

**Investigation into the circumstances surrounding the
death of a man at HMP Wandsworth, in August 2009**

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

July 2010

This is the report of an investigation into the death of a male immigration detainee at HMP Wandsworth. The man died at St George's Hospital, Tooting, on 23 August 2009, having been admitted three days earlier. The cause of death was found to be multi organ failure due to chronic liver disease with a secondary condition of an intra-abdominal haemorrhage and carcinomatosis (cancer). I offer my sincere sympathy and condolences to the man's family and all who have been affected by his death. I apologise for the delay issuing my report and any additional distress this may have caused.

The investigation was carried out by an Investigator from my office. A review of the man's medical care in prison was carried out by the medical director of Wandsworth Primary Care Trust. I am most grateful to the Clinical Reviewer for his assistance.

I would also like to thank the Governor and staff of Wandsworth for their full and ready co-operation. My particular thanks go to the Safer Custody team for their work in liaising with the investigator.

Shortly after his arrival at Wandsworth, blood tests revealed the man to have significant abnormalities in his liver function. This is usually associated with excess alcohol consumption. Although some follow up tests were made, others were omitted. However, I am satisfied that even had they all been carried out, that the outcome for the man was unlikely to have been any different. Nevertheless, I make five recommendations amongst which I suggest that a review should take place to ensure that tests are carried out to prison doctors' instructions.

Jane Webb
Acting Prisons and Probation Ombudsman

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SUMMARY

The man was remanded into custody at HMP Wandsworth on 27 October 2008. When he was seen by a prison doctor on his first evening at Wandsworth, the man said he had trouble standing and often got pins and needles in his legs. An appointment was made with a local hospital and the prison doctor requested blood tests be taken. The results of the blood tests showed that the man had significant abnormalities in his liver function, which would usually be associated with heavy alcohol consumption. The tests were repeated twice over the following month and, although there was some improvement, the results were still significantly abnormal.

Although a prison doctor requested the tests be repeated for a fourth time, this did not happen. I recommend that the healthcare manager reviews local procedures for ordering such tests. The Clinical Reviewer, who reviewed the man's medical care, suggests that prison doctors assumed the abnormalities in the man's liver function tests were caused by cirrhosis (the destruction of liver tissue usually caused by drinking excess alcohol). However, he considers that scans of the liver could have been arranged to confirm this diagnosis. I also recommend that a named doctor take responsibility for periodically reviewing patients with abnormal test results, to ensure that any follow up is not missed.

An examination of the man's back in January 2009 revealed the pins and needles in his legs was caused by a spinal condition. He successfully underwent surgery in June to free trapped nerves in his back.

In July, the man's health began to deteriorate. His already poor mobility became worse when he developed swollen feet and ankles and a swollen and painful abdomen. The liver function tests were now repeated, with significant abnormalities again found. By 20 August, the man was nearly bed bound and was admitted to a local hospital for tests. Two days after his admission, the man was admitted to the intensive care unit. He died the following afternoon at 12.10pm.

The post mortem report found that the man died of multi organ failure caused by chronic liver disease. This liver disease was caused by cirrhosis and a cancerous tumour in the man's liver. The Clinical Reviewer thinks it possible that the tumour developed when the man began to show signs of liver failure in July 2009. He concludes that, even if the cirrhosis and tumour had been identified earlier, the overall outcome was likely to have been the same.

Although there are some concerns over the failure to refer the man for further investigation when his abnormal liver function tests first came to light in November, the Clinical Reviewer concludes that his overall management was satisfactory. I make a further three recommendations in addition to those already identified. Two relate to nursing care when the man began to deteriorate in July 2009. The final recommendation considers the necessity of handcuffing an older prisoner with very limited mobility in an outside hospital.

