Investigation into the circumstances surrounding the death of a man at HMP Winchester In February 2009

Report by the Prisons and Probation Ombudsman for England and Wales

November 2009

This is the report of an investigation into the circumstances surrounding the death of a man. He was 68 years old when he died from a heart attack in February 2009 at HMP Winchester. He collapsed whilst alone in his cell and was found by an officer unlocking cells shortly before 5.00pm. Despite a concerted effort by healthcare staff and paramedics to revive him, he died in his cell.

The man had suffered two earlier heart attacks in June and October 2008. On both occasions he had been taken to hospital, but had chosen to discharge himself against medical advice.

I would like to offer my sincere condolences to the man's family and to all those affected by his death. He seems to have been a prisoner who added to the colour of everyday life in Winchester.

The investigation was conducted by one of my Investigators. One of my Family Liaison Officers contacted the man's sister to explain the nature of my investigation and offer her the opportunity to discuss any concerns she had about her brother's time in custody.

A clinical review of the treatment which the man received in custody was undertaken by a clinical reviewer on behalf of the local Primary Care Trust (PCT). I am grateful to him for his assistance. (A copy of his review is annexed to my report.)

I would also like to thank the acting Governor and staff and prisoners at Winchester for their full cooperation whilst my investigation took place. I especially acknowledge the liaison officer who liaised with my investigator and organised the interviews.

Whilst the man's death was sudden, it followed two recent admissions to hospital in relation to heart failure. I have concluded that his death could not have been prevented, but my investigation has highlighted a significant number of problems at Winchester that require attention. I make 12 recommendations, and endorse three additional recommendations made by the clinical reviewer.

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

Stephen Shaw CBE
Prisons and Probation Ombudsman **November 2009**

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SUMMARY

The man was released from custody on licence in February 2007. He breached the terms of the licence at the end of March and absconded. He was arrested several months later and remanded into HMP Winchester on 4 September. He presented with poor blood circulation and the prison doctor planned to refer him to hospital. However, before this could happen he transferred to HMP Belmarsh on 18 September.

Over the next few months, the man's health was poor. He suffered from a lack of mobility, dizziness, shortness of breath and other symptoms connected to heart disease. He fell more than once and lost a considerable amount of weight. On 8 January 2008, he was supposed to attend court but a doctor declared him unfit to travel for a fortnight. The next day he was admitted to hospital with a chest infection, from which he recovered. A prison doctor referred him to hospital as a result of his heart problems and ill health, but before the referral could be acted upon he transferred back to Winchester on 1 February.

A first reception health screening was not completed when the man arrived at Winchester. Later in February, he received a four year prison sentence in relation to an offence committed the previous spring. His health seemed to stabilise and he was placed on the chronic disease register as a result of a diagnosis of coronary heart disease. He was referred to hospital in April. The doctor who assessed him thought that his weight loss was related to the medication he was taking for his heart problems, but a CT scan was performed in May to rule out the possibility of cancer. The results gave no cause for concern.

The man had a heart attack on 30 June. He was taken to hospital and discharged himself against medical advice on 3 July. He attended several hospital appointments over the next few months before suffering a second heart attack on 17 October. On this occasion he had to be resuscitated by healthcare staff and was again admitted to hospital. He remained there until 24 October, before once more discharging himself against medical advice. In January 2009, he underwent an angiogram that confirmed signs of heart disease. The type of coronary artery disease that he had could not be operated on.

During afternoon lock-up in February, the man collapsed whilst alone in his cell (his cellmate had moved out a couple of days earlier). He was found by an officer unlocking the cells on the landing shortly before 5.00pm. Healthcare staff were requested urgently and attempted to resuscitate him. When the paramedics arrived they reported a delay in gaining admission to the prison. However, having reached the wing, they agreed that resuscitation should stop. The man was declared dead in his cell at 5.15pm.

The man's poor health was a long standing problem and his heart attack was perhaps not unexpected in the context of his medical history. Nonetheless, my investigation has identified a significant number of concerns, principally relating to the delivery of healthcare at Winchester. I make 12 recommendations and endorse three made by the clinical reviewer.

THE INVESTIGATION PROCESS

1. My Investigator was formally notified of the man's death on 9 February 2009. Notices were subsequently issued to both staff and prisoners at HMP Winchester, informing them of the investigation process and giving the opportunity to contact my Investigator if they felt that they could provide any relevant information. No prisoners came forward.

2. My investigator made contact with the prison's liaison officer. She provided him with records relating to the man's time in custody and organised the interviews subsequently conducted at Winchester.

3. Having examined the relevant documents relating to the man's imprisonment and the medical treatment he received, my investigator visited Winchester on 24 and 31 March and 22 May. He interviewed one of the governors, two prison officers and four members of healthcare staff.

4. My Investigator wrote to the local Coroner's office to inform them of the nature and scope of the investigation and request a copy of the post mortem. HM Coroner will be provided with a copy of my report.

5. My investigator contacted the local Primary Care Trust and asked that a clinical review be carried out with regard to the medical treatment which the man received in custody. The purpose of the review was to establish whether the care which he received in prison was comparable with that he would have been offered in the community. The clinical reviewer completed the clinical review, which is annexed to my report.

6. On 6 March, one of my Family Liaison Officers contacted the man's sister as his nominated next of kin. The Family Liaison Officer explained the purpose of my investigation and provided her with the opportunity to ask any questions. The man's sister did not express any specific concerns about the treatment her brother received in custody. She spoke very positively both about the care he received at Winchester and the support she had been offered by prison staff following his death.

7. The man's sister said that her brother would call her every week and never complained. He would tell her that he was being well looked after. His sister was aware that he had suffered previous heart attacks in prison. She mentioned that the prison had contacted her when this had happened and had kept her updated about his condition. I hope that my report gives her a better understanding of the circumstances surrounding her brother's death.

HMP WINCHESTER

8. Winchester is a category B prison built in 1846 with a maximum population of 544 male prisoners. As a local prison, the majority of prisoners arrive directly from court appearances and the population changes frequently. Many of the prisoners are either held on remand or are serving short sentences. Those prisoners who are serving longer sentences will often be transferred to a different prison, but part of Winchester consists of a small category C training wing.

