Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Sean Huntroyd, a prisoner at HMP Winchester, on 7 May 2020

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Sean Huntroyd died of internal bleeding caused by ruptured veins in his abdomen on 7 May 2020, while a prisoner at HMP Winchester. He was 46 years old. We offer our condolences to Mr Huntroyd's family and friends.

Mr Huntroyd had a number of significant chronic health conditions, including cirrhosis of the liver and type 2 diabetes. He also had a long history of illicit drug use and alcohol abuse.

The clinical reviewer concluded that the clinical care that Mr Huntroyd received at Winchester was good and equivalent to that which he could have expected to receive in the community.

I am concerned that it was left to another prisoner, Mr Huntroyd's son, to collect medical equipment during the emergency response. This was inappropriate and caused a slight delay while Mr Huntroyd was receiving emergency treatment – although I am satisfied that this did not contribute to his death.

I have also made recommendations about family liaison and accessing medical equipment.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Sue McAllister
Prisons and Probation Ombudsman **1 April 2022**

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Summary

Events

1. On 29 January 2020, Mr Sean Huntroyd was remanded to HMP Winchester for shoplifting and breach of a community order. This was not his first time in prison.

2. Mr Huntroyd had type 2 diabetes and cirrhosis of the liver. He also had a significant history of illicit drug and alcohol misuse. He was seen regularly by the Integrated Substance Misuse Services (ISMS). He completed an alcohol detox but remained on a methadone programme throughout his time at Winchester.

3. On 18 March, Mr Huntroyd was taken to hospital by emergency ambulance after he felt unwell and collapsed. Hospital doctors found that he had had an intra-abdominal/variceal bleed (bleeding from swollen veins in the abdomen, a recognised complication of advanced liver cirrhosis). He remained in hospital until 23 March, when he was discharged back to Winchester with medication to manage his conditions.

4. Just after 4.00pm on 7 May, an officer called for a member of healthcare to check on Mr Huntroyd after he said he felt 'funny'. The officer thought that Mr Huntroyd was under the influence of drugs and Mr Huntroyd confirmed that he had smoked 'spice', an illicit psychoactive substance.

5. A prison paramedic arrived at the cell. She was unable to get a blood pressure reading using the manual blood pressure (BP) cuff, which meant that his blood pressure was low. She asked one of the officers to collect another BP machine from the treatment room on the wing. Mr Huntroyd's son (who lived in the cell next door to his father's) ran to the treatment room to collect the medical equipment but when he arrived, he was told that he could not have it. He returned to the cell and one of the officers ran and collected it instead.

6. At 4.21pm, officers radioed a code blue medical emergency (indicating a life-threatening situation) and an ambulance was called immediately. Mr Huntroyd's condition deteriorated very quickly. Additional nursing staff arrived and attempted to give Mr Huntroyd oxygen, but he resisted as he was quite agitated.

7. The ambulance crew arrived at Mr Huntroyd's cell at 4.32pm. As they began to treat him, he stopped breathing and no pulse could be detected. They began CPR and took Mr Huntroyd to hospital by emergency ambulance.

8. Mr Huntroyd's condition continued to deteriorate and at 5.37pm, it was confirmed that he had died.

9. The post-mortem found that he had suffered a catastrophic internal bleed caused by cirrhosis of the liver.

Findings

10. The clinical reviewer concluded that the care Mr Huntroyd received at Winchester was equivalent to that which he could have expected to receive in the community.

11. We are concerned that both medical and prison staff allowed Mr Huntroyd's son (also a prisoner at Winchester) to collect medical equipment during the emergency response. This led to a slight delay in obtaining the equipment. Although this did not impact on the treatment or outcome for Mr Huntroyd, it could be critical in future medical emergencies.

12. Although the prison told us that they had appointed two family liaison officers, they were unable to provide us with a copy of the Family Liaison Officer Log, as they should have done. As a result, the investigation was not initially able to establish what steps the FLOs took to notify Mr Huntroyd's nominated next of kin of his death. However, following issue of our initial report the prison provided handwritten notes completed at the time, which detailed the process.

