Investigation into the circumstances surrounding the death of a man at Royal Hampshire County Hospital in September 2006, whilst a prisoner at HMP Winchester

Report by the Prisons and Probation Ombudsman for England and Wales

September 2007

This is a report into the circumstances surrounding the death of a man at the Royal Hampshire County Hospital in September 2006. He was 59 years old and a prisoner at HMP Winchester. He had only been at Winchester for a couple of months, having been transferred from HMP Bullingdon.

The man who died was a life sentenced prisoner who had been in custody since August 1971. He had served his sentence at 13 different prisons. As appears to be common amongst those serving very long sentences, imprisonment seems to have had a detrimental effect on his health. At the time of his death he was diagnosed with chronic diabetes, angina, osteoarthritis, cardiovascular disease, partial blindness and deafness. One doctor involved in his care wrote that his state of health was consistent with someone much older than 59.

The death of a loved one is always distressing. I would like to add my condolences to the man's family and loved ones to those already expressed by one of my Family Liaison Officers.

This investigation has been undertaken by a member of my team. I would like to thank the Governor of Winchester and his staff for their co-operation.

A review of the care the man received whilst in prison and in hospital was carried out by Hampshire Primary Care Trust. The extent of his health problems and care needs has meant that the report took longer to complete than I would have liked. Indeed, the Coroner has already held the inquest into the man's death and is satisfied that he died as a consequence of natural causes. However, the complexity of the case warranted thorough investigation and I thank the clinical reviewer for taking the lead in interviewing healthcare staff and for her comprehensive report.

This was an unusual case in that it became apparent at an early stage that all of the issues relating to the man's management were clinical in nature. For that reason I have relied heavily on the clinical review. The review makes 13 recommendations in total, ten of which are directly relevant to my investigation. The rest are reminders of best practice, and I have addressed these to the Chief Executive of the Primary Care Trust in a separate letter. I also comment on one example of good practice.

Stephen Shaw CBE
Prisons and Probation Ombudsman **September 2007**

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SUMMARY

The man who is the subject of this report was remanded into custody in August 1971. On 2 November of the same year, he appeared at Chelmsford Crown Court and received a sentence of life imprisonment.

Over the years, he made slow but steady progress through the prison system. In 1999, he was transferred to open conditions but he struggled to adapt to the regime. He was returned to a closed prison in June 2000 after his security category was upgraded.

Over the course of his sentence, the man's health noticeably deteriorated. In 1987, he had a heart attack and three years later he was diagnosed with diabetes. In 1994, a disorder of the nervous system was noted and in 2001 he developed facial paralysis. In 2002, he suffered a series of small strokes and had another heart attack. In January 2006, he developed a severe pressure sore at the base of his spine and spent time in Queen Alexandra Hospital in Portsmouth. Later in the year, he spent a further period in hospital with anaemia and kidney disease. Shortly after his discharge to HMP Bullingdon, he was transferred to HMP Winchester where he was admitted to the inpatient unit. His health needs were assessed and a nursing care plan was drawn up. This focussed on managing his various health problems and encouraging him to mobilise.

From July 2006 onwards, the man's health deteriorated further. Tests revealed that he had a urinary tract infection for which he was prescribed a course of antibiotics. Two days later, a doctor recorded that he had developed kidney disease and he was referred for blood tests. A week later, he attended the Accident and Emergency Department of the Royal Hampshire County Hospital for a scheduled appointment relating to the management of the pressure sore on his spine. He was given advice on pain reduction and control and returned to the prison.

During the early hours of 29 July, the man was found on the floor of his cell complaining of neck pain. He was checked for injuries before being helped back to bed by healthcare staff. On 5 August, he was assessed by a doctor as he was unable to swallow, was not eating and was unable to take his medication. After discussion between the doctor and the local hospital, the man was sent to the Emergency Assessment Unit at the hospital. He was admitted as an inpatient shortly afterwards.

Over the next few weeks, the man who later died was subject to a series of tests and examinations. His family was told that he had been admitted to hospital but unfortunately personal reasons meant they could not visit him. During the morning of 20 August, the man suffered a heart attack. He was moved to the Intensive Care Unit, where it was established that he had suffered brain damage.

On 31 August, a comprehensive assessment of the man's condition was undertaken. Based on the results, a senior consultant at the Royal Hampshire decided to withdraw treatment at 7.15pm. Over the next few hours, hospital staff attempted to make him as comfortable as possible. He stopped breathing at 2.50am on 1 September and was formally pronounced dead at 3.45am.

