Heagren's family and friends.

Mr Heagren died 10 days after entering prison. He was admitted to hospital with a suspected broken hip on 12 December and died two days later.

This is a worrying case in many respects. Mr Heagren's age, frailty and poor mobility meant that it was always going to be challenging to manage his complex needs in a prison environment. Nevertheless, he could have been managed better and we have identified a number of serious concerns about the healthcare he received.

I am also disappointed to have to repeat a recommendation that I have made previously to Wormwood Scrubs about the inappropriate use of restraints on a very frail prisoner.

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**

July 2020

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Summary

Events

1. On 4 December 2019, Mr William Heagren was sentenced to 27 months in prison and taken to HMP Wormwood Scrubs. He was 87 years old.
2. When he arrived in prison, Mr Heagren was referred to the prison GP for a review of his complex medical needs, including a previous hip injury that affected his mobility. The GP stopped his prescribed pain relief prescription (tramadol) in favour of a less effective pain relief that she considered put him at less risk of bullying. She also cancelled an outstanding hospital appointment for security reasons, because Mr Heagren knew the date and time of the appointment. Mr Heagren was taken to the first night centre.
3. On 5 December, Mr Heagren fell and hurt his hip. A nurse practitioner examined him and concluded that he had not fractured his hip. She arranged for him to transfer to the prison's inpatient unit on 6 December to manage his needs better.
4. On 7 December, a nurse arranged for an ECG after finding that Mr Heagren's pulse was a little fast. The results were received by the prison that day, but not reviewed by a GP until 11 December.
5. On 11 December, another prisoner alerted healthcare staff that Mr Heagren was in severe pain. The responding nurse was concerned about the severity of his pain, so retrieved his community GP records and eventually arranged for a nurse practitioner, then a GP, to review Mr Heagren and prescribe him tramadol.
6. Mr Heagren's pain continued and on 12 December a nurse practitioner arranged for him to be taken to hospital for urgent assessment. He was restrained with an escort chain until the afternoon of 13 December, when all restraints were removed.
7. On 13 December, a CT scan showed that Mr Heagren had a hip fracture. He died in hospital on 14 December.

Findings

8. The clinical reviewer concluded that Mr Heagren's care fell below the standard of care he could have expected to receive in the community. She identified the following concerns:
 - Mr Heagren's pain was not well managed. The decision to stop his tramadol prescription on 4 December was "incorrect" and should have been reviewed when he moved to the prison's inpatient unit on 5 December. It was only after the extensive efforts of an individual nurse that effective pain relief was finally reinstated when Mr Heagren had become bedbound on 11 December.
 - The initial GP review should have resulted in a care plan to manage Mr Heagren's complex needs, including a personal evacuation plan, a falls assessment and a more detailed assessment of his care needs.

- The prison GP cancelled an outstanding hospital appointment without arranging for a manager to risk assess whether it could go ahead, and took no action to arrange for the appointment to be re-booked.
 - The results of Mr Heagren's ECG on 7 December were not followed up sufficiently promptly.
 - His community GP records were not obtained until 11 December.
 - The examination of Mr Heagren's hip after his fall on 5 December was full and appropriate, but the conclusion that he had not broken his hip should have been revisited when his condition deteriorated on 11 December.
9. We share the clinical reviewer's concern that this investigation has uncovered a number of issues around the capacity and capability of the healthcare team to provide effective healthcare services at Wormwood Scrubs.
 10. We are concerned that Mr Heagren was restrained with an escort chain when he was taken to hospital and remained restrained for 15 hours. We consider this was not appropriate given Mr Heagren's age and frailty and the fact that he was in severe pain.
 11. We consider that Mr Heagren's family should have been informed that he had been admitted to hospital on 12 December.
 12. We commend individual members of staff for the care they showed in their dealings with Mr Heagren.

Recommendations

- The Governor and the Head of Healthcare should ensure that appropriate care plans are in place to meet the complex needs of older prisoners.
- The Head of Healthcare should ensure that all prisoners receive immediate and effective pain relief according to their clinical needs.
- The Head of Healthcare should organise a learning event for clinical staff on the diagnosis and management of hip fractures.
- The Governor and the Head of Healthcare should ensure that:
 - clinically necessary pre-arranged hospital appointments are not automatically cancelled unless there are overriding, documented security reasons for doing so;
 - where healthcare staff consider that pre-arranged hospital appointments are clinically necessary, they do not cancel them without discussion with security staff; and
 - where pre-arranged hospital appointments are cancelled, they are re-booked as soon as possible.

