

**Investigation into the death of a man
whilst in the custody of
HMP Wandsworth in February 2010**

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

August 2010

This is the report of an investigation into the circumstances surrounding the death of a man at HMP Wandsworth. He died aged 52 years, in February 2010. A post mortem showed that his death was caused by lung disease.

I would like to offer my sincere sympathy and condolences to the man's family for their loss.

The investigation was carried out on behalf of the Acting Ombudsman by my colleague. Both he and I would like to thank the Governor of Wandsworth and all his staff for their full co-operation during the course of our enquiries.

Wandsworth Primary Care Trust (PCT) were commissioned to conduct a clinical review of the healthcare the man received whilst in custody. I would like to thank them for appointing the clinical reviewer. I have attached the review as the first annex to the investigation report.

As the man died from natural causes the findings of the clinical review play an essential part of my report. I am pleased that the review shows that he received a good standard of care which was equitable to that he could have expected in the community. I recognise the good practice of the early intervention of the family liaison officer.

The version of my report, published on my website, has been amended to remove the name of the man who died and those of staff and prisoners involved in my investigation.

Jane Webb
Acting Prisons and Probation Ombudsman

August 2010

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SUMMARY

On 18 November 2005, the man was charged with sexual offences and remanded in custody. He went to HMP Pentonville where it was established that he had Interstitial Lung Disease (disease affecting the tissue and space around the air sacs of the lungs) and a history of type II diabetes in his family, and was on appropriate medication.

The man appeared in court on 27 April 2006 and was given an indeterminate sentence for public protection due to the nature of his offence and was transferred to HMP Wandsworth. In the months that followed, his wellbeing was closely monitored by healthcare staff at Wandsworth and he was referred to specialists at St George's Hospital.

By May 2008, his lung condition had markedly deteriorated and the consultant confirmed that his prognosis was that he had one to two years left to live.

On 10 December, the man's end of life care was discussed including liaison with Trinity Hospice. It was acknowledged that the prison would only be able to care for him up to a certain point and then he would be transferred to either a hospital or hospice.

At approximately 4.30am in February 2010, a nurse was called to see the man who was distressed and had difficulty in breathing. The nurse provided another oxygen cylinder for him to use. Uniformed officers passed his cell at 7.30am and 7.50am and noticed that he was in his wheelchair, apparently asleep.

A prisoner from the same unit went into the man's cell at 8.15am, and found that he was not breathing. He raised the alarm and an emergency ambulance was called. A nurse responded and noted that rigor mortis had set in and the man had been dead for some time. Paramedics arrived but took no action as they agreed with nurse's assessment. A prison doctor certified his death at 9.30am.

The prison family liaison officer visited the person nominated by the man to break the news of his death. At this visit the governor was given details of other family members, and subsequently contacted the man's brother and sisters. The prison offered financial assistance towards the cost of the funeral.

I am satisfied that the care and attention the man received at Wandsworth was equitable to what he could have expected to receive in the community. I recognise the good practice of the early intervention of the family liaison officer.

THE INVESTIGATION PROCESS

1. I appointed my colleague to investigate this case on 16 February 2010. He was assisted by another colleague. Notices were issued to staff and prisoners, inviting those who wished to submit information relating to the man's death to make themselves known to the investigator. A prisoner from the same unit as the man contacted the investigator as a result of these notices.
2. My colleagues visited Wandsworth on 19 February to collect copies of relevant documentation relating to the man. My colleagues returned to Wandsworth on 10 and 16 March to interview seven members of staff and the prisoner.
3. The Chief Executive of Wandsworth Primary Care Trust (PCT) commissioned a clinical reviewer to review the man's clinical care. My colleagues met the clinical reviewer at Wandsworth and discussed the man's care. The clinical reviewer was provided copies of the transcripts of interviews. The clinical review can be found at the first annex to this report.
4. The investigator contacted Her Majesty's Coroner for the Inner West London District to inform him of the nature and scope of my investigation and request a copy of the post mortem report. Upon completion, the report will be sent to the coroner into the man's death.
5. One of my family liaison officers contacted the man's family at the beginning of the investigation and offered the opportunity to raise questions and concerns for consideration. The man's sister said that she had no concerns about the treatment her brother received in prison.

