

**Investigation into the circumstances surrounding the
death of a man in hospital, whilst a prisoner at HMP
Wormwood Scrubs in April 2007**

**Report by the Prisons and Probation Ombudsman for
England and Wales**

December 2007

This is the report of an investigation into the death of a man who died of natural causes in April 2007 in hospital, whilst in the custody of HMP Wormwood Scrubs.

I would like to add my personal condolences to those already expressed to the man's family on behalf of this office by one of my Family Liaison Officers.

This investigation was undertaken by one of my investigators. We would both like to thank the prison's Governor and his staff for their participation in the investigation. Hammersmith and Fulham Primary Care Trust undertook a review of the man's clinical care, and I also appreciate their assistance and very full and thorough review.

As is the case in many of my investigations following a death from natural causes, I am greatly influenced by the findings of the clinical review. In this case it appears that, while the man was treated for individual medical issues, there are concerns about the holistic care he received and about internal and external communications. Improved communication, both within the prison and with external healthcare partners, would provide greater safeguards for patient safety.

It is very unfortunate that the man's family was not informed when he was extremely ill in hospital towards the end of 2006. However, after his death, the prison was expeditious in gaining contact details for his family, making contact with them, and meeting the costs of returning the man's body to Africa.

I make six recommendations to the Governor and Primary Care Trust.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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SUMMARY

The man was convicted of serious offences and sentenced to seven years' imprisonment.

On reception into prison it was noted that he suffered from ill-health, specifically diabetes and hypertension. Healthcare recommended that he should remain on the reception wing due to the possible effects on his diabetes if he was subject to the stress of moving wings.

Between reception in August and November, healthcare monitored his known health problems. He also complained of other medical issues including dizziness, chest pain (on more than one occasion) and blurred vision.

By mid-November, his physical and mental health had taken a turn for the worse and he was admitted into hospital. After initially being aggressive to hospital staff, he became quite ill and was transferred to the Intensive Care Unit. While the prison kept in daily contact with the hospital, his family was not kept informed of developments as no family next of kin details were recorded. He remained in hospital until mid-December.

Over the next few months his health continued to be monitored, and he complained of further problems which included chest pains. He was again admitted to hospital in April 2007, but was returned to prison after he failed to comply with medical treatment and escort staff became suspicious of his behaviour. He was referred back to the hospital the following day and admitted overnight. He returned to prison the next day, but two days later was again admitted to hospital. He remained in hospital until he died four days later from heart disease.

The clinical review has identified that, while the man did receive appropriate care for each individual medical problem, there was the absence of a holistic view of his health. This was particularly true as regards his complaints of chest pain.

THE INVESTIGATION PROCESS

1. My investigator visited HMP Wormwood Scrubs and spoke to staff who dealt with the man during his imprisonment and transfers to and from hospital. He interviewed three members of staff, and these interviews were tape-recorded. Transcripts were forwarded to the staff to sign and return, but at the time of writing these had not been received. In addition, notices were posted to staff and prisoners about the investigation, inviting contributions.
2. My investigator studied all relevant prison records relating to the man. These include his main prison record, medical records and statements made by staff.
3. The Hammersmith and Fulham Primary Care Trust identified a clinical reviewer to carry out a review of the man's clinical care. I am grateful to him for undertaking a very thorough review.
4. My investigator contacted Her Majesty's Coroner to inform her of the nature and scope of my investigation and request a copy of the Post Mortem report. Upon completion, my report was sent to the Coroner to assist in her enquiries into the man's death.
5. One of my Family Liaison Officers contacted the man's wife and son to offer them the opportunity to raise any questions or concerns for the investigation to consider. They were also offered the opportunity to see my report at draft and/or final stages. At the time of contact, the family chose not to raise any matters for the investigation and did not request a copy of my report. My Family Liaison officer gave contact details for my office and advised them not to hesitate to contact us if they changed their minds at any stage in the future.
6. My investigator discussed aspects of the man's treatment with both staff at Wormwood Scrubs and with the clinical reviewer. Additionally, the clinical reviewer convened a clinical review panel of expert and interested parties regarding the healthcare the man received in custody. My investigator attended this panel.

