Investigation into the circumstances surrounding the death of a man at HMP Winchester on 31 July 2004

Prisons and Probation Ombudsman for England and Wales

June 2005

This is the report of an investigation into the circumstances surrounding the death of a prisoner who was sentenced to 12 weeks imprisonment on 23 July 2004. He was sent to HMP Winchester and on the morning of 31 July 2004 was found dead in his cell. A Coroner's inquest recorded his death as due to natural causes.

All deaths of prisoners in custody are investigated, including those from natural causes. The responsibility for carrying out investigations traditionally fell to the Prison Service itself but has now been passed to the Prisons and Probation Ombudsman's Office to bring independence and greater consistency.

I offer my sincere condolences to the family and friends of the man who died. I must apologise for the delay in completing this report.

I am grateful to the Governor of HMP Winchester and her staff for their co-operation with this investigation.

This report makes three recommendations concerning the issuing of medication and one concerning Winchester's contingency plan for dealing with deaths of prisoners.

Stephen Shaw CBE — June 2005
Prisons and Probation Ombudsman

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Summary

The subject of this report was 56 years old when he died on 31 July 2004 at HMP Winchester. He had been sentenced to two months and 23 days imprisonment on 23 July 2004 for threatening behaviour. It was not his first period of imprisonment at Winchester, having been released from there in May 2004 after serving another short sentence. Whilst he did not mention any medical problems on reception, it was noted that he was in poor physical health. He was prescribed dietary supplements, medication for a chest infection and inhalers for breathing difficulties.

The man who died had a history of mental illness which was managed successfully with medication. However, two years before his death, he stopped taking his medication and this led to the disintegration of his personal relationships and a decline in his health.

On the evening of 30 July, he complained of being short of breath and was given two inhalers by an officer. He was found dead in his shared cell the next morning.

After initially being unable to contact the next-of-kin whom the man had named on his reception at Winchester, one of his sisters was located. She has concerns about the way she was informed of her brother's death and the contact she has had since with Winchester.

A post mortem examination of the man found that he had died due to acute exacerbation of chronic obstructive pulmonary disease. The Coroner's inquest into his death took place on 24 November 2004. It found that he had died of natural causes.

Investigative process

My practice in cases of apparent deaths from natural causes is to conduct an initial review to determine the extent of investigation required.

My investigator and a colleague visited HMP Winchester on 4 August 2004 and spoke to staff informally to gather the facts relating to the subject of this report's time at Winchester. They were given access to his records, including his medical records.

The Prison Officers Association and Independent Monitoring Board were offered the opportunity to meet with the investigators. Neither had any issues they wished to draw to our attention.

Notices to staff and prisoners were distributed, telling them that an investigation would be taking place into the prisoner's death. No responses were received. His cell mate was released from Winchester shortly after the death of the man and could not be contacted.

The investigator contacted the man's sister.. She spoke of her brother's ill-health, expressed her concern that she had not been told of his death in an appropriate manner, and felt that she had been treated poorly. These issues are examined further in my report.

A clinical review of the man's health care at Winchester was carried out..

The deceased

He was 56 years old at the time of his death. He was divorced and had one son. His sister described him as a highly intelligent but complicated person. He had been a popular and affable man, running his own successful building company until 2002 when he had encountered personal difficulties and had been unable to continue. He had suffered from depression and had received occasional psychiatric treatment over the past 30 years but had been able to live a relatively stable life provided he took Lithium to control his symptoms.

The man who died stopped taking his medication about two years before his death and, as a consequence began to suffer from mood swings. He was unable to continue his work and experienced financial problems. According to his sister, these might have been resolved but he was unable to tackle them rationally. In addition, he had received unclear advice about claiming benefits.

Sadly, he began to drink more frequently, and his marriage foundered. Although his sister had attempted to secure in-patient psychiatric treatment for him, this was not possible as he was not thought to be in imminent danger to himself or others. He gradually began to suffer more markedly from poor health and physical decline. He became verbally abusive and aggressive to others. This resulted in him being imprisoned at Winchester four times in the last 18 months of his life for public order offences.

