Investigation into the circumstances surrounding the death of a man at the a local hospital, whilst in the custody of HMP Winchester, in March 2010

Report by the Prisons and Probation Ombudsman for England and Wales

November 2010

This is the report of an investigation into the circumstances of the death of a male prisoner at HMP Winchester on 24 March 2010. The man had a long history of chronic obstructive pulmonary disease (COPD) and had undergone a tracheotomy in 2008 as part of treatment for the condition. A post mortem found that the main cause of death was broncho pneumonia and COPD. I would like to offer my sincere condolences to the man's family and all those who knew him and were affected by his death.

An investigator from my office conducted the investigation. An independent review of the man's medical care was undertaken by a panel led by a doctor who is an Associate Clinical Director at NHS Hampshire, together with two colleagues. I am grateful for their contribution. I am also indebted to the Clinical Manager from National Patient Safety Agency, for her Root Cause Analysis Investigation Report which contributed to the review.

I would also like to thank the Governor of Winchester, his staff and prisoners on D wing where the man lived, for their assistance. I am particularly grateful to the liaison officer for a very high standard of liaison with my office.

One of my family liaison officers contacted the family. The man's daughter did not wish to raise any issues regarding her father's care at Winchester.

I judge that the man's death could not have been anticipated or prevented. However, nursing and clinical staff were not proactive in his care. This may not have affected the circumstances of the man's death, but may prove critical in the future. I make five recommendations. The majority relate to clinical issues highlighted by the clinical review panel such as the need for better clinical record keeping and the provision of a specialist respiratory nurse. There is a need for a protocol on the admission and discharge of prisoners to hospital and prison healthcare staff should provide a full medical history to ambulance staff. My report will be drawn to the attention of the South Central Ambulance Service Trust. I have also asked for consideration of a multi-agency action plan to manage imminent deaths events. I hope that the necessary changes in practice identified in the clinical review and this report are adopted.

I am pleased to commend the actions of a nurse who, in the face of resistance, steadfastly insisted that the man be taken to hospital when his condition deteriorated a few months before his death. I also acknowledge the foresight and planning of the duty governor when the man died, in respect of support for staff and the man's next of kin.

The family's response to the report is documented on page 20 of the report. The National Offender Management Service has accepted the recommendations and commendation and their response can also be found on page 20 of my report.

Jane Webb
Acting Prisons and Probation Ombudsman **November 2010**

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SUMMARY

The man had served five months of a 16 month prison sentence when he died on 24 March 2010. He had a long history of lung disease and had been unable to work since 2003.

When he arrived at Winchester on 2 October 2009, the man gave nursing staff a past history of gastrointestinal disease[1] and palpitations on breathing. He had suffered from chronic obstructive pulmonary disease (COPD)[2] and had undergone a tracheotomy[3] in an intensive care unit. The investigation found that, despite giving this history, he did not see a prison doctor until 12 October. The man was initially accommodated in the healthcare centre, but later moved to a residential wing.

On 30 December, the man's condition deteriorated and an ambulance was called. The paramedics thought that he was suffering from a chest infection and initially refused to take him to hospital. However, the duty nurse insisted that a prison doctor give a second opinion and they were then persuaded of the seriousness of his condition. I have commended the nurse for her actions. The man was discharged from hospital three weeks later. He was sent to the wing as a bed was not available in the healthcare centre. The Clinical review panel were critical of the lack of communication between the prison and the hospital and I have therefore made a recommendation in this regard.

The man's condition deteriorated again on 20 March, and he was admitted to hospital as an emergency. The following day it became clear to prison staff that he was terminally ill. In light of his condition, a risk assessment was carried out and his restraints were removed on 22 March. During the final days of the man's life, the prison contacted HMP Liverpool who agreed to send family liaison officers to give the man's daughter the news of his death. This was good practice. The man died on 24 March. The family liaison officers from HMP Liverpool visited the man's daughter to break the news of his death. Two members of staff from Winchester visited her the following day.

The clinical review panel has judged that, while not affecting the outcome, some aspects of the man's care fell short of the standard expected and was not proactive. I make five recommendations regarding record keeping, the admission and discharge of prisoners from hospital, the provision of relevant information to the ambulance service and increasing the healthcare department's expertise in managing prisoners with chronic respiratory conditions. During the hot debrief, staff suggested an action plan to manage the imminent death of a prisoner. I have also made a recommendation in this regard.