13. There was also initially no evidence provided that a staff de-brief had taken place following Mr Huntroyd's death on 7 May or that staff were offered support. The prison has since provided handwritten notes that detail this process although the process was not minuted. The investigation has learnt since issuing of our initial report that the requirement for minutes of such de-briefs to be recorded is no longer valid, and therefore a previous recommendation has been removed. The notes also indicated that staff support was offered.

Recommendations

- The Governor and Head of Healthcare should all remind staff that it is not appropriate to request or expect prisoners to collect medical equipment in medical emergencies.

- The Governor should ensure that all decisions taken are recorded in the Family Liaison Officer's log.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Winchester informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

15. The investigator obtained copies of relevant extracts from Mr Huntroyd's prison and medical records. She interviewed six members of staff at Winchester in July 2020 and received written statements from four members of staff and one from Mr Huntroyd's son. All of the interviews were conducted by telephone due to revised working practices during the COVID-19 pandemic. The investigation was subsequently reallocated to one of Ms Boddy's colleagues, to produce the investigation report.

16. NHS England commissioned a clinical reviewer to review Mr Huntroyd's clinical care at the prison. The clinical reviewer jointly interviewed two healthcare staff with the original investigator.

17. We informed HM Coroner for Hampshire Central of the investigation. Our investigation was suspended while we waited for the cause of death. The coroner gave us the post-mortem report. We have sent the coroner a copy of this report.

18. One of the Ombudsman's family liaison officers contacted Mr Huntroyd's nominated next of kin to explain the investigation and to ask if they had any matters, they wanted the investigation to consider. They did not respond to our letter.

19. An inquest was concluded on 29 November 2023 and found Mr Huntroyd's death was the result of natural causes.

Background Information

HMP Winchester

20. HMP Winchester is a local prison serving courts in Winchester, Southampton, Portsmouth, Bournemouth, Salisbury, Aldershot and Basingstoke. It holds around 700 adult remanded and sentenced men. It includes a separate Category C unit for up to 129 sentenced men nearing the end of their sentence. At the time of Mr Huntroyd's death, Central and Northwest London NHS Foundation Trust provided healthcare at the prison and 24-hour healthcare cover.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Winchester was conducted in June and July 2019. Inspectors concluded that the inspection overall was "disappointing". However, Inspectors noted that senior managers had been appointed relatively recently and were supported by a team of managers who were as optimistic and committed. Inspectors also noted that the Governor and his team had articulated a clear vision for the future of the establishment and seemed to be working to a plan that appeared to have arrested decline and gave some evidence of early improvement.

22. Inspectors found that the range of health provision was appropriate, and prisoners had good access to most clinics, although the management of long-term conditions needed better coordination. Substance use support was good, and a wide range of psychological interventions and patient-centred clinical treatment was available.

23. In June 2020, HMIP conducted a short scrutiny visit at Winchester to look at key issues during the COVID-19 pandemic. They found that healthcare provision was good. Mental health support remined proactive and support to overcome substance misuse problems continued, although in a curtailed form.

Independent Monitoring Board

24. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to May 2021, the IMB reported that Winchester was to be commended for its response to COVID-19 and its success in preventing internally generated infection. Winchester was one of the last of all the local prisons to be designated as an 'outbreak' site (in January 2021) it controlled and reduced the incidents as well as could be expected.

Previous deaths at HMP Winchester

25. Mr Huntroyd was the tenth prisoner to die at Winchester since May 2018. Of the previous deaths, five were from natural causes and four were self-inflicted. There have been seven deaths at Winchester since Mr Huntroyd's death. Five were from natural causes and two were self-inflicted deaths.

26. In a previous investigation into a death at Winchester in March 2019, we were concerned about the prison's emergency response procedures. We recommended that the Governor should remind staff of the importance of using the correct medical emergency codes in an emergency and the potential consequences of not doing so. The prison accepted our recommendation and said that the Governor had re-issued a notice to staff in January 2020, to remind staff of the importance of using the correct emergency codes immediately, in line with PSI 03/2013, which also outlined the potential consequences of any delays in calling the appropriate emergency code.

