

**Investigation into the circumstances surrounding the death
of a prisoner at HMP Winchester**

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

July 2006

This is the report of an investigation into the circumstances of the death of a man at HMP Winchester. Following post mortem examination, his cause of death was recorded as sudden unexpected death in epilepsy.

I extend my sincere condolences to those who knew this man.

He had spent the vast majority of his life in care and in psychiatric units, and was remanded to HMP Winchester, following an alleged assault on a member of staff at the residential home where he lived. It was clear to the judge at the time that prison was not the most appropriate location for the man. No reader of this report will doubt otherwise.

I would like to thank the Governor of Winchester at the time of our investigation. I am also grateful to those members of his staff who assisted us, particularly the duty governor on the night of the prisoner's death, who acted as a liaison officer for the investigation team. At the time of death, this man was not in contact with any members of his family. I have found the prison's efforts to locate his family and their subsequent contact with his brother to have been both sensitive and respectful.

I am grateful to Mid Hants Primary Care Trust for their clinical review of this man's medical care whilst he was at Winchester, the findings of which have informed this report.

I make seven recommendations and draw one other matter to the Governor's attention.

Stephen Shaw CBE
Prisons and Probation Ombudsman

July 2006

Contents

Summary	5
The investigation process	7
The man who died	8
HMP Winchester	9
The events leading up to the man's death	10
The day the man died	16
Discussion of the issues	20
Findings and conclusions	25
List of recommendations	28

Summary

1. The man was 34 years old when he arrived at Winchester. He had been remanded into custody at Southampton Crown Court, following an alleged assault on a member of staff at the residential home where he lived. He had suffered from a form of epilepsy and mild to moderate learning difficulties from an early age. He had spent time in custody some 15 years earlier when he had been charged with Grievous Bodily Harm.
2. At the time of remanding him into custody, the judge hearing the case expressed his reservations in doing so. He asked the prosecuting barrister to contact Winchester to explain his vulnerabilities and to ensure that efforts were made to seek alternative accommodation for him. The barrister duly sent a fax, asking the duty governor to contact him. The fax was received by the prison and sent to the Healthcare Centre. The duty governor at the time has no recollection of seeing it.
3. Shortly after his arrival in Winchester, the man was located in a single cell in the Healthcare Centre. A first reception health screen was eventually carried out for him four days after his arrival at the prison. It was only following his reception health screen that he was prescribed anti-psychotic tranquillisers and medication to control his epilepsy.
4. Throughout the months that followed, considerable efforts were made by the prison Community Mental Health Team (CMHT) to find alternative accommodation for the man. Indeed, the CMHT had managed to locate a place for him, and were in the process of making arrangements for his transfer, when he died. He therefore remained in a single cell in the Healthcare Centre until his death.
5. The man had difficulties comprehending the reasons for his imprisonment and was, at times, a challenging person for staff to care for. He spent much of his time on "three man unlock" (meaning that three officers needed to be present if his door was opened) whilst in the prison and so did not often engage in the normal regime in the Healthcare Centre. He suffered several epileptic fits during his time at Winchester and would not consistently take his medication.
6. At approximately 05.40am on the day of his death, the man was seen by the Night Duty Nurse to be lying on a strange position. She and the Night Duty Officer Support Grade (OSG) were unable to rouse him and the nurse suspected that he had died in his sleep. Neither the OSG nor the nurse held keys to open the cell door and, given that the man was on "three man unlock", the nurse requested that the Night Orderly Officer send three officers to unlock the cell. The three officers arrived in the Healthcare Centre approximately six minutes later and entered the cell along with the nurse. The man had no pulse and was cold to the touch, and the nurse believed he was dead. The officers and the nurse left the cell and the door was locked and sealed.

7. The nurse had some difficulty in getting a doctor to attend to certify the man's death and this was finally done at 08.40am by a prison doctor.
8. The man was not in contact with any members of his family. His brother, who had never met him, was located by Buckinghamshire Constabulary and was told of his death and how to contact the prison.
9. A post mortem report into the man's death recorded the cause as sudden unexpected death in epilepsy and the inquest into his death concluded that he died of natural causes. The clinical review of his care has been conducted by Mid Hants Primary Care Trust, the findings of which are included in this report. I make seven recommendations.

Investigation process

10. One of my investigators visited Winchester and met with a member of the Independent Monitoring Board and a representative of the Prison Officers' Association (POA). She also visited the Healthcare Centre, where the man had spent his time since he arrived at Winchester.
11. The investigator issued notices to staff and prisoners informing them of the investigation and inviting comment.
12. Access to the man's prison records, including his medical records, was provided to my investigator. A copy of the post mortem report into his death was provided by HM Coroner.
13. Formal and informal interviews were conducted with several officers and members of healthcare staff.
14. One of my family liaison officers wrote to the man's brother to explain the purpose of the Ombudsman's investigation and to discuss any questions the family might have had. His brother did raise any concerns with my Family Liaison Officer and has not expressed any wish to meet with either her or the investigator.
15. The Prison Service has been given an opportunity to comment on a draft of this report and, where appropriate, their responses to recommendations have been included.