7. HMP WORMWOOD SCRUBS

8. Wormwood Scrubs is a Victorian prison, parts of which have been upgraded in recent years. The population is a mixture of adult male convicted and unconvicted prisoners, up to a maximum of 1,256. The prison predominantly serves the West London courts and has a high reception and discharge rate, averaging around 40 new prisoners each weekday.
9. Prisoners are held in a mixture of single and double cells. A typical cell contains either a single or bunk bed and a sink and toilet. Additionally, there is one freestanding locker and chair for each prisoner.
10. Provision of healthcare is the responsibility of the Hammersmith and Fulham Primary Care Trust. The healthcare centre is located on two floors (H2 and H3). The out-patient and day centre are located on H2. The in-patient unit is located on H3 and has 17 beds, 12 of which are single cells. H3 includes a gymnasium and relaxation room. Healthcare provision is modelled on a primary care service with the serious conditions being referred to the local hospital.
11. For emergencies, the prison operates a medical code system. If emergency medical assistance is required, then the designated Hotel 1 call-sign responds, assesses the situation, and commences any treatment before deciding on the next course of action. Hotel 1 is available 24 hours a day and is contactable from the communications room via the prison communication system.
12. Medication is administered on a weekly and/or monthly basis to those prisoners who have been risk assessed as suitable to hold it in their own possession. It is administered on a daily basis to other prisoners, when they are considered to be at risk or the medication is considered unsuitable to be held in their possession.
13. Whilst healthcare staff at Wormwood Scrubs may be trained to administer intravenous fluids, this is not a procedure that the prison expects to undertake. Staff will only be called upon to do so infrequently, so there are confidence issues to consider. Furthermore, cell doors are locked during the night and nursing staff do not have keys to gain access to cells to administer intravenous fluids. There are also issues of sterility and cleanliness. This leaves it open to question whether the prison is a good environment for such a procedure to be carried out.

Foreign national prisoners

14. As at May 2007, there were 575 prisoners in Wormwood Scrubs who were foreign nationals out of a total prisoner population of 1,256. This represents 45 per cent of the population.
15. Because the prison has such a high number of foreign national prisoners, care groups are organised to ensure appropriate support is available, particularly for those prisoners who do not speak English. Induction packs contain information

for prisoners who are foreign nationals and point to where they can find support. Additionally, there are foreign national orderlies: prisoners who are trained to help deal with issues that other foreign national prisoners might face.

Common law in the treatment of patients

16. Under common law, a patient in either prison healthcare or hospital is entitled to refuse medical treatment and cannot be forced to receive treatment unless they lack the mental capacity to do so. They can only be compelled to receive treatment if there are grounds under the Mental Capacity Act, 2005. If the patient cannot give consent, those treating him must do their best for that patient, including arranging a transfer to hospital if necessary.

KEY FINDINGS

17. The man arrived at Wormwood Scrubs in August 2007. He was initially allocated to B Wing. At his initial health screening, he told healthcare staff that he had high blood pressure and was an insulin-dependent diabetic. He was taking medication for both conditions. He said that he did not drink, smoke or take illegal drugs. It was noted that his weight was rather high.
18. No mental health issues were identified. Nursing staff requested that, if possible, the man should be kept on B Wing because of the unstable nature of diabetes and the possible effects of the stress of moving.
19. On 23 August, the man complained of dizziness and tightness in his chest and was advised to see the wing doctor. He saw the doctor two days later, having had no further problems in the interim. Healthcare staff set in place a plan for the man to monitor his weight, blood pressure and blood sugar and to conduct urinalysis. An electrocardiogram (ECG, a test used to measure the rate and regularity of heartbeats as well as the presence of any damage to the heart) was also carried out. This did not find any abnormalities. However, there is no indication that any further action was taken to assess the nature of his chest pain. He continued to receive his prescribed medication. This was to be reviewed after two weeks.
20. No further problems were reported until the man complained on 3 October that he was not eating properly and had blurred vision. Tests revealed no major problems with his blood and, after an eyesight test, he was supplied with bifocal spectacles.
21. The man reported no further health problems until 27 October when he said he was feeling unwell after taking his statin. (Statin is a drug used to control cholesterol. Many diabetics have raised cholesterol levels and it is good practice to be prescribed statin.) He was advised to adjust the times he took his medication so they did not coincide with his mealtimes.
22. On 10 November, the man complained to healthcare staff of muscular pain, although it was not severe. He subsequently complained of feeling unwell during the night of 12 November. He saw the doctor again on 13 November. He refused to attend the treatment room for his insulin, and appeared to be distracted. When, later that day, he did accept his medication, he had no memory of being called for his medication earlier.
23. On 14 November, the man told nursing staff that he had difficulty breathing and felt that he was dying. Staff noted that he was sometimes vague.
24. In the early hours of 16 November, he was reported by medical staff to be vague and agitated. He called nursing staff for what he described as an emergency, saying that he needed insulin urgently. Later that morning, he attended healthcare for his insulin but refused to have his blood sugar level monitored. Staff were concerned at an apparent deterioration in his mental

health. He was subsequently taken to the Accident and Emergency Unit in hospital.