THE INVESTIGATION PROCESS

1. The investigation was opened on 24 August 2009 when the Investigator, issued notices announcing the investigation to staff and prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to the investigator. One prisoner wrote to the investigator as a result.
2. The Investigator visited Wandsworth on 28 August and collected copies of the man's prison files, including the medical record. He returned to Wandsworth on 19 November and interviewed three members of staff. The Investigator also met with representatives of the United Kingdom Border Agency (UKBA) during this visit.
3. An independent clinical review of the man's health care whilst he was in custody was carried out by the Medical Director of Wandsworth Primary Care Trust. The Clinical Reviewer visited Wandsworth on 10 March 2010 and discussed the investigation with one of the prison doctors.
4. One of the Ombudsman's family liaison officers, contacted the man's niece, his nominated next of kin, and his brother. This was to explain the purpose of the investigation and to provide the opportunity for them to ask questions or raise any concerns they might have. The man's niece and nephew are his only relatives in the United Kingdom and were nominated to represent the family in their contact with the Ombudsman's office. The Family Liaison Officer spoke to the man's niece on 1 October 2009, and was told that the family were considering taking legal advice. The family have subsequently instructed a solicitor to act on their behalf. I hope this report clarifies any issues that might remain unclear for the man's family and helps them better understand what happened in the time leading to his death.

HMP WANDSWORTH

5. HMP Wandsworth is the largest prison in the United Kingdom, holding up to 1,655 adult male prisoners. It is a local category B prison, accepting prisoners on remand, convicted and sentenced from courts within its catchment area. The prison is formed of five residential wings and two specialist units. The man lived on three of the residential wings. After spending one night on E wing, the first night centre, he lived on C wing, the induction wing, for around five months. The man then moved to A wing, a general population wing holding both remand and convicted prisoners.
6. Around one third of prisoners are foreign nationals and, in June 2009, there were 27 foreign national prisoners detained beyond the end of their sentence. There are five full-time members of staff from UKBA based at the prison whose role is to advise and assist prisoners in the progress of their immigration cases.
7. Health services are commissioned by Wandsworth Primary Care Trust and provided by Secure Healthcare. Most of the primary care provision is delivered from healthcare treatment rooms on each wing. One nurse is the nominated lead for the care of older prisoners.
8. Her Majesty's Chief Inspector of Prisons, conducted a full announced inspection in June 2009. She found that there were a number of vacancies in the primary care team. This resulted in an "overdependence on bank and agency staff and an inconsistency of approach to prisoners". Her Majesty's Chief Inspector of Prisons also found that prisoners reported long waiting times to see a prison doctor, although in urgent cases same day appointments were available.
9. The Independent Monitoring Board (a body of local people who independently monitor and report on the prison) report for 2008-09 also noted a high dependency on bank and agency healthcare staff at Wandsworth. However, they complimented a "strong and proactive team" of senior nurses and reported that prisoners have an "increasing confidence and satisfaction in the level of medical care provided".
10. This was the third death that the Ombudsman investigated at Wandsworth in 2009. There have subsequently been a further four deaths at the establishment. One of the previous deaths in 2009, and one of the latter deaths, were due to natural causes. The previous investigation reported on a prisoner who had a number of long standing medical conditions. The Ombudsman found that his care was "managed appropriately" by staff.