The man who died

16. The man was born in 1970 and was placed into care by his natural mother when he was a baby. She subsequently returned to her birthplace in the Caribbean, and had no further contact with her son. He had an aunt and uncle with whom he was no longer in touch. The man also had a brother whom, sadly, he had never met. When the man was eleven, he developed herpetic meningo encephalitis (an infection of the brain), an illness which left him with a form of epilepsy and mild to moderate learning difficulties. He had difficulties with speech and comprehension and attended special schools from an early age.

17. The man was described by those who knew him as a likeable, but unpredictable man. His relationship with staff at the prison was variable. He had formed positive relationships with some members of staff, but his condition caused his mood to fluctuate. He would occasionally react aggressively to certain members of staff or if he felt he was being treated in a negative way.

HMP Winchester

18. Winchester is a category B local prison, with a category C resettlement unit, West Hill. The prison was last inspected by HM Chief Inspector of Prisons in November 2004, when a short unannounced inspection was carried out. Acknowledging that Winchester was, like many other local prisons, around 50 per cent overcrowded, the Chief Inspector found Winchester to be a prison with a number of improvements still to make. However, the Chief Inspector also commented upon the vision and commitment of managers and many staff and welcomed improvements in certain areas including healthcare.
19. The man spent all of his time located in the Healthcare Centre whilst he was at Winchester. The prison has a 22 bed patient healthcare facility and medical cover 24 hours a day. From Monday to Saturday, two locum GPs work in the prison, covering approximately half of the shifts each. There is also a senior healthcare officer, healthcare officers and a mixture of general nurses and psychiatric nurses. During the night, the prison's healthcare cover is provided by a nurse who is based in the Healthcare Centre. In addition to the nurse, there is always an Officer Support Grade (OSG) on duty overnight in the Healthcare Centre. An out of hours service is provided by Primecare Forensic (who provide advice and call out doctors from 5.00pm until 9.00am, Sundays and bank holidays).
20. Two other prisoners have died at Winchester since April 2004. Both of those deaths were due to natural causes. The investigations into the deaths highlighted issues of concern regarding the delivery of healthcare at Winchester.

The events leading up to the man's death

9 June 2005

21. The man appeared at Southampton Crown Court charged with two counts of assault on members of staff at the care home where he lived. His defence barrister presented the court with a psychiatric report which suggested that the man was unfit to plead and was not suitable to remain long term in a voluntary care home setting. The prosecution team requested that the case be adjourned until 4 August, in order for them to obtain their own psychiatric assessment. The man was remanded into the custody of Winchester prison until this date.
22. On the morning of 9 June the barrister for the prosecution team sent a fax to the duty governor at Winchester to which he attached a copy of the man's psychiatric report. The fax outlined the details of his case and highlighted some concerns expressed by the judge, who had remanded him into prison custody. The investigation team spoke to the barrister for the prosecution, who reiterated the contents of the fax and explained what he could remember of the man's court appearance. The man had appeared at court accompanied by staff from the care home where he lived. The staff informed the judge that, due to the man's assaults on staff at the care home, he could no longer be offered a bed there. The judge had agreed that a second psychiatric report was needed and that the most likely (and desirable) outcome was for the man to be found a bed in a medium secure mental health unit. The judge remanded the man to custody, but asked the barrister for the prosecution to contact the prison to urge them to do all that was possible to transfer the man to a more suitable setting than prison. The barrister's fax highlighted that the man's psychiatric assessment stated that his mental health was likely to be adversely affected by the stress of being in prison. This fax went on to provide his contact details and to ask for the duty governor to contact him. The barrister explained to my investigator that he had never been contacted by any member of staff from the prison.
23. The duty governor on 9 June told my investigator he had no recollection of receiving the prosecution barrister's fax. The fax found its way to the Healthcare Centre, but it is not clear how or when this happened. It appears that the first person to read the fax was a Senior Officer in the Healthcare Centre on the morning of 13 June.
24. The man's Prisoner Escort Record (PER) indicated that he arrived at Winchester at 13.00 on 9 June and his name appears on the Reception List at 13.46. Boxes on the PER form were ticked to indicate he had a medical condition, a mental condition, could be violent and was vulnerable. A note was also made in the section headed "further information about risk" which indicated that the man had epilepsy.

25. Ordinarily, when prisoners arrive in reception at Winchester their warrant is checked by officers, their property is taken from them and they are searched. They then speak to a number of people who each check and collect information about them. One of the people they see is a nurse, who carries out an initial assessment of their health needs. If they need to see a doctor, this is usually arranged for the next day. This prisoner had his photographs taken in reception, but no initial health screen was carried out for him and no cell share risk assessment was completed.

26. The prisoner was sent to the Healthcare Centre and located in a single cell.

10 to 12 June 2005

27. An entry about the man was made on a daily record of nursing care on 10 June. It noted that there was very little information available about him and that he was not very communicative. He had been placed in a safer cell in the Healthcare Centre. However, the investigator was told by the prison doctor that this was not because there were concerns that he might harm himself, but simply because there are a number of safer cells in the Healthcare Centre and they are used as normal accommodation, due to pressures on space.

28. Two separate entries were made in the record on 11 June, the first noting inappropriate behaviour and the second noting that the prisoner was still uncommunicative. The second entry also records that a full assessment was still needed.