Key Events

27. On 29 January 2020, Mr Sean Huntroyd was remanded to HMP Winchester for shoplifting and breach of a community order. He had been in prison before.

28. During his initial health screen, Mr Huntroyd said that he was currently on medication for type 2 diabetes. It was also recorded that he had a significant history of illicit drug and alcohol misuse. The nurse referred him to the prison's substance misuse team. Mr Huntroyd said that he had previously self-harmed but currently had no thoughts or intentions of suicide or self-harm.

29. Later the same day, a nurse completed an initial drug and alcohol assessment with him. She recorded that he had been in police custody for one day, during which time he had been given diazepam for alcohol withdrawal and dihydrocodeine for opiate withdrawal. Mr Huntroyd told the nurse that he smoked and injected heroin and also used 'crack' cocaine and illicit methadone in the community and had been drinking a bottle of vodka and two bottles of wine and cider a day before his arrest. Mr Huntroyd said that he had last used drugs the day before arriving at Winchester.

30. The nurse noted that Mr Huntroyd was displaying mild symptoms of both opiate and alcohol withdrawal and planned to administer 10mls of methadone on the first night in custody, increasing to 20mls daily for 3 days, pending a review. Mr Huntroyd was also prescribed alcohol detoxification medication. It was planned that he would be located in a cell with an observation hatch rather than a panel, so that his withdrawal could be closely monitored.

31. On 5 February, Mr Huntroyd was moved from C wing to D wing at his own request because his son was located there. They began sharing a cell.

32. On 8 February, a prison GP recorded that Mr Huntroyd had a history of pancreatitis (inflamed liver) and liver cirrhosis (scarring of the liver) as a result of alcohol dependency. She also recorded that in 2019, he had had an episode of haematemesis (vomiting blood) and melaena (blood in the stools), both symptoms of an upper gastrointestinal bleed (a recognised complication of cirrhosis). Following examination, she recorded a possible diagnosis of an enlarged liver. She requested blood tests and asked healthcare staff to obtain the results of a colonoscopy Mr Huntroyd had had in the community.

33. Mr Huntroyd continued to be monitored regularly and managed by the Integrated Substance Misuse Services (ISMS). He completed his alcohol detox but remained on a methadone programme throughout his time at Winchester. The healthcare team also reviewed Mr Huntroyd regularly in order to monitor his long-term conditions.

Events of March 2020

34. On 17 and 18 March, Mr Huntroyd attended sessions run by Phoenix Futures, a charitable organisation helping prisoners with drug and alcohol addiction. However, on 18 March, Mr Huntroyd complained of feeling unwell and had to leave the session early. Once outside the classroom, he collapsed. Staff radioed a code

blue (indicating a prisoner is unconscious or having breathing difficulties) and an ambulance was called immediately.

35. Two prison paramedics and the prison GP went to his cell in response to the code blue. The prison GP recorded that Mr Huntroyd was cold, clammy and pale and had low blood pressure. She suspected that he had had an abdominal aortic aneurysm perforation (internal bleed) which had caused his collapse. Mr Huntroyd was taken to hospital by emergency ambulance.

36. Mr Huntroyd was admitted to hospital as an inpatient and investigations were undertaken to determine the cause of his collapse. The hospital said that Mr Huntroyd was "not a well man". The prison notified Mr Huntroyd's son who was given access to a telephone to notify other family members.

37. While in hospital Mr Huntroyd tested negative for COVID-19.

38. On 23 March, Mr Huntroyd was discharged from hospital and returned to Winchester. His discharge notes recorded that his collapse was due to an intra-abdominal/variceal bleed (a bleed from swollen veins in the abdomen) and that he had marked cirrhosis of the liver, liver varices (enlarged or swollen veins,) portal hypertension (increased pressure in the vein carrying blood from the digestive organs to the liver) and calcification of his aorta. He was prescribed appropriate medication to manage his conditions and was to be seen regularly for review.