KEY FINDINGS

11. At the time of his imprisonment, the man suffered from high blood pressure and high cholesterol. He took a variety of medication for these conditions, including lisinopril and amlodipine (both for high blood pressure), simvastatin (to reduce cholesterol) and aspirin (to prevent heart attacks).
12. Shortly after his arrival at Wandsworth on 27 October 2008, the man was seen by a nurse for a reception health screen (a routine health screen for all new arrivals into prison). The nurse noted the man's high blood pressure and cholesterol, and he added that he had circulatory problems. He said he did not currently drink alcohol and did not misuse drugs. The man was referred to a prison doctor. On his way from reception to E wing, the first night centre, he fell over. He did not suffer any visible injuries.
13. Later that evening, the man was seen by a prison doctor. The man told the doctor he had been experiencing an "odd feeling" in his legs for three months, and spoke of pins and needles. The man also said his legs felt weak when standing up and he sometimes fell over as a result. The doctor thought this might be a neurological condition (a disorder of the nervous system, which includes disorders of the brain and spinal cord) and, two days later, referred the man to St George's Hospital, Tooting. During the consultation, he told the doctor what medication he took in the community and the doctor prescribed it for him.
14. After spending his first night on E wing, the man moved to a ground floor cell on C wing, the induction wing. Blood tests were taken that morning, at the request of a prison doctor. The results were available that evening and were examined by another prison doctor. (Each night a prison doctor examines incoming test results on a computer and chooses an appropriate action from a drop down menu.) The results of the liver function test showed a gamma-glutamyl transferase level (gamma GT, an enzyme that occurs in the liver cells) of 715 microlitres (u/L), compared to a normal level of less than 64 u/L. A high gamma GT level is particularly associated with heavy alcohol consumption. In the light of these results, the doctor recommended that an appointment be made with a prison doctor.
15. An appointment was made for 30 October, which the man did not attend. However, he saw a prison doctor, the following day and said he had been late for his previous appointment. As is standard practice, the doctor spoke to the man's community doctor to confirm that he had been prescribed the correct medication. However, the doctor was away from his practice and suggested telephoning the surgery reception the following week (it was a Friday and the reception was by then closed for the week).
16. The prison doctor was able to speak to the community surgery on 4 November, when she was next working in the prison. The man's medication was confirmed as that listed in paragraph 11. The doctor also

made a second neurology referral to St George's Hospital. On this occasion, the referral was marked "urgent".

17. Two days later, the man saw another prison doctor. He said that he was still experiencing pins and needles and pain in his legs. This was especially the case when he walked, but eased when he sat down. The prison doctor asked that the man's blood tests be repeated.
18. A blood sample was taken the following morning and the results were available that evening. The gamma GT level was again abnormal, although it had fallen to 615 u/L. The results were examined by a prison doctor, who again asked that an appointment be made with a prison doctor.
19. The man next saw a prison doctor on 19 November, some 13 days later. He told the doctor he was still experiencing pain and pins and needles after walking a few yards. The doctor suggested that this might be intermittent claudication (cramping in leg during exercise caused by a lack of oxygen to the muscles due to a poor blood supply). She made a referral to the department of vascular surgery at St George's Hospital and asked for the blood tests to be repeated.
20. As previously, a blood sample was taken the following morning and the results were available that evening. By now, the man's gamma GT level had fallen to 557 u/L. On this occasion, the doctor examined the results and asked that the liver function tests be repeated in one month. This did not happen.
21. Six days later, the man again saw the doctor for a review. They discussed the man's high gamma GT level, although the doctor noted that this was improving. The man said he drank a bottle of red wine a night when he was in the community and was advised to reduce his intake when he was eventually released.
22. When he next saw the prison doctor on 10 December, the man continued to complain of pins and needles and pain in his leg. He said he was able to walk with his stick and could stand for three to five minutes before the pins and needles made him want to sit down. The man also said he was struggling to shower as he was unable to stand for long. The doctor noted that he needed a chair for the shower.
23. A week later, on 18 December, the man saw a consultant vascular surgeon at St George's Hospital. The consultant thought the man's symptoms were more likely to be related to a neurological condition than claudication, and suggested that this line of enquiry be pursued.
24. Five days later the man returned to St George's, this time to see a consultant neurologist. The consultant arranged for the man to return for an MRI scan (a type of scan using strong magnetic fields to produce a

detailed image of the inside of the body) of his spine. An appointment was subsequently made for 26 January 2009.