29. Similarly, two entries were made in the record on 12 June. The first note refers to the prisoner's behaviour as being markedly mentally unstable and on the difficulty of persuading him to return to his cell. The second entry refers to his lack of understanding of the reasons for his imprisonment.

30. A nursing care plan was completed for the man on 12 June in which his identified problems were recorded as:

- memory lapse - unable to give full account of events leading to imprisonment
- poor hygiene
- poor diet taken.

The interventions identified to address the prisoner's problems were:

- to give time and listen as he was remembering a little more every time
- encourage personal hygiene
- make contact with Community Mental Health Team (CMHT) as soon as possible.
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It was also noted that a short term goal in the man's care was to encourage him to eat the meals he was served.

13 June 2005

31. On Monday 13 June a Senior Officer (SO) completed an initial health screen for the prisoner. In interview, the SO explained that he had not been on duty between 9 and 12 June. He explained that, from what he could remember, he had completed the man's health screen on the morning of 13 June, because it had been picked up by another member of staff that it was still not completed. The SO believed that the man had been very uncommunicative and thought that might have been an explanation why the assessment had not been completed up to that point.
32. A copy of the prisoner's prescription was obtained and this was faxed through to the prison. The SO could not remember whether this information came directly from the prisoner's GP or was obtained from his Community Psychiatric Nurse (CPN). The address of his GP is not recorded on his initial health screen, but there is note of the CPN's telephone number. It appears that the prisoner's GP records were never requested.
33. Many sections of the initial health screen were not completed. Two out of the eight pages were not completed at all. The SO explained in interview that he completed the man's health assessment both by asking him questions and through use of the information contained in the fax sent by the barrister for the prosecution. The SO described the prisoner as having difficulties with his speech and as being very uncommunicative.
34. Following his initial health screen, the prisoner was referred to see a doctor. He was seen by the prison doctor at some point during 13 June. The second health screen was never completed for the prisoner, so no details were taken of his weight, height or blood pressure. The doctor made notes referring to the details contained in the barrister's fax and also commented that the prisoner was hesitant in his speech and had a stutter. A prescription chart was started for the prisoner, prescribing the following medication:

Cetirizine, 10 mgs daily
Clobazam, 10mgs in the morning, 20mgs at night
Procyclidine, 5mgs three times daily
Risperidone, 1mg twice daily
Sodium Valproate Chrono, 1g twice daily

14 June to 7 October 2005

35. On 14 June the prison doctor attended his weekly meeting with the Community Mental Health Team (CMHT), a meeting which is known as the Joint Liaison Ward Round. A note was made in the prisoner's medical record by this doctor, indicating that the prisoner needed a psychiatric assessment.
36. The man was seen by a consultant psychiatrist for the prison CMHT, on 21 June. The psychiatrist completed an Outpatient Care Plan for the man, in which he stated that he did not feel any change needed to be made to the

man's medication as he was not presently depressed or psychotic. The Psychiatrist indicated that, as part of the man's care plan, the prison CMHT would liaise with the prisoner's local CMHT to establish what steps had been taken to find alternative accommodation for him.

37. The man was seen again by the consultant psychiatrist on 12 July. He told him that he had been stressed and had been getting angry at times. The consultant psychiatrist assessed his patient as being unfit to plead. His situation was discussed at the prison CMHT's team meeting later that day. A number of alternative placements for him were discussed including a specialist care home for clients with acquired brain injury and a care home where he would be under the care of a psychiatrist with a specialism in brain injury.
38. The man was seen by a nurse from the first care home on 28 July. On 2 August, the prison CMHT were advised that they would be unable to accept the man due to his unpredictable behaviour.
39. Nursing staff and discipline officers told the investigator that the man would not always return to his cell when requested to do so and would occasionally become aggressive and confrontational. The Head of Healthcare told the investigator that the man's unpredictable behaviour and occasional aggression meant that he spent much of his time at Winchester on "three man unlock". (This means that, due to the behaviour or attitude of a prisoner, they have been assessed as needed to have three officers present when they are released from their cell.) The Head of Healthcare explained that, as the man's temperament was changeable, a daily review was undertaken as to whether he needed to have three officers present to unlock his cell.
40. Due to his condition, the man was not always able to participate in the daily regime in the Healthcare Centre and did not receive any visits during his time in the prison. He struggled to understand the reasons for his imprisonment and often expressed his frustrations to members of staff at the prison and to the prison CMHT staff. He was a keen cricket fan and was avidly following the Ashes test series during his time in Winchester. He also wrote poetry, some of which has been published.
41. On 4 August, the man appeared at Southampton Crown Court, despite the consultant psychiatrist's assessment of 12 July when he was found unfit to plead. His case was again adjourned.
42. On 16 August, the man was assessed by the consultant psychiatrist as unfit to plead. On 30 August, he refused to speak to this psychiatrist, who noted in a letter to the prison doctor that a neuro-psychiatric report was still awaited from a doctor at the other care home.
43. The consultant psychiatrist assessed the man again on 6 September. He considered that he seemed more settled than on his previous meeting with him, but that he had stated he was frustrated in healthcare.