9. Since April 2004, I have investigated 12 deaths at Winchester. Of these, seven were as a result of natural causes. Six of my earlier investigations resulted in the same recommendation (which I repeat in this report) regarding the importance of completing a first reception health screening when a prisoner arrives at Winchester. In the man's case, no screening is evident in his medical record.

10. My investigation of a prisoner's death in April 2007 raised concerns regarding the completeness of prisoners' medical records. I have identified a similar problem with regard to the man's file, from which documents were missing. More recently, my investigation of the death of a prisoner in March 2008 resulted in a recommendation regarding the emergency response codes used by staff over the radio net. The same area of concern was identified by staff after the man's death.

11. As of October 2008, primary healthcare services at Winchester are commissioned by the NHS and provided by the Community and Mental Health Services. The healthcare department is located separately from the main prison building. It has a 22 bed inpatient facility and provides 24 hour nursing cover. The majority of nurses work between 7.30am and 5.30pm. Three nurses work between 5.30pm and 8.30pm, and two work overnight. Doctors attend the prison from a local practice to hold surgeries in the mornings from Monday to Saturday, as well as offering an all day surgery on Tuesdays. An electronic patient record keeping system called VISION was introduced in June 2007. Upon arrival in custody, each prisoner is supposed to undergo a health screening process to identify any concerns.

12. HM Chief Inspector of Prisons carried out an announced inspection of Winchester between 16 and 20 April 2007. She found a 'reasonably well performing local prison' but identified a number of problems, notably a 'negative staff culture'. She noted that, whilst some improvements had been made with regard to healthcare provision, some aspects of the treatment offered were not comparable with advances being made in community medicine.

13. The most recent annual report published by the Independent Monitoring Board (IMB) covers the year from June 2007 to May 2008. (The IMB at each prison is made up of members of the public who are both independent and unpaid. They monitor the day-to-day life in their local prison and ensure that proper standards of care and decency are maintained.) The IMB considered

that Winchester performed well as a local prison facing ‘tight financial constraints’. With regard to the provision of healthcare, they criticised the use of healthcare beds to relieve overcrowding in the main prison and highlighted a lack of nursing staff.

KEY FINDINGS

14. The man was released on licence to a probation service approved premises (hostel) in south London on 23 February 2007. A few weeks later, on 30 March, he failed to return to the hostel and therefore breached the terms of his licence. The paperwork necessary to recall him to prison was prepared by probation staff on 4 April. Whilst he remained at liberty for several months he committed a further offence. The police appealed to the public in the media and he was eventually arrested in September 2007 at a hospital in London.

15. The man's licence was revoked and he was remanded into custody, entering HMP Winchester on 4 September. A primary health screening was carried out during which he did not initially report a history of heart disease. However, he presented with poor health and the next day he was assessed by a doctor. He had high blood pressure. He was prescribed aspirin, tramadol (a pain killer) and ramipril (used to treat high blood pressure and to reduce the likelihood of a heart attack).

16. On 11 September, the man appeared at the magistrates' court. The next day he was prescribed paracetamol and digoxin (used to treat a variety of heart conditions). A few days later on 15 September, he attended another doctor's appointment complaining of poor blood circulation in his legs. The doctor decided that an outpatient's appointment at the hospital should be organised after the weekend.

17. However, before this referral could be made, the man transferred to HMP Belmarsh in London on 18 September. The next day, both an initial health reception screening and a secondary health assessment were completed. He did not report a history of heart disease.

18. Because he mentioned experiencing dizzy spells, twice weekly checks on the man's blood pressure were scheduled from 2 November. Six days later, having complained of shortness of breath, he was referred to a doctor. He was advised to stop any exercise and was admitted to the healthcare unit as an inpatient. The next day he was feeling less breathless and his blood pressure and pulse were taken and found to have returned to normal.

19. Healthcare staff had regular contact with the man during this period in relation to a number of medical problems. He was having to use a Zimmer frame, and, amongst other complaints, suffered from a lack of mobility, poor circulation, a skin condition and difficulty passing urine. He was becoming progressively more unwell.

20. On 14 November, healthcare staff ordered blood tests. Four days later, the man fell in the exercise yard but did not sustain any injuries. He said that he had not fallen as a result of dizziness. It was noted that the results of the blood tests ought to be followed up, but it does not appear that these were ever recorded in his medical file.

21. A few weeks later, on 8 December 2007, the man fell out of bed in the early morning. He hurt his knee in the fall. Staff wrote in his medical record that he was slightly breathless and was not eating properly. He had lost 11 kilograms in weight in the space of a month. A few days later he seemed to be eating a little more, but he was now having difficulty sleeping. On 13 December, he remained dizzy and short of breath, and his notes were requested from his local doctor in the community.

22. Having had very little sleep, the man was found slumped on the floor on 20 December. His condition improved in the next few days, and by Christmas Day he was eating and drinking normally. Just before New Year, he complained to healthcare staff that they were not helpful enough.

23. Because he was becoming incontinent, the man was given a catheter on 1 January 2008 and kept under regular observation. Staff felt that his behaviour was becoming quite difficult to deal with and he was often verbally aggressive towards them. A week later, on 7 January, he was due to appear at Crown Court, but because of his breathlessness and poor mobility was deemed unfit to travel.

24. The following day, a doctor decided that the man should not attend court for at least two weeks to allow his health to improve. A referral was made to the local hospital as a result of his history of heart problems and frequent dizzy spells. (However, this referral did not result in a hospital appointment because he transferred to HMP Winchester at the start of February. Copies of his blood tests were forwarded on from Belmarsh.)

25. The man was taken to hospital in an emergency ambulance the next day, 9 January. He had been found lying on the floor by his bed shortly after 8.00am. When he regained consciousness after about ten minutes, he explained to staff that he had fallen off the bed whilst sleeping, scraping his knees in the process. Arriving at the emergency department at hospital, he was found to have an acute chest infection. He returned to prison the same day and was moved to another ward in the healthcare wing for closer observation. He fell off the bed again at 10.00pm that night.