25. There, the man was found to be dehydrated and possibly suffering from a urinary tract infection. He was returned from the hospital to prison, the hospital doctor having made the prison doctor aware that the man required intravenous fluids. However, this seems to have been based on a misunderstanding as the treatment is not available in the prison because of security issues and the requirement for cell doors to be locked during the night. There were also issues around the cleanliness of the prison environment. The man did not therefore receive the treatment recommended by the hospital.
26. The following day (17 November), the man's mental state deteriorated further and he became very confused and disorientated. He initially refused to take his medication, then complained of feeling unwell although he could not specify in what way. A mental health review was conducted by healthcare and he showed signs of left-sided weakness, facial asymmetry and a rapid pulse. He was diagnosed as being in a delusional state, with the possibility of a condition caused by a temporary reduction in blood and oxygen supply to part of the brain. He was re-referred to the prison doctor for admission to the inpatient unit. However, a bed was not available so this did not happen. His level of care and observation was increased, but the clinical reviewer has said that it would have been a better use of resources if he had been admitted to the inpatient unit.
27. The doctor reviewed the man early that afternoon, and re-referred him to hospital. He was again admitted to hospital. He had not previously presented as a control risk, but on this occasion he was initially aggressive to hospital staff and prison staff had to be called to restrain him. He remained in hospital until 15 December, and whilst there he became extremely ill and was moved to intensive care. He was diagnosed as suffering from encephalitis (a swelling of the brain tissue), pneumonia and mild mastoiditis (inflammation of the bone behind the ear).
28. During this time, prison healthcare staff were in daily contact with the hospital. However, the man's family was not informed of what was happening as he had not provided any next of kin details on reception. The man had provided his solicitors' contact details in the event of an emergency, but they were not contacted at this stage.
29. On 15 December 2006, the man was well enough to return to the prison and, following his reception, he was located in healthcare. He was placed in a gated cell so that he would not disturb other prisoners when he received his medication, and so that staff could monitor him more effectively. On 22 December, he said that he did not feel well enough to leave healthcare, but described his joy at being alive and out of intensive care. He had not realised how ill he had been.

30. Over the course of the next few weeks, the man was generally in better health, although at the end of March he did complain of some pressure on his chest when lying down. A further ECG gave no indication of any problems.
31. In early April, the man's mental state again deteriorated, and vital signs such as blood sugar, blood pressure and pulse rate all became more erratic. There were recorded incidences of him refusing medication, food, drink and clinical observations, as well as either not responding when spoken to or not responding appropriately. He was taken to hospital on 3 April. Escorting staff were informed that he was in a diabetic coma although, when they arrived to take him to hospital, he walked into the ambulance. He was escorted by two prison officers.
32. Prior to leaving the prison, as part of the security briefing given to escorting staff, the two escorting officers were made aware of a security report that stated that on escort the man was to be treated with extreme caution. He had been aggressive to staff on a previous occasion, and on each hospital visit he had tried to have his cuffs removed. He had also asked staff to "help" him, which was interpreted to mean help him to escape.
33. On arrival in hospital and whilst waiting for an x-ray, escort officers became concerned about the man's behaviour. He asked for help without specifying what help he wanted. This was interpreted as a request to have his security cuffs removed. Whenever hospital staff entered the room, he made eye contact with them and then looked down at his cuffs. The officers interpreted his movements as an attempt to influence them to request that the cuffs were removed. Given that escorting staff had been told that his admission stemmed from his refusal to eat or accept medication, which could be construed as self-induced, there was suspicion of his intentions.
34. When a hospital porter arrived with a wheelchair to take the man to the x-ray department, he stood up and again looked from the porter to his cuffs. One of the escorting officers reiterated that the cuffs would not be removed. The man sat back down on the trolley and would not get into the wheelchair. After a period, the porter said he would not wait any longer if the man would not get into the wheelchair. He made no move to do so and the porter then left the room.
35. Escorting staff explained to the man that, if he refused treatment, he would have to return to the prison. One of the escorting officers contacted Wormwood Scrubs and described the situation to their Principal Officer. The escorting officer said that the man had refused treatment and, if he continued to do so, he would be returned to the prison.
36. Security staff at Wormwood Scrubs have confirmed that, if escorting officers have security concerns over a prisoner, they must still give due regard to his medical situation. If staff have security concerns, but medical advice is that the prisoner is not well enough to be removed from the hospital, then security at the hospital will be enhanced.