25. On 23 January, the man was served with a 'notice of liability to deportation' letter by the UKBA. This notice explained to the man that, following his conviction, he fulfilled the criteria for deportation. The man was invited to respond and submit evidence that he qualified under an exception to automatic deportation. He did not reply.
26. The MRI scan confirmed a diagnosis of central stenosis (narrowing of the spine causing trapped nerves, usually because of spinal deterioration due to ageing). The man was put on a waiting list for decompression (an operation whereby bone or ligament in the spine is removed in order to free trapped nerves). Two days after his scan, the man saw a prison doctor for a consultation. They discussed the results of the scan. The doctor also sent a memo to C wing asking for the man to be unlocked when it was quiet as he needed regular gentle exercise.
27. Towards the end of April, the man moved from C wing to A wing where he again lived in a ground floor cell. There was another prisoner on A wing who required 24 hour care and who therefore had a carer employed to look after him. The man was given the cell opposite this prisoner so the carer could also assist him with his medical needs and personal hygiene. A prisoner known as a disability orderly (a prisoner who is paid to assist those with poor mobility) was assigned to help the man with activities such as cleaning his cell and collecting meals.
28. The man saw a prison doctor on 6 May for a review. She noted there was still no appointment for the man's spinal surgery. (The following day an appointment came through for a consultation on 3 June.) The man told the doctor that his mood was low. After speaking to him for a while, the doctor thought he was depressed but the man said that he did not want to take antidepressant medication.
29. On 3 June, the man attended his outpatient appointment at St George's Hospital. No details of the outcome are available in his medical record, although it is likely that this was a preparatory consultation prior to his surgery later that month.
30. Two weeks later, on 15 June, a letter was received at Wandsworth from St George's Hospital. The letter was recorded as typed on 1 June, and said that the man had missed an appointment at the department of neurology on 24 April. It is not clear why this appointment was missed.
31. A second 'notice of liability to deport' letter was served by UKBA on 15 June. On this occasion, the man requested that the letter be sent to his solicitor. This happened the following day, although the only reply received from the man's solicitor was that they represented him in criminal matters only.

32. The man was admitted to St George's Hospital on 17 June for decompression surgery. The surgery went ahead on the day of his admission, and the man remained as an inpatient until 23 June so that his recovery could be monitored. The discharge summary indicates that the man was able to move without restriction, although he was given a walking frame on discharge to assist him. Following his discharge, the man appeared to settle reasonably well back into prison life on A wing.
33. On 18 July, a nurse saw the man in his cell. He was concerned because his feet were swollen. The nurse told the investigator that the man had no other symptoms, although his mobility was not good and he was spending a lot of time in his cell. She noted in the medical record that it was a mild swelling and advised the man to walk around more and to elevate his feet when he could. The nurse also listed the man for an appointment with a prison doctor, although this did not take place for some time.
34. Five days later, another nurse was called to see the man in his cell as he said he felt dizzy. His ankles were still swollen. The man also said his abdomen was swollen and he had had a cough for around seven days. The nurse examined the man's abdomen, which was soft and causing mild pain in the centre. She also listened to his chest, which was clear. The nurse spoke to a prison doctor, who decided to reduce the man's dose of amlodipine to help his swollen ankles. It was also requested that the man's blood pressure be monitored daily, although it is not clear if this happened as no checks were recorded in the man's medical record. A few days later, the man began a course of frusemide (a medicine known as a diuretic, used to treat swelling and fluid retention due to liver or kidney disorders or heart failure).
35. The man was due for release on 27 July. As he was liable for deportation, his continued detention had to be authorised by UKBA. The relevant detention papers were faxed to the prison on 24 July, where they were served on the man.
36. A blood sample was taken on 28 July, with the results reviewed by a prison doctor. The gamma GT level had fallen from the previous reading, to 413 u/L, although it was still well above the normal level. After reviewing the results, the doctor asked that an appointment be made with a prison doctor.
37. Two days later, the man again saw the nurse that initially saw him in his cell. The man's feet were still swollen, although the nurse told the investigator that this was no worse than when she had seen him 12 days earlier. The nurse noted that a review was planned with the doctor that afternoon. There is no indication that this took place, although the nurse said that she may have discussed the man with a doctor but could not recall. The nurse also noted that nursing staff should start to make twice daily checks on the man. She explained that this was because the prisoner in the cell opposite had been released and therefore the carer was no longer employed. The nurse was concerned that the man might

become isolated and wanted staff to make regular checks on his welfare. The disability orderly continued to help the man.

