# Investigation into the circumstances surrounding the death of a male prisoner at HMP Wormwood Scrubs, who died in May 2005

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

**December 2006**

This is the report of an investigation into the circumstances of the death of a prisoner at HMP Wormwood Scrubs who died on 28 May 2005.  The man had been suffering from severe coronary disease and died from coronary failure.

I extend my sincere condolences to the man's family and friends for their loss.

The man was on remand for a charge of intimidating a witness and had never been in prison before.

I would like to thank the Governor of Wormwood Scrubs at the time of our investigation, and the members of his staff who assisted us.  I am particularly grateful to the prison's Liaison Officer.

It is not possible to say whether the man's death could have been prevented. However, his family has raised several questions about the standard of healthcare he received.  I have benefited from two separate reviews of clinical matters and the findings have been incorporated into this report.

I make seven recommendations.

**Stephen Shaw CBE**
**Prisons and Probation Ombudsman** **December 2006**

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## Summary


1. The man who died was born in Pakistan in 1951. He had, however, spent the majority of his life in Britain and had semi-retired around five years ago. He spent much of his time with his family and was a devout Muslim.

2. The man was remanded into the custody of Wormwood Scrubs on 7 February 2005, charged with intimidating a witness. He had never been in prison before and found it difficult to be away from his family. He was located in a single cell on E wing at Wormwood Scrubs, a large wing with three landings. Staff described him as polite and respectful and he was well liked amongst prisoners on his wing.

3. The man underwent a first reception health screen when he arrived in custody on 7 February. He reported that he sometimes had chest pain when he was breathless. The man was seen again by a doctor on five separate occasions between then and the day of his death.

4. On his fifth consultation with a doctor on 26 May, he described experiencing pain in his chest, shoulders and upper arms. It is recorded on the man's medical record that he should have an ECG and a chest x-ray. However, there is no documentary evidence of when these investigations were to be carried out.

5. On the morning of Saturday 28 May, the man's cell door was unlocked at approximately 8.40am as he was due to receive a visit. He told the landing officer that he was feeling very unwell, could not lie down or walk, and had pains in his stomach. The officer asked a healthcare officer (HCO) to come and see him. The HCO gave the man a dose of medication to ease his pain and advised him that he would ask the doctor to come and see him.

6. At approximately 9.50am, the landing officer went to see the man with the wing senior officer (SO). They arranged for a soft chair to be brought for him to make him more comfortable. The HCO who had seen the man earlier that morning went to the Healthcare Centre and spoke to the doctor on duty. He agreed that he would bring the man to see the doctor in the Healthcare Centre in order for him to be assessed. He then took a wheelchair to E wing to collect him.

7. Tragically, the man collapsed whilst he was being helped to walk down the flight of stairs from the second landing to the first landing. He was taken to the doctor's room on the first landing where healthcare staff and then paramedics attempted to resuscitate him. The man could not be resuscitated and was pronounced dead at 11.32am.

8. The duty governor and a senior officer visited the man's family on the afternoon of 28 May to inform them of his death.

9. The clinical reviews into the man's medical care drew attention to some shortcomings and made a number of recommendations for improving practice.

10. This report includes seven recommendations.

11. Prior to the finalisation of this report, an inquest was held into the man's death. The jury returned a verdict of 'natural causes to which neglect contributed'.

## Investigation process

12. Two of my investigators visited Wormwood Scrubs and met with a member of the Independent Monitoring Board and a representative of the Prison Officers' Association (POA). They also visited the wing where the man had lived. The investigator leading the investigation issued notices to staff and prisoners informing them of the investigation and inviting comment.

13. The man's prison records, including his medical records, were provided to the investigator during their visit to Wormwood Scrubs. The Metropolitan Police kindly provided the investigators with statements taken by them.

14. My investigator returned to Wormwood Scrubs with my Deputy Ombudsman and conducted interviews with a number of prison officers and healthcare staff. The investigator also met with some of the prisoners who knew the man, and with the senior officer on E wing.

15. One of my family liaison officers contacted the man's family. One of my family liaison officers and the investigator went to visit the man's family to explain the purpose of the Ombudsman's investigation and to discuss any questions or concerns the family might have. The man's family had several concerns about the standard of care he received whilst he was at Wormwood Scrubs and were particularly worried about his medical treatment whilst in custody.

16. A review of the man's medical care whilst he was in prison was carried out on behalf of Hammersmith & Fulham Primary Care Trust, for which I am grateful. However, as I felt that there were areas that would benefit from further exploration (standards of record keeping; the use of secondary health screening; the appropriateness of intubation within a secure environment), it was decided that an independent clinical investigator for the Prisons and Probation Office, would lead a clinical panel review. In order to prevent the man's family waiting any longer than they already had, an interim draft report was issued in November of 2005. The report was then amended to reflect the results of the clinical panel review and a second draft report was issued in July of 2006. Both the man's family and the Prison Service received a copy of my interim draft report and the second draft report and both have had the opportunity to comment on the reports. Their comments are included in the text where relevant.