- Care UK should:
 - undertake a review of the arrangements in place for the clinical staff to provide an acceptable and safe level of care to the prisoners in Wormwood Scrubs; and
 - report the conclusions of the review to the Regional Healthcare Commissioner and the Governor.
- The Head of Healthcare should review the arrangements for the provision of unscheduled care to ensure that there are systems in place to ensure it is available in a timely way.
- The Head of Healthcare should meet with all the GPs and advanced nurse practitioners to review the way they manage clinical uncertainty and how they work as a team.
- The Governor and the Regional Healthcare Commissioner should satisfy themselves that the healthcare provision at Wormwood Scrubs is adequate for the needs of the population in the light of the findings of this investigation.
- The Governor should ensure that all staff undertaking risk assessments for escorting prisoners to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.
- The Governor should ensure that staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill.
- The Head of Healthcare should share this report with a nurse and commend her for the exemplary clinical care she provided Mr Heagren on 11 December.
- The Governor should share this report with the Custodial Manager and commend him for the care and compassion he showed in his dealings with Mr Heagren.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Wormwood Scrubs informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
14. The investigator obtained copies of relevant extracts from Mr Heagren's prison and medical records.
15. NHS England commissioned independent clinical associates to review Mr Heagren's clinical care at the prison. An independent clinical reviewer carried out the clinical review on their behalf.
16. The investigator and the clinical reviewer interviewed nine members of staff and one prisoner at Wormwood Scrubs on 4, 6, 13 and 26 February 2019.
17. We informed HM Coroner for London 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.
18. One of the Ombudsman's family liaison officers contacted Mr Heagren's next of kin, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Heagren's family responded to say that Mr Heagren had a medical report (from his community GP) with him when he arrived at Wormwood Scrubs. His solicitor also contacted the prison to underline Mr Heagren's frailty, vulnerability and medication. She asked the investigation to consider the following issues:
 - Did the prison adequately manage Mr Heagren's complex medical needs, given his age, frailty and vulnerability?
 - Why did the prison not continue Mr Heagren's tramadol prescription when he first arrived in custody?
 - Why did the prison cancel Mr Heagren's hospital appointment on 9 December?
 - Why did Mr Heagren fall twice in prison?
 - Why did the prison not tell Mr Heagren's family about his broken hip or his hospital admission?
19. Mr Heagren's family received a copy of the initial report. The solicitor representing his family wrote to us pointing out some factual inaccuracies. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor
20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Wormwood Scrubs

21. HMP Wormwood Scrubs is a local prison in West London, which can hold nearly 1,300 men. The prison holds men on remand from West London courts and London prisoners serving short sentences or coming to the end of long sentences. Care UK is contracted to provide primary care and several other health services at Wormwood Scrubs.
22. In August 2018, Wormwood Scrubs was selected to be part of the “10 Prisons Project” which seeks to improve safety, security and decency in the prisons involved. The project is focusing on reducing violence, improving living conditions, preventing drugs from entering the prison and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Wormwood Scrubs was in September/October 2019. Inspectors found that health services outcomes were generally good, but care for those with long-term conditions was insufficient. The care pathway for these patients was unclear and care and treatment was not well coordinated. They noted that few patients with long-term health conditions had personalised care plans in place to inform their on-going care. Of 12 clinical records inspectors reviewed for patients with a diagnosed long-term health condition, only three had a care plan in place.
24. Inspectors noted that Wormwood Scrubs was building links with another prison that could better accommodate older prisoners’ personal care needs.

Independent Monitoring Board

25. 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 reported that Wormwood Scrubs had undergone significant improvement in some areas, although there was still much more progress to be made. The physical environment, cleanliness and basic decency had all benefitted from investment, but they considered safety and violence reduction remained problematic.

Previous deaths at HMP Wormwood Scrubs

26. Mr Heagren was the ninth prisoner to die at Wormwood Scrubs since January 2018, and the fourth prisoner to die from natural causes. Since Mr Heagren’s death, there has been one further death (a self-inflicted death) in April 2020. We have previously made recommendations about appropriately risk assessing prisoners before using restraints and the adequacy of clinical care plans.