THE INVESTIGATION PROCESS

1. My investigator opened the investigation on 13 September 2006. He obtained copies of the man's prison documentation, including his clinical records, and spoke at length to one of the prison governors. The governor told my investigator that the man had been transferred from Bullingdon as it was thought his health problems could be better managed at Winchester.

2. Prior to my investigator arriving at Winchester, notices were issued to staff and prisoners announcing the investigation and inviting anyone who had information relevant to the man's death to make themself known to the investigator. In the event, nobody came forward.

3. One of my Family Liaison Officers contacted the man's next-of-kin (his sister) to offer her the opportunity to participate in the investigation process. She did not raise any concerns about the circumstances surrounding her brother's death, but did tell us that the man had been concerned at times about his diabetes. She said she and her husband visited the man in prison regularly and wrote to him every two weeks, providing him with support. She asked to see our report when complete and I hope it answers any outstanding questions she may have.

4. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation. An inquest into the man's death has since been held and recorded that it was the result of natural causes.

5. Hampshire Primary Care Trust (PCT) conducted a review of the care the man received whilst in prison and in Royal Hampshire County Hospital.

HMP WINCHESTER

6. 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.

7. The man who is the subject of this report spent all of his time located in the Healthcare Centre whilst he was at Winchester. The prison has a 22 bed in-patient healthcare facility and medical cover 24 hours a day. From Monday to Saturday, doctors from the local Friarsgate surgery provide a full range of General Practitioner services. There is also a senior healthcare officer, healthcare officers and a mixture of general 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. An out of hours paramedic service is provided by Hampshire Ambulance Service.

8. Prior to the man's death, three other prisoners had died at Winchester since April 2004 when I assumed responsibility for investigating all deaths in custody. Two of these were due to natural causes. The investigations into the deaths highlighted issues of concern regarding the delivery of healthcare at Winchester, particularly in relation to the quality of record keeping. I am disappointed to be repeating similar recommendations as a result of this investigation. Since the man's death, two more prisoners have died at Winchester, apparently of natural causes.

KEY FINDINGS

9. Prior to being moved from Bullingdon to Winchester, a nurse from Winchester visited the man to assess his suitability for transfer. According to the clinical review, the nurse concluded that Winchester could offer no better care than that which he was already receiving. However, this opinion was not recorded in the man's clinical records and the transfer went ahead as planned on 7 July 2006.

10. Upon reception, the man was admitted to the inpatient unit in the Healthcare Centre where it was recorded that he was mobile, catheterised and had unstable blood sugars. It was noted that his physical health was deteriorating, that he had a pressure sore, diabetes, angina, a history of strokes and poor eyesight and hearing.

11. On 9 July, a nursing care plan was completed by a Registered General Nurse (RGN). The nursing care plan is a single page document with four sections which detail how the patient's health problems will be managed. Section one asks for information about the problems, and sections two and three require the person filling out the form to set short and long term goals. The final section asks how the goals are going to be achieved in terms of the actual approaches and interventions used.

12. On the man's nursing care plan, angina, reduced mobility, deafness in left ear, blindness in left eye, long term use of a urinary catheter and a pressure sore were identified as the problem areas. The short term goals were to prevent further deterioration and promote healing and reduce the risk of infecting the pressure sore. The long term goals were to heal the sacral sore, optimise mobility and increase independence. The interventions were described as follows:

    - encourage catheter care and change regularly
    - encourage mobility and use of aids, if appropriate
    - ensure diabetic diet, monitor bowel movements give insulin as prescribed
    - dress sacral sore every three days
    - encourage position changes and use of pressure aids as required
    - review regularly.

    The plan is dated 9 July and a review date of 16 July has been set. (These dates are written under two other dates which have been crossed through with a single line – 9.10.7 and 16.10 respectively, which are obviously incorrect.)

13. During the afternoon of 15 July, the man was seen by the prison doctor for the first time. He was noted to have high blood sugar levels and to require insulin, which was administered on a sliding scale according to need. The doctor also documented that a ripple mattress was put on his bed in order to alleviate the pressure sore. The following day, it appears the man's nursing care plan was reviewed. No changes were made to it and that day's date (16 July) was struck through with a single line. A review date of 30 July was written next to it.