## The man who died

17. The man was born in Pakistan in 1951 and was 54 years old when he died. Part of a large family, he had ten children and 15 grandchildren. He had spent the majority of his life in Britain and for much of that time worked in the grocery trade. The man semi-retired around five years ago and was enjoying spending time with his wife, children and grandchildren. He was a devout Muslim and spent much of his time praying.

18. The man was remanded into the custody of Wormwood Scrubs on 7 February 2005, charged with intimidating a witness. His trial date had been set for 1 June 2005. He had no previous convictions and was surprised and distressed when he was remanded into custody. He had never been in prison before and found it difficult to be away from his family.

**HMP Wormwood Scrubs**

19. Wormwood Scrubs is a large local prison, situated in West London and predominantly serving the London Courts. In common with many local prisons, Wormwood Scrubs receives and discharges a high number of prisoners each day. It has an operational capacity (maximum capacity with overcrowding) of 1,167.

20. In her 2003 inspection report, HM Chief Inspector of Prisons described Wormwood Scrubs as a prison with a troubled recent history and reputation. The report went on to describe an establishment that is improving, with attitudes of staff becoming more positive and 75 per cent of prisoners reporting that they were treated with respect by most staff.

21. The prison has a Prison Service star rating of three (with four being the highest and one being the lowest). The rating is based upon several factors including performance against area targets, Prison Service National Standards, and the outcome of independent inspections by HM Chief Inspector of Prisons.

22. Healthcare at Wormwood Scrubs was not under the management of the Primary Care Trust at the time of this man's death. The PCT took over commissioning responsibility in April 2006.

23. The prison does not offer a personal officer scheme but assigns support officers to prisoners who appear to be vulnerable or who have specific needs.

24. This man is the fourth prisoner to die at Wormwood Scrubs since 1 April 2004. Each of the other deaths at the prison during that period has apparently been self inflicted.

**The events leading up to the man's death**

25. Despite his shock at being remanded into custody, the man appeared to prison staff to be coping with life in prison. He was located on E wing at Wormwood Scrubs, a large wing with three landings. He had a single cell and was located on the second landing. He was described by staff as a pleasant, respectful and polite man. During his time in custody, he became friends with many of the other prisoners on his landing, frequently joining in with an informal study group and playing pool.

26. On the man's first day in custody (7 February 2005), he underwent a first reception health screen. During the screen the healthcare officer (HCO) noted that the man described sometimes experiencing chest pains when breathless. It was also noted that he was a smoker. The health screen was not comprehensively completed and seven sections were left completely blank.

27. On 22 March, the man visited Healthcare and complained to a doctor (whose name is not printed in the records) that he was experiencing abdominal pains. He was prescribed 20mg Losec daily for 28 days. This prescription was repeated on 18 April. There is no documented evidence that investigations to identify the cause of the abdominal discomfort were either considered or requested.

28. The next entry in the man's medical record was made on 10 May when the notes suggest that he may have been presenting with depression. He was given a prescription of 20mg Prozac for 14 days and another repeat prescription of 20mg Losec. Again, the name of the doctor is not printed but the handwriting appears to the same as that of the doctor who saw the man on 22 March.

29. Notes on the man's prison records throughout the period of 7 February to 22 May indicate that he was observed to be quiet, respectful and compliant with wing rules. There are no references made to the man's health until the morning of 28 May.

30. The man's family spoke to him on the telephone every day and visited the prison as often as they could. They had been worried that his health had been declining since he arrived in custody and, at various times, had communicated these concerns to the man's solicitor. Despite my investigator writing to the solicitor and making several phone calls to him, it has not been possible to establish whether he passed these concerns on to anyone at the prison.

31. The man's family told my investigator that he had had been suffering from toothache and had waited for seven weeks to see a dentist. In the end the tooth had become so painful that he had removed it himself. Despite the efforts of my investigator and the staff at the prison, it has

not been possible to establish if the man was placed on the waiting list to see the dentist, and if he was, how long he had been waiting. The prison was able to confirm that he had not ever seen a dentist at the prison as a dental patient record had never been created for him. Staff in the prison's healthcare centre advised by investigator that there was an emergency dental clinic available on Friday mornings, and that prisoners urgently needing attention would usually be seen within a week or two of requesting an appointment. For prisoners needing routine appointments, it would not be at all unusual to wait up to twelve weeks to be seen.

*The events of 26 and 27 May*

32. On 26 May, the man visited Healthcare again. He complained to a doctor (whose name is not printed in the medical records and whose signature is not legible) of pains in his chest, both shoulders and upper arms. Notes in his medical record indicate that the man's father had had heart disease. The doctor checked the man's heart which sounded normal. He also checked his lungs and found them to be clear. His blood pressure and pulse were checked and found to be within normal limits. The doctor advised the man to stop smoking and a note was made that he should receive a chest x-ray and an ECG. He was given a repeat prescription of 20mg Prozac for 14 days. There was no indication of when the ECG or chest x-ray should be carried out.

33. The staff on E wing were not aware that the man was feeling unwell. The investigation team asked the wing's Senior Officer (SO) whether there is a protocol for communicating this kind of information about a prisoner. The SO said that, if Healthcare staff had concerns over a prisoner, she would expect this would be communicated to the wing staff. They should then make a note in the handover book. No information about the man's health was passed to staff on E wing following his visit to the doctor on 26 May.