Key Events

27. On 4 December 2019, Mr William Heagren was sentenced to 27 months in prison for two offences: death by dangerous driving, and causing serious injury by dangerous driving. He was 87 years old. Mr Heagren was sent to HMP Wormwood Scrubs.
28. At an initial health screen at 8.40pm, a nurse noted that Mr Heagren was 5 feet 5 inches tall and weighed just over 9 stone. He had a history of Chronic Obstructive Pulmonary Disease (COPD - a lung condition), atrial fibrillation (an abnormal heart rhythm) and osteoarthritis in his right hip. He used a wheeled Zimmer frame. The nurse recorded that in the community Mr Heagren was prescribed tramadol (a strong opioid based painkiller), three different types of asthma inhalers, and sotalol for his heart condition. The nurse referred Mr Heagren to the prison GP for review.
29. An agency doctor who regularly works at Wormwood Scrubs, reviewed Mr Heagren at 9.30pm. He told her that he took tramadol for pain in his hip after falling down the stairs at home nearly two years previously, and that he was due to attend a hospital for an appointment about his hip on 9 December. The agency doctor prescribed Mr Heagren co-codamol (a paracetamol and codeine based painkiller), explaining that prescribing strong painkillers like tramadol could put him at risk of bullying from other prisoners on the wing. In interview, she said that she knew that co-codamol would not manage his pain as effectively as tramadol, but did not plan to review his pain relief. The doctor also cancelled Mr Heagren's hospital appointment for security reasons, because he knew the date of the appointment in advance.
30. Mr Heagren was sent to the six-bed dormitory in the first night centre (a residential wing where new prisoners go to receive a prison induction). Despite Mr Heagren having reduced mobility, no one completed a 'risk of falls assessment' or a Personal Evacuation Plan, or drew up a care plan to manage his complex needs.

5 December

31. On 5 December, Mr Heagren fell while helping another prisoner move a mattress. He said he had hurt his right thigh. When a nurse examined him, he noted that his right thigh was tender but he found nothing abnormal. He asked that a doctor review Mr Heagren later that day.
32. An Advanced Nurse Practitioner examined Mr Heagren that night. Mr Heagren said that he could move normally after his fall but he was still in pain. She examined both of his legs and hips and found no swelling or bruising. After her review, she recorded that she thought Mr Heagren was vulnerable on the wing and he would be better suited to the prison's inpatient unit.

6 December

33. On the morning of 6 December, Mr Heagren had a visit from family. A Custodial Manager (CM), who was responsible for visits, arranged for Mr Heagren to see his family in the legal visits area. Mr Heagren was taken down the stairs in an

'evac- chair' and was then taken by wheelchair to the visit. The CM told the investigator that this done because of Mr Heagren's poor mobility – he said he was moving very slowly – and so the journey could be completed as quickly as possible.

34. A nurse arranged for Mr Heagren to move to the prison's inpatient unit in the afternoon. She recorded that Mr Heagren needed "minimal assistance" to walk down two flights of stairs from the first night centre to the inpatient unit.

7 December

35. While taking Mr Heagren's routine clinical observations on 7 December, a nurse noted that his pulse was faster than normal, so he arranged an ECG. He sent the ECG results to an ECG Interpretation Service, who reported that Mr Heagren could have possible left ventricle atrophy (thickening of the heart muscle). The nurse spoke to the duty GP about looking at the ECG, but as the GP was busy and it was not urgent, it was agreed it would be left until 9 December.

8 December

36. The nurse told the investigator that Mr Heagren was still moving well and bearing his weight on both legs when he saw him on 8 December. He described Mr Heagren as frail. He noted in Mr Heagren's medical record that he still had some outstanding blood and urine tests and that he was due to see the doctor the next day to discuss the outcome of his ECG. He also recorded that Mr Heagren was walking slowly with a Zimmer frame.

9 December

37. A nurse recorded that Mr Heagren was mobilising slowly in his cell and on the unit during association. No other concerns were noted. He was not seen by the duty doctor.

10 December

38. A nurse recorded that Mr Heagren was "mobilising around the unit with his walker independently". She noted that the ECG had still not been reviewed, but that Mr Heagren's pulse and blood pressure were within normal ranges, so she did not think it was urgent. She also noted that the prison was still chasing Mr Heagren's community GP records.