HMP WANDSWORTH

6. HMP Wandsworth is a busy prison in South London. The prison can hold a maximum of 1665 sentenced or remand adult prisoners. Since 1989, there has been an extensive refurbishment programme which is still ongoing.
7. There are two units, Heathfield and Onslow. Heathfield is the main prison, and Onslow houses up to 350 vulnerable prisoners. These prisoners are kept apart from the rest of the prisoners because of their vulnerability, largely due to the nature of their offences. Onslow was where the man resided.
8. In addition there is a healthcare unit providing 24 hour cover along with a 12 bed inpatient facility. Health services are commissioned by Wandsworth Primary Care Trust (PCT) and were provided by Secure Healthcare from July 2007 to September 2009. From September 2009, Wandsworth PCT assumed responsibility for healthcare services at the prison.
9. The Independent Monitoring Board (IMB), monitors day-to-day prison life to ensure proper standards of care and decency for all prisoners. In the summary of their latest annual report, the Chair of the IMB at Wandsworth said:

“It is very encouraging to be able to report that Wandsworth has continued upwards in performance improvement. There are significant improvements in a number of areas compared with last year and overall it is a better place than it was this time last year. Prisoners tell us that the “old” Wandsworth has almost disappeared and that the “new” Wandsworth provides a much more acceptable regime for prisoners and that this compares very favourably with most other large local prisons.”

10. Her Majesty’s Chief Inspector of Prisons last reported on Wandsworth following an announced inspection in June 2009. In her report, the Chief Inspector concludes:

“Patients received thorough reception screening, but there were gaps in the provision of care, with only one life-long condition clinic being run and no immunisation clinics. There were a number of staff vacancies on the primary care team, resulting in an over-dependence on bank and agency staff and an inconsistency of approach to prisoners. Healthcare staff did not work as an integrated team. There were links with outside care providers, but too many external appointments were cancelled or missed. Dental services were good. There were a considerable number of pharmacy issues requiring attention. There were no inpatient services for prisoners with physical illnesses. Mental health services appeared good and were responsive to prisoners’ needs.”

11. The Diversity Team at Wandsworth appoints disability orderlies from the prisoner population to assist the disabled and elderly prisoners. Their duties include making beds, collecting meals, cleaning cells, doing laundry and

helping prisoners move around. A risk assessment is conducted for each prisoner prior to their appointment as an orderly.

12. The rules that govern all aspects of running a prison are set out in a series of documents called Prison Service Orders, (or PSOs). PSO 2700 – ‘Suicide prevention and self-harm management’ details prison procedures for looking after prisoners at risk of suicide or self harm. Assessment, Care in Custody and Teamwork (or ACCT) is the system used by prisons to identify, monitor and support prisoners at risk of self harm. Any member of staff can start the ACCT process, by raising a ‘Concern and Keep Safe’ form, explaining the reasons for their concern. An Immediate Action Plan is written by the manager of the wing where the prisoner is located and within 24 hours an ACCT assessment is carried out by a member of staff who has the required training.
13. After the ACCT assessment has taken place, a multi-disciplinary ACCT case review is held to determine what measures can be taken to monitor and support the prisoner effectively. The prisoner attends the case review and is encouraged to contribute to the decisions being made. An ACCT CAREMAP is drawn up with details of each of the actions required to keep the prisoner safe and identifies who is responsible for carrying out each action. Case reviews are held at regular intervals, usually monthly, to review the actions and the prisoner’s level of risk.
14. On each occasion a prisoner is escorted outside of the prison to hospital a risk assessment is completed which considers the risk to the public, potential for escape and likelihood of outside assistance. The assessment informs the decision about the number of escorting officers and the type of restraint to be used (single handcuffs or two metre long escort chain with a cuff at either end). It also determines the circumstances and the authority required for the restraints to be removed. The risk assessment is reviewed each day that a prisoner is in hospital and amended where necessary.
15. Since the Ombudsman was given the responsibility for investigating all deaths in prison custody in England and Wales in April 2004, nine other prisoners have died from apparent natural causes at Wandsworth. The last death occurred in August 2009. There is nothing from the investigations into the previous deaths that is relevant to the circumstances of the man’s death.