38. A review with a prison doctor took place on 3 August, at which the man said he still had a cough. The doctor examined the man and noted symptoms including continued swelling, crepitations (crackling noises heard on the chest) and a protruding liver. The doctor thought these symptoms suggested a degree of congestive cardiac failure (meaning the heart is not strong enough to pump blood around the body, leading to the accumulation of fluid). He asked for an appointment to be made for the man to have a chest x-ray.
39. The chest x-ray went ahead two days later, at St George's Hospital. The report compared the results of this x-ray with one taken five months previously (it is not clear exactly when this x-ray took place). The x-ray of 5 August found an opacity (meaning an area that cannot be seen through by the scanner) of around seven centimetres at the right base of the lung which was not present on the previous scan. The radiologist suggested that, given the sudden onset of this opacity, a CT scan (a scan similar to an x-ray) should be undertaken to determine whether this was a cancerous lesion.
40. The results of the x-ray were received at Wandsworth on 10 August, and a review was arranged with a prison doctor for the following day. The man told the doctor that he felt he was deteriorating, and referred to his poor appetite, enlarged abdomen and swollen legs. The doctor examined the man and found that his abdomen was more swollen than previously, although his chest and heart sounded normal. It was recorded that he was able to walk for more than 50 yards with the help of his walking frame without becoming short of breath. The doctor noted the results of the x-ray and referred the man for a CT scan via the two week wait pathway (whereby investigations for those with suspected cancer are expected to take place within two weeks of referral).
41. On 17 August, the man attended an outpatient appointment at St George's Hospital to follow up his recent spinal surgery. The outcome of the appointment is not recorded in his medical record. The man moved to a cell on the first floor of A wing the same day. This was nearer to the treatment room and, as the nurse that initially saw the man in his cell told the investigator, "so we could keep a closer eye on him ... because his mobility was deteriorating then quite rapidly".
42. Three days later (20 August), the man was reviewed by a prison doctor. The man said he was hardly eating anymore and it was noted that his mobility had declined to the extent that he was almost bed ridden. The doctor examined the man and noted that his abdomen was more enlarged than previously and he was jaundiced. After discussing the symptoms with St George's Hospital, the doctor decided to admit the man for further investigation in advance of his upcoming appointment.

43. The man was accompanied in hospital by two officers and cuffed to one of these by means of an escort chain (a long chain with a handcuff at each end). An x-ray was taken on the evening of 20 August and, the following afternoon, he had another scan. The man was described as sitting up in bed and comfortable on 21 August.
44. At around 5.20pm on 22 August, the man began to have difficulty breathing and was given an oxygen mask. Fifty minutes later he had to be resuscitated by hospital staff. At the same time the escort chain was removed by the prison escort staff. Later that evening, he moved to the intensive care unit. His niece was informed of his condition by a hospital nurse.
45. The man was visited by his niece the following morning. He died at 12.10pm, shortly after her arrival. Following a post mortem examination, the cause of death was recorded as multi organ failure due to chronic liver disease with a secondary condition of an intra-abdominal haemorrhage and carcinomatosis (cancer). The man's funeral was held on 15 September. The investigation found that the prison's contribution to the funeral costs was in accordance with PSO 2710 (the Prison Service Order that sets out the actions to be taken following a death in custody).