11 December

39. A nurse told the investigator that she had not met Mr Heagren before 11 December. She described him as standing next to his bed leaning on his walker and recorded that he said he was in so much pain in his right hip that he could not move. Mr Heagren told her that he was still not taking tramadol which he said he had been prescribed by his community GP to manage his pain.
40. When she reviewed his medical record after their conversation, she realised that the prison had still not received Mr Heagren's community GP records, so she contacted the community GP, who immediately sent his medical summary to the prison. She wanted to show the prison GP confirmation of Mr Heagren's

tramadol prescription so she could prescribe tramadol with no further delay. Initially, both the nurse practitioner and the GP said that they were too busy with other duties to review Mr Heagren.

41. At about 12.30pm on 11 December, another prisoner rang his cell bell to tell staff that Mr Heagren was in pain. The nurse spoke to Mr Heagren who said he had had a sudden increase in the pain around his right hip. The pain was severe, he felt unable to move and was finding weight-bearing difficult. It took three people to help him into bed.
42. She recorded in Mr Heagren's medical notes that she considered he needed a GP review that day. She spoke to the agency doctor and a nurse practitioner, but they were both busy and unable to see Mr Heagren at that time.
43. Mr Heagren had a legal visit that afternoon. A CM said that he was told that Mr Heagren could no longer walk at all. He therefore asked a nurse if the visit could take place in the healthcare centre so that Mr Heagren did not have to walk to the visits area. He said that the nurse was very helpful and got the other prisoners out of the dormitory so the solicitors could speak to Mr Heagren in the dormitory while he remained in bed.
44. The CM said that legal visits usually took place in the legal visits area and that it was unusual to allow lawyers into the prison. However, he said this was a particularly unusual circumstance. Having met Mr Heagren a few days before, he knew that he was appealing against his custodial sentence and he was keen to make sure he had access to his legal team.
45. After the visit, the nurse told Mr Heagren's solicitor that Mr Heagren had not yet been prescribed tramadol because the prison had only just received his GP records to confirm the prescription. She told the solicitor that she was trying to arrange for Mr Heagren to be prescribed tramadol that day.
46. She went back to a second nurse, who reviewed Mr Heagren at about 3.30pm. He told her that the pain had eased slightly but that he experienced severe pain when he tried to move. The second nurse noted that another nurse had previously concluded that Mr Heagren had not fractured his hip when he fell on 5 December. She did not review this diagnosis. She gave Mr Heagren a bottle to use if he needed the toilet and went to find the duty GP.
47. The agency doctor reviewed Mr Heagren's records at about 4.30pm, but did not see him in person. She noted that his ECG results were broadly normal but that his hip pain needed to be monitored. She also reviewed the community GP medical summary, reiterated her reason for stopping Mr Heagren's tramadol prescription, but then prescribed him tramadol to start the next day.
48. When a nurse read the record of this review, she realised that it meant that Mr Heagren would not receive the tramadol until the following day. She therefore spoke to the agency doctor to ask her to prescribe Mr Heagren an urgent dose of tramadol to take that evening, which she did at 8.00pm. Mr Heagren received a dose shortly afterwards.

12 December

49. At 3.00am on 12 December, a nurse responded to Mr Heagren's cellmate's cell bell to find Mr Heagren in severe pain. Mr Heagren said he had got out of bed to use the toilet but had been unable to walk more than a few steps because of the pain. The nurse offered Mr Heagren a bedpan, but he refused and, with the nurse's assistance, he used his walker to get to the commode and back to his bed. He recorded that Mr Heagren seemed confused. He also noted his concerns about the safety of managing Mr Heagren in the healthcare unit.
50. At 10.20am, a nurse checked Mr Heagren's clinical observations because he was still saying he was in pain. She recorded that all his observations were normal, but he was still in pain when he moved.
51. A nurse checked Mr Heagren again at 2.15pm, because healthcare staff were saying that he had not moved and he was in a lot of pain. She examined his hip and the movement in his leg and found no bruising or swelling but noted that his right foot was rotated. Because of this and the severity of his pain, she recorded that he needed to go to hospital urgently.
52. Mr Heagren was taken to a hospital at 6.15pm that evening. The duty governor completed an emergency escort risk assessment, which concluded that the escorting officers should use an escort chain in the ambulance. There is no room on the emergency escort form to record the impact of Mr Heagren's physical condition on his level of risk.
53. Mr Heagren was admitted to hospital.