KEY EVENTS

16. The man was born in July 1957 and lived in the London area. He was single and had two sisters and a brother. He was 52 years old when he died.
17. On 18 November 2005, he was charged with sexual offences and remanded into HMP Pentonville. He underwent an initial healthscreen which established that he had Interstitial Lung Disease and a history of type II diabetes in his family. He was taking appropriate medication which was salbutamol (for treatment of asthma and chronic obstructive pulmonary disease), ipratropium (for treatment of chronic obstructive pulmonary disease), frusemide (for treatment of congestive heart failure), azathioprine (for treatment of lung disease), omeprazole (for treatment of dyspepsia), simvastatin (for treatment of cardiovascular disease) and prednisolone (for the treatment of inflammatory and auto-immune conditions).
18. The man appeared in court on 27 April 2006 and was given an indeterminate sentence for public protection (a minimum period of imprisonment and release only takes place once this period has been served and the Parole Board is satisfied that the risk of harm the prisoner poses to the public is acceptable.). The court ordered that he was to serve a minimum of four years before parole could be considered. He was transferred to HMP Wandsworth.
19. In the months that followed his wellbeing was closely monitored by healthcare staff at Wandsworth and he was referred to hospital specialists at St George's Hospital in Tooting. Due to his many medical conditions he used a wheelchair and used oxygen through a nasal cannulae (tubes that are inserted in the nasal passages). He lived on the ground floor of the Onslow unit and, following an assessment by healthcare staff, a healthcare assistant helped with his care and personal needs 24 hours a day. He also so had assistance from the disability orderlies. There are many recorded instances where he would refuse to take his medication. He also initially refused to participate in the Sex Offender Treatment programme (SOTP).
20. By May 2008, his lung condition had markedly deteriorated and his dependence on oxygen increased. He was referred to the respiratory consultant at St George's Hospital by a nurse and advice was sought from the Trinity Hospice regarding palliative care (to prevent and relieve suffering and to improve quality of life for people facing serious, complex and terminal illness).
21. On 25 May, the man saw a second nurse. He said that he did not want to live and insisted he was entering the final phase of his life. He initially refused to take his medicine. He also told the nurse that, in the event of a cardiac arrest, he did not wish to be resuscitated. The nurse discussed the consequences of not taking his medication and persuaded him to do so.
22. The first prison doctor examined him on 3 June and recorded that his condition had worsened. The doctor noted that the palliative care team had suggested his medication should include lorazepam (for treatment of anxiety) and