34. The man was visited by members of his family on the afternoon of 26 May. He told them he felt very unwell and had lost his appetite. They thought he seemed to be in low spirits and were concerned. The family also told the investigation team that, following their visit to see him, the man's solicitor had contacted someone at the prison to discuss his health and the family's concerns for him. Regrettably, despite efforts by my investigator, it has not been possible to establish if and when the solicitor made contact with the prison.

35. My investigator spoke to the prisoner who was located in the next cell to the man. On 26 May, the man had commented to him that he had seen the doctor and that he had been having pains. The man had continued to fetch his meals and to come out onto the landing to play pool and socialise with the other prisoners.

36. The investigator spoke to another E wing prisoner, who was a friend of the man's and also had a cell on the same landing. He remembered the man talking about feeling ill a few weeks before his death. He recalled that he had been feeling unwell at night, one or two nights before his death. He had advised the man to drink water and keep his window open to get some air. The prisoner could not remember the man speaking to a member of staff about his condition.

*28 May*

37. On the morning of 28 May, the wing cleaners on E wing were the first to be unlocked to enable them to start their duties. Shortly after that, at approximately 8.40am, any prisoners due to receive visits were also unlocked. The man who is the subject of this report was due to receive a visit from three members of his family that morning and his door was unlocked by one of the landing officers. After opening the man's door, the officer carried on along the landing to continue unlocking prisoners for their visits. A wing cleaner looked in on the man and saw that he was not well. The wing cleaner fetched the officer who immediately returned to the man's cell and asked him what was wrong. He explained that he could not walk and had not eaten or slept for two days. He also said he was in pain and pointed to his stomach. The officer went to speak to the Healthcare Officer (HCO) who was downstairs on the first landing administering morning treatments.

38. The HCO explained to the investigation team that he was aware that the man had recently been given Losec for abdominal pain. He thought that this was suspected to be caused by a gastric ulcer. He also knew that the man was due to have an ECG that afternoon and a chest x-ray the following week. When the officer came downstairs to speak to him, the HCO finished administering the treatments he was dealing with and went up to the second landing. He arrived at the man's cell at about 9.30am. The man explained that he had not slept well, felt weak and listless and that he felt he had heartburn. He did not complain of any chest pains. The HCO told the investigation team that he had received reports of lack of sleep and feeling unwell from approximately half a dozen prisoners that morning. He thought that this was because it had been a very hot and humid night. The HCO gave the man 20 mls of magnesium trisilicate and told him that he would ask the doctor to see him.

39. The HCO then went to try and contact the duty doctor to ask him to see the man. The duty doctor would at this time of the day have been doing his round of visits. These visits would have taken him through the Segregation and Detoxification units and then on to a ward round of the inpatient unit in Healthcare. Doctors in the prison do not carry radios or pagers and it therefore took the HCO some time to find the doctor. The HCO eventually located him in the Healthcare Centre and agreed that he would take the man across to see him. He then walked back to E wing with a wheelchair to collect the man.

40. Three members of the man’s family had arrived at the prison to visit him that morning. They were admitted to the prison and had been searched, but once they entered the visits area they were told that the man had flu and would not be attending for his visit. After the man’s family learned of his death, they were very upset that they had been told he had flu when they went to visit him that morning. They also felt especially saddened that they had not been able to see him that morning as it would have been their last chance to see him alive. The investigation team was able to establish that, on the morning of 28 May, an officer from the visits centre went to E wing with a list of prisoners who had visitors. The officer then asked E wing staff to call out the names on the list and for those prisoners to come down to the wing office. When the man did not come to the office, it appears that one of the E wing staff told the visits officer that he was ill and would not be attending. The prison was not able to confirm which officer from the visits centre attended E wing, or to which E wing officer they spoke.

41. Another officer on E wing spoke to the man about his ill health during the morning. At approximately 9.50am, the second officer spoke to the man and noted in his prison records that he would be seeing the doctor after lunch.

42. Also at about 9.50am, the first officer who had attended to the man that morning told the wing’s SO that she was worried about the man and she and the SO went to speak with him. The man indicated to the officer and the SO that he would like to be able to sleep sitting up and the SO arranged for a comfortable chair to be brought for him. The first officer who attended to the man was given no specific instructions by the HCO to monitor the man. She made an entry in the man’s prison record noting that he was unwell and had been seen by a nurse. She then checked on him a few times throughout the morning. When she looked in on him at approximately 10.20am, the man was dozing in his chair.

43. The HCO did not arrive back on E wing until shortly before 11.00am. There is a cargo lift on E wing but it does not go up to the second landing. For that reason, the wheelchair was left at the bottom of the staircase on the first landing. The HCO then helped the man to walk down the stairs to where the wheelchair was waiting. As they were walking down the second of the flights of stairs, the man appeared to feel faint and collapsed. Two prisoners who were on the first landing helped to lift him into the wheelchair.