Events leading up to the deceased's death

The man who died had a short history of offending, but in 2004 he came to the police's attention several times. On 2 April 2004, he was verbally aggressive to staff in a travel agency, left the shop and returned shortly afterwards with a scaffolding pole which he used to smash the entrance door window. He was then abusive to the police officers who arrived to arrest him. On 27 May, he was sentenced to three months in custody for criminal damage.

He was sentenced to two months and 23 days imprisonment on 23 July for threatening behaviour and sent to HMP Winchester. His automatic release date would have been 2 September 2004.

On reception at Winchester, the man was seen by a Health Care Officer and asked a series of standard questions about his health. He said that he had seen his General Practitioner (GP) recently for a general examination, but that he was not receiving any form of treatment, had not had any operations and had no worries about his general health. He gave the name and address of his GP. He said he was a moderate drinker and smoked 20 cigarettes a day. He was asked specifically about his mental health and answered that he had not suffered from any psychiatric illness in the past and had not been prescribed any medication for his "nerves". He added that he had expected to be sent to prison, no one knew he was there and he was not expecting any contact with family or friends whilst he was in Winchester. He said that he was not allergic to anything. However, his medical record has "allergic to penicillin" across the front.

On 24 July, the man saw a doctor for a medical examination, which is normal practice for newly-received prisoners. The man told the doctor that he did not have a previous medical history but had had an operation for a gastric ulcer without his consent. The doctor noted that he had a post operative scar below his navel. He described the man as unwell, and noted bilateral crepitation (crackling noise) in his lungs and that he was wheezing audibly.

On 28 July at 2am, it was noted in the man's medical record that he was banging and kicking his cell door, complaining of shortness of breath. He was physically examined in his cell by a health care worker, at which time he also complained of constipation. He said he was coughing up green sputum but the nurse records that it was white. The man was told that the nurse was unable to find anything especially wrong and would not give him laxatives as there was no evidence he had constipation.

A doctor saw the man on 29 July and noted that his breathing was distressed, that there was bilateral wheezing and his body appeared wasted. He prescribed antibiotics, inhalers and steroids for asthma, and Fortisip, an energy drink to build him up. The man collected the antibiotics, steroids and Fortisip on 29 July.

On 30 July at about 7:30pm, an officer answered the man's cell bell. He was sharing the cell with another prisoner.. The man said that he was "wheezy,

short of breath and asthmatic". He told the officer he was having trouble breathing and asked him to get an inhaler. The officer spoke to the nurse in the Treatments Room on C2 landing, who checked the man's file and asked whether the man would collect the inhaler. The officer said that as the man was short of breath, he would take it to him. The man's cell was three floors up from the treatment room. The nurse gave the officer two inhalers which were given to the man. The officer watched him take a dose and then left.

According to the cell mate's police statement, he and the man were not particularly close. The night before his death they had argued because the man had taken half of his breakfast pack (sachets of tea, jam and sugar) without asking. The cell mate ignored the man after that and they both watched a film on television which had ended around midnight, although the man was asleep before the film finished.

In the morning of 31 July, at about 8:30am, an officer placed some milk in the cell. This woke the cell mate. He got up and made a cup of tea for both himself and the man, but could not wake him. He noticed that the man's was cold and that his skin was mottled. He rang his cell bell and kicked the door. An officer came to the door quickly and summoned assistance. The cell mate was taken to another cell and then given the opportunity to speak to a Listener, a prisoner trained by the Samaritans to offer other prisoners support in crisis situations.

Healthcare staff arrived at 8:35am, although the Inmate Medical Record is incorrectly dated as 30 July. Resuscitation was not attempted as rigor mortis had set in, but a doctor was called. The doctor pronounced the man dead at 9:20am.

Events after the deceased's death

The man who is the subject of this report had named his next of kin. A prison Chaplain attempted to contact the person named, but was not successful. The police were asked to help but were unable to make progress, so the task was passed to the Coroner's officer to pursue. The Chaplain subsequently checked one of the man's previous prison records and found details his sister. His sister was told by the Chaplain on 1 August that her brother had died. She was surprised that the Chaplain had telephoned her and had expected that the Governor would contact her also. She telephoned the prison and spoke to the Duty Governor. She says the governor said he had not said anything to her because he "had nothing to say." This remark had annoyed her deeply as she did not regard her brother's death as "nothing" and considered that Winchester did not appreciate the hurt they had caused her. A governor, telephoned her later to say that it was normal for the Chaplain to break the news of a family member's death and that he was sorry for her brother's death. She felt angry that it had taken conversations with three people before a senior manager expressed their sympathy to her.