39. On his return to Winchester, Mr Huntroyd was taken back to D wing where he was allocated a single cell as a precautionary measure against COVID-19. (His son lived in the cell next door.) His health was closely monitored.

40. On 29 March, the prison GP recorded that although test results had indicated that Mr Huntroyd's liver function had improved, his platelets were low. (Platelets help form blood clots and stop or prevent bleeding and a low platelet count can lead to internal bleeding.) The prison GP recorded that she planned to discuss this with the hospital haematology team.

7 May 2020

41. Just after 4.00pm on 7 May, an officer went to Mr Huntroyd's cell to ask if he was ready to collect his medication. The officer said that Mr Huntroyd was standing in his cell making a cup of tea and raised no concerns. The officer said that he had no concerns about Mr Huntroyd's appearance. The officer said that he then went further along the landing to speak to another prisoner. While he was doing so, Mr Huntroyd shouted out to the other prisoner. The prisoner went to Mr Huntroyd's cell and then returned and said to the officer, 'You might want to go and see if Sean is ok.'

42. The officer said that he went back to Mr Huntroyd's cell and found Mr Huntroyd leaning against the wall. Mr Huntroyd said that he felt 'funny'. The officer said that Mr Huntroyd, 'did not look quite right' and that he therefore radioed for a member of the nursing team to come and check on Mr Huntroyd. The officer said that he did not call a medical emergency code because he initially thought that Mr Huntroyd was under the influence of 'spice', an illicit psychoactive substance.

43. At around the same time, another officer was walking along the landing with Mr Huntroyd's son when a second prisoner told them they should go to Mr Huntroyd's cell. The second officer said that there was no urgency in the prisoner's voice. The second officer went to the cell and Mr Huntroyd's son followed him. When they arrived, they saw that the first officer was trying to encourage Mr Huntroyd to lie on his bed and calm down. He said that they asked Mr Huntroyd whether he had taken any illicit substance. Initially, Mr Huntroyd did not answer but then said, 'Yes, spice.'

44. In a written statement Mr Huntroyd's son also said his father had told the officers he had taken 'spice', although he said that he told them he did not think 'spice' was the problem and that his father's symptoms were the same as when he had collapsed a few weeks earlier.

45. A prison paramedic arrived at the cell at 4.07pm. She said that she only took a small emergency bag with her as she knew that Mr Huntroyd was conscious and breathing. When she arrived at the cell, the officers told her that Mr Huntroyd had said that he had used 'spice.' Mr Huntroyd's son said in his statement that he told her he thought his father was having a repeat of his symptoms a few weeks earlier.

46. The prison paramedic said that Mr Huntroyd was sitting on the edge of his bed. He was very pale, and his skin was cold to the touch. He had a low temperature and said he could not breathe. She attempted to feel for a pulse but was unable to detect one, so she knew that his blood pressure was low. She was unable to get a blood pressure reading using the manual blood pressure (BP) cuff. She asked one of the officers to collect another BP machine (which was not in the emergency bag) from the treatment room on the wing. Mr Huntroyd's son ran to collect the medical equipment. Healthcare staff told him that that he could not have it so he returned to the cell and one of the officers ran and collected it instead.

47. The prison paramedic asked the officers to radio a code blue because she considered that Mr Huntroyd needed to go to hospital. The code blue call was recorded at 4.21pm. An ambulance was called immediately.

48. The prison paramedic said that Mr Huntroyd's condition deteriorated very quickly. Additional nursing staff arrived and attempted to give Mr Huntroyd oxygen, but he resisted and was quite agitated. The ambulance arrived at the prison at 4.27pm and ambulance staff were with Mr Huntroyd at 4.32pm. The officer told them what Mr Huntroyd's son had said about his previous collapse.

49. When the ambulance crew arrived at the cell, Mr Huntroyd was still responsive but, as they began to treat him, he stopped breathing and no pulse could be detected. He was immediately moved onto the floor and a defibrillator was attached to his chest. The ambulance crew started chest compressions and a second ambulance crew arrived. Mr Huntroyd was transferred to the waiting ambulance was taken to hospital.