26. Four days later, an urgent referral was made to the prison doctor after the man lost control of his bowels. He was given a single cell and his own toilet facilities. Over the next few days he continued to be very unwell and was observed at ten minute intervals in case he collapsed again. However, his health gradually improved.

27. The man transferred from Belmarsh to Winchester on 1 February. There is no record of a health screening being conducted during the reception process. The next day he was assessed by a doctor who prescribed his ongoing medication for heart disease, including digoxin, ramipril, aspirin, furosemide (used to treat heart failure), metoprolol (used to treat high blood pressure) and ferrous sulphate (an iron supplement to treat anaemia). Later that month, he received a four year prison sentence at Crown Court in relation to the offence

he committed whilst he had absconded in breach of his licence the previous spring.

28. The acting Head of Healthcare between 1 April 2008 and 3 May 2009 told my Investigator that the man was placed on Winchester's chronic disease register because of his heart problems. She said that he was assessed at regular intervals by the chronic disease nurse and was encouraged to give up smoking (which he chose not to do) and take up a healthier lifestyle.

29. On 20 March, a doctor at the prison referred the man to hospital because he had recently lost five and a half stones in weight. (The weight loss was initially identified on 12 February.) A month later on 22 April, he attended an appointment with a doctor at hospital.

30. The hospital doctor wrote to the prison healthcare team on 13 May indicating that the man's weight loss was probably due to the treatment he was receiving in relation to his coronary heart disease. However, in order to rule out the possibility of cancer, he recommended that a computerised tomography (CT) scan be carried out. (This type of scan helps medical staff to see what is happening inside a patient's body.)

31. The CT scan took place at the hospital on 15 May. My Investigator has been unable to locate the results of this scan. They do not appear to have been added to the man's medical record. However, a subsequent letter from the hospital referred to the results as being 'essentially normal'.

32. At the end of June, the man suffered a heart attack. He reported arm and shoulder pain and breathlessness and was admitted to hospital at 7.45am on 30 June. He stayed at the hospital (which is just across the road from the prison) until 3 July when he discharged himself against medical advice and returned to Winchester. He was told that he risked suffering another heart attack by going against the doctors' advice. He was found to be profoundly anaemic, having stopped taking iron supplements in April because they were upsetting his digestion. He was admitted to the healthcare centre when he returned to the prison.

33. A few weeks later, on 8 August, the man attended the medical imaging department at hospital to have his arteries examined. The results of this assessment are not evident in his medical record. He returned to mainstream prison life from the healthcare centre on 11 August. Some weeks later, he attended appointments at the gastroenterology department on 29 September and the medical imaging department at the hospital on 7 October. During the latter appointment his knee was x-rayed.

34. The man suffered a second heart attack in custody on 17 October. He had arrived in the healthcare centre for a doctor's appointment when he collapsed in the corridor. He was initially unresponsive when staff reached him and a defibrillator was used to administer an electrical shock to his heart. A doctor, two nursing staff and the acting Head of Healthcare spent several minutes

resuscitating him. He was successfully revived and was taken to hospital where he stayed for a week.

35. Once again, the man chose to discharge himself against medical advice on 24 October. He had lengthy discussions with the doctors and was made aware that he was risking his health by leaving the hospital. He was advised to undergo an angiogram (this procedure allows a doctor to examine a patient's arteries to check the extent of their heart disease). He refused and returned to the prison.

36. Having spoken with nursing staff, my Investigator has ascertained that the man remained relatively mobile, independent and in good spirits during the next few months. The acting Head of Healthcare said that he had essentially returned to normal life on the wing, but they had talked about his ongoing heart condition.

37. The man was prescribed simvastatin (used to treat high cholesterol and heart disease) in addition to his other medications on 11 December. An angiogram was ordered on the same day, and took place on 7 January 2009 at a hospital in Basingstoke. The results of the examination showed single vessel coronary artery disease, and further treatment was recommended.

38. Later that month (14 January 2009), the man failed to attend an appointment at the prison's cardiac clinic. A few days later, on 18 January, he reported having pain in his upper right leg after a catheter was inserted (this is a tube allowing the injection or drainage of fluids). Near the end of the month, on 27 January, he kept a further appointment at the prison's cardiac clinic. He continued to be prescribed digoxin, metoprolol, ramipril, aspirin, furosemide and ferrous sulphate.

39. At about 7.30pm on 5 February, the man spent time with one of the prison visitors (volunteers who agree to spend time with prisoners who do not have regular visits from family or friends). This was the third time that she had methim . She found him in good spirits and told my Investigator that he had been 'his normal self'. He did not report any pain to her. (The prison visitor was very surprised when she heard that he had died.)

40. As is normal for a Friday afternoon, the man was locked in his cell on B2 landing after lunch. There is a minimum of activity available to prisoners on Friday afternoons at Winchester. (From Monday to Thursday the man would have had the opportunity to attend education classes in the afternoon.) On that day, he would have been offered the chance to exercise between 8.30am and 9.15am, but he did not usually attend these sessions because of his health problems. During the morning he would have spent a small amount of time on association with other prisoners. He would have been unlocked for lunch at 11.45am, but then locked up for the afternoon at 12.30pm. He was not due to be unlocked again until between 4.30pm and 5.00pm for the evening meal. It was during this period that he collapsed in his cell.

41. The man's cellmate had moved out a couple of days previously and another had not yet been allocated, so he was alone in a dual occupancy cell. An officer discovered him at 4.49pm. Timings vary across the different statements staff provided, so I have chosen to refer to the daily events log recorded in the control room. Regardless of the different accounts provided, it is agreed that about 25 minutes passed between the man being found and the paramedics certifying his death.

42. As he unlocked the man's cell, the officer could not see him either sitting on the bed or standing up. He knew he was supposed to be in his cell so he looked carefully and realised that the man was lying on his side on the floor at the back of his cell near the washbasin. He was obscured by a cabinet (which had been placed next to the bed to place a mug of tea on), but the officer could see part of the man's bare legs through the gap. It was thought he had been washing himself at the basin because he was naked from the waist down. Having raised the alarm, the officer was joined by another officer who was working with him on the landing.

43. The officers entered and found the man to be cold to the touch. There was vomit by his mouth. Using his radio, the first officer notified the control room of a 'code 1' emergency on B wing. (A 'code 1' requires healthcare staff to respond immediately.)