- Oramorph (morphine based pain relief for severe pain). The doctor noted that Oramorph needed to be administered with great care as this was an opiate based medicine. The prison doctor also noted that the governor had been informed that starting such treatment would mean that the man was likely to die in custody.
23. On 29 July the man was seen by a second prison doctor. The man had suffered from shortness of breath for a few days and had coughed up sputum. The doctor prescribed an increase in prednisolone to 40mg and a 14 day course of clarithromycin (antibiotic for treatment of throat and chest infections).
 24. During the early days of August, a review of the man's palliative care was conducted by a palliative nursing specialist from Trinity Hospice. The first prison doctor amended the man's prescription in line with the advice given by palliative consultant. The first prison doctor also asked the governor whether the man's cell door could remain open to facilitate palliative care and this was agreed.
 25. At the end of August, a second nurse assessed the man and told him that once the prison was unable to meet his care and personal needs, the plan was to transfer him to Trinity Hospice if a bed was available. If this was not possible, then he would be taken to hospital.
 26. A consultant in respiratory medicine at St George's Hospital sent a letter to the man, his solicitors and the prison on 17 September to confirm that the man's prognosis was that he had one to two years to live. A subsequent review into the man's health by the palliative nursing specialist at Trinity Hospice produced no new concerns and no indication to increase dosage of medications.
 27. On 11 November, a second governor at Wandsworth asked healthcare for an assessment of the man's fitness to attend a SOTP course. He was advised there were no issues that prevented the man from attending.
 28. The man saw the second prison doctor on 27 November as his chest condition had become worse over the past few days. The doctor prescribed clarithromycin for seven days.
 29. A third prison doctor, reviewed the man on 1 December, and noted that he was still taking antibiotics with no evidence of fever. The man was seen by a fourth prison doctor, the following day as he complained of chest pain, but said he felt better having taken the antibiotics. The doctor recorded that there was no sign of fever and changed the man's medication to cefalexin (antibiotic for treatment of respiratory tract infections).
 30. The first nurse assessed the man on 23 December and noted that he looked pale and tired. The man told the nurse that he was keen to undertake the SOTP course. He then became tearful and said that he never received any visitors. He reassured the nurse that he had no thoughts of suicide or self harm.

31. On 10 January 2009, the man was examined by a third nurse as he complained of a pain in his chest that was worse when he coughed. The nurse noted that the man looked unwell and referred him to a doctor. The man was seen by a fifth prison doctor, later that same day. The doctor prescribed clarithromycin for 14 days. Ten days later, despite encouragement from staff, the man refused to take his medication even though he had been told of the detrimental effect upon his health.
32. On 26 January, the man saw a sixth prison doctor, as he was experiencing pain in his right leg from the hip downwards. The doctor prescribed 5mg diazepam (short term pain killing drug) for one night. The following day the fourth prison doctor reviewed the pain in the man's right leg and increased the pain relief to 15mg.
33. The man complained of a persistent cough again on 19 February. The third nurse referred the man to the fifth prison doctor who found that the man's throat was mildly inflamed, which was an oral reaction to taking long term antibiotics. The doctor prescribed nystatin oral suspension (for treatment of fungal infections).
34. A week later the fourth prison doctor examined the man in his cell. The man complained that he had experienced pain in his right foot for a week. He described the pain as like severe cramp that would last for approximately five minutes and happen two or three times a day. The doctor recorded that both his feet were swollen, pink and warm to the touch and prescribed quinine (anti-inflammatory medication).
35. The man saw the second prison doctor on 11 March as he had a swollen left leg and was short of breath. The doctor prescribed an increase in frusemide to 120mg and advised him to elevate his leg as much as possible during the day.
36. Eight days later the man saw the fifth prison doctor and complained of coughing more, poor sleep and pain in his right leg. The doctor prescribed Augmentin (antibiotic for treatment of respiratory tract infections), sugar free linctus and paracetamol (four times a day). The man then saw the sixth prison doctor on 24 March as he still complained of pain when coughing. The doctor prescribed morphine sulphate.
37. On 7 April, the man visited the dentist as he needed several teeth to be removed. As this was to be carried out under local anaesthetic, it was arranged that the dentistry work would take place over three separate morning visits, so that he could be monitored by healthcare staff for the rest of the day.
38. Between 8 April and 13 July, the man saw prison doctors eight times and nurses on two occasions and received treatment for nausea and a persistent cough. He had been prescribed domperidone (for treatment of nausea and vomiting) and erythromycin (antibiotic for treatment of respiratory tract infections).