[1] Gastrointestinal disease is disease of the stomach, colon, bowels, or rectum.

[2] Chronic obstructive pulmonary disease is a non reversible lung disease that is a combination of emphysema and chronic bronchitis; usually patients have been heavy cigarette smokers.

[3] A tracheotomy is a surgical operation that creates an opening in the windpipe to assist breathing.

INVESTIGATION PROCESS

1. The man died on 24 March 2010. I was notified of his death later the same day. Terms of reference and notices were issued to staff and prisoners at Winchester telling them that an investigation would be taking place, and inviting those who wished to see the investigator, to make themselves known. The investigator requested copies of the man's core record, clinical record, and other records relevant to his time in custody and his death.

2. My investigator also contacted HM Coroner to inform him of the nature and scope of my investigation. The coroner's officer told her that a post mortem found that the man died of:

    1a Broncho pneumonia
    1b Chronic end stage obstructive pulmonary disease.

3. A panel led by a General Practitioner and Associate Clinical Director from NHS Hampshire conducted a clinical review. The panel comprised of a Registered General Nurse and Head of Patient Safety from NHS Hampshire and a Primary Care Integrated Governance Development Manager. They focussed on the clinical care given to the man at Winchester. A Root Cause Analysis Investigation Report undertaken by a Clinical Manager from the National Patient Safety Agency, was used during the review. A third report completed by a Associate Medical Director Patient Safety WEHCT reviews the man's care in hospital.

4. The Investigator and the clinical reviewer visited Winchester on 11 May 2010. They met, a governor, who acted as prison liaison for my office and was duty governor at the time of the man's death. The Investigator and the clinical reviewer visited the healthcare centre and spoke with staff. They also toured the wing in which the man's cell was located before his death and spoke with prisoners and staff who knew him. The investigator wrote to the Governor, on 10 June 2010 updating him on the status of the investigation.

5. My family liaison officer wrote to the man's daughter to explain the investigation process and invite her to contact my office with any concerns or issues regarding her father's care. There was no response to this letter at the time of writing the report, but she will be given an opportunity to have sight of this investigation report.

HMP WINCHESTER

11. HMP Winchester is a category B[4] local male training prison located outside Winchester city centre. It has a maximum capacity of 707 prisoners following the extensive refurbishment of C wing. It has four residential and one administrative wing[5]. The West Hill unit is a separate resettlement unit for category C men.

12. Healthcare at Winchester is provided by Solent Healthcare. The in-patient unit has 18 beds, with the majority of prisoners suffering from mental health problems. A member of healthcare staff is allocated to work on each wing, including the West Hill unit. At the time of this investigation, there were two chronic disease registers with 120 prisoners on the asthma register and six on the register for chronic obstructive pulmonary disease. Dental and Pharmacy services are provided. At the time the investigator visited, the role of Head of Healthcare was divided between two members of staff who shared the role.

13. The prison has 24 hour healthcare facilities. Doctors are not on site during the night or after midday on Saturday. The local out of hours medical service is available for medical emergencies when doctors are not on duty.

14. The Independent Monitoring Board (IMB) is a voluntary body comprised of individuals drawn from the community. They monitor all aspects of prison life and produce an annual report. The IMB report for 2008/2009 is positive in a number of areas including healthcare, although the Board has some concerns regarding low staffing levels.

15. The most recent inspection by HM Inspectorate of Prisons, was carried out in 2007. The resulting report described Winchester as remaining a reasonably well-performing prison as a whole.

16. There have been 15 deaths at Winchester since my office began investigating all deaths in prison custody in 2004. Record keeping and chronic disease management have been a concern in past investigations and the clinical review panel found that they continue to remain so.

[4] When they enter prison, prisoners are risk assessed and given a category based on their offence and the risk that they pose to the public should they escape. There are four categories: A, B, C and D, with category A being the most dangerous. Category B are prisoners for whom the highest security conditions are not necessary but for whom escape must be made very difficult. Category C are those who cannot be trusted in open prison conditions, but would not have the ability or resources to make a determined escape.

[5] An administrative wing is where the governors office is located, together with all the other administraive staff necessary to the everyday working of the prison such as finance, security, activities.

KEY FINDINGS

17. The man was convicted and sentenced to 16 months imprisonment at a local Crown Court on 2 October 2009. He was sent to HMP Winchester on the same day and had served around five months of his sentence when he died on 24 March 2010.