44. At this point, the man was conscious but was moaning. The HCO pushed the wheelchair into the doctor’s room which is based on the first landing. The man was beginning to lose consciousness but was still breathing. The HCO tried to contact the duty doctor over his radio but the battery was flat. There is a telephone in the doctor’s room and so he phoned control and asked them to put a call out for Hotel 1 (a

radio call sign for emergency healthcare assistance) to attend immediately and for an ambulance to be called. The call was made to the control room at 11.07am and the ambulance was requested at 11.08am.

45. The HCO briefly left the doctor's room to fetch the emergency bag from the treatment room which is next door. The man was then given oxygen from the emergency bag. The HCO called to two prisoners on the landing to help lift the man onto the treatment couch so that he could start Cardiopulmonary Resuscitation (CPR). At about this time, the duty doctor and the Healthcare Nurse (HCN) who was acting as Hotel 1 arrived in the doctor's room.

46. The HCN acting as Hotel 1 told the investigator that she received the call to attend E wing and was there within one to two minutes. She was given no further information about the nature of the emergency and had not had any previous dealings with the man she was called to attend to. When she first saw the man, he looked cyanosed (a blue colour to his skin) and she could not find his pulse. She began CPR immediately. The oxygen cylinders in the emergency bags do not last for very long and the HCN had to ask for additional cylinders. Another HCN, who had just arrived at the doctor's room on E wing, went to collect oxygen cylinders and the defibrillator machine from the Healthcare Centre.

47. There was no output or response from the man for the duration of the CPR. The defibrillator machine (which automatically gives an indication of whether any heart rhythm can be established) indicated that it could not be used on the man. The HCN acting as Hotel 1 used the suction equipment to extract fluid from the man's airway. No line was inserted into him to administer drugs.

48. London Ambulance Service's activation log showed that an ambulance was despatched to the prison at 11.12am and arrived there at 11.20am. The first paramedic reached E wing at 11.27am. CPR had been carried out by the HCN acting as Hotel 1 for approximately 15 minutes before the paramedics arrived, at which point they took over the resuscitation. They were not able to establish any response from the man and he was pronounced dead by the duty doctor at 11.32am.

49. The police were called and officers from the Metropolitan Police attended the prison, visited the scene of the man's death and took statements from members of staff who had been involved.

50. The man's family were visited by the duty governor on the afternoon of 28 May. She was accompanied by an SO who had recently been trained in family liaison. They arrived at the family's address at 4.25pm. The duty governor told the investigation team that she had found the family visit very difficult. She thought that the man's family had taken the news of his death very badly and, understandably, were

extremely upset and emotional. The duty governor said that at points during the visit she had felt threatened by the strength of emotion shown. She explained that at one point during the visit a member of the man's family picked a knife up from the draining board and waved it around. Neither the duty governor or the SO were personally threatened with the knife and other members of the family acted quickly to defuse and calm the situation. The duty governor said that, whilst she fully understood how distressed the family were feeling, she found the experience very intimidating.

51. The family was told they could visit the prison and see the man's cell, and a number of family members decided to do this. The man's family took the majority of his belongings from his cell when they visited the prison. Amongst his belongings were packets of aspirin, Ibuprofen and Omeprazole and a Salamon CFC-free inhaler. These medications did not appear on the man's prescription chart and it is unclear why they were in his cell.

52. The prison did not initially discuss with the man's family the possibility of contributing to the costs of his funeral. Following a discussion with my investigator, the prison wrote to the man's family on 1 September 2005 and offered to contribute towards the cost of his funeral.

53. A post mortem examination of the man was carried out by a Consultant Forensic Pathologist for Forensic Pathology Services. The pathologist found the man's death to have been caused by a heart attack and that he had been suffering from coronary disease.

## Discussion of the issues

***The medical care given to the man***

*The man's initial assessment*

54. The clinical review panel considered that the fact that the First Reception Healthscreen form was inadequately completed, with seven sections left completely blank. The lack of information documented and questions asked did not permit an accurate assessment of the man's healthcare needs. It is acknowledged that Reception nurses are often under pressure to see a high number of prisoners in a short space of time, and this can affect the amount of information that is obtained about a prisoner. However, despite the man saying that he experienced chest pain, he was not referred for further medical assessment as would have been appropriate. In addition, it was not noted whether or not the man had a GP. If he did, the GP should have been contacted to supply his medical notes. In turn, these may have indicated whether he had been treated for chest pain before.

55. The review panel considered it surprising that the man was not seen by a prison doctor shortly after his First Reception Healthscreen was completed, despite reporting chest pain. A thorough history should have been taken for him, including details such as the type, frequency and duration of the pain experienced. Patients should be referred to a 'Rapid Access Chest Pain Clinic' if appropriate, or be seen by a cardiologist or registrar. The panel also commented that, if a referral is not deemed necessary, a note should be made in the medical records of the action to be taken in the event of further pain.

56. The First Night Centre Tuberculosis (TB) assessment form was not completed for the man. The full clinical review highlights the importance of assessing TB in the prison population and recommends a revision of the local and national policy on assessing and treating TB in prisons[1].