44. On 15 September, the man attended Southampton Crown Court. Despite having been recommended as unfit to plead, the evidence against him was heard and he was found guilty of assault. Sentencing was adjourned until 27 September to await a further psychiatric report.
45. The man appeared at Southampton Crown Court again on 27 September when sentence was adjourned for another month.
46. On 4 October, the consultant psychiatrist was advised by a doctor from the other care home that it might be possible to admit the man to the unit under Section 48 of the Mental Health Act 1983. The necessary paperwork was prepared by the prison CMHT. On the following day, 5 October, an arrangement was made between the care home and the prison CMHT that a care planning meeting would take place on 27 October to manage the man's transfer and future care.
47. The clinical review carried out by Mid Hants PCT noted a number of points relating to the man's care during this time:

- a) The history of medicines administration is incomplete. This is because administration was not always recorded with clarity. Codes used to indicate refusal of medicine varied and were sometimes recorded over a signature suggesting that the medicines were signed as given but then refused by the prisoner.
- b) Nursing notes indicate that the prisoner required considerable encouragement to take his medicines on many occasions. With this support he remained compliant for much of his time in Healthcare. There were occasional days when he took some or none of his medication and there appears to be no obvious pattern to this behaviour. In addition to these occasional days, there were two longer periods of time when he refused all or most his medicines for several days. The first occasion occurred in mid July, and the second just prior to his death on 8 October.

Even when non-compliant with most of his medicines, the man tended to take his Sodium Valproate to help control his epilepsy.

Respiridone is an atypical antipsychotic drug which reduces the efficacy of Sodium Valproate. An increase in the dose of the Respiridone would have had the effect of reducing the effect of Sodium Valproate in controlling seizures. The man's dose of Respiridone was increased from 1mg twice a day to 2mg twice a day on 18 July. This issue is explored further in the discussion section of this report.

- c) Circumstances surrounding refusal of medicines in July. On 21 June, the consultant psychiatrist reported no evidence of depression or psychosis and indicated to continue with current medication. On 11 July, another doctor reported that the man remained psychotic. On 12 July, the consultant psychiatrist reported that he did not believe that the

man was psychotic and that there was no evidence of depression or psychosis. He advised to continue with the current medication. Nursing notes on 17 July reported the man to be compliant with medication, but on 18 July he refused his lunchtime medication (Procyclidine).

From 19 to 26 July, the man refused all medications except for Sodium Valproate. From 26 July, he began to refuse less medication, returning to reasonable compliance (with continued encouragement) on 4 August. The refusal of medications became pronounced on 19 July and coincided with the increase of Respidone.

- d) Circumstances surrounding refusal of medicines in October. Until 4 October, the man had – with encouragement – been taking his medicines on the majority of occasions. For reasons that are unclear, he refused most of his medications on 6 and 7 October. It appears that he continued to take his Sodium Valproate on the evening of 6 October and both doses on 7 October, although the recording for the morning of 6 October is unclear.

8 October 2005

48. During the night of 7 October and morning of 8 October, the prison's healthcare cover was provided by an agency nurse who had been working night shifts at the prison for about two years. On the night of 7 October she was accompanied by an OSG.
49. The OSG told the investigation team that part of his role during a night shift is to carry out "pegging", which means patrolling the landings and clicking a mechanical device at designated points around the Healthcare Centre. The OSG said that, as he is carrying out this pegging, he will often check on prisoners by looking through the observation panels in their cell doors. In this prisoner's case, the OSG explained that he would not look into his cell every time he went past it (which was every 20 minutes), as the man tended to be very sensitive to the noise of opening the panel, and would be annoyed if it woke him up. The OSG said he would usually check the man once after he seemed to have turned his TV off and to be asleep, and then once or twice more through the night. On the morning of 8 October, the OSG remembered checking on the man through the observation hatch at about 3.00am. He seemed to be sleeping and was lying in a normal position.
50. The OSG told the investigator that, on 7 October, there had been several prisoners who had been identified as being at risk of suicide or self harm and were therefore being monitored at regular intervals under the Assessment, Care in Custody Teamwork (ACCT) scheme. As was normal when there were prisoners on ACCT to check, he and the agency nurse carried out the necessary checks between them throughout the night. Similarly, whilst "pegging" was the OSG's responsibility, the agency nurse would often check on prisoners periodically throughout the night.
51. The agency nurse told the investigator that, at about 5.40am on 8 October, she was checking on prisoners through the observation hatches on their cell doors. When she looked in on the man he was lying in a strange position. She described his legs as hanging off the bed and him being in an unnatural sleeping position. She called out his name, but got no response. The OSG was in the process of carrying out his pegging and heard the agency nurse calling to the prisoner. He asked the agency nurse if she thought the man was okay and she replied that she thought he had passed away. The OSG looked into the cell and saw the prisoner lying in a strange position. He explained that he and the agency nurse put the man's light on and continued calling to him, but that he did not respond in any way.
52. The OSG told the investigator that at the time he had thought he could see the man breathing. While he was still looking through the observation panel into the cell, he was aware then that the agency nurse had returned to the nurses' station (located only metres away) and was making a phone call to the main prison requesting officers to come over and open the man's cell door.