ISSUES

The man's failing liver

46. The post mortem examination found the chronic liver disease that led to the man's multi-organ failure was caused by "severe cirrhotic changes in the liver" (cirrhosis is the destruction of liver tissue usually caused by drinking excess alcohol) and the presence of a cancerous tumour in the liver.
47. Blood tests taken on his second day in prison (28 October 2008) revealed the man had a gamma GT level more than ten times the normal limit. These tests were repeated on 7 November and 20 November. On both occasions the gamma GT level had fallen from the previous test, but was still considerably higher than the normal range. A high gamma GT level is usually associated with heavy alcohol consumption. The man gave contradictory accounts of his consumption outside prison. At his reception health screen he said he did not currently drink, but at a consultation with a prison doctor on 26 November he said he drank a bottle of red wine each night.
48. Following the third blood test, the prison doctor asked that the tests be repeated in one month. This did not happen and no further tests were undertaken until late July 2009. At Wandsworth, if a prison doctor determines that blood tests are required, they complete a request form and pass it to the nursing staff. The request is entered in the relevant wing's nursing handover diary (stored in the nursing treatment room) for the day on which the tests are due. There were no entries in the C wing nursing handover diary requesting that the man's blood be taken for testing.

The healthcare manager should review the local procedures for ordering blood tests and ensure that tests are carried out to doctors' instructions.

49. The Clinical Reviewer writes in the clinical review:

"Overall the medical management of this patient was satisfactory ... Regarding his abnormal liver function tests I do have some worries that these could have been followed up more aggressively. It was noted that these were abnormal from admission to Wandsworth. I can only presume there was an assumption that there was underlying cirrhosis. From a medical point of view at this stage I would have arranged a scan of his liver which could have supported the diagnosis. It would also have been helpful to have repeated his liver function tests before July 2009 to monitor the progress of this condition."

50. Unfortunately the doctor who ordered these tests no longer works at Wandsworth and it has not been possible to interview her for the purpose of this investigation (as is the case with the doctor who oversaw the man's

hospital admission in August 2009). However, the Clinical Reviewer adds that “there is little active treatment for [cirrhosis]”.

51. The blood tests resumed in late July 2009 when the man reported a swollen abdomen and swollen feet and legs. The Clinical Reviewer describes this as “evidence of decompensated liver disease”. (Decompensated is a medical term relating to the deterioration of a previously working system.) The liver functions tests showed the man’s gamma GT level had fallen since November 2008, but was still well above the normal range.
52. As a result of the man’s symptoms, a prison doctor requested a chest x-ray. This went ahead on 5 August and identified a possible cancerous tumour in the man’s lung. (The post mortem examination found this was a tumour that had spread from the primary site in the man’s liver.) The tumour had developed since a previous x-ray taken around five months earlier.
53. The Clinical Reviewer notes “from July 2009 there was evidence of decompensation from a liver point of view ... which is possibly when the liver cancer developed”. He concludes:

“Even if [the man’s cirrhosis and cancerous tumour] had been identified earlier it is unlikely the overall outcome would have altered significantly as these conditions are extremely difficult to treat.”

54. However, it is still the case that there was no follow up by a prison doctor in relation to the abnormal blood test results over the period December 2008 to July 2009. Prisoners with abnormal results should be reviewed at regular intervals by prison doctors to monitor their progress and ensure that test results or follow ups are not missed.

A named prison doctor should assume overall responsibility for periodically reviewing prisoners with abnormal test results, to ensure any required follow up is not missed.

Nursing care following the man’s move to A wing

55. The man moved from C wing to A wing in late April 2009. At the time of his move, the man required the use of a walking stick. He was given a ground floor cell opposite a prisoner with very poor mobility who had a carer employed to help him. The carer was also asked to assist the man with his medical needs and personal hygiene. In addition, a disability orderly was assigned to help him with other tasks, such as cleaning his cell.
56. In mid July, the man’s mobility began to deteriorate when his feet and ankles started to swell. After consulting a prison doctor on 23 July, a nurse made an entry in the man’s medical record requesting that his blood

pressure be taken daily. It is not clear if this took place. The man's blood pressure is only recorded in two later entries in his medical record.

The healthcare manager should review arrangements for monitoring prisoners' blood pressure and ensure that checks are carried out and recorded in line with doctors' instructions.