39. On 14 July, the man was assessed by a consultant cardiothoracic physician, at St Georges Hospital. The consultant cardiothoracic physician confirmed that the man had end stage respiratory failure, that there was evidence of pulmonary hypertension and right heart failure, which was consistent with end stage lung disease. It was the consultant's opinion that there were no operative procedures or therapies that would benefit the man.
40. A week later an eighth prison doctor, saw the man who complained of swelling in both his legs and described his left leg as bluish in colour. The doctor assessed that these symptoms, along with the man's family history, could mean that he was diabetic and referred the man to a diabetic nursing specialist.
41. A diabetic nursing specialist saw the man on 4 August. The nurse diagnosed that the man had type II diabetes and suggested he take metformin (for treatment of diabetes). He was referred to a doctor for a prescription.
42. The fourth prison doctor saw the man the following day who accepted the diagnosis of diabetes and plans were made to change his diet. The man told the doctor that he was happy to take the prescribed diabetic medication.
43. The diabetic nursing specialist saw the man on 11 August to review his diabetes. The nurse told him that he needed to take the metformin with food and not after food. The nurse also increased the level of metformin to 500mg.
44. On 21 August, the man saw the fourth prison doctor as he had not kept any food or fluids down for the past 24 hours and also had diarrhoea. He told the doctor that he generally felt unwell but had no fever. The doctor advised him that he was likely to be suffering from gastroenteritis. The doctor advised him not to have food that day, just drinks of water and he would be seen the next day.
45. The following day a ninth prison doctor saw the man as he said he felt sick, had still not eaten but had been taking sips of water following the advice of the fourth prison doctor. The ninth prison doctor recorded that the man looked tired and drawn, advised him to keep drinking fluids and prescribed Dioralyte (rehydration salts).
46. A couple of days later, the third prison doctor saw the man who still had a poor appetite, felt sick but had no diarrhoea and was still only having sips of water. The doctor recorded that the man's cough was producing yellow phlegm and prescribed clarithromycin and more Dioralyte.
47. On 25 August, a tenth prison doctor saw the man who said he still felt very unwell and refused to take his medication as he was unable to swallow. The man also told the doctor that he had been vomiting but had no diarrhoea. The doctor decided to admit the man to St George's Hospital. A security risk assessment was completed, assessing that two officers would escort the man, and should use a long escort chain (a two metre chain with a single cuff at

either end). The escort chain was to be removed for treatment as requested by the hospital staff.

48. The man was in hospital from 25 August to 8 September. He was diagnosed with shortness of breath, cough and high fever. The prison healthcare unit maintained contact with the hospital ward. In hospital, the man was treated with doxycycline (antibiotic for bacterial infections) and ertapenem (intravenous antibiotic for severe bacterial infections) which resolved the infection, cough and shortness of breath. On his discharge the hospital advised to continue the prednisclone medication for a few days.
49. The diabetic specialist nurse saw the man on 23 September. The man said he still could not keep food down, but was trying to eat so that he could take his medication.
50. On 29 September, the man complained that the oxygen equipment in his cell was not working. A fourth nurse checked the equipment and found it to be working properly. The nurse recorded that the man had stopped taking prednisclone and appeared to need more oxygen. The nurse referred the man to a doctor.
51. The man was seen by a ninth prison doctor the next day. The doctor noted that the discharge medication was at odds with the consultant in respiratory medicine at St George's Hospital's recommendation that the man should take long term prednisclone and azathioprine. The doctor recorded that the man should continue to take the existing medication until confirmation was sought from the consultant in respiratory medicine at St George's Hospital.
52. On 2 October, the man saw a fifth nurse who was concerned about the man's breathing. The nurse recorded that the oxygen cylinder was fully open. The man was advised of the dangers but he told the nurse to go away. Later that day the first nurse saw the man who told him that the technician had checked the oxygen equipment which was working properly, and it would automatically cut out if the flow of oxygen was too high. The technician locked the equipment to prevent unauthorised access. The nurse explained to him that the reasons for having the correct amount of oxygen were for his own benefit.
53. An eleventh prison doctor saw the man on 22 October, and prescribed prednisclone following confirmation from the doctors at St George's Hospital.
54. The following day the man saw the fifth nurse. The nurse noted that he had his nasal cannulae in his mouth and would not put it in his nose despite being told that the oxygen would go straight to his stomach and not his lungs. The man said to the nurse that he wanted the oxygen equipment unlocked. The nurse told him that the technician had locked the oxygen to prevent him from tampering with it and it was set in accordance with medical advice to dispense the correct amount of oxygen.
55. On 27 October, the second nurse contacted St George's Hospital to arrange an urgent appointment with the chest clinic for. This was arranged for 4

November. A care plan was drawn up for the man that incorporated daily checks, weekly reviews of his condition, appropriate use of oxygen equipment, encouragement of an appropriate sitting position to assist breathing and continued liaison with St George's Hospital.