44. The second officer shook the man and called his name, but he did not respond. She tilted his head because she was worried about him choking on vomit. A Senior Officer (SO) and a third officer arrived and began removing other prisoners from the area around the cell.

45. About two minutes after the first officer found the man, he contacted the control room again by radio to request an emergency ambulance. A minute later, two staff nurses arrived at the cell and started to try to resuscitate the man. The first nurse brought an emergency bag with him from the central treatment area. Neither nurse could find either a pulse or signs of life. They placed the man on his back in order to start cardio-pulmonary resuscitation (CPR). The first nurse began chest compressions.

46. A third staff nurse entered the cell at about 4.53pm and took over from the second nurse. Assisting the first nurse, the third nurse inserted a plastic airway into the man's throat (this keeps the windpipe clear of obstructions) and then used an ambu-bag (a device consisting of an air bag attached to a mask designed to assist breathing) to help get oxygen to his lungs.

47. When the man was discovered, another nurse was working in the detoxification unit. As a 'detox' nurse, she was not necessarily required to provide the initial response to an emergency, but would volunteer to assist. Her manager carried the only radio in their department and was in the bathroom when the call came through. The detox nurse did not therefore hear the request for an emergency response. However, very shortly afterwards she answered the telephone and spoke to a member of staff who she thought worked in the control room. She was asked to go to B wing to

see a patient, but did not feel that the request was urgent. However, she walked swiftly across to the wing and found the emergency unfolding.

48. Entering the cell at about the same time as the third nurse, the detox nurse took over from the first nurse and continued chest compressions in an attempt to resuscitate the man. She asked for a defibrillator to be brought and the second nurse went to collect one. Very shortly after the detox nurse, a Principal Officer (PO) arrived and instructed any prison officers present to withdraw from the cell to let the healthcare staff continue their work.

49. The manager of the detoxification unit had followed the detox nurse onto the wing, and contacted the control room on her radio to ensure that an ambulance had been called (which it had). She then began recording a log of events as no prison staff had yet done this. At about 4.55pm, the acting Head of Healthcare arrived on the wing.

50. A minute later, the ambulance pulled up outside the gate lodge. However, it seems that the vehicle may not have been immediately spotted by staff inside the lodge. (The paramedics complained to the first nurse after the emergency was over that they encountered a delay in gaining access to the prison.)

51. The duty gatekeeper that day recalled that the ambulance could not be ushered immediately through into the prison courtyard as there was no room for it. Winchester is an old Victorian prison with a small interior area for vehicles. As it was around 5.00pm on a Friday afternoon, escort vehicles had filled the yard having returned with prisoners from the local courts. The duty gatekeeper said that the paramedics had to park the ambulance on the driveway outside, collect their kit and be escorted into the prison on foot. He estimated that a two or three minute delay may have resulted.

52. At about the same time as the paramedics arrived at the gate, the duty governor reached the man's cell. He was in the healthcare centre some way from the wing when the 'code 1' came over the radio. The PO told him what had happened so far and advised that the nurses thought it highly likely that the man was already dead, having probably collapsed some time earlier whilst alone in his cell. The duty governor spoke with the two officers who had initially found the man to check on their wellbeing. In the knowledge that the man was very unlikely to be resuscitated, he then left the wing and went to the control room to put in place the contingency plan that has to be initiated when a prisoner dies.

53. During the next few minutes, before the paramedics reached the wing, staff continued their efforts to resuscitate the man but got no response. The first nurse attached the defibrillator (which had now been brought to the cell) to him but, as the machine indicated that no heart rhythm was detected and that no shock should be administered, manual resuscitation was continued.

54. The paramedics arrived in the cell at approximately 5.10pm. The first nurse told them how long staff had been attempting to resuscitate the man, and the paramedics asked them to continue for five more minutes while they

completed their assessment. Having examined him, they confirmed that resuscitation should stop and he was declared dead at about 5.15pm.

55. The first nurse covered the man lower half to preserve his dignity. The prison chaplain (a Methodist minister) asked to say a prayer for him in his cell. The duty governor ensured that the cell was sealed until the Coroner's officer and the police arrived. Prisoners in neighbouring cells were offered the chance to speak to Listeners (prisoners trained by the Samaritans who offer support to others in distress) and to move cells, but they declined to do so. Other prisoners who were close to the man were also given the opportunity to speak with Listeners, and some took up this offer.

56. Within an hour, the police and the Coroner's officer arrived. At 5.50pm, the Care Team Leader held a 'hot debrief' for all staff involved in the response to the man's collapse. (The debrief gives staff the chance to have an initial discussion about the emergency and reflect on how the response was handled.)

57. The duty governor began the process of contacting the man's sister, his nominated next of kin. Because of poor weather, the distance to the sister's home, the relatively late time and a lack of immediate availability amongst his staff, he contacted the duty governor at HMP Belmarsh. The duty governor asked for one of that prison's Family Liaison Officers (FLO) to visit the man's sister to break the news to her as Belmarsh was local to her home address.

58. However, one FLO at Belmarsh was on leave and the other could not be contacted. Staff therefore arranged for the local police to go to the man's sister's home. When the duty governor realised that the staff at Belmarsh had made this decision, he tried to contact the police officers to prevent them from reaching the man's sister. He planned for Winchester's FLO to travel to speak with her early the next day. Unfortunately, he was unable to get in touch with the police officers before they reached the man's sister's home. (Although the man's sister did not complain about being told by the police, it is self-evidently preferable – and in line with Prison Service policy –that, wherever possible, it should be prison staff who break the news of a death to relatives.)

59. At about 8.00pm, having been provided with the duty governor's contact details by the police officers, the man's sister telephoned the prison and spoke with him. He organised for Winchester's FLO, along with the chaplain, to visit her the next day. The man's sister later told my FLO that she had appreciated the support she received from prison staff following her brother's death.

60. The deputy governor wrote to the man's sister expressing his condolences on Monday 9 February. The funeral (paid for by Winchester in accordance with Prison Service policy) was held on 20 February in East London, with the prison FLO attending on behalf of the prison. The man's sister told the Ombudsman's FLO that the funeral had been 'wonderful'. A memorial service was held at Winchester on 3 March.