57. On 30 July, another nurse noted in his medical record that nursing staff should make twice daily checks on the man. (This was because the prisoner in the cell opposite had been released and the carer was therefore no longer employed.) Although there is no indication in his medical record that these checks took place, the nurse told the investigator that she wanted staff to check on the man and ensure he was not isolated. She added that she would only expect an entry to be made in the medical record if there was any change in the man's health.
58. By 17 August, the man's mobility had deteriorated further. He therefore moved to a cell on the first floor near to the nursing treatment room, so nursing staff could keep a closer eye on him. Three days later he was admitted to hospital.
59. It is clear that the man's health deteriorated during his last month at Wandsworth. He was already an ill man, requiring a walking frame to get around his wing and needing help with his personal hygiene and other daily activities. The man also had a history of high blood pressure and high cholesterol. In July 2009, his mobility deteriorated significantly when he developed swollen feet and ankles. He also began to experience pain and swelling in his abdomen and, later, a poor appetite. Additionally, the man was recovering from the operation on his spine.
60. Despite his numerous medical needs and deteriorating health, the man did not have a nursing care plan. Whilst he was seen every day by the nursing staff, such conversations do not constitute a formal review or health assessment. A care plan would set out what interventions healthcare staff will deliver, and what the patient could be expected to do for himself.

The healthcare manager should ensure that all prisoners with complex care needs have a care plan to reflect all of their needs.

Use of restraints

61. The man was admitted to hospital on 20 August. He was accompanied by two prison officers and cuffed to one of them by an escort chain. The decision regarding whether or not to cuff a prisoner in hospital is made by means of a risk assessment, with the final decision being made by a senior manager. The risk assessment considers factors such as the prisoner's escape risk and the risk to the public if they did escape. An assessment of the prisoner's physical capacity to escape unaided is also considered.

62. The risk assessment completed on 20 August concluded that the man was of medium risk to the public (on a scale of low, medium, high) and of medium potential to escape. No medical objections to the use of restraints were recorded. The risk assessment concluded that an escort chain should be used until the man became mobile, after which standard handcuffs should be applied. No new risk assessment was conducted on 21 or 22 August. The escort chain was removed when the man had to be resuscitated on the evening of 22 August. It was not reapplied.
63. The man had very poor mobility and was described as being “nearly bed ridden”. The original offence for which he was imprisoned was non-violent. In addition, the man was held at Wandsworth as an immigration, rather than a criminal, detainee.
64. The decision about whether to cuff a prisoner in hospital is a difficult one and the balance between decency and security can be hard to judge. Nevertheless, in these circumstances I do not think it would have been unreasonable to escort the man in hospital without the use of restraints. Given his condition, I judge the presence of the two prison officers would have been an adequate security arrangement.

The Governor should encourage senior managers to take less risk averse decisions when determining the cuffing levels for seriously ill, older prisoners with very limited mobility.

65. This recommendation was not accepted by Wandsworth. Their response was that there is “no evidence” to support the recommendation. As I have noted above, the man was an older prisoner with very poor mobility. He was not a violent offender. I am disappointed that the Governor does not agree with my view that the use of restraints was not necessary in these circumstances and hope he will reconsider his response.