18. A first reception healthcare screen was carried out when the man arrived at Winchester. Although the clinical records do not say when the required second healthscreen was carried out, a registered mental health nurse, told the investigator and the clinical reviewer that the second healthscreen has to be completed within 72 hours of arrival into the prison. She said that it was likely that the healthcare professional who carried out the first healthscreen, may have had time to do the second one immediately afterwards. This was common practice if reception was not too busy. She described the second healthscreen as focussing on whether the prisoner had hepatitis B and taking a family history. As the clinical record has entries for 2 October relating to a family history, it can be assumed that the member of staff that did the initial screening did both health screens at the time and the registered mental health nurse, confirmed this was the case.

19. The clinical record shows that the man gave a past history of gastrointestinal disease (acid reflux), palpitations on breathing, chronic obstructive pulmonary disease (COPD) and cervical spondilosis[6]. The man's refusal to stop smoking despite his COPD condition is notable and there is no evidence that he was offered support or practical help in dealing with it. Importantly, the clinical reviewer saw that the man told the member of staff that carried out the screening that he had undergone a tracheotomy[7] and the doctor referred to both respiratory failure and the tracheotomy in his report.

20. There is no evidence that the concerns set out in the pre-sentence report regarding the man's health and disability needs were picked up by reception staff at Winchester and passed to the healthcare department. Equally, there is no evidence that the court or probation staff at the local Crown Court passed the concerns on to the prison.

21. The man was accommodated in the healthcare unit because of his poor mobility. Entries in the clinical record show that healthcare staff observed him twice a day. His refusal to stop smoking was also noted but as mentioned previously there is no evidence that the man was offered practical help to stop smoking at this point.

22. The clinical record shows that the man was prescribed medication but did not see a doctor until 12 October. This appointment was made because he asked for a nebuliser[8] to be prescribed to help his lung condition as he had used one in the community prior to his imprisonment.

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[6] Cervical spondylosis is a degenerative disease of the neck vertebrae

[7] a tracheotomy is a surgical operation that creates an opening into the windpipe with a tube inserted to provide a passage for air; performed when the pharynx is obstructed by oedema or cancer or other causes

[8] a nebuliser is a device that produces a fine spray or mist often used for breathing treatments in patients with **COPD**.

23. A prison doctor, assessed the man on 12 October. He noted that the man had swollen ankles, shortness of breath and advised him to stop smoking. He did not prescribe medication for the man to use with his nebuliser. From mid October to early December, the man was seen twice a day by healthcare staff and there did not appear to be any major concerns.

24. On 8 December, healthcare staff assessed the man as fit for transfer to another prison. No other information was provided and it is not clear whether the assessment was routine or because the man had been selected to transfer. It is also not clear from the records when the man was assessed as fit to move from the healthcare unit to a cell on a residential wing. From the clinical record, it appears likely he moved to a wing before 29 December as on that date, the record shows that a nurse was called to the man because he had breathing difficulties. When he went to the cell, the nurse, saw that the cell was "humid and smokey" and the man's cellmate opened the window. The nurse gave the man oxygen and an appointment was made for the prison doctor to review him.

25. In the early hours of 30 December, the man's health deteriorated again. The nurse went to the cell at 4.00am and again at 4.30am and noted the man's shortness of breath on each occasion. An entry in the offender contact log made by a member of the wing staff, at 5.37am confirms that the man was given oxygen in his cell in the early hours of the morning because he was struggling to breathe. The log shows that the man was also given a nebuliser to help with his breathing. He was told that smoking was not helping his condition and he was advised to either cut down or stop. His cellmate was also a heavy smoker who was told not to smoke as the man was "gasping to breath". The member of wing staff suggested that a cell move for health reasons might be beneficial to the man. The nurse decided to send the man to hospital to stabilise his condition but this information did not reach wing staff.

26. In interview with the investigator and the clinical reviewer, a nurse said that she was allocated to work on 'D' wing during the day on 30 December. Before she started her duty, night nursing staff had told her that the man might need to go to hospital. Therefore, when she arrived on the wing, she was already aware that the prison had previously made arrangements for the man to go to hospital. Healthcare staff and the Orderly Officer (Oscar 1)[9] knew of the arrangement but wing staff did not. The nurse told the investigator and the clinical reviewer that she thought that the man had already gone to hospital when she arrived on the wing. She was surprised to find he had not.