56. Until his hospital appointment, the man had refused all of his medication despite encouragement from healthcare staff. He also continued to use his nasal cannulae in his mouth. Again he told staff he wanted the oxygen equipment unlocked as he said it was not working. He was told that the technician had done this to prevent him from tampering with it and it was set in accordance with medical advice.
57. The man was taken to St George's Hospital on 4 November where he was seen by consultant in respiratory medicine. A risk assessment was completed and the same arrangements were put in place as before. The escort chain was to be removed for treatment as requested by the hospital staff. The consultant confirmed by letter to the prison that the man had symptoms of a respiratory tract infection and needed increased oxygen. The doctor decided to admit him to a ward for treatment with controlled oxygen, antibiotics and fluids.
58. From 4 to 18 November, the man stayed in St George's Hospital. He said that he felt suicidal and was seen by a mental health nursing specialist. The nurse assessed that the man did not have an acute depressive illness but suffered from chronic frustration with his physical condition and had poor coping mechanisms. The nurse decided that no changes in his medication were required. This was recorded in the man's medical record.
59. On his discharge from hospital back to prison the man's level of oxygen was increased from two litres to four litres and the level of prednisolone was reduced. There is no evidence in the prison documentation that the man's previous suicidal thoughts were explored with him or that there was any consideration as to whether to open an Assessment, Care in Custody and Teamwork (ACCT) document (used to support and monitor those considered at risk of suicide or self harm).
60. On 26 November, the man was seen by a sixth nurse as he said that it hurt him to breathe. The nurse recorded that he was unwell and struggled for breath and admitted him to hospital again.
61. The man returned to St George's Hospital from 26 November to 7 December. During this time he received antibiotics, fluids and oxygen. Hospital staff assessed that his lung disease had deteriorated, however there were no changes to his level of medication.
62. A multidisciplinary meeting between staff from prison healthcare, St George's Hospital and Probation to discuss the man's health was held on 10 December. The man's lung function had deteriorated significantly and end of life care was discussed. It was acknowledged that the prison would only be able to care for the man up to a certain point, as there are no hospital facilities and he would

have to be transferred to either a hospital or hospice. Arrangements were made for representatives from St George's Hospital and Trinity Hospice to visit the man on 22 December.

63. On 22 December, the man saw the first nurse, a second respiratory nursing specialist from St George's Hospital and a lady from Trinity Hospice. The man was examined and it was agreed that he needed an oxygen mask as well as a nasal cannulae. His medication of prednisolone was to be increased and he was continue taking Oramorph and lorazepam. His morphine sulphate medication was to continue. It was agreed a further review should take place in a further two weeks.
64. A third governor started family liaison officer (FLO) involvement on 24 December and the man expressed his relief of having a FLO appointed. He told the governor that he would provide him with a letter of his wishes to be acted upon when he died. The governor met the man again on 28 December when he said he was lonely and frightened and did not want to die. They met again on 4 January 2010, when the man said he was concerned about having no contact with members of his family and requested that they be told when he died. The governor advised the man that he could make contact with his family, however he chose not to make contact.
65. On 13 January, a review by first nurse, the second respiratory nursing specialist and the lady from Trinity Hospice took place and it was recorded that the man seemed calmer and happier than previously. It was decided to reduce his level of prednisolone and he was instructed on how to use his portable oxygen and oxygen converter equipment. The nursing specialist and the lady from Trinity Hospice assessed it was likely that his life expectancy was six months.
66. The following week he man was found to be incontinent of faeces and staff helped wash and dress him as his physical activity had declined. On the same day the man attended St George's Hospital for an outpatient appointment with the consultant in respiratory medicine. A risk assessment was completed and the same arrangements were put in place. The escort chain was to be removed for treatment as requested by the hospital staff.
67. The consultant in respiratory medicine's assessment was that the man had a chest infection and his lung disease had deteriorated further. The doctor was also of the opinion that the man was at risk of contracting a hospital acquired infection as some wards at the hospital were closed due to norovirus (infection causing vomiting and acute diarrhea). The consultant requested that the man return to prison for care. He prescribed Augmentin (antibiotic for respiratory tract infections) and clarithromycin for a ten day period. The doctor also wanted the opiate medication to continue. It was also noted that the man did not like using his oxygen mask and the consultant was content for him to put the nasal cannulae in his mouth.