53. Neither the OSG nor the agency nurse hold keys during their night shifts. A sealed pouch containing a set of keys is kept in the Healthcare Centre, but this is only to be used in an urgent situation. Although there needed to be three officers present to unlock the prisoner, even if a prisoner was not on three man unlock, the nurse and OSG on duty would have to ask for two officers to attend if they needed to open a cell door during the night. In the man's case, the agency nurse telephoned through to the Night Orderly Officer (NOO), and requested that three officers make their way to healthcare. The agency nurse explained to the investigation team that she could not remember exactly what she had said to the NOO during the telephone conversation. She thought she had explained that she thought the prisoner had died, but that the OSG believed he was still breathing.
54. The NOO told my investigator that, at approximately 5.42am, he received a telephone call from the agency nurse explaining that she could not rouse one of the prisoners and that she needed to get into their cell. The NOO sent three officers to the Healthcare Centre to open this prisoner's cell. The NOO told the investigation team that the three officers arrived approximately six minutes after he had received the agency nurse's telephone call. The nurse estimated that the officers took about ten minutes to arrive and the OSG thought it took about fifteen minutes. The three officers also noted in their incident reports that they were requested to go to healthcare at approximately 5.45am, but did not record the time that they arrived there. One of these officers told the investigator that he estimated it took him and the other officers about six minutes to make their way from the prison centre office to the prisoner's cell. This officer told the investigator that, once at the cell door, he asked why the prisoner was on three man unlock, looked through the observation hatch and then unlocked the door.
55. The above officer entered the cell first, immediately followed by the agency nurse and the other two officers. He stated that he believed the man was dead and the agency nurse said that he felt cold to the touch and she could find no pulse. She and one of three officers turned the man on to his back and she checked his pupils, which were unresponsive.
56. The agency nurse explained that she attempted to put the man's socks back on him, but one of the officers told her not to touch anything and that they must leave the cell. She and the three officers then left the cell and the door was sealed.
57. The NOO was informed that the man had died and so contacted the duty governor. The NOO then, together a further Officer, began to work through the death in custody contingency plans. Hampshire Constabulary were contacted and two police officers arrived at the prison at 6.30am.
58. The agency nurse was asked to arrange for a doctor to attend the prison in order to certify the man's death. She contacted the company which provides the prison's out of hours medical cover and was told that they were not able to

certify death and that a police doctor would have to be contacted. The man was eventually pronounced dead by a police doctor, at 8.40am.

59. At approximately 7.30am, a hot debrief was held in the Healthcare Centre. This debrief was attended by the duty governor, the head of healthcare, the duty nurse, the OSG and the three officers who attended the scene.

Events following 8 October

60. The duty governor explained that, following the man's death, he went through his prison record to identify next of kin to inform them of his death. The man had given his next of kin details as that of his solicitor and the Community Psychiatric Nurse (CPN) from the residential care home where he had lived before his imprisonment. The duty governor contacted the telephone number given for the care home, but was not able to get through to anyone from the mental health team. He informed the member of staff on duty that the man had died and asked for a message to be passed on to the mental health team.

61. The duty governor also telephoned the number given for the man's solicitor. As it was a Saturday morning, he spoke to the duty solicitor who advised that she would get a message to the man's solicitor, but that it was unlikely to be before Monday.

62. At approximately 9.00am, the duty governor contacted Hampshire Constabulary to request their assistance in tracing the man's next of kin. At 4.20pm, he was informed that the police had not had any success in tracing anyone and were now dealing with a major incident so could offer no further assistance until after the weekend. The duty governor checked whether the man had ever had any visits and found he had not. A check of the prisoner's medical records had shown that he had an aunt and brother, but no names or addresses were recorded.

63. On Monday 10 October, the duty governor contacted the man's CPN again and was able to get through to him. The CPN explained that he had known the man only in his professional capacity and that, whilst he was very sorry to hear of his death, it was not appropriate for him to act as the man's next of kin. The CPN also referred to the man's brother and aunt, but did not have addresses for either of them and only knew the town they had lived in. The duty governor contacted the man's solicitor again, but was told he was unavailable and so left a message for him to return his call. By approximately 2.00pm, Hampshire Constabulary had located a possible address for the man's brother and this had been passed to Buckinghamshire Constabulary. The duty governor attempted to contact the man's solicitor again, but was told that he had gone home sick.

64. The duty governor spoke to the man's solicitor on 12 October and advised him of the man's death. The solicitor advised that he would make the necessary arrangements to close the man's case, but that he wanted no further involvement and did not want to act as a next of kin.

65. Some weeks after his death, Buckinghamshire Constabulary successfully located the man's brother and, after confirming that he was related to the man, they advised him of his death and provided contact details for the prison. The brother advised that he

and the man had never met. The brother did get in contact with the prison and arranged to receive a photograph of him. At the time of writing, he has not met staff from the prison and is seeking legal advice about acting as the prisoner's official next of kin. The duty governor wrote to the prisoner's brother on 31 October confirming that, as requested, the prisoner's property was being retained by the prison. The letter also advised that Hampshire Constabulary were in possession of some jewellery belonging to the prisoner.