61. The post mortem report confirmed that the man died as a result of heart disease. The duty governor told my investigator that a critical incident debrief (intended to offer staff a fuller opportunity to learn lessons from the way the emergency was dealt with) was scheduled by the prison management team but was cancelled because nobody wished to attend.

ISSUES

Clinical care

62. The man had suffered two heart attacks in June and October 2008. On both occasions he discharged himself from hospital a few days later against medical advice. He underwent several investigative procedures whilst in custody and took a significant amount of prescribed medication to try to manage his heart disease.

63. In September 2007, the man was referred to hospital by a doctor at Winchester, and a similar referral was completed at Belmarsh in January 2008. On both occasions the intended referral did not take place because he transferred to a different prison. A referral to a specialist was subsequently made successfully whilst he was at Winchester in April 2008. The clinical reviewer has found that the failure to complete hospital referrals as a result of the man being transferred between prisons did not have an adverse effect on his heart condition.

64. The clinical reviewer concludes that the type of heart disease which the man was diagnosed with could not have been successfully treated by surgical intervention. In other words, his condition could only be managed with drugs and check ups. He finds that the man had 'significant pre-existing health problems'. He praises the healthcare staff who successfully resuscitated him after his second heart attack, noting that this was a relatively rare outcome when a patient collapses outside a hospital setting. His final heart attack, whilst sudden, was not unexpected in the wider context of his ill health.

65. Having reviewed the care the man received, the clinical reviewer expresses some concerns. He has examined the code system that officers used on 6 February to communicate over the radio net that the emergency was in progress. Winchester uses the following codes:

- Code 1 – indicates a life threatening situation, for example a prisoner found hanging or having a heart attack

- Code 2 – indicates serious but not life threatening situations, for example a prisoner having an epileptic fit or harming themselves

- Code 3 – indicates less serious incidents, for example a prisoner feeling very ill.

66. Many other prisons use the terms 'code blue' (indicating the prisoner is not breathing) or 'code red' (indicating that the prisoner is bleeding) during an emergency. There was some discussion at the 'hot debrief' meeting after the man died regarding the potential use of a colour coded system.

67. In the recently issued draft report of my investigation into the death of another prisoner at Winchester, I recommended that the Governor and the Head of Healthcare consider introducing a colour coded communication system during

the response to an emergency. I will not repeat the recommendation in this report, as the prison has not yet had the opportunity to carry out the necessary review of its procedures.

68. With regard to the emergency response bag that staff collect on their way to the scene of an emergency, the clinical reviewer notes that a defibrillator had to be fetched separately once nurses had begun working on the man. It was not brought with the bag. Whilst this did not affect the chances of resuscitating him, I make the following recommendation:

Healthcare staff should ensure that a defibrillator is always brought with the emergency response bag when responding to a 'code 1' call.

69. When the man collapsed, all available healthcare staff made their way to the cell. The clinical reviewer is concerned that, unusually, no particular members of the medical team seem to have been designated as the emergency responders. A call sign such as 'Hotel 1' is often allocated to nursing staff in prisons to clarify whose responsibility it is to provide the initial response. A specific radio is allocated to that member of staff:

The Head of Healthcare should confirm that a protocol is in place to ensure that a member of nursing staff is always designated as the 'first responder' in the event of a 'code 1' emergency.

70. The clinical reviewer comments on the fact that the officers who found the man did not attempt to resuscitate him, but waited for healthcare staff to arrive. It does not appear that this delay of perhaps two minutes proved decisive, as he had collapsed during the afternoon, and in all likelihood the subsequent attempts by the nursing staff to revive him had no chance of success. Nonetheless, early intervention by those members of staff who find a prisoner collapsed may prove critical in future, and I make the following recommendation:

The Governor and the Head of Healthcare should consider whether to offer some prison officers training in cardiopulmonary resuscitation.

Delay in paramedics entering the prison

71. Both the first nurse and the detox nurse told my Investigator that the paramedics who attended the emergency complained they had encountered a delay in gaining access to the prison. The record of events kept in the control room indicates that the ambulance arrived at the prison gate at 4.56pm, approximately five minutes after it was requested. Healthcare staff continued to work on the man until about 5.15pm. It would seem that some minutes may have passed before the paramedics were able to gain access to the prison. The ambulance's arrival and departure is not recorded in the Gatekeeper's Daily Occurrence Book (although the subsequent arrival of the undertaker is noted).

72. My Investigator spoke with the duty gatekeeper on 6 February. All official visitors to the prison must pass through the gate, either on foot or in a vehicle. He was therefore responsible for ensuring that the paramedics were admitted to the prison as rapidly as possible. He was not aware of any complaints from the paramedics during the emergency.

73. When the duty gatekeeper spoke with my Investigator, they discussed the possibility of gate staff not responding immediately to the arrival of the ambulance. He confirmed that he and his colleagues would have been able to follow the emergency progressing over the radio. Although they would not have heard the first officer's initial calling through of a 'code 1' emergency, all subsequent transmissions from both the control room and B wing would have been heard in the gate after the control room switched all radios to 'talk through' mode (meaning that staff equipped with radios could hear both sides of the conversation).

74. Because a 'code 1' emergency was in progress, gate staff could reasonably have anticipated that an ambulance would be called. They would have heard staff on B wing request an ambulance over the radio. The control room would have advised gate staff when an ambulance was on its way. The duty gatekeeper confirmed that the control room (which has a monitor linked to a CCTV camera trained on the barrier by the main road) would also have advised the gate staff when an ambulance entered the prison grounds.

75. With regard to the delay in admitting the paramedics, the duty governor thought that the response from the ambulance service was so rapid that staff in the control room might not have had time to properly brief gate staff. (The hospital is located across the road from the prison.) However, given that seven minutes passed between the first officer finding the man and the ambulance arriving (and that gate staff should have been listening to their radios throughout), staff in both the gate and the control room must have known that an emergency was unfolding. They would have known that the hospital was very close by and that an ambulance could therefore be anticipated imminently.