50. Mr Huntroyd's condition continued to deteriorate in hospital and at 5.37pm, it was confirmed that Mr Huntroyd had died.

Contact with Mr Huntroyd's family.

51. Following Mr Huntroyd's death, the prison appointed two officers as Family Liaison Officers (FLOs). The investigation was unable to initially establish what steps the FLOs took to inform the next of kin of Mr Huntroyd's death as no FLO Log was provided.

Support for prisoners and staff

52. There is evidence to indicate that the prison conducted a debrief and that prison and healthcare staff were offered support.

53. The prison posted notices informing other prisoners of Mr Huntroyd's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Huntroyd's death.

Post-mortem report

54. The pathologist gave Mr Huntroyd's cause of death as haemoperitoneum (bleeding in the abdominal cavity) caused by a ruptured peritoneal varix (ruptured veins in the abdominal cavity as a result of portal hypertension), which was in turn caused by cirrhosis of the liver.

55. The pathologist said that he considered that the origin of the bleeding was likely to have been similar to that when Mr Huntroyd had collapsed in March 2020, but that on this occasion the bleeding was catastrophic and resulted in massive blood loss leading to sudden death.

56. The pathologist said that some drugs may increase blood pressure and so increase the risk of intraperitoneal haemorrhage. However, no toxicology tests could be carried out to determine whether Mr Huntroyd had taken any illicit substances as the samples of urine and blood taken during the post-mortem had been disposed of by the police without being analysed.

Findings

Clinical care

57. The clinical reviewer concluded that the clinical care that Mr Huntroyd received at Winchester was good and equivalent to that which he could have expected to receive in the community.

58. She found that the prison GP and the prison's healthcare team reviewed Mr Huntroyd at regular intervals, and that this included reviews of his medication and blood test results and implementation of the recommendations made by hospital doctors following Mr Huntroyd's discharge from hospital on 23 March 2020. She also found that the ISMS team met regularly with Mr Huntroyd and provided ongoing support to him during his time at Winchester.

59. The clinical reviewer did, however, identify a number of concerns relating to general healthcare provision. We do not repeat her recommendations in this report as the issues she raises did not directly impact on Mr Huntroyd's death, but the Head of Healthcare will need to address them.

Emergency response

60. When the prison paramedic was unable to obtain a BP reading using the manual BP cuff, she asked that an automated BP machine be collected from the treatment room. At this point it appears that Mr Huntroyd's son was either sent for it or took it upon himself to go and collect the machine. However, because he was a prisoner, healthcare staff refused to give it to him, so a member of staff was sent to collect it.

61. Staff should not have relied on Mr Huntroyd's son to collect the equipment. While the slight delay in obtaining the equipment did not impact on the treatment or outcome for Mr Huntroyd, it could be critical in other circumstances. We make the following recommendation:

    The Governor should remind staff that it is not appropriate to request or expect prisoners to collect medical equipment in medical emergencies.

Family liaison

62. Prison Service Instruction (PSI) 64/2011 on safer custody says that following a death in custody, the next of kin must be contacted by an appropriate person. The next of kin must be given an accurate account of what has happened and what will happen next, and an offer must be made to contribute to funeral expenses.

63. The prison told us that they had appointed two family liaison officers, but they did not provide a copy of the Family Liaison Officer Log as they should have done. As a result, the investigation has not been able to establish what steps the FLOs took to notify the next of kin of Mr Huntroyd's death. Following publication of the initial report, the prison provided handwritten notes that indicated that the officer had taken steps to contact and notify the next of kin as listed by Mr Huntroyd. The notes only detail that initial attempts to make contact were unsuccessful and that

other means of contact were sought. Mr Huntroyd's son was also informed about his father's death and supported via the chaplaincy team. We recommend:

The Governor should ensure that all decisions taken are recorded in the Family Liaison Officer's log.

64. The prison paid toward the cost of Mr Huntroyd's funeral in line with national policy. National policy states that a contribution of up to £3000 toward 'reasonable' costs should be made.

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