Discussion of the issues

The man's care from 9-13 June

66. The PER form completed for the man on 9 June, indicated a number of factors to staff. The senior officer on duty in reception on 9 June explained to the investigator that it was not unusual to see indicators of problems such as mental health or medical issues. He could not remember this man specifically.
67. The nurse on reception on 9 June explained to the investigator that medical staff do not routinely have access to documentation about prisoners and so would not know if certain risks had been highlighted. She described the system for reception staff passing information to healthcare staff as being "ad hoc".
68. The SO confirmed that he had written "straight to healthcare" on the front of the prisoner's core prison record. He explained that this decision would have been taken by a member of healthcare staff. The SO could not remember discussing it with any member of healthcare. He explained that there is no nurse based on reception during the lunch time period so, ordinarily, if he wanted to discuss a prisoner with a nurse he would have waited for the nurse to return from lunch and then seek their advice.
69. The man's PER form indicated that he arrived at the prison at 1.00pm. His name then appeared on the reception list timed at 1.46pm. The SO explained to the investigator that the Prison Service's computer system, the Local Inmate Data System (LIDS), is updated over the lunch time period and it is therefore not possible to enter data onto it. If officers need to add data to the system during this period, they have to wait until the update is complete and then enter the information retrospectively. This means that it is not possible to know whether the man waited outside on the escort van for 45 minutes or whether he came straight into reception. Either way, his details were not entered until some time afterwards.
70. The nurse told the investigator that she had been based in reception for all of that day, apart from an appointment from approximately 9.00am until 10.30am and a lunch break from 12.30pm until 1.30pm. Another nurse took over from her at 5.00pm. The nurse could not remember seeing the man in reception and explained that it was quite possible that she was at lunch for the time that he spent there. She made an entry in the medical reception register reading "not seen- straight to healthcare". She explained that, even if a prisoner was acting in a way which made it difficult to carry out a formal assessment, she would still observe them as much as possible and would open a medical record. The nurse told the investigator that she believed her entry in the medical reception register meant that she literally had not seen the man in reception.

71. Another nurse was on duty in the Healthcare Centre on 9 June. She told my investigator that she had no recollection of the man arriving in healthcare, or of being told that he had not had a healthcare reception screen carried out.
72. One of the prison doctors explained to the investigator that he had no recollection of being asked to see the man on 9 June. He confirmed that two doctors were on duty at the time: the first doctor was responsible for problems arising in reception and for issues in the main prison, whilst the second was responsible for Healthcare Centre (and any problems arising in West Hill - the Category C unit attached to HMP Winchester).
73. The prison doctor explained that he had checked the healthcare diary to confirm which doctors were on duty on 9, 10 and 11 June. On 9 and 10 June, the he was responsible for reception and the main prison and a second doctor was responsible for the Healthcare Centre. The first prison doctor explained that, in June 2005, he believed (although could not be certain) that every new prisoner was being seen by a doctor. This would ordinarily happen the morning after their arrival at the prison and would take place on BETA unit (Benefits, Education, Training and Accommodation). This unit is near to A wing (induction) and the assessment by the doctor would take place as part of induction. However, if someone in reception needed to be seen by a doctor on the afternoon of their arrival, this would be arranged. The prison doctor said this is relatively rare and happens maybe once every two weeks.
74. The first prison doctor went on to explain that, as in this man's case, if a prisoner arrived in the prison at 1.00pm and was sent straight to the Healthcare Centre, the priority would be to get him located in a cell. Arrangements could then be made for the doctor on duty on the Centre to assess him. The doctor added that, on Thursday afternoon, he would have been running a surgery at West Hill, so it might have been easier to have the prisoner assessed in the Healthcare Centre, rather than getting him to come over from the other side of the prison.
75. The second doctor told the investigator that he could remember the man, but had no recollection of him arriving into the Healthcare Centre or of being asked to assess him. He explained that, when a patient is admitted into the Healthcare Centre, he would expect them to be identified to him on a ward round. He also said that, in view of the communication difficulties the man suffered, he was surprised to learn that he had not been drawn to his attention, either on his ward round on the Thursday afternoon or during the day on Friday.
76. The man was a individual who presented as having a number of problems. The decision to quickly transfer him to the Healthcare Centre was no doubt the right one. However, given his epilepsy and need for prescribed medication, the failure to complete a thorough healthcare assessment for him for four days is worrying. At the time of the man's arrival at Winchester, there appears to have been no particular member of staff with responsibility for overseeing admissions to the Healthcare Centre and ensuring that the necessary health assessments had been carried out.

77. My investigator wrote to the Governor on 29 November, to express concern that a first reception health screen had not been carried out for the prisoner for four days. The Governor wrote back to the investigator on 1 December, confirming that the issue was receiving immediate attention.
78. In addition, the Head of Healthcare told the investigator that she had written a protocol to improve the admissions and discharge procedures in the healthcare department and that this had now been approved by management at the prison. She felt that the protocol would reduce the likelihood of prisoners failing to be properly assessed.
79. It has not been possible to establish why the fax from the barrister for the prosecution did not come to the attention of anyone until the morning of 13 June. In the event, the fact that the fax was not seen until then does not appear to have had any effect on the man's wellbeing. However, it is surprising that such important information was not viewed with more urgency.
80. It is also of concern that no cell share risk assessments were carried out for prisoners at the time of this man's arrival at Winchester. I acknowledge, however, that the SO on duty in reception on 9 June told the investigator that these assessments are now being undertaken.
81. The first prison doctor also stated that he has a vague recollection that, when he was asked to assess the man on Monday 13 June, it was mentioned to him that "he's been here a while, we need to get him sorted out". He does not recall who said this.
82. During the man's first four days at Winchester, it appears that members of the nursing staff had attempted to engage with him and a care plan was formulated.