13 December

54. On 13 December, Mr Heagren had a CT scan which showed a fracture of the right hip. He was scheduled to have an operation on his hip on 14 December.
55. At 3.15pm, the Head of Security authorised the escorting officers to remove the escort chain.

14 December

56. A nurse found Mr Heagren unresponsive at 11.30am. The bedwatch officers informed the duty governor at 11.40am that Mr Heagren had gone into cardiac arrest and that hospital staff were trying to resuscitate him. Mr Heagren did not recover and at 12.35pm, a hospital doctor confirmed that he had died.

Contact with Mr Heagren's family

57. On 13 December, a legal representative from Gateley Legal emailed the prison requesting Mr Heagren's medical records. The Deputy Head of Healthcare, replied to this email, explaining that Mr Heagren was currently in hospital and they would need to gain his consent before sharing such information. Mr Heagren's family and solicitor were unaware that he had been admitted to hospital.
58. At about 6.00pm on 13 December, Mr Heagren's next of kin telephoned the prison's family liaison officer (FLO). He said that hospital staff had told him that

Mr Heagren was very unwell and he asked if the family could visit him the following day. After speaking to the security department, who carried out a risk assessment, the FLO told Mr Heagren's next of kin that they could visit on 14 December and it was agreed they would do so in the afternoon.

59. At 11.41am on 14 December, the FLO rang Mr Heagren's next of kin to say that Mr Heagren was critically ill. They were already on the train to the hospital. They arrived at 1.00pm and were taken to the hospital's family room to be told that Mr Heagren had died.

Support for prisoners and staff

60. After Mr Heagren's death, a prison manager debriefed the staff involved to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
61. The prison posted notices informing other prisoners of Mr Heagren's 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 Heagren's death.

Post-mortem report

62. The post-mortem report showed that Mr Heagren died from ischaemic heart disease caused by severe coronary artery atheroma, with aortic valve disease and chronic bronchitis as underlying conditions which contributed to but did not cause his death.

Findings

63. When Mr Heagren was sentenced, the judge made her reasons for imposing a custodial sentence clear. However, we want to note that many of the prison and healthcare staff we interviewed referred to this and expressed their views about the challenge of supporting him in the prison environment. They expressed compassion and concern for Mr Heagren and wanted to do the best they could for him within the bounds of the environment at Wormwood Scrubs.

Healthcare

Clinical care

64. Mr Heagren's age, mobility and frailty presented a particular challenge for healthcare staff and officers caring for him in a prison environment. The clinical reviewer did not consider that the healthcare he received at Wormwood Scrubs overall was equivalent to that he could have expected to receive in the community.
65. Prison Service Order (PSO) 3050, *Continuity of Healthcare for Prisoners*, requires that "an initial assessment of the healthcare needs of all newly received prisoners is undertaken within 24 hours of first reception by an appropriately trained member of the healthcare team to identify any existing problems and to plan any subsequent care".
66. The clinical reviewer considered that Mr Heagren should have had a care plan in line with the PSO requirements, including a personal evacuation plan, a falls assessment and a more detailed assessment of his care needs.
67. The clinical reviewer was also concerned that the results of Mr Heagren's ECG on 7 December were not followed up sufficiently promptly and that his GP records were not obtained until 11 December.
68. We make the following recommendation:

The Head of Healthcare should ensure that appropriate care plans are in place to meet the complex needs of older prisoners.

Pain management

69. The clinical reviewer also had significant concerns about the management of Mr Heagren's pain.
70. During her initial GP screen, the agency doctor did not re-prescribe tramadol, and prescribed Mr Heagren co-codamol instead. A nurse told Mr Heagren's solicitor that he was not prescribed tramadol because his community prescription had not been confirmed (which is what she assumed at the time). However, the agency doctor told the investigator that she did not prescribe tramadol because she thought it would make him vulnerable to bullying on a standard wing, because it is a tradeable medication in prison. The agency doctor said that she knew the co-codamol would not manage Mr Heagren's pain as effectively as tramadol, but she did not plan to review his pain management.