76. The duty gatekeeper was unable to recall events in February with complete clarity. He thought that the paramedics had had to be admitted to the prison on foot because there was no room for the ambulance in the prison's courtyard. As I have noted earlier, he said that because it was about 5.00pm on a Friday afternoon when the ambulance arrived, the yard would have been full of cellular vehicles bringing prisoners back from court appearances. He explained that this can be the busiest time of the week in terms of traffic entering the prison. He commented that it would not have been practical either in terms of security or time to remove an escort vehicle from the yard in order to admit the ambulance.

77. Because the ambulance could not be admitted to the prison, the duty gatekeeper accepted that there had probably been a two or three minute delay whilst the paramedics collected their equipment and were walked

through to B wing. To the best of his recollection, he estimated that the paramedics reached B wing within five minutes of their arrival.

78. My Investigator asked the duty gatekeeper to explain why there might have been some delay in staff noticing that an ambulance had pulled up outside the gate. When the paramedics arrived, he thought that a member of staff behind the large gate (through which vehicles pass) would have looked through an observation flap. He said that they would then have left the gate, approached the ambulance and instructed the paramedics to park the vehicle and walk into the prison because the yard was full.

79. The gate lodge is directly adjacent to the gate itself. It has no windows facing onto the driveway where vehicles pull up. I gather that the gate was redesigned in the last two years. Unfortunately, this refit has not resulted in staff having an awareness of the 'outside world'. This has implications for the admittance of ambulances or other vehicles during an emergency.

80. My Investigator visited the gate lodge and confirmed that only one of its two CCTV monitors was working at that time. The monitor that did work showed an obscured view of the barrier next to the main road which would allow staff to glimpse an ambulance entering the grounds. The broken monitor is supposed to show a view of the gate and would have alerted staff to the ambulance's arrival.

81. Staff cannot see a vehicle either waiting to gain entry to the prison or approaching down the driveway from inside the gate lodge. The duty gatekeeper accepted that paramedics would need to activate flashing blue lights and a siren to ensure that their arrival was noticed. At present, it seems that the gate staff rely heavily on the control room, located inside the prison in a basement area, to tell them what is happening out on the driveway. Staff in the control room can see a CCTV image of vehicles waiting outside the gate (which gate staff are supposed to be able to look at).

82. From all the accounts given by staff who tried to resuscitate the man, it would seem that he had collapsed some time before he was found, and that it was highly unlikely from the moment he was discovered that he could be revived. Whilst the delay in admitting the paramedics to the prison on this occasion did not in all likelihood affect the outcome, such a delay might prove crucial in future. Given the proximity of the hospital, it might be advisable for a member of the gate staff to stand on the driveway to await the ambulance as soon as a 'code 1' emergency is underway. The poor state of repair of the monitor in the gate lodge will need to be addressed urgently to ensure that staff are properly able to carry out their duties:

The Governor and the Head of Healthcare should establish a protocol with regard to the admission of ambulances to the prison. Gate staff should expect an ambulance as soon as a 'code 1' emergency begins and paramedics should be escorted into the prison without delay.

The monitor in the gate lodge should be fixed as a matter of urgency.

The arrival and departure times of all parties involved in an emergency should be accurately recorded in the Gatekeeper's Daily Occurrence Book.

Communication during the emergency

83. After the 'code 1' emergency was transmitted to staff over their radios, the manager of the detoxification unit told the control room that she could not go immediately to B wing because she was in the bathroom. She asked control room staff to contact her colleague by telephone. She had with her the only radio in the detoxification unit, so the nurse was not yet aware of the emergency.

84. The detox nurse answered the telephone in the office. She felt that there was a lack of urgency in the conversation that followed. She told my Investigator that the member of staff to whom she spoke (who she presumed was calling from the control room) had said, 'Could you go and help on B wing?' The fact that a 'code 1' had been given was not stated during the telephone call. Fortunately, she made her way to B wing without delay and was able to assist her colleagues. I gather that an additional radio has now been provided in the detoxification unit and she told my Investigator that she now feels better equipped:

During an emergency, control room staff should ensure that 'code 1' is stated not only over the radio but also during all related telephone calls.

Incomplete medical record

85. Having examined the man's medical record, my Investigator and the clinical reviewer both found that several important pieces of information were missing. For example, the man underwent a CT scan on 15 May 2008 to rule out the possibility that he might have cancer. The results of this test are not recorded in the medical record, although subsequent correspondence would seem to indicate that the scan gave no cause for concern.

86. As noted, the man suffered two heart attacks in Winchester on 30 June and 17 October 2008, both of which led to hospital admissions. The clinical reviewer expected to find more detail regarding these incidents within the medical record so that healthcare staff had access to a full picture of his condition. However, information is only relatively briefly recorded.

87. The second heart attack in October 2008 was extremely serious and the man had to be resuscitated. When my Investigator interviewed the acting Head of Healthcare at the time she said that she had asked the doctor present during the emergency to record what happened.

88. Although the documentation of a 'bed watch' (a prisoner's stay in hospital whilst accompanied by prison officers) is not the responsibility of the healthcare department, I note that my Investigator could find no evidence of a

log being kept during the man's stay in hospital after his first heart attack between 30 June and 3 July 2008. It would seem that this paperwork may have been mislaid.

89. With regard to the missing documents, all prisoners' medical records are now stored electronically. The acting Head of Healthcare confirmed that any letters or test results from the hospital are shredded after being scanned into the computer. She was not aware of this procedure until she checked during my Investigator's visit. She agreed that there is considerable room for improvement with regard to the upkeep and maintenance of medical records. She accepted that documentation is not one of the healthcare department's strengths. I note that I have previously made a recommendation regarding the poor standard of medical record keeping at Winchester.

90. She speculated that the missing documents might not have been scanned into the electronic record keeping system, might have been lost, or might not have been received in the post in the first place. If the latter is the case, staff should have contacted the hospital to obtain the man's test results. The clinical reviewer notes in his clinical review that letters received from the hospital were often not date stamped as they should have been, and that the quality of prisoners' medical records at Winchester 'remains a concern' and falls below the normal standard found in general practice surgeries in the community:

Comprehensive notes should be made in a prisoner's medical record by the healthcare staff involved if a prisoner is taken to hospital unexpectedly.