First reception health screen

83. When the man's reception healthcare screen was carried out on 13 June, many sections of the form were not completed and the information about him therefore remained vague. The SO who completed the healthcare screen, explained that this was due to the man's unwillingness or inability to communicate. No secondary health assessment was completed, so key information about the man, such as his height, weight, and blood pressure, was not recorded.

The man's care after 13 June

84. Aside from the delay in assessing the man during his first four days in prison, efforts appear to have been made by healthcare staff to care for him, and commendably by the prison CMHT to seek alternative accommodation for him. However, Mid Hants PCT's clinical review does raise some concerns about the prescription and administration of medicines:

- a) No reason for the increase in Respiridone could be found in the prisoner's medical notes. The PCT interviewed the prison's second doctor, who is a locum, in an attempt to establish the circumstances leading to the change in medication and to learn any lessons as appropriate. The second doctor described the prisoner's compliance with medication as poor, but agreed that it improved with the encouragement provided on the many occasions when he had initially refused medication.

The second doctor agreed that he had increased the Respiridone dose on 18 July, but could not remember the circumstances surrounding this. He said that medication changes for this type of patient would only be instigated on the recommendation of a specialist. The clinical reviewer could find no evidence that this is the case and, subsequent to their interview with this doctor, the PCT has confirmed with Prison Healthcare Service and Hampshire Partnership Trust that, whilst it is desirable for significant medication changes to be undertaken on the advice of a psychiatrist, in practice GPs do on occasion instigate changes without such advice.

The second doctor fully acknowledged that he had not recorded the reason for his decision to increase the dose of Respiridone. He described the chaotic circumstances that occur within prison that can result in a lack of adequate record keeping. The clinical reviewer provided advice on appropriate action in future.

- b) The need to review and possibly modify the dose of Sodium Valproate in the light of the change to the Respiridone dose. The second doctor told the clinical reviewer that, due to the short stay of most of the prisoners at Winchester, it was not common practice to make changes to medications used to treat long term conditions. He indicated that the management of the man's epilepsy had never been an issue in his care. The prisoner did have occasional fits and when these occurred they would be brought to the attention of the duty doctor. It has been established that there is no mechanism to manage long term conditions in Winchester prison. As a result, no change was made to the man's epilepsy medication throughout his time at the prison, despite periodic reports of seizures. This lack of proactive review is a weakness in the health care offered and has already been highlighted by the clinical reviewer.

The need for a review of the man's epilepsy medication in the event of change to his antipsychotic medication, was highlighted in a report from the consultant psychiatrist following an assessment of the prisoner on 21 June. In addition, a psychiatric report prepared for the courts describes a change of medication in August 2004 where an increase in antipsychotic medication appears to have contributed to an increase in the man's epilepsy. The clinical reviewer goes on to state that, although there were varying views regarding the control of this epilepsy in August and September 2005, the consistent opinion was that there

should be no change to medication pending the opinion of a psychiatrist who would be further assessing him.

The clinical reviewer considered that the reasons for the increase in the man's medication may be documented in the minutes of one of the case reviews undertaken every morning by the psychiatrist and the locum doctors. However, the reviewer was able to establish that any written records of these case reviews would have been made in the man's medical records.

The response to the man's death on 8 October

85. After the agency nurse had called the NOO, it appears that – although the timings are inexact – the three officers arrived at the Healthcare Centre reasonably speedily. Once the officers arrived, they took the necessary steps to ensure that there was no risk to staff, opened the cell door and quickly entered the man's cell. Whilst the officers attended the Healthcare Centre without delay, if any other incidents had been occurring in the prison at that time it might have proved very difficult to get three officers to attend so swiftly. If there is an urgent need to unlock the cell of someone on "three man unlock", there could be implications for the remainder of the prison were there to be other incidents.
86. Following the discovery of the man's death, the prison's death in custody contingency plans were appropriately followed and the necessary individuals contacted. However, the difficulties experienced by the agency nurse in getting a doctor to certify the man's death are not acceptable. She told my investigator that the duty doctor explained that they could not certify the death, because they were not "forensically trained". The refusal of the doctor to attend is surprising and resulted in a delay in certifying the man's death of approximately three hours.
87. The duty governor made efforts to trace members of the man's family and was saddened by the difficulties he encountered in contacting people who had known him. Once the man's brother was traced, the duty governor's contact with him has been considerate and timely.

Findings and Conclusions

88. The judge who remanded the man to Winchester did so with some reluctance. The prosecuting barrister's efforts to convey information to the prison about the man's vulnerability were commendable.
89. The man did not understand why he was in custody and the complexity of his problems made him a challenging person to care for. As is the case all too often, it is questionable whether prison represented an appropriate location for a man with such significant disability.
90. When the man arrived at Winchester, a certain amount of information was available about him. A fax was sent by the prosecuting barrister, detailing concerns about the prisoner's vulnerability and urging the prison to contact him. His PER form noted his epilepsy, vulnerability, potential violence and medical and mental health issues. However, while the nurse on reception on 9 June did not in fact see the man in reception, she told the investigator that it is not routine for PER forms to be available to the member of healthcare staff who completes the first reception health screen.
91. PER forms can contain crucial information and it is important that they are available for healthcare staff to have sight of this when carrying out a health assessment for a prisoner.