*The man's treatment on 22 March*

57. On 22 March, the man was seen by a doctor as he was experiencing abdominal pain. The clinical review panel noted that the doctor recorded that magnesium trisilicate was not helping to relieve his symptoms, and he was prescribed Losec. The doctor did not document any thoughts about the diagnosis and did not record any more specific information about the pain. The panel considered that it

[1] I acknowledge that in the Prison Service's response to the draft report they commented that tuberculosis was not a relevant factor in the man's death. They therefore felt it inappropriate for the report to have examined this issue. The conclusions reached by the clinical review panel are based upon the experience and expertise of the practitioners involved and it is therefore not for me to prescribe which issues they consider to be relevant, or to challenge their recommendations.

would have been appropriate to instigate tests and investigations to rule out a diagnosis such as angina.

58. It is noted that none of the doctors who saw the man between 22 March and 26 May printed their names in his medical records.

*Assessment of the man on 10 May*

59. The man presented to the doctor feeling low and reporting some features of depression. The doctor prescribed Prozac for the treatment of his symptoms. The panel considered it would have been appropriate to have offered the man the opportunity to discuss the reasons for his depression and perhaps to have arranged a referral to the mental health team. Neither of these things appears to have been done.

*The man's treatment on 26 May*

60. On 26 May, the man told a doctor about a family history of heart disease. It appears this was the first time he had mentioned this to a member of medical staff at the prison. The clinical panel considered that his description of the pain he was experiencing appeared to indicate that the man was suffering from unstable angina. He should have been referred for further investigations urgently. If an ECG was to be carried out (as was indicated in the notes), then this should have been performed the next time he was experiencing the pain. The panel added that a discussion between the multi disciplinary healthcare team might have been beneficial in deciding the best course of treatment for the man. It appears that the note made in his medical records on 26 May - "no history suggestive of peptic ulcer" - contradicts an earlier entry made by another member of staff on 18 April.

*The response to the man on 28 May*

61. The review panel noted that the HCO who attended to the man on the morning of 28 May took appropriate action in trying to contact the doctor when his condition suddenly deteriorated that morning.

62. Since the man's arrival at the prison, several opportunities to investigate his chest pain had been missed. The staff who responded to his report of illness that morning were therefore unaware of the seriousness of his condition. Under the circumstances, the HCO responded appropriately. The clinical panel commended the caring approach of the landing officer in arranging for a chair for the man and checking on him whilst he waited to be taken to Healthcare.

63. The panel noted that the HCO's radio battery was flat when he tried to contact the doctor as the man collapsed. They commented that, when the emergency call was out for Hotel 1 to attend, no code or further

information was given. They considered that the emergency calls coding system should be clarified and communicated to all staff. The panel also commented that it would have been preferable for Hotel 1 to have taken the defibrillator machine with her when she responded to the emergency call.

64. The nurse acting as Hotel 1 carried out CPR on the man on her own for approximately 15 minutes, despite the presence of several other members of healthcare staff including a doctor. The review panel highlighted the need for medical staff (and prison officers if possible) to be aware of the latest guidelines issued by the UK Resuscitation Council. It was noted that one person CPR can be very tiring and - for this reason - can become ineffective.

65. The panel commented on the importance of staff being aware of where to locate spare oxygen cylinders and of the availability of full size suction equipment on the wings.

*Other issues raised by the clinical review panel*

66. The review panel was concerned to note that aspirin, Ibuprofen and an inhaler were found in the man's cell after his death. None of these items appeared on his prescription chart. It is not clear where the man had obtained these medications from or whether he had actually used any of them.

67. The panel noted that healthcare staff were not included in the debrief that was held following the man's death. This is not good practice.

***The response of discipline staff to the man's condition***

68. Healthcare staff have a duty to protect their patient's right to confidentiality. In doing so, they do not routinely divulge details of a prisoner's medical history to wing staff. The investigation team was told that, on occasions where healthcare staff were concerned about a prisoner and felt that they should be monitored, these concerns should be passed onto wing staff. Wing staff should then record this in the wing observation book. Both healthcare staff and officers said that, in practice, this does not always happen.

69. The staff on E wing could not have been expected to have known how ill the man was. They were not given any information by healthcare staff and it appears that the man had not told staff he was feeling unwell. He continued to socialise out of his cell, to collect his meals and to play pool. Despite the man's symptoms, his behaviour on the wing did not appear to indicate that that he was feeling unwell. The prisoner in the cell next door to the man told the investigation team that the man who died was a quiet and proud man, and that he had not seemed to attract any attention to the fact he was feeling ill. On 28

May, when the man's condition appeared to have worsened dramatically, the staff on E wing acted promptly and compassionately.

70. The man's family informed the investigation team that his solicitor had contacted the prison to communicate their concerns about the man's health. Unfortunately, at the time of writing, the man's solicitor has not been able to confirm whether this happened.

71. Wormwood Scrubs prison is located next to a large hospital. The family of the man who died were concerned to learn that the ambulance which attended the prison had not come from there, and that there might therefore have been an unnecessary delay in the arrival of the ambulance. Although this is not strictly within the remit of my investigation, the investigation team has made some enquiries.