71. The agency doctor said that she could not ask for a prisoner to be admitted directly to the prison's inpatient unit, even though this would have put Mr Heagren at less risk of bullying for medication. She told the investigator that decisions about the location of a prisoner were security matters for prison managers to decide.
72. The clinical reviewer considered that the agency doctor's failure to continue Mr Heagren's tramadol prescription was "incorrect" and a serious break in the continuity of his clinical care, which would have caused him significant unnecessary discomfort. Although it was not unreasonable for the GP to be concerned that he might be bullied, the clinical reviewer said that Mr Heagren's tramadol could have been prescribed in a form that would make supervised consumption possible in order to avoid the risk of bullying.
73. We also consider that, although the location of prisoners is a matter for the prison, not healthcare, the agency doctor should still have recommended that Mr Heagren be admitted directly to the inpatient unit if she thought that was clinically appropriate.
74. We are also concerned that, even though Mr Heagren was admitted to the prison's inpatient unit on 6 December, where he was arguably less vulnerable to bullying, no consideration was given to re-prescribing him tramadol and his pain relief was not reviewed. He was prescribed tramadol only after he became bedbound on 11 December, when the matter was forced by a nurse.
75. We make the following recommendation:

The Head of Healthcare should ensure that all prisoners receive immediate and effective pain relief according to their clinical needs.

Mr Heagren's hip fracture

76. The clinical reviewer said that, with hindsight, it is clear that Mr Heagren sustained a hip fracture when he fell on 5 December. There is no evidence that Mr Heagren fell again either on 11 December, as his family believe, or at any other time while he was at Wormwood Scrubs.
77. The clinical reviewer is satisfied that a nurse adequately assessed Mr Heagren and treated his hip pain after his fall on 5 December. She considered that this aspect of Mr Heagren's care was equivalent to that he could have expected in the community.
78. At the time the nurse, who examined Mr Heagren, did not consider that he had sustained a fracture. She thought that his pain could have been a result of the change to his analgesic regime or just the background level of pain he always suffered from. The clinical reviewer noted that the nurse has worked in acute settings, including as a paramedic, so has experience at assessing patients for and diagnosing hip fractures.
79. The clinical reviewer also said that the diagnosis of a hip fracture, particularly if it is undisplaced, can be a clinical challenge in any setting, including A&E. In

uncertain cases, imaging is required and even a plain x-ray can miss a fracture. If clinical suspicion remains, an MRI scan is required.

80. Mr Heagren was able to mobilise independently after his fall, until 11 December, when there was a clear change in his situation and he effectively became bedbound. The clinical reviewer considered that the extent of Mr Heagren's deterioration should have prompted a nurse practitioner to review the original diagnosis and that there should have been a more structured discussion between the agency doctor and a nurse about his condition. The clinical reviewer also considered that Mr Heagren should have been sent to hospital urgently on the evening of 11 December, rather than the following day.

81. We recommend:

The Head of Healthcare should organise a learning event for clinical staff on the diagnosis and management of hip fractures.

Pre-arranged hospital appointments

82. When Mr Heagren arrived in prison on 4 December, he said he had an outstanding hospital appointment to review his hip pain on 9 December. His family emailed the prison about the importance of the appointment. The agency doctor cancelled the appointment. She told the investigator that she understood from prison officers that all outstanding hospital appointments should be cancelled because of the security risk of a prisoner knowing the time and date of an appointment in advance.

83. The Prison Service's National Security Framework does not require hospital appointments to be cancelled automatically when prisoners know the time and date, although our experience is that prisons often do this without sufficient reason. The national security guidance expects that the prisoner's condition and the urgency of the treatment required should be taken into account when making such a decision. If necessary, additional security arrangements can be put in place rather than cancelling appointments.

84. Wormwood Scrubs' Head of Security told the investigator that where a pre-booked hospital appointment is considered clinically necessary, he or the duty governor would consider whether the appointment could go ahead, taking into account clinical need and any security intelligence about the prisoner. He said that in practice they were rarely asked to consider such requests.

85. It is difficult to see that Mr Heagren would have posed a risk of escape or a risk to others if he had attended his appointment. However, we accept that Mr Heagren may not have suffered a significant detriment if his appointment had been cancelled and rescheduled by the prison. We are, however, concerned that the appointment was automatically cancelled by the agency doctor without any apparent consideration of whether it was clinically necessary or discussion with the security department. In addition, we have seen no evidence that the agency doctor took any action to ensure that the appointment was re-scheduled.