27. The South Central Ambulance Service Trust Patient Clinical Record shows that an ambulance was called at 10.23am. It arrived at the prison at 10.28am. The paramedic's comment on the record shows that prison nursing staff treated the man but they did not have salbutamol to nebulise him. Ambulance staff noted on their

[9] The Orderly Officer (Oscar 1) is the discipline officer with overall responsibility for the running of the prison wings.

record that the man's salbutamol inhalers had run out and should have been replaced. In the circumstances the paramedics were reluctant to take the man to hospital as their assessment of the situation was that the man appeared to have run out of medication.

28. In interview with the investigator and the clinical reviewer, the nurse said that the paramedics told her that they were not prepared to take the man to hospital on the basis that he may have a chest infection. The paramedics told the nurse to ask the prison doctor to write a prescription for the medication that he needed. According to the nurse, valuable time was lost while they discussed the matter. She said that the paramedics did not understand that prison healthcare doctors had to write a prescription and then the medication was ordered from Lloyd's Pharmacy in the high street.

29. The matter was resolved through the nurse's insistence that the man's condition was unstable and that he should be taken to the prison doctor in healthcare to confirm this. The man was wheeled to healthcare and the prison doctor confirmed the seriousness of his condition. The man left the prison at 11.25am arriving at the local Hospital at 11.31am.

30. The man remained in hospital for three weeks. The clinical reviewer obtained copies of the man's hospital records. They showed he had a chest X-ray, a computerised tomography (CT) scan (an x-ray which provides detailed images) and a bronchoscopy.[10] Tests for cancer of the windpipe were negative. He received treatment for his lung condition including the use of positive pressure masks. He found the mask difficult to tolerate and asked for this treatment to stop. He allowed oxygen treatment and nebulised medicines to continue.

31. On 21 January, the man returned to the prison. There is no evidence in the clinical record that the prison and the hospital communicated to arrange the man's discharge back to the prison. There were no available beds in healthcare when the man returned so the duty governor found the man an available cell on a wing. The investigator asked the nurse that confirmed she thought the same member of staff would have completed both screenings if the hospital contacted the prison to warn that a prisoner was to be discharged back to the care of the prison. The nurse replied that, in her experience, the prison "have to do the running" in finding information from the hospital. I address this matter later in the report.

32. A prisoner and friend of the man spoke with the investigator and clinical reviewer. He recalled that the man was admitted to hospital at the end of December. When the man returned to the prison, he remembered that he was placed with a cellmate whose cell hygiene was poor. The man was given help if he needed it as officers and prisoners knew that he could not collect his meals or clean the cell himself. He told him that he thought he had around six to nine months to live. The friend did not

[10] A Bronchoscopy is a procedure used to look at a patient's lungs, airways and voice box

know who had given the man this information. He commented that, despite his poor health, the man did not complain.

33. A review by a prison doctor was arranged for 23 January. The clinical reviewer noted that the man had been prescribed a high dose course of steroids at the hospital to help to reduce his symptoms with the dosage to gradually reduce until finished.

34. The clinical record shows that the man remained on the wing and continued to receive regular visits from healthcare nursing staff. The clinical reviewer has noted that observations on the man were not recorded in the medical record. On 5 March, the man was admitted again to the hospital for treatment of his COPD condition. He returned to the prison on 7 March, with antibiotic and steroid medication and without further planned appointments to monitor his condition. He was allowed to keep all his medication in his cell and an appointment was made for a review with the prison doctor.

35. On 13 March, the clinical record shows that the man ran out of prednisolone[11] and the prison doctor was asked to prescribe more. He received this two days later.

Events on 20 March 2010

36. On 20 March, the man's condition deteriorated further and wing staff called healthcare staff to see him. A nurse responded to the call and found the man struggling to breathe. She gave him oxygen and then handed his care to day staff when she went off duty.

37. The investigator and the clinical reviewer spoke with a prison doctor. The doctor had not met the man before 20 March but was told by nursing staff that he had "given up". She said that he was on the maximum amount of medication that the prison could give and it was clear to her that he needed to be admitted to hospital. The man told the prison doctor that he had been ill like this before. The prison doctor was aware that using oxygen was a problem as the man was a heavy smoker. She told the clinical reviewer and investigator that there is new NICE [12] guidance which says that despite smoking, a patient cannot be denied oxygen. The prison doctor took a brief history from the man and examined him. She arranged for admission to hospital for assessment because of his worsening COPD.