72. We were advised by representatives from the Department of Health that 999 calls are automatically routed to the ambulance crew who are the nearest crew available to respond. The investigation team was also advised that the Healthcare Commission's key target for ambulance responses to 'category A' calls (emergency calls requiring an urgent response) is for the ambulance to arrive with a patient within 14 minutes in an urban area and 19 minutes in an rural area. The London Ambulance Service activation log does not give an indication of when the call was received by them. It has therefore not been possible to establish whether they received the call at 11.08am (when the prison's records indicate it was made) or some minutes later, nearer to the time at which the ambulance was despatched.

73. The ambulance arrived at the entry gate of Wormwood Scrubs some eight minutes after it was despatched. It then took a further seven minutes for the ambulance crew to arrive onto E wing and attend to the man. The investigation team was told by the head of security at the prison that, although the gate staff are not issued with written guidance on the procedures for letting an ambulance into the prison, they are all aware of the need to allow the vehicle to gain entry as quickly as is possible.

***Equipment***

74. The HCO who tried to contact the control room via his radio found its battery to be flat. There is a telephone in the doctor's room on E wing and so he was able to telephone the control room without delay. The HCO told the investigation team that it is not unusual for radios to go flat with little or no warning. If the man had collapsed in an area where there was no telephone nearby, the HCO might have had to leave him unattended whilst he went to fetch help. It is noted that the prison has subsequently addressed this issue. The investigator was informed that new batteries have been purchased and consideration is being given to the purchase of a new radio system. I welcome this.

75. The HCN who was acting as Hotel 1 told the investigation team that the small oxygen cylinders supplied in the emergency bags are not adequate for more than a few minutes. Healthcare staff had to fetch further supplies of oxygen as the cylinder was running out. The HCN felt that, if full size oxygen cylinders were located in the treatment rooms, this would avoid staff having to leave the scene of a medical emergency to replace equipment.

76. However, I acknowledge that the prison's Head of Healthcare explained to the investigation team that the oxygen cylinders located around the prison provide 40 minutes of oxygen. In addition, it was her opinion that not all staff are aware of the number of cylinders available and their locations around the prison. The investigation team was also told that a decision had been taken to use smaller portable cylinders rather than full size cylinders as this meant that a prisoner could be treated in their cell or elsewhere if they needed oxygen. Whilst the merits of this arrangement are clear, it is important that all staff are made aware of where the oxygen cylinders are located.

77. The investigation team was also told by the nurse acting as Hotel 1 that she had found the handheld suction equipment inadequate and felt it was inferior to wall mounted suction equipment.

***The man's family***

78. The man's family were not told of his death until almost five hours afterwards. The man was pronounced dead at 11.32am and his family was informed at 4.25pm. The man's family told the investigation team that they had been very upset by the delay in being told of his death. They felt that the delay was compounded by the fact that they had been told that he had flu earlier that day. They felt that the truth of the man's condition had been concealed from them in various ways throughout the day, and were very angry and distressed about this. It is indeed unfortunate that inaccurate information was passed on to the man's family earlier that day.

79. The duty governor at the time of the man's death told the investigation team that she felt the news was broken to his family as promptly as was possible. In the intervening period, she opened a Command Suite and then acted as the Silver Commander. The Command Suite was closed at 2.45pm and duty governor and the SO who accompanied her then had to wait for a taxi to arrive to take them to the man's family address.

80. The duty governor explained to the investigation team that she and the SO had difficulty getting a taxi from the prison and that this delayed their arrival at the man's home. It is important that the news of a prisoner's death is broken to their family as quickly as is possible. Given the pressure the duty governor was under, consideration should

perhaps have been given to another senior manager visiting the man's family along with the SO.

81. The duty governor told the investigation team that she and the SO had followed the advice given in the Family Liaison Officer (FLO) training on breaking the news of a death before they visited the man's family. The investigation team consulted with a Prison Service trainer who had delivered this training to FLOs, including those at Wormwood Scrubs. One session of the FLO training explores the factors that should be taken into account when delivering such sad news to the family of a prisoner who has recently died. Staff are advised to contact the police to arrange for a Police National Computer (PNC) check to be carried out on the address which they are visiting. They are also advised to consider the environment and circumstances in which the family live and any cultural and language issues that may arise. Staff are advised to be aware of their own personal safety and to consider whether it may be appropriate to be accompanied by police officers. The training recommends FLOs be prepared for families to react in many different ways, and advises that anger, hostility and confusion are amongst the many understandable reactions to be expected.

82. The duty governor had not personally attended the FLO training and so worked closely with the SO to follow the advice given in the training prior to breaking the news of the man's death to his family. The duty governor explained to the investigation team that she had not felt sufficiently prepared for the reaction of the man's family to the news of his death, and felt herself and the SO to have been in a very vulnerable position.

83. The SO felt very differently about the visit to the man's home, explaining that the FLO training had prepared her well for delivering the news of a prisoner's death to their family. She said that, whilst no amount of training would prepare you for the strength of emotion you were likely to face, she had not been surprised at the reaction of the man's family to hearing the news of his death. In addition to the SO's comments, the Prison Service provided the investigation team with evidence of feedback from members of staff who had taken part in the FLO training. They had found the training to be very useful in preparing them for the reactions they may face. Subsequently, I have observed the FLO training myself and can vouch for its sensitivity and authenticity.