68. The man had a meeting with the third governor on 24 January where he handed over his letter of wishes. A day later the man was racially abusive to a seventh nurse and refused any nursing or personal assistance.
69. Two members from the SOTP team, made a psychiatric assessment of the man on 4 February. The assessment concluded that there was no evidence to suggest that the man suffered from a mental illness and neither were there any concerns about self harm. It was noted that he was physically frail but not in need of a place at a hospice. It was also noted that he still presented a significant risk to the public.
70. The man had a meeting with the third governor on 13 February. He reiterated his letter of wishes and confirmed his nominated next of kin who was not a member of his family.

Events of 15 February

71. At approximately 4.30am on 15 February an eight nurse was called to see the man in his cell on the wing. The nurse recorded that the man was distressed, had difficulty breathing and she provided another oxygen cylinder. The man had also been incontinent of urine and initially refused to have his clothes changed. Following some persuasion he did eventually agree to allow the nurse to change his T-shirt and place a towel down his trousers to minimise his discomfort and skin breakdown.
72. At interview, the nurse said that it was not uncommon for the man to be in his chair most of the night. The nurse said that he communicated with her using hand signals as he sometimes did not speak. She recalled that the man had a good colour, had calmed down after having the oxygen cylinder but did not want to be touched. The nurse said that she returned to see the man at approximately 5.30am and his breathing had improved but he still would not allow her to assist him in any way. She was satisfied that, when she left the man, he was less distressed and did not want any further assistance.
73. The first officer conducted the morning roll check (a manual count of all prisoners) at 7.30am and noted the man was in his wheelchair apparently asleep. A second officer was unlocking the cells on the wing at 7.50am, and on passing the man's cell, he noticed his colour. He raised his concerns to healthcare support worker (HCSW) and requested the man be checked. The HCSW said that the man was asleep and not to disturb him. At interview The HCSW said that the last time she checked the man was at 7.00am.
74. A prisoner from the same unit checked the man at 8.15am and found that he was not breathing. He raised the alarm and an emergency ambulance was called. The first nurse responded and found the man slumped in this chair with his cannulae in his mouth. The nurse checked for a pulse but could not find one and noted that rigor mortis was present. It was the nurse's opinion that the man had been dead for some time and that cardio pulmonary resuscitation was inappropriate. Paramedics arrived but took no action as

they agreed with the nurse's assessment. The fifth prison doctor certified death at 9.30am.

75. Later that morning the third governor visited the person nominated by the man to break the news of his death in person. At this visit the governor was given details of family members to contact, and he subsequently contacted the man's brother and sisters. The prison offered financial assistance towards the cost of the funeral.
76. That same morning a debrief was held for prison staff and a care team were available to staff for those who felt the need for support, and support was also made available for prisoners.

ISSUES

Clinical care

77. The clinical review considered the man's medical condition and care that he received whilst at Wandsworth and made the following comments:

“Reviewing the medical records from Wandsworth Prison from April 2008 it is clear that the man suffered from chronic interstitial lung disease which is a progressive condition leading to end stage respiratory failure. He was on oxygen therapy throughout this period and his condition steadily declined. He had a number of admissions to St George's hospital for intercurrent infections and was also incidentally diagnosed to have diabetes mellitus in the later part of his stay in Wandsworth prison.