38. The clinical reviewer reviewed the hospital notes. The hospital assessed the man as having end stage respiratory failure. Treatment was withdrawn with the man's consent and he was kept comfortable on a syringe driver[13].

[11] Prednisolone is used to treat inflammatory conditions
[12] NICE stands for the National Institute of Health and Clinical Excellence
[13] A syringe driver is a small, portable battery-driver infusion pump, used to give medication subcutaneously via a syringe usually over a 24 hours period.

39. The form for assessing the man's risk at hospital was completed by the duty governor on 20 March. The man was restrained by double handcuffs linked to a chain and attached to a prison officer. The risk assessment noted that if a defibrillator[14] had to be used, restraints with a single handcuff should be used so that they could be swiftly removed in an emergency.

21 and 22 March 2010

40. The bedwatch log completed by the escort officers records that the restraints were removed on 21 March at the doctor's request for treatment and replaced afterwards. (The bedwatch log is a history of time and events which take place while a prisoner is out of the prison as an inpatient at hospital.) The risk assessment was reviewed and the restraints removed on 22 March because of the man's serious condition. A Officer recorded in the bedwatch log that a governor should attend the hospital to undertake a risk assessment and update the paperwork. The entry on the risk assessment shows that this was done.

41. The bedwatch log entry for 21 March shows that, on at least two occasions, nursing staff asked the man if he wished his next of kin to be contacted. He said he did not. The man's condition continued to deteriorate and he was aware that he was dying. He accepted morphine and nebulisers but found the oxygen mask too difficult to tolerate despite repeated encouragement by nursing staff that it would help.

42. The duty governor visited the hospital on 22 March after escort staff told the prison that the man had a very short time left to live. He arranged for the chaplain, to visit and he did so later that day.

23 March 2010

43. In his statement an officer and member of the Care Team[15], said that the duty governor telephoned him at 7.15pm and asked him if he was willing to be ready in his role as staff care team member to help staff if the man died.

44. The duty governor log for deaths in custody recorded by the duty governor showed he visited the hospital at 8.00pm. Nursing staff told him that the man was dying. A statement made by one of the escort officers, said that when the duty governor arrived at the hospital, he checked that the officers felt able to deal with the man's death if it happened while they were on duty. The officer and the other escort officer, said that the duty governor talked them through the procedures to be followed when the man died.

[14] a defibrillator is a machine that gives an electric shock of preset voltage to the heart through the chest wall in an attempt to restore the normal rhythm.

[15] The Care Team is made up of members of prison staff who are able to deal with concerns and look after staff's emotional well being following a difficult or distressing event in the prison.

24 March 2010

45. The man continued to deteriorate and he died on 24 March at 5.15am. One of the escort officers said he received a telephone call at 5.17am to confirm this. He then went to the hospital to support the escort officers, arriving at 6.05am.

46. An entry in the duty governor's log says that at 6.55 am, the duty governor returned to the prison and spoke to the Governor . Details of the man's next of kin were held in the Governor's safe. This revealed that the man's next of kin was his daughter who lived in Liverpool, a considerable distance from the prison. The duty governor telephoned HMP Liverpool and spoke to the deputy governor. (The log suggested that Liverpool had been forewarned of the situation the day before.) Liverpool arranged for two family liaison officers, to visit the man's daughter later that morning to break the news.

47. A hot debrief was held at 8.30am led by the duty governor, with the officer from the care team in attendance. (A hot debrief is a meeting for staff to discuss emotive issues and any lessons learned following serious events such as deaths in custody.) Prisoners who knew the man well were told the news personally by duty governor and the chaplain. The support and listener scheme[16] was offered.

48. The man's daughter was told of his death at around 11.30am. She told the family liaison officers that she had known her father was ill and his death was expected. She said she was not close to him and asked that his prison property and money be given to charity. The prison asked that she review this as they had found evidence that the man had owned a property and she might wish to deal with this. She agreed to do so.

49. A prison chaplain, and a senior officer and family liaison officer, visited the man's daughter and offered her his prison property the day after his death. The prison paid for his funeral.

[16] Listeners are prisoners vetted and trained by the Samaritans to provide confidential emotional support to fellow prisoners in distress.

ISSUES

Clinical care

50. The clinical review was undertaken by a panel led by a doctor from NHS Hampshire. They reviewed the man's medical records as well as records from the Royal Hampshire County Hospital and South Central Ambulance Service. The investigation has also benefited from a Root Cause Analysis Investigation Report[17] conducted by a Clinical Manager which makes a number of recommendations on clinical matters. A third report was submitted to my office from a colleague of the clinical reviewer who is an Associate Medical Director of Patient Safety.