84. The SO had undertaken FLO training only a month prior to making the visit to the man's family. She told the investigation team that, at that time, the prison had not formulated its own local policy for family liaison following a death in custody, nor had it put in place a structure to support and supervise the work of the FLOs. The SO also commented that no debrief was held following the visit to the man's family; she felt this to have been a missed learning opportunity.

85. The duty governor told us that no amount of training could have prepared for her for the experience she was faced with, as she felt her safety was compromised. However, I consider that her experience highlights the importance of delivering FLO training to those members of staff likely to deliver the news of a prisoner's death to their family. I also acknowledge that a draft family liaison protocol has now been issued, which I welcome.

86. The family was told they could visit the prison to see the man's cell. Several of the man's family members decided to do this. The prison made every effort to facilitate their visit and ensured that members of the man's family were able to meet his friends from E wing.

87. The man's family were concerned that his watch had not been given to them along with the rest of his property. The investigation team discovered that the watch was in the possession of the police and made arrangements for the family to retrieve it from them. Following discussions with the investigation team, the prison arranged for the money from the man's cash and phone credit account to be sent to his family in the form of a cheque.

## Findings and Conclusions

88. The man had not given the staff on E wing any cause to be concerned about his health until the morning of 28 May. The healthcare staff did not pass on any information about the man to the officers on E wing, who were unaware that he was awaiting further medical assessment. The Governor may wish to consider whether the current advice to healthcare staff for the passing of pertinent information about prisoners to wing staff is adequate.

89. The man's family was concerned about his health and believed that he seemed in low spirits. His demeanour on the wings did not appear to give staff or other prisoners reason to be concerned about him. Once they were aware of the man's condition on 28 May, the staff on E wing showed concern and compassion and acted appropriately.

90. A clinical review panel considered whether the man received appropriate medical treatment whilst in prison. The panel highlighted a number of areas where his clinical care was not appropriate. In light of the conclusions of the panel, I endorse the findings and recommendations summarised below.

91. The panel noted that a new Prison Service Order (PSO 3050) had been issued on Continuity of Healthcare for Prisoners. This covers first reception, information management, transfer of prisoners and release/discharge. However, the panel stated that the following issues in respect of initial assessments for prisoners should be given consideration by the Prison Service:

- The First Reception Health Screen should be used to assess the mental health of the prisoner, check whether they require access to any vital medication and to reassure them that they will have time to chat the following day.

- A secondary health screen should be performed the next day to discuss their past medical history and any current concerns. Appropriate referral to the GP/mental health team should be made at that stage if the prisoner has answered 'yes' to any questions. Comprehensive notes of the conversation with the prisoner should be made by the nurse in the clinical records. This would relieve the pressure felt by nurses, prison officers and the prisoner on reception into prison and also improve the initial health screening and consequently the follow-up care provided.

- A general comments section added to the reception screen form would enable the reception nurse to communicate important information and/or the reasons for the form being incomplete, e.g. language difficulties – interpreter required, heavy workload – further assessment required.

- Following the signature, the writer's name and designation should be printed.

**I recommend that medical staff should be reminded of the importance of accurate and thorough completion of initial Healthcare Assessments. Consideration should be given to amending the form used to complete these assessments**

The Prison Service accepted this recommendation and made the following comment: "An internal audit has taken place of both the Don Grubin screen and the locally derived Part Two Healthscreen. It is accepted that not all the documentation was completed as thoroughly as it could have been and re-training is taking place. This will be audited again in three months to check on progress."

92. The clinical review panel also said that local and national policy for TB assessment and treatment should be reviewed to take into account the following factors:

- Prisoners have been shown to have high rates of active and undetected tuberculosis (TB);
- Prisoners have been shown to have high levels of drug resistant TB;
- Incarceration is a known risk factor for TB treatment interruption;
- There is an increased risk of onward transmission in congregate settings (confined shared air space);
- Prisoners are more immunocompromised than the general population due to HIV and lifestyle factors (drugs and alcohol); immunocompromised prisoners are at risk of TB infection and rapid progression to active disease;
- There is a responsibility to prisoners and to staff to ensure that the risk of TB transmission within the prison system is managed to as low a level as is reasonably possible.

**I recommend that the national and local policy for TB assessment should be reviewed.**

The Prison Service accepted this recommendation and made the following comment: "TB management at Wormwood Scrubs is currently being reviewed by London CSIP and a specialist TB nurse who works in a prison. New NICE Guidelines on the management of TB have recently been published. The Executive Summary of these guidelines was distributed to all prisons."

93. Appropriate tests and investigations should be arranged quickly, and referral made to appropriate specialists to investigate the complaint, confirm diagnosis and appropriate treatment.