The Head of Healthcare should train all staff in proper record keeping to bring the standard up to that found in community general practice.

All medical documentation should be scanned into the electronic record keeping system and the originals kept for a reasonable period of time agreed by the Governor and the Head of Healthcare.

Emergency log

91. When a death in custody occurs, a member of prison staff is required to complete a detailed log of events. When the man died a member of healthcare staff kept this record. Her colleague told my Investigator that her manager had stepped in because the officers present did not seem to be aware that a minute by minute record of events needed to be maintained:

The Governor should ensure that all discipline staff are aware that a log of events should be kept as soon as a 'code 1' emergency begins.

Lack of reception health screening

92. The then acting Head of Healthcare has confirmed that there is no record of a first reception health screening being carried out when the man arrived at

Winchester on 1 February 2008. The only entry on his medical record is a confirmation of the medication he was taking. There is no record of any self-reported health problems upon arriving at the prison. When my Investigator discussed this matter with healthcare staff, it was thought that a full screening might not have been carried out because the man had been held in Winchester a few months previously and his records were therefore perceived to be 'up to date'. This is not best practice since a prisoner's health can change rapidly, particularly when they have chronic health problems like his. Prison Service Order 3050 states that:

> 'Receiving a new prisoner, following transfer, is equivalent to registering with a new NHS primary care practice … There are good reasons in the prison system to ensure that prisoners are seen by a member of the healthcare team before the prisoner's first night of arrival …'

93. I have raised the same concern regarding the importance of completing a first reception health screening during *six* previous investigations of deaths in custody. I must once again repeat my recommendation:

The Head of Healthcare should remind all staff that every prisoner should undergo a new first reception health screening each time they transfer into Winchester.

Notifying the next of kin

94. As I have detailed, due to the time of night, the poor weather and the distance involved, the duty governor decided to ask a Family Liaison Officer (FLO) from Belmarsh to visit the man's sister to break the news of his death. Unfortunately, the duty governor at Belmarsh was unable to locate an available FLO and instead asked the local police to visit the man's next of kin. The duty governor attempted to stop the police from going to the address, because he was aware that a representative from the Prison Service is supposed to perform this duty wherever possible. However, he was unable to contact the police in time. The man's sister does not appear to have been troubled by the way the news was broken to her. She rang the duty governor for more information straight after the police had left her, and the next day the FLO and chaplain from Winchester visited her.

95. The duty governor took the opportunity to express his regret regarding the way the news was broken when he spoke to my Investigator. It would seem that he contacted staff at Belmarsh with the best of intentions. He is of the opinion that staff there thought they were doing the right thing by asking the police to break the news when they could not locate an available FLO. I consider that the actions of all staff involved were both well-intended and entirely reasonable in the circumstances.

Staff support

96. At the time the man died, the first nurse was a relatively newly qualified member of staff and the emergency on 6 February was the first time he was required to deal with a death in custody. He told my investigator that he had felt supported by prison staff at the 'hot debrief' that took place later the same day. (The 'hot debrief' meeting allows staff involved to discuss how the emergency was dealt with and to address any immediate lessons to be learnt.)

97. However, the nurse did not seem to feel sufficiently supported by his own healthcare team in the weeks after the man died. Additionally, once the debrief was over, he was not taken off duty, and had to carry on working his shift until 9.00pm with only one other healthcare colleague present (who had not been involved in the emergency). Although he was somewhat disappointed at a perceived lack of support from his manager, he was pleased with a letter he received from management within the Primary Care Trust itself.

98. The third nurse also remarked upon a perceived lack of support available to less experienced nurses within the team. He thought that they would have to ask for help if they needed it. However, he was keen to praise the response from the care team (designated members of staff who can be approached by those who require support following an emergency).

99. The reason that the first nurse may have perceived a lack of support from the acting Head of Healthcare at the time was that she did not even realise that he had been involved in the attempt to resuscitate the man. She told my Investigator that, by the time she arrived on B wing, the nurse had stepped out of the cell and the third and fourth nurses were attempting to resuscitate the man. She did not observe the first nurse in the cell, and thus did not register that he had been the first member of healthcare staff to arrive on B wing and start resuscitation. She only discovered this some while later whilst speaking with another member of staff, who happened to be the first nurse's wife.

100. The acting Head of Healthcare left work for the day very soon after the man was declared dead. She told my investigator that this was because of childcare responsibilities. She did not attend the 'hot debrief' with other healthcare staff where she would have learnt of the first nurse's involvement. She did ask her staff if they were 'okay' before she left, but does not seem to have accounted for who precisely was involved. She accepts that she did not read the minutes of the 'hot debrief', and therefore missed another chance to pick up on the first nurse's involvement.

101. It seems that the first nurse was quite deeply affected by the man's death. He had known him quite well and this was the first time he had had to resuscitate a prisoner. The acting Head of Healthcare was unaware that the nurse had no previous experience of a death in custody. She accepts that this was an

oversight on her part. She recognises that she could have offered more support to staff.

102. She took the first nurse at his word when she subsequently asked him if he was 'fine' and he told her that he was. Some staff involved in traumatic incidents may find it difficult to express how they are really feeling. She told my investigator that she generally expects staff to ask for help if they need it:

The Head of Healthcare should ensure that arrangements are in place so that staff who have attempted resuscitation during a death in custody should not carry on working their shift if they do not wish to do so.

The Head of Healthcare should attend the 'hot debrief' after a death in custody where possible and/or should read any published minutes. They should make every effort to establish which staff were present at the emergency to ensure they get offered the support they need.

Cell allocation and personal alarms

103. The man was by himself in a double occupancy cell when he collapsed. It was thought by all staff involved in responding to the emergency that he had suffered a heart attack quite some while before he was found, as he was cold to the touch. My investigator was told that the man's cellmate had moved out a couple of days before he died. Another prisoner had not yet been allocated to the cell.

104. There are a number of reasons why prisoners might be alone in their cells. For example, some prisons have far more single cell accommodation than Winchester. Whilst I do not make a formal recommendation on this matter, the Governor and the Head of Healthcare may wish to consider how they ensure that those prisoners such as the man, who have a history of serious ill health, are not left alone unnecessarily. He had suffered two heart attacks in the previous eight months and it would perhaps have been sensible for him to have some company whilst locked up for the whole afternoon.