“Overall I feel the level of medical input was good considering his underlying condition. Sadly there was probably little that could be done to alter the eventual outcome, even if he had been managed in a community or other hospital setting the outcome would have not differed”

78. The clinical review also commented on the effect of the man's non-compliance with his oxygen therapy as follows:

“There were numerous instances of reports of his difficulty with breathing and some of the issues related to compliance with the usage of oxygen therapy, he frequently used the nasal cannulae orally and was therefore probably not getting the levels of oxygen one would expect. This in itself would probably have accelerated the decline in his general condition as the rationale behind using oxygen levels is to reduce the strain on his heart.”

79. Healthcare staff assessed in 2008 that the man required assistance with his personal care needs and he had access to a healthcare support worker 24 hours a day along with the assistance of disability orderlies on the Onslow unit.
80. A healthcare plan was in place for the man. If he became distressed at any time because of his health, an ambulance should be called and he would be admitted to hospital.

Assessment, Care in Custody and Teamwork

81. Following the man's discharge from hospital 18 November 2009, healthcare staff were aware that he had been seen in hospital by a mental health specialist because of his declared suicidal thoughts. As the prison was aware of this information it would be expected that the ACCT process was to be followed. There is no evidence to show the man's suicidal thoughts were discussed with him, and whether opening an ACCT was considered. Whilst, this had no impact on the man's care, I have investigated other apparently self inflicted deaths of terminally ill prisoners and it is important this lesson is not lost.

82. Although I make no recommendation in this case, I draw the matter to the attention of the Offender Safety, Rights and Responsibilities team in the Prison Service. The next review of the ACCT process should consider whether terminally ill prisoners are potentially at risk of suicide or self-harm.

Events of 15 February

83. During the early hours of 15 February, the man's health deteriorated and he had difficulty in breathing. The eighth nurse responded to the call for medical assistance at 4.50am. At interview the nurse said that when she first saw the man he was in a high degree of distress and she provided a further cylinder of oxygen. When she returned some 30 minutes later he was breathing far more freely.
84. The clinical review comments on the man's condition at that time as:

“He was reviewed by the night nurse during the night of the 14th & 15th February where the symptoms he described are similar to those reported in previous episodes”.

It was the nurse's clinical judgement that the man's condition was not serious enough to be admitted to hospital.

85. In advance of my investigation, the PCT had taken the decision to suspend the eighth nurse and an internal investigation was being conducted. I am satisfied that the PCT will take appropriate action to ensure that prisoners, such as the man are referred to hospital as soon as it is required.

Use of restraints

86. Unfortunately there have been too many reports where the Ombudsman has been critical of the use of restraints when prisoners are under escort in outside hospital. It is pleasing therefore to recognise that in this case Wandsworth ensured that the man was treated with dignity and respect during his various visits and treatment in hospital.

Family liaison

87. A prison family liaison officer (FLO), the third governor was assigned to the man several weeks before his death. The man was happy with this arrangement and supplied a letter with his final wishes. Following the man's death the governor ascertained that the person nominated by the man was in fact not a member of his family.
88. Family members were contacted by the governor and the prison complied with the requirements of Prison Service Order 2710 “Follow up to death in custody” and offered financial assistance towards the cost of the funeral. In the days that followed, the prison family liaison officer maintained contact with the man's family. I recognise the efforts made by the governor, which was good practice and helped to reassure the man as he reached the end of his life.

CONCLUSION

89. During his time at Wandsworth, the man had regular contact with healthcare staff and doctors which were well documented. Like the clinical reviewer, I believe that the care he received was equitable to that expected in the community. There were occasions where the man exercised his right to refuse treatment or did not follow medical advice on the use of his oxygen therapy. The clinical review confirms that his medical treatment was appropriate and that his death could not have been prevented.