86. We make the following recommendations:

The Head of Healthcare and Governor should ensure that:

- **clinically necessary pre-arranged hospital appointments are not automatically cancelled unless there are overriding, documented security reasons for doing so;**
- **where healthcare staff consider that pre-arranged hospital appointments are clinically necessary, they do not cancel them without discussion with security staff; and.**
- **where pre-arranged hospital appointments are cancelled, they are re-booked as soon as possible.**

Healthcare workload and capacity

87. The clinical reviewer considered that the investigation into Mr Heagren's care had uncovered a number of issues around the capacity and capability of the healthcare team to provide effective healthcare services at Wormwood Scrubs. She noted that many of the staff, particularly the GP and the advanced nurse practitioners, referred to their workload, about being busy, and about having to deal with their regular workload and unscheduled care on a regular basis. She noted in particular that:

- The systems in place for obtaining information from the community GP did not work in this case and that the person responsible for completing this task said they had not managed to do it because they were too busy.
- When Mr Heagren had an ECG on 7 December, the duty doctor that day did not have time to look at it and it is not entirely clear whose responsibility it is to review test results each day. The ECG was only reviewed on 11 December after the agency doctor had been prompted to look at it.
- On 11 December, a nurse had considerable difficulty in ensuring that Mr Heagren was assessed by an appropriate clinician. It is evident from all the interviews that this was due to workload and capacity constraints rather than any other reason.

88. The clinical reviewer considered that these issues around workload and capacity present a potential risk to patient safety and need a detailed consideration by the healthcare providers. We recommend:

Care UK should:

- **undertake a review of the arrangements in place for the clinical staff to provide an acceptable and safe level of care to the prisoners in Wormwood Scrubs; and**
- **report the conclusions of the review to the Regional Healthcare Commissioner and the Governor.**

The Head of Healthcare should review the arrangements for the provision of unscheduled care to ensure that there are systems in place to ensure it is available in a timely way.

The Head of Healthcare should meet with all the GPs and advanced nurse practitioners to review the way they manage clinical uncertainty and how they work as a team.

The Governor and the Regional Healthcare Commissioner should satisfy themselves that the healthcare provision at Wormwood Scrubs is adequate for the needs of the population, in the light of the findings of this investigation.

Restraints

89. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.
90. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.
91. Four hours elapsed between the decision to send Mr Heagren to hospital and the ambulance arriving to take him. We consider that this was adequate time for the prison to have completed a full risk assessment and ensured that any restraints used were commensurate to the risk of a frail 87-year-old man who was unable to walk. Instead, the prison used an emergency risk assessment that did not allow for Mr Heagren's deteriorating physical health and mobility to be considered.
92. The Head of Security revisited this decision the following day and rightly assessed that Mr Heagren's risk of escape and risk to the public was low, and restraints were removed. By then Mr Heagren had been restrained for 15 hours.
93. We consider it was unacceptable that Mr Heagren was restrained at all during his escort to the hospital given his age and physical condition, and we make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for escorting prisoners to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Contact with Mr Heagren's family

94. Mr Heagren's family were not told that he had been taken to hospital on 12 December.
95. Prison Rule 22 requires prisons to notify a prisoner's spouse or next of kin "at once" if a prisoner becomes seriously ill or sustains a severe injury. Given Mr Heagren's age and general frailty, a suspected fractured hip was a serious injury. We therefore consider that the prison should have informed Mr Heagren's family on 12 December that he had been admitted to hospital.
96. We recommend:

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

Good practice

97. The clinical reviewer highlighted the actions of a nurse on 11 December, who pursued both the nurse practitioner and the GP until they reviewed Mr Heagren and eventually prescribed him tramadol for his severe pain. We agree that the nurse's behaviour was exemplary that day and commend her for her actions.
98. We also commend a CM who showed flexibility and compassion in making special arrangements for Mr Heagren's visits on 6 and 11 December.

We recommend:

The Head of Healthcare should share this report with a nurse and commend her for the exemplary clinical care she provided Mr Heagren on 11 December.

The Governor should share this report with a Custodial Manager and commend him for the care and compassion he showed in his dealings with Mr Heagren.

**Prisons &
Probation**

Ombudsman
Independent Investigations