37. One of the escorting officers spoke to one of the Accident and Emergency doctors and said that, as the man was refusing treatment, she was minded to take him back to prison. The doctor agreed that, if he was refusing treatment, there was nothing she could do and so had no objection. The escorting officer therefore made arrangements for a transfer back to the prison on the afternoon of 3 April.
38. The following day (4 April), the man had a medical review and was re-referred to hospital where he was admitted and diagnosed with dehydration and confusion. He remained in hospital overnight and was treated with fluids and antibiotics. The medical staff also recommended a mental health review.
39. Having been returned to prison on 5 April, over the following two days the man became increasingly unresponsive to staff, pacing round his cell and acting in an unusual manner. This included shouting, pushing his cell call bell, stripping and washing his clothes in the sink, and washing himself in his cell toilet resulting in the cell and landing being flooded. He also stood naked by his bed, just staring blankly. He was kept under observation and assessed by staff.
40. On 7 April, the doctor diagnosed him as hypertensive and hypoglycaemic, and once again referred him to hospital. The man was taken to hospital that afternoon, and admitted to a ward that night. He was quite ill, and for the following two days did not engage much, if at all, with staff. For most of the time, he lay on his hospital bed, talking neither to escort nor hospital staff.
41. On 10 April, healthcare staff contacted the hospital to enquire about his progress. They telephoned during an unrelated emergency on the ward and were asked to call back later. They did so but hospital staff said that they were unable to give out information over the telephone. Prison healthcare staff were advised to ask the escort officers for an update.
42. Sadly, on 11 April the man died whilst still in hospital. One of the escorting officers contacted the prison and informed them of the man's death. The officers returned to the prison and were immediately taken to the Deputy Governor's office for a debrief. They were offered support if they felt they needed it. Both officers completed incident report forms upon completion of the debrief.
43. The prison got in touch with the solicitors listed as the man's emergency contact, and obtained his wife's contact details. She was formally notified of her husband's death by one of the prison's governors at 1.15pm on 11 April. This governor acted as the family's liaison officer. The prison arranged for the man's body to be flown back to his family in Africa, and met the costs incurred in doing so.
44. Notices to prisoners informing them of the man's death were placed on each landing in B Wing and in healthcare. Prisoners were reminded that, should they wish to talk about concerns or problems, they should speak to a member of staff. Listeners were also made available. (Listeners are a Samaritan-

supported scheme run in many prisons, whereby trained prisoners provide confidential emotional support to other prisoners.)

45. The post mortem report was compiled by a Consultant Forensic Pathologist, for Her Majesty's Coroner's Office for Hammersmith and Fulham. The report showed the cause of death as:
 - a: acute left ventricular failure
 - b: coronary artery disease.
46. This is consistent with a death from natural causes.

ISSUES

Clinical care

47. A review of the man's medical care was undertaken on behalf of Hammersmith and Fulham Primary Care Trust and a panel was convened to discuss the review's findings. The review looked extensively at the man's clinical care during his imprisonment and reached a number of conclusions that I summarise in the paragraphs below.
48. If prisoners are unable appropriately to refer themselves for treatment, particularly where a collection of complaints could be indicative of a more serious problem, they rely upon clinical staff in the prison. Particularly where complaints concern chest pain, prison healthcare should look to refer prisoners for further assessment at an early stage. Whilst in prison, the man showed possible cardiac symptoms including blurred vision, abdominal pain and difficulty eating, heartburn, difficulty breathing and left-sided weakness and facial asymmetry.
49. The clinical reviewer also comments that improved communications within healthcare, and between healthcare and the hospital, would help to safeguard prisoners' wellbeing. This would enable the early identification and treatment of prisoners with deteriorating health. It would also improve the standard of care provided between the provision of emergency care and ongoing care. Care ownership needs to be improved, with better links between the healthcare team at Wormwood Scrubs and the hospital. This would include better and clearer knowledge of what care can be provided in the prison, which can then be incorporated into a treatment plan.

The Governor and Primary Care Trust should consider setting in place a protocol between prison healthcare and the hospital so each is aware of the services available in the other, and so that communications regarding prisoners in hospital can be more easily facilitated.