51. The panel identified a number of areas of concern. They judged that the man clearly had severe lung disease with a significant reduction in his life expectancy. This would have been evident when he arrived at the prison and gave his medical history to nursing staff. The panel considered his care at Winchester was reactive, rather than the proactive care expected in the best NHS general practice. The man was not given flu injections, COPD monitoring, pre-emptive medical or specialist nurse reviews. He was not referred to a local specialist and information was not sought from his previous consultant doctor. It would have been appropriate to have done this and the lack of disease management is a concern.

52. The panel also commented that on 30 December, the man's inhaler ran out and he could not take medication in a nebuliser as it had not been prescribed. He was found to have a chest infection. While the lack of inhalers would not have prevented the problem, their absence increased his cough and other symptoms. The panel acknowledged difficulties in supplying medication to prisoners on the wings. The man would have found attending a "hatch" window difficult because of his poor mobility and there is a reliance on the prisoner to take responsibility for ordering medication in good time. The panel found that the 72 hours for replacement medication compares well with the community general practice given security and supply issues.

53. The man was discharged from the hospital and went to a residential wing because there were no beds available in the healthcare unit. The review panel judged that this could have been avoided with prior planning between the prison and the hospital. No formal discharge arrangements were made and communication between the hospital and prison healthcare staff appears to be poor. In her review, the colleague of the clinical reviewer has acknowledged that:

> "We do realise, however, that there may be some educational work to be done around discharge back to prison care and recognising that this is not the same as discharge home."

[17] A Root Cause Analysis is an analytic tool used to review critical incidents. It includes the identification of root and contributory factors, identification of risk reduction strategies and development of action plans.

The actions of the hospital do not fall within the remit of this office, but it is clear that prison staff could be more proactive about seeking and following through information about the management of prisoners admitted to hospital.

The Primary Care Trust, the Head of Healthcare and the Governor should establish a joint protocol regarding the admission and discharge of prisoners from outside hospitals. Timely and accurate information should be obtained and provided to both discipline and prison healthcare teams by nominated staff. Also, healthcare staff should ensure that they receive appropriate discharge plans, with an action plan for any ongoing care by the prison. In the event that these are not provided by the hospital, the healthcare department should actively request this.

54. Record keeping at Winchester falls short of the standards set by the Nursing and Midwifery Council. Entries are dated but not timed and are often without any key clinical observations or findings. In addition, the professional status of the member of staff making the entry is not always clear. The panel acknowledged that a prison using a computer system meant for a general practice setting causes difficulties as the coding arrangements are not always appropriate. The panel said that "record keeping is a consistent weakness found in other Death in Custody reviews at HMP Winchester". The review also described inconsistent use of the computer system, citing a number of instances in which incorrect codes had been entered, leading to inaccurate information being recorded. In conference with the Governor, the clinical reviewer and the investigator were told that a new computer system is due to be installed but a date had not been agreed.

The Head of Healthcare should remind healthcare staff of the necessity of accurate and timely recording in accordance with standards set by the Nursing and Midwifery Council in Principles of Good Record Keeping.

55. The reluctance of ambulance staff to take the man to hospital is a concern and is raised by both the panel in their review and the Clinical Manager in her Root Cause Analysis Investigation Report. She points out that a more timely removal might have reduced the man's discomfort and prevented further deterioration of his condition. This incident has highlighted a possible training issue for paramedics responding to emergency calls at the prison as they might be unaware of the structure and management of a prison healthcare department. This is outside the remit of my investigation. However, the failure of healthcare staff to tell the paramedics that the man had undergone a tracheotomy previously may have given the paramedics the impression that the man had simply run out of medication and was not as seriously ill as evident. The investigator and the clinical reviewer discussed this issue with the Governor. He has agreed that it may be appropriate for the ambulance service to consider visiting the prison healthcare department as part of their training.

The Governor and Head of Healthcare should ensure that healthcare staff provide all relevant clinical history to staff in the ambulance service if a

prisoner has to be taken to hospital as an emergency. This will prevent delay in treating acutely ill prisoners. The Governor should also contribute, as required to the review of the protocol between the ambulance service and the Primary Care Trust.