My investigators discussed the breaking of news of a bereavement with the governing Governor. She said she had understood that the person named as the next of kin was unhappy that the Chaplain had contacted her as opposed to someone more senior. As far as she was concerned, the Chaplain's role was appropriate as the person named as the next of kin (whom she understood, wrongly, at that time was the man's ex wife) was not strictly next of kin in legal terms.

Winchester's Contigency Orders for a death of a prisoner state:

> "If next of kin are within reasonable travelling distance, arrange a meeting between them and a nominated Governor and appropriate Chaplain. Another Governor and Chaplain to be named as stand-in and a record kept."

Prison Service Order 2710: Follow up to Deaths In Custody, chapter 6 paragraph 4 states:

> "A senior member of staff must be appointed as the named point of contact for the family and a second person named as available in the first person's absence … Continuity in dealing with the family will enable the establishment to meet its primary task, i.e to establish rapport and trust with the family in helping them to come [to] terms with what has happened …"

The man's sister lives over 100 miles away from Winchester. The contingency plans do not specify how families should be contacted and by whom, if they live outside a "reasonable travelling distance" from the establishment.

Post mortem and inquest

A post mortem examination took place on 2 August 2004. The pathologist concluded:

> "There is sufficient natural disease present to explain the death, in the form of longstanding chronic obstructive pulmonary disease (emphysema and chronic bronchitis) and patchy infection (an acute change). Chest infection is a common complication of chronic obstructive pulmonary disease of this severity. There are no significant older injuries to the chest, including no old and healing rib fractures, which may have precipitated the development of such an infection. There are no fresh injuries to the body and no findings to suggest restraint."

The Coroner's inquest into the man's death was held and the jury returned a finding of death by natural causes.

Clinical review

The clinical review concludes that Winchester provided the man with appropriate care and management for his presenting symptoms. It notes that the man did not provide Winchester with all the relevant information about his health during the initial health screen. The review makes two recommendations about the fact that inhalers were not issued to the man directly by healthcare staff, and that they were issued without an assessment of the man's current medical problems.

Conclusion

I take the view that, during the time he was in Winchester, the prison provided reasonable care to the man who died. I have, however, three concerns about the way Winchester dealt with the man's health care.

First, although the man did not tell the prison of any health problems when he arrived, the doctor who saw him on 24 July noted that he was unwell. The prison ought, therefore, to have obtained the man's consent for his GP to be contacted to obtain his full medical history. There is no evidence that this was done.

Second, health care staff should not have issued prescription medication to the man on 30 July without first checking his clinical condition. I appreciate that the medication had been prescribed the previous day, but on 30 July the man who died was complaining of serious symptoms and a further medical assessment would have been prudent.

Third, the medication should have been issued to the man by health care staff, and not by a prison officer, to make sure that the medication reached him and that he knew how to use it.

Although I think it is best practice for a Governor grade to contact the family in the event of a death in custody, I understand why this role is often fulfilled by the Chaplain. Their training and experience of means that they will frequently have come into contact with, and have experience of, dealing with families at crisis points. Nevertheless, it would have been good practice for a governor if not *the* Governor, to have contacted the man's sister shortly afterwards to reflect the view that the death of the man was taken seriously. Once the man's sister felt she had to telephone the prison to find out why no Senior Manager had contacted her, the chances of establishing effective rapport between herself and Winchester had diminished.

Recommendations

I recommend that the Governor works with the prison's health care service to ensure that:

Where prisoners are observed or noted to have health problems, consent is sought to contact their GP to obtain their medical records;

Heath care staff do not issue prescription medication to patients without having assessed their clinical condition;

Health care staff issue medication direct to patients, and do not use third parties to deliver medication.

I recommend that the Governor of Winchester amends the establishment's death in custody contingency plans to specify that a Senior Manager should contact the bereaved family once the Chaplain has made the initial contact.