FAMILY RESPONSE TO THE DRAFT REPORT

66. I received a number of comments from the man's family on the draft report, which I have discussed below. I hope that my comments help to clarify any outstanding issues that the man's family might have.
67. The man's family commented that "there is evidence to suggest that the man did not receive satisfactory medical care". They felt that prison doctors "failed to recognise the urgency" of the abnormal liver function test results and should have arranged further scans at a much earlier stage. The man's family thought that he would have had these scans had he been in the community rather than prison, and that this might have prolonged his life.
68. The Clinical Reviewer writes in the clinical review that the abnormal liver function test results "could have been followed up more aggressively" and that he would have arranged a scan at an early stage. I agree with his view. My second recommendation aims to address the lack of early follow up and was accepted by the National Offender Management Service (NOMS). However, the Clinical Reviewer concludes that earlier identification of the man's cirrhosis and cancerous tumour would be "unlikely [to have altered] the overall outcome."
69. The man family also queried whether he could have been admitted to hospital at an earlier stage. They referred specifically to the symptoms the man presented with when he saw the prison doctor on 3 August 2009, and the result of the chest x-ray two days later.
70. Unfortunately it was not possible to interview this doctor for the purpose of this investigation, to ask whether he considered earlier admission. However, it should be noted that when the man went to St George's Hospital on 5 August the consultant seemingly did not consider it necessary to admit him. The results of the chest x-ray, received at Wandsworth on 10 August, suggested that the man might have a cancerous lesion but that further investigation was required to confirm this. The prison doctor subsequently referred the man for a CT scan under the two week wait pathway. As I have noted earlier, the clinical review finds that, overall, the man's medical management was "satisfactory".

CONCLUSION

71. The man was an older prisoner with poor mobility when he arrived at Wandsworth in October 2008. Blood tests carried out during the man's first month in custody revealed he had significantly abnormal gamma GT levels, usually associated with heavy alcohol consumption. Follow up blood tests ordered by a prison doctor did not go ahead, although the clinical reviewer thinks they could have gone further still and requested a scan to confirm the presumed diagnosis of cirrhosis.
72. By July 2009, the man health began to deteriorate significantly. As a result of his failing liver he developed swollen feet and ankles and a swollen abdomen. This led to his already poor mobility deteriorating further to the extent that, by 20 August, the man was almost bed ridden. He was admitted to hospital for further investigation, but sadly died three days later.
73. The clinical review finds that the man's overall medical management was satisfactory and his death could not have been prevented. Nevertheless, there are some areas that could have been improved. In particular, I am concerned that blood tests requested by a prison doctor to monitor the man's abnormal liver function did not go ahead.

RECOMMENDATIONS

1. The healthcare manager should review the local procedures for ordering blood tests and ensure that tests are carried out to doctors' instructions.

Accepted – bloods are ordered by the doctor and taken by a nurse or healthcare assistant. The logging of blood tests ordered and results received is under review and is to be discussed at the next Clinical Governance Management meeting.

2. A named prison doctor should assume overall responsibility for periodically reviewing prisoners with abnormal test results, to ensure any required follow up is not missed.

Accepted – blood results are reviewed by the duty doctor on a daily basis and action taken on abnormal results. The threat to this process is the lack of prison doctors and therefore the need to rely on locums who are unfamiliar with prison protocols and practice – a locum pack has been written to ensure best and safe practice.

3. The healthcare manager should review arrangements for monitoring prisoners' blood pressure and ensure that checks are carried out and recorded in line with doctors' instructions.

Accepted – chronic disease management (CDM) is under review along with all other clinics as it is accepted that CDM clinics are essential at HMP Wandsworth. A review of all clinics (doctor, vaccination and CDM) has taken place and has been restructured to include new premises and protocols.

4. The healthcare manager should ensure that all prisoners with complex care needs have a care plan to reflect all of their needs.

Accepted – it is accepted that not all prisoners who require a care plan have one in place. It is also accepted that treatment rooms on each wing on different landings produce fragmented nursing care and a lack of full time nurses and the need to rely on agency nurses further complicates the issue. Prisoners who require a higher level of care will be nursed, if they do not require immediate hospital intervention in the Jones Unit which is due to open on 17 May 2010. All prisoners in the Jones Unit will have an up to date, evidence based care plan. Prisoners who have healthcare needs and who are located on the wings will have an up to date, evidence based care plan which will be held in the treatment room on A2 when this has been put in place.

5. The Governor should encourage senior managers to take less risk averse decisions when determining the cuffing levels for seriously ill, older prisoners with very limited mobility.

Not accepted – there is no evidence to suggest that managers at HMP Wandsworth are risk averse when determining cuffing levels.