56. The clinical review panel have taken action on a number of issues with the Primary Care Trust and other stakeholders following their review of the man's clinical care. These include reviewing the provision for specialist healthcare for prisoners with chronic long term conditions and improving communication between members of the prison healthcare team. The South Central Ambulance are reviewing the protocol for ambulance staff and I hope that the recommendation above enables the prison to be actively involved.

Root Cause Analysis Investigation Report

57. The author has identified lessons learned from the man's death and has made a number of recommendations in her report which also support the findings of the clinical review panel. I am pleased to endorse her recommendations where they fall within the remit of my office. Other recommendations made by her are outside my remit, but can only improve practice. Notably, the recruitment and training of nursing staff in the management of long term conditions is being addressed and funding is available for two nurses in 2010. Also, meetings giving opportunities for shared learning are to be implemented.

58. During their visit, the investigator and the clinical reviewer noted the lack of communication between the healthcare staff and prison doctor. The clinical review found that despite being in the healthcare centre when he first arrived, the man was not assessed by a doctor until ten days after his arrival. Thereafter, he was not examined by a doctor unless nurses made an appointment or specific request in spite of his severe, ongoing medical condition. The doctors have little involvement in the day to day running of the healthcare inpatient centre despite the doctors' office being located down the corridor from this facility. The clinical manager has recommended joint assessments and care planning between the prison and healthcare staff for prisoners resident in the healthcare unit, as well as weekly reviews between healthcare staff including prison doctors. While not relevant to the man's death, if implemented, the clinical manager's recommendations are necessary to improve practice and communication within healthcare and the prison.

59. The clinical review panel and the clinical manager have identified a need for greater links with a respiratory specialist nurse in order to increase the expertise in the healthcare team in managing prisoners with medical conditions similar to those of the man. The review found that Solent Healthcare, who provide healthcare services for the prison, are reviewing the provision of specialist nurse care to prisoners with long term condition such as COPD. Given the high number of prisoners at Winchester with respiratory conditions, I am pleased to endorse the clinical manager's recommendation.

The Head of Healthcare should engage the services of a respiratory specialist nurse in order to provide increased expertise and support nursing staff in managing prisoners with chronic respiratory conditions.

Use of restraints

60. The man transferred to hospital under restraint. While his death was not expected, it was evident that he was very unwell. A risk assessment was carried out and it was decided that he should be restrained by handcuffs, with a chain attached to an officer. When the man deteriorated on 21 March, a hospital doctor asked for the restraints to be removed in case electrical equipment needed to be applied. When the man improved, the doctor said that the restraints could then be reapplied. A decision was taken later that day for the restraints to be permanently removed when his condition deteriorated further. I am pleased that the prison was responsive in conducting a review and showed compassion in removing the restraints.

Advice on smoking

61. The clinical manager identified smoking as a contributory factor to the man's condition. The clinical reviewer considered that stopping smoking would have been the most significant way of reducing his risk of death and he found that staff had given the man advice on this. I acknowledge that he chose not to give up, but there is no evidence that the man was offered alternatives to smoking such as nicotine replacement therapy or the opportunity to attend relevant clinics at the prison. I make no formal recommendation on this point. However, I encourage the Head of Healthcare to take steps to ensure that healthcare staff are aware of the role of the smoking cessation lead nurse and the referral process for clinics. Also, that prisoners who suffer from illness where smoking is an aggravating feature are actively targeted and staff record referrals in the clinical record.

Debrief on 1 April

62. Minutes of a death in custody debrief held on 1 April show that a number of issues arose. Prison staff felt that when they have advance knowledge of a possible death in custody, it would be helpful to have a multi-agency meeting with healthcare, chaplaincy, family liaison officer and police liaison officer so that an action plan can be created. This would form part of the bedwatch folder of information for staff. This would be a proactive response and good practice. I therefore make the following recommendation.

When the expected or imminent death of a prisoner is notified to the prison, the Head of Healthcare should inform the Governor at the earliest opportunity. This will enable the Governor to convene a multi-agency meeting with all relevant staff with the aim of creating an action plan for staff to manage events.

63. Paramedics initially refused to take the man to hospital on 30 December. Through the insistence of a nurse, the man was taken to the healthcare centre. A doctor then confirmed the nurse's assessment that the man's condition was unstable and he needed urgent treatment. The nurse is to be commended for her tenacity and actions which enabled an urgent and appropriate transfer to hospital.

    The Governor should write to the nurse regarding her challenge to the initial refusal to take the man to hospital. I commend her sound professional judgement and insistence that the man be taken to hospital urgently by the paramedics.