50. There were difficulties passing information about the man's treatment between the hospital and the prison. Privacy and confidentiality are of course important, and it is right that the hospital should be circumspect about releasing information. However, owing to the proximity of the two establishments there are likely to be a number of prisoners receiving treatment at the hospital. Escort officers are not medically trained and as such should not be expected to relay medical information. It would be advantageous if there were a protocol in place to ensure smooth communications between prison healthcare and the hospital.
51. The clinical reviewer believes that the care afforded to the man in prison was appropriate for his medical complaints, but that there is no evidence of proactive referrals to specialist cardiologists. It is the reviewer's opinion that this would have been of benefit to him. When the man complained of chest pain in August 2006, a care plan appropriate to his symptoms should have been put in place and followed up. He did receive treatment, including an

ECG, but it is not documented that he was assessed further to find out the exact nature of the chest pain. There should be frameworks in place to measure the impact on prisoners who suffer a series of what may together prove to be cardiac events.

The Primary Care Trust should ensure that prisoners' care is viewed holistically, particularly where issues of chest pain are involved.

52. On one occasion, the man was referred to the prison doctor for admission to the in-patient unit but bed shortages stopped this from occurring.

The Primary Care Trust should consider introducing a system so that any failure to implement a care plan or medical recommendation is followed up.

Family contact

53. When the man was seriously ill in hospital in November/December 2006, his family was not notified. Although he had not provided his next of kin details, he had provided emergency contact details for his solicitors. However, this emergency contact was not used, despite prison healthcare being in daily contact with the hospital and thus aware of how serious the man's health had become.

The Governor should ensure that, if a prisoner is seriously ill, the prison does all it can to keep the family/nominated contact informed.

Communication

54. There was some confusion about the reason for referral when the man was taken to hospital on 3 April. Escorting staff were told that he was in a coma, yet when they arrived to escort him to hospital he walked into the ambulance. When the man subsequently displayed erratic behaviour in hospital, the escorting staff were quite reasonably suspicious. Escorting staff are not medically trained to be given clinical diagnoses, and prisoners are of course entitled to patient confidentiality. But escorting staff should be in possession of reasonable information as to what they might expect of a prisoner's behaviour. This clearly was not the case when they were led to believe that the man was in a coma yet arrived to find him awake and walking. This planted a degree of suspicion which may have been alleviated had they been given full and correct information from the beginning.

The Governor should ensure that escorting staff have sufficient information on prisoners they are escorting to allow them to make reasonable assessments of the prisoners' behaviour.

55. When the man refused treatment in hospital on 3 April, escort officers were concerned that this might be part of an escape attempt. Before they returned him to prison, they sought advice from the prison and from hospital staff but did not consult prison healthcare. In this instance it is unlikely that there was any

adverse effect. However, there is a possibility that medical information could be misinterpreted. Good practice would suggest that healthcare staff should be informed and consulted prior to a decision being taken to return a prisoner refusing treatment.

When a prisoner refuses medical treatment, prison healthcare staff should be informed before he is taken back.

CONCLUSION

56. The man was a sick man who suffered ill-health during his imprisonment. He spent a good deal of his sentence in healthcare and hospital, including a long period in intensive care towards the end of 2006. In my view, the care the man received was appropriate to his condition and staff were sensitive to his need for treatment.
57. However, while the healthcare he received was appropriate for each individual symptom, there are concerns about the lack of a holistic view of his ongoing condition. He did receive adequate treatment for each incidence of ill-health he suffered. But it is the view of the clinical reviewer that systems in the prison's healthcare did not make it easy for staff to take an overview of his health, and in particular his cardiac health.
58. There were also some concerns around links between prison healthcare and the hospital. This led at times to confusion about available treatment, as well as making it difficult for prison healthcare staff to obtain updates on the man's condition from hospital.
59. It is also most unfortunate that his family was not kept informed of his health while he was seriously ill in hospital during November and December 2006. The man had not provided next of kin contact details, instead giving the details of his solicitors to be contacted in the case of an emergency. Although the prison used the information promptly when the man died, it is my view that the family should have been contacted at an earlier stage.

RECOMMENDATIONS

Clinical care

1. The Governor and Primary Care Trust should consider setting in place a protocol between prison healthcare and the hospital so each is aware of the services available in the other, and so that communications regarding prisoners in hospital can be more easily facilitated.
2. The Primary Care Trust should ensure that prisoners' care is viewed holistically, particularly where issues of chest pain are involved.
3. The Primary Care Trust should consider introducing a system so that any failure to implement a care plan or medical recommendation is followed up.
4. When a prisoner refuses medical treatment, prison healthcare staff should be informed before he is taken back.

Family contact

5. The Governor should ensure that, if a prisoner is seriously ill, the prison does all it can to keep the family/nominated contact informed.

Communication

6. The Governor should ensure that escorting staff have sufficient information on prisoners they are escorting to allow them to make reasonable assessments of the prisoners' behaviour.