I recommend that a review is undertaken of how information about prisoners is communicated to members of healthcare staff who are required to carry out initial assessments.

The Prison Service have accepted this recommendation, commenting that the following steps were to be taken by May 2006: "Review to be conducted by the Head of Operations with the Head of Health Care to ensure an effective system is in place to make sure any necessary information that comes into the prison on Reception is communicated from Reception Staff to Health Care Staff".

92. The staff who dealt with the man when he first arrived at Winchester recognised his vulnerabilities and, quite rightly, sent him directly to the Healthcare Centre. Regrettably, the man's medical needs were not assessed and his medication was not prescribed for four days. Given that he was epileptic, was taking anti-psychotic medication, the implications of this could have been very serious. The lack of accountability for admissions to healthcare seems to have contributed to the prisoner being overlooked. When the man's health screen assessment was carried out, numerous sections of the assessment form were not completed.

I recommend that an urgent review of the admission to healthcare procedures is undertaken and that all staff are reminded of the importance of adhering to any protocol which is in place.

The Prison Service accepted this recommendation: "Healthcare Inpatient Policy written and signed off by Head of Health Care and Governor in December 2005. Disseminated to all staff. Admissions & discharge protocol displayed on notice board in nursing station."

93. When the man's first reception health screen was completed, the information gleaned from him was very brief. I acknowledge that the SO at the Healthcare Centre found him to be very uncommunicative, however several sections of the form were not completed at all. No record was made of the man's GP's details and no attempt appears to have been made to request his medical records.

I recommend that staff are reminded of the importance of completing thorough healthcare assessments, and an audit of the timeliness and quality of reception healthcare screens should be carried out.

Again, the Prison Service accepted the recommendation and made the following comment: "All relevant staff have been reminded; Head of Health Care has put management checks in place to review all new reception screens."

94. After the man's initial four days at Winchester, it appears that he was appropriately cared for and considerable efforts were made by the prison CMHT to locate a bed in a more suitable setting. There are examples of good practice in the form of the agency nurse's efforts to encourage the man's compliance with his medication, and by members of the CMHT keeping thorough and comprehensive records of their attempts to find alternative accommodation for him. However, a number of areas of potential improvement have been identified by the clinical reviewer. Based upon the findings of that review, I make the following recommendations:

I recommend that nurses are reminded of the importance of using the correct annotation to indicate refusal of medication and that doctors (including locums) are reminded of the importance of recording the reasons for medication changes clearly in the drug chart.

The Prison Service accepted this recommendation and confirmed that a memo has been issued to staff.

I recommend that procedures are put in place to ensure appropriate clinical management of long term conditions such as epilepsy, asthma and diabetes where the failure to do so could put the patient at significant risk of injury or death.

Accepting the recommendation, the Prison Service made the following comment:

“Nurse qualified in CDM has now joined bank and is carrying out regular clinics. IT is also essential to enable monitoring and to set reviews. Plans in place to install IT system within the prison.”

I recommend that all clinical decisions taken by General Practitioners in the absence of specialist advice are considered to be “exceptional” and are reviewed at the next case meeting. Further to this, I suggest that consideration be given to reinstating the weekly case meetings between doctors and psychiatrist.

In response to this recommendation, the Prison Service said the following:

“GPs should ensure that any clinical decisions are passed onto specialists as appropriate. This (and all) recommendations to be shared with provider practice, and taken through clinical governance arrangements. Weekly case meetings are not currently possible due to the high number, and therefore lack of continuity, of doctors (currently 9 on rotation). This recommendation could only work in practice with 1 or 2 regular doctors.”

I recommend that guidance is provided to clinical staff on appropriate management and reporting of non compliance of medication where this could be critical to the patient’s well being.

The Prison Service accepted this recommendation and made the following comment:

“ ‘Lack of Capacity to Consent’ policy is in place and will be reviewed. Guidance on non-compliance to be issued to staff.”

95. The response to the discovery of the man’s apparent death was well handled, with staff acting swiftly and following the prison’s contingency plans appropriately. However, the failure of the duty doctor to attend and certify death is surprising and the Governor may wish to consider consulting the Service Level Agreement and take this forward with the out of hours medical service accordingly.
96. I consider that the attempts to locate the man’s family were timely and well handled and that the duty governor’s efforts to trace and correspond with the man’s brother have been sensitive and appropriate.

List of Recommendations

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- 2. I recommend that an urgent review of the admission to healthcare procedures is undertaken and that all staff are reminded of the importance of adhering to any protocol which is in place.**
- 3. I recommend that staff are reminded of the importance of completing thorough healthcare assessments, and an audit of the timeliness and quality of reception healthcare screens should be carried out.**
- 4. I recommend that nurses are reminded of the importance of using the correct annotation to indicate refusal of medication and that doctors (including locums) are reminded of the importance of recording the reasons for medication changes clearly in the drug chart.**
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- 7. I recommend that guidance is provided to clinical staff on appropriate management and reporting of non compliance of medication where this could be critical to the patient’s well being.**