105. The management team may also wish to consider issuing prisoners like the man with a pendant alarm. The pendant is intended to be worn around the neck and allows elderly or infirm prisoners to raise the alarm if they collapse. This is a new initiative that has recently been introduced at HMP Shepton Mallet:

The Race and Equality Action Group (REAG) and Offender Health should consider if the provision of pendant alarms for elderly or infirm prisoners needs to be the subject of national guidance.

CONCLUSION

106. From the interviews my Investigator has conducted, I am satisfied that the response to the man's collapse was carried out in a professional and calm manner. The third nurse was singled out by his colleagues for particular praise, and the Governor and PCT should consider if his actions should be formally recognised.

107. Despite staff's best efforts, all who attended thought that the man had collapsed in his cell quite some time before he was found, and therefore the chances of resuscitating him were very remote. He had a history of health problems and this was the third time he had suffered a heart attack in eight months. Whilst nothing could be done to prevent his death, I hope that lessons can be learnt from this investigation. In particular, aspects of the provision of healthcare at Winchester require immediate attention.

RECOMMENDATIONS

1. Healthcare staff should ensure that a defibrillator is always brought with the emergency response bag when responding to a 'code 1' call.

   The prison accepted this recommendation. The Head of Healthcare agreed to implement this measure after briefing their staff.

2. The Head of Healthcare should confirm that a protocol is in place to ensure that a member of nursing staff is always designated as the 'first responder' in the event of a 'code 1' emergency.

   The prison accepted this recommendation. The Head of Healthcare confirmed that staff will ensure that the first responder is always clearly identified at the handover between shifts.

3. The Governor and the Head of Healthcare should consider whether to offer some prison officers training in cardiopulmonary resuscitation.

   The prison partially accepted this recommendation. The Head of Operations and the Head of Healthcare will discuss the feasibility of and need for officers to be trained in cardio-pulmonary resuscitation.

4. The Governor and the Head of Healthcare should establish a protocol with regard to the admission of ambulances to the prison. Gate staff should expect an ambulance as soon as a 'code 1' emergency begins and paramedics should be escorted into the prison without delay.

   The prison accepted this recommendation. The Head of Healthcare and the Head of Operations have agreed to introduce a new protocol for the admission of an ambulance to the prison when a 'code 1' emergency begins.

5. The monitor in the gate lodge should be fixed as a matter of urgency.

   The prison accepted this recommendation and confirmed that the monitor is now in working order.

6. The arrival and departure times of all parties involved in an emergency should be accurately recorded in the Gatekeeper's Daily Occurrence Book.

   The prison accepted this recommendation. Staff will be briefed on the importance of correctly recording movements through the gate lodge. The recording of information in the Daily Occurrence Book will be monitored.

7. During an emergency, control room staff should ensure that 'code 1' is stated not only over the radio but also during all related telephone calls.

   The prison accepted this recommendation. The Governor will instruct control room staff to correctly inform colleagues being sent to an emergency of the nature of the incident they are responding too.

8. Comprehensive notes should be made in a prisoner's medical record by the healthcare staff involved if a prisoner is taken to hospital unexpectedly.

   The prison accepted this recommendation. Staff have been told how to complete full and proper entries in a prisoner's medical record. Regular management checks will be implemented to ensure that this is being done.

9. The Head of Healthcare should train all staff in proper record keeping to bring the standard up to that found in community general practice.

   The prison accepted this recommendation. Further IT training for healthcare staff is planned throughout 2009 - 2010. It is expected that a new electronic patient record keeping system will be introduced in 2010.

10. All medical documentation should be scanned into the electronic record keeping system and the originals kept for a reasonable period of time agreed by the Governor and the Head of Healthcare.

    The prison accepted this recommendation. The Head of Healthcare agreed to discuss a reasonable timescale with the Primary Care Trust's records management department. More training for staff with regard to scanning is planned for 2009 - 2010.

11. The Governor should ensure that all discipline staff are aware that a log of events should be kept as soon as a 'code 1' emergency begins.

    The prison accepted this recommendation. The Governor agreed to publish a notice to staff to ensure they are aware of their responsibilities when dealing with this type of incident.

12. The Head of Healthcare should remind all staff that every prisoner should undergo a new first reception health screening each time they transfer into Winchester.

    The prison accepted this recommendation. The Head of Healthcare confirmed that first reception health screenings are taking place. Regular management checks are to be implemented to ensure they are being completed in the case of every prisoner who transfers into Winchester.

13. The Head of Healthcare should ensure that arrangements are in place so that staff who have attempted resuscitation during a death in custody should not carry on working their shift if they do not wish to do so.

    The prison accepted this recommendation. The Head of Healthcare confirmed that this staff welfare measure falls within the wellness checks provided by the Primary Care Trust and that debriefs are taking place as required.

14. The Head of Healthcare should attend the 'hot debrief' after a death in custody where possible and/or should read any published minutes. They

should make every effort to establish which staff were present at the emergency to ensure they get offered the support they need.

The prison accepted this recommendation. The permanent Head of Healthcare is now back in post and has agreed to implement the suggested measures.

15. The Race and Equality Action Group (REAG) and Offender Health should consider if the provision of pendant alarms for elderly or infirm prisoners needs to be the subject of national guidance.

Because this recommendation was initially addressed to the NOMS Safer Custody and Policy Group, REAG and Offender Health did not have the opportunity to respond to the recommendation before the final report was published.

THE RESPONSE OF THE FAMILY TO THE DRAFT REPORT

The man's sister, along with other family members, read the draft report. She told the Ombudsman's FLO that some family members were concerned that he had collapsed alone in his cell during the afternoon and had not been found for some time. However, her own view was that prison staff had done what they could for her brother. The man's sister said she was interested to read the Ombudsman's findings and recommendations. She expressed the hope that improvements would be made at Winchester and that other prisoners would benefit from these changes. She thought that the Ombudsman's recommendations adequately reflected the concerns she and her family had had.