**I recommend that medical staff should be reminded of the importance of following up on initial diagnosis.**

The Prison Service accepted this recommendation and made the following comment: "System to be implemented whereby medical and nursing staff follow up on tests and investigations during GP surgeries. Hammersmith & Fulham PCT are assisting with the development of an electronic records system to ensure that aspects of care do not remain solely in the IMR which is located away from the practice surgery."

94. Effective communication within the multidisciplinary team is vital if patients are to receive the most appropriate and the highest standard of care available. Medical staff should be reminded that, when recording pertinent information about a prisoner, they should print their name and designation along with the entry in the prisoner's medical records.

**I recommend that medical staff should be reminded of the importance of multidisciplinary communication.**

This recommendation was also accepted by the Prison Service: "This has always been a difficult area as staff believe they would be breaching medical in confidence information. There has been some work done around this externally and all areas of the prison are now in possession of the SECURE Document which explains what information may be shared and in what circumstances."

95. Staff who respond to an emergency must go to the incident with appropriate equipment. There should be full size suction machines available in the treatment rooms on the wings. There should be emergency sealed bags on every wing with appropriate equipment in them.

**I recommend that the policy for equipment and action required in an emergency should be reassessed.**

In responding to this recommendation the Prison Service referred to their response to the recommendations regarding resuscitation training and the provision of equipment (please see below).

96. Healthcare staff (and, if possible, prison officers) should receive annual up-dates to ensure they are aware of the latest guidelines on resuscitation.

**I recommend that the UK Resuscitation Council guidelines should be followed.**

This recommendation was accepted by the Prison Service: "Training now being organised through Hammersmith and Fulham PCT and the Resuscitation Council. One group of staff up to date with two further training sessions to follow. Due to be completed by end Sep 2006."

97. I endorse the clinical review panel's view that, in common with many prisons, the initial healthscreen for the man appears to have been completed when the nurse was under pressure. In addition, First Reception Healthscreens are likely to be carried out when the prisoner is stressed and tired. The combination of these factors is not conducive to eliciting thorough and accurate information about a prisoner's health needs. The man appears to have been reluctant to complain about his illness, and therefore the seriousness of his condition was not as evident to healthcare staff as it might have otherwise been. However, there were several missed opportunities when he could have been referred for specialist investigation into his on-going chest pain. While it is not possible to say whether earlier action would have prevented the man's death, correct diagnosis early on could have resulted in the appropriate treatment being administered in time to alter the course of events

98. The HCO's radio had gone flat when he tried to contact the control room to request an ambulance. He told the investigation team that it is not unusual for radios in the prison to go flat with little or no warning. I welcome the Governor's swift action to remedy this problem.

99. The HCN acting as Hotel 1 was heavily involved in attempting to resuscitate the man. She told the investigation team of the inadequacies of the suction equipment used within the prison. She also discussed her concerns over the size of the oxygen cylinders available and the speed with which they ran out. The Head of Healthcare said that, in her opinion, not all staff are aware of the location of the cylinders.

100. The Governor may wish to ensure that all staff are aware of the locations of oxygen cylinders around the prison.

**I recommend that the Governor gives consideration to equipping each of the treatment rooms with wall mounted suction equipment.**

The Prison Service rejected this recommendation. They made the following comment: "The small cylinders were purchased specifically for the emergency bags because they were mobile. The nurse has given factually incorrect information. Each cylinder holds up to 40 minutes of oxygen and given that there is already one on each wing and one in the emergency bag there would have been over an hours worth for this particular incident. Ambulances have never been delayed at the gate and in fact the paramedics were on scene within 15 minutes as per the report.

"Installation of full size cylinders is unnecessary given the amount of oxygen currently being used by the establishment and has a health and safety implication since they are very heavy.

"It is also not accepted that wall mounted suction should routinely be installed in the GP Surgeries, however, it may be necessary to review the type of hand held suction equipment currently available in the emergency bags."

101. The duty governor told the investigation team that she felt the news of the man's death was broken to his family as promptly as was possible. Understandably, in the hours following his death, the staff at the prison had numerous procedures to follow. However, given the importance of informing a prisoner's family promptly, consideration should perhaps have been given to whether this could have been done at an earlier stage - possibly by another senior manager from the prison.

102. The duty governor and the SO had very different feelings about the reaction of the man's family to the news of his death. The Prison Service provided evidence of positive feedback from those who had taken part in the FLO training. Experiences such as that of the duty governor highlight the value in delivering FLO training to those members of staff likely to deliver the news of a prisoner's death to their family.

**List of recommendations**

1. **I recommend that medical staff should be reminded of the importance of accurate and thorough completion of initial Healthcare Assessments. Consideration should be given to amending the form used to complete these assessments.**

2. **I recommend that the national and local policy for TB assessment should be reviewed.**

3. **I recommend that medical staff should be reminded of the importance of following up on initial diagnosis.**

4. **I recommend that medical staff should be reminded of the importance of multidisciplinary communication.**

5. **I recommend that the policy for equipment and action required in an emergency should be reassessed.**

6. **I recommend that the UK Resuscitation Council guidelines should be followed.**

7. **I recommend that the Governor considers to equipping each of the treatment rooms with full size oxygen cylinders and wall mounted suction equipment.**