64. The duty governor during the last few days of the man's life, assumed the responsibility for telling the family that the man was terminally ill. The man's next of kin live a great distance from the prison. The duty governor arranged for family liaison officers from nearby HMP Liverpool to go to the man's daughter's home and personally deliver the news of his death. Staff from Winchester visited the family the following day to return his property. This was sensitive to the family.

65. The duty governor also put in place support for the escort staff from the care team once it became clear that the man's death was imminent. This demonstrated good practice, consideration and support for staff, as well as an understanding of the difficulties staff would potentially face.

CONCLUSION

66. The man had served over five months of a 16 month prison sentence when he died of broncho pneumonia and end stage COPD on 24 March 2010. He had been diagnosed with a chronic lung disease a number of years before and gave a history of ill health when he arrived at the prison. Despite his incapacity and the immobility arising from his condition, his death was sudden and unexpected.

67. The clinical review panel were critical of aspects of the man's care and I have made recommendations on relevant issues. However, the review concludes that the failings identified did not materially alter the outcome for the man.

68. The nurse is to be commended for taking a firm and positive stance in ensuring the man was sent to hospital. I am also pleased to note the proactive and sensitive arrangements by the duty governor in respect of liaising with the man's next of kin and early provision of support for the prison staff who escorted him in his last hours.

RECOMMENDATIONS AND COMMENDATION

1. The Primary Care Trust, the Head of Healthcare and the Governor should establish a joint protocol regarding the admission and discharge of prisoners from outside hospitals. Timely and accurate information should be obtained and provided to both discipline and prison healthcare teams by a nominated staff. Also, healthcare staff should ensure that they receive appropriate discharge plans, with an action plan for any ongoing care by the prison. In the event that these are not provided by the hospital, the healthcare department should actively request this.

   Accepted. Head of Health Care to liaise with Clinical Services Manager for Solent Healthcare and establish a joint protocol for outside hospital admission / discharge.

2. The Head of Healthcare should remind healthcare staff of the necessity of accurate and timely recording in accordance with standards set down by the Nursing and Midwifery Council in Principles of Good Record Keeping.

   Accepted. Head of Health care to brief all nursing staff of the importance of accurate and timely recording on Vision system. This to be added as an SPDR objective and management checks to ensure compliance.

3. The Governor and Head of Healthcare should ensure that healthcare staff provide all relevant clinical history to staff in the ambulance service if a prisoner has to be taken to hospital as an emergency. This will prevent delay in treating acutely ill prisoners. The Governor should also contribute, as required to the review of the protocol between the ambulance service and the Primary Care Trust.

   Accepted. Head of Health Care to liaise with Solent Heath Care Head of Clinical Services and arrange for 'quick glance' medical records to be held in HCC for those prisoners who are deemed 'at risk' of hospital escorts due to ill health or medical complications. The list of prisoner's names that require this measure should be checked and updated daily.

4. The Head of Healthcare should engage the services of a respiratory specialist nurse in order to provide increased expertise and support nursing staff in managing prisoners with chronic respiratory conditions.

   Accepted. Some nurses have undergone respiratory training already, and others are pencilled in for future training. Head of Health Care to provide a list of those trained in managing chronic respiratory conditions.

5. When the expected or imminent death of a prisoner is notified to the prison, the Head of Healthcare should inform the Governor at the earliest opportunity. This will enable the Governor to convene a multi-agency meeting with all relevant staff with the aim of creating an action plan for staff to manage events.

   Accepted. Head of Health Care to put in place procedures that will inform the Governor immediately of any expected / imminent death of a prisoner .Governor to appoint an Inquest Liaison Officer and put in place a protocol is to guide the ILO through the process.

Commendation

The Governor should write to the nurse regarding her challenge to the initial refusal to take the man to hospital. I commend her professional judgement and insistence that the man be taken to hospital urgently by the paramedics.

The nurse has already received her Commendation from the Governor.

The family's response

The family have thanked my office for the report. They do not wish to add anything other than to ask that their thanks be passed to the nurse who insisted that the man was taken to hospital. The Investigator will write separately to the governor to ask if he could pass the family's thanks to the nurse on their behalf. The family are pleased to see that, since the man's death, 'steps have been taken' to improve the care and conditions for other prisoners with chronic breathing conditions. The family have said that they are happy for their comments to be included in the final report.