14. On 17 July, tests revealed that the man had a urinary tract infection. He was prescribed a course of trimethoprim, an antibiotic widely used in the treatment of this condition. Two days later, on 19 July, the Consultant Diabetologist from the Royal Hampshire County Hospital reviewed the man's clinical notes and recorded that he had kidney disease. The doctor specified that the man needed various blood tests to be carried out, and these were done the following day. A urine test was also requested.

15. Three days later, the man was assessed by the prison doctor for faecal incontinence. His pressure sore was also reviewed and it was noted that the ripple mattress was broken. The prison doctor's assessment was that the man was less mobile and less able to look after himself. He recorded that it might be worth considering a referral to a geriatrician because the man's health was consistent with someone older than 59 years of age. He also indicated that a new nursing care plan was required to take into account his deteriorating mobility and ability to look after himself.

16. On 25 July, the man attended the Accident and Emergency Department of the Royal Hampshire County Hospital for a scheduled appointment relating to the management of his pressure sore. He was given advice on pain reduction and control and returned to the prison.

17. At 1.45am on 29 July, he was found on the floor of his cell complaining of neck pain. He was checked for injuries before being helped back to bed by healthcare staff. He was given painkillers and slept until the morning.

18. The man's deteriorating health was discussed on 1 August by a doctor and the healthcare team. In the clinical notes, the doctor wrote that a GP review was required. In her interview with the clinical reviewer, the doctor said that she could not recall the details of the discussion, but indicated that such an entry usually results from a conversation about a prisoner's medication.

19. Three days later, on 4 August, it was recorded that the man was moving about again. He walked to the treatment room in the healthcare centre for a new catheter to be inserted.

20. The following day, the man was seen by the prison doctor who found that his condition was a stark contrast to that of the previous day. He was unable to swallow, and so was not eating and was unable to take his medication. Following discussion between the prison doctor and the Medical Registrar at the Royal Hampshire County Hospital, the man was sent to the Emergency Assessment Unit at the hospital. He was accompanied by bedwatch officers from the prison and restrained, as per the Prison Service's bedwatch guidance, with handcuffs.

21. Upon admission, the man underwent a series of tests. These showed that his pulse was raised and he was suffering from a fever. His blood pressure was also abnormal and he was found to have paralysis of one side of his body. The initial diagnosis was a stroke with blood poisoning.

22. At 3.45pm on 7 August, in view of the man's serious condition, the prison authorised that the handcuffs could be removed. Later that day, he was given a blood transfusion.

23. On 11 August and 14 August, the man was visited in the hospital by the prison chaplain. On 15 August, he also received a visit from a member of the prison's Independent Monitoring Board to check that everything was in order and that he was being looked after. Later in the day, an electrocardiogram (ECG) was carried out. The doctor who examined the results told the bedwatch officers that the man required surgery to repair a faulty heart valve.

24. During the morning of 17 August, the man's intravenous drip was removed and so he was more mobile. Consequently, he was restrained by the use of an escort chain. However, the chain was removed the following day when the drip was reinstated.

25. At 1.25am on 20 August, the man suffered a heart attack. He was moved to the Intensive Care Unit where it was established that he had suffered brain damage. At 4.40am, one of the bedwatch officers noted in the man's records that he was paralysed and heavily sedated.

26. Over the next few days, the man's condition was stabilised although he remained very poorly. He was visited by the prison chaplain on a number of occasions. At 8.00pm on 23 August, the prison authorised that the man's bedwatch should be reduced from two officers to one.

27. During the morning of 28 August, the man was assessed by a physiotherapist who expressed concern about his continued lack of consciousness, despite the fact that sedation had been withdrawn earlier in the day. However, when the physiotherapist visited him later in the day, he was observed to be more responsive. He regained consciousness at 6.00am on 30 August. At 2.50pm, an x-ray was carried out which revealed that he had fluid on his lungs.

28. On 31 August, a comprehensive assessment of the man's condition was conducted. Based on the results, a senior consultant at the Royal Hampshire took the decision to withdraw treatment at 7.15pm. Over the next few hours, hospital staff attempted to make him as comfortable as possible. He stopped breathing at 2.50am on 1 September and was formally pronounced dead at 3.45am.

29. At 4.50am, a governor from the prison arrived at the hospital and was briefed by both the bedwatch officer and nursing staff. The governor was told by the nursing staff that one of the doctors had spoken to the man's sister the previous evening and the family was fully aware that treatment, including life support, was going to be withdrawn. The nurses told the governor that they would contact the man's sister around 7.00am to tell her that her brother had died.

30. At 8.15am, the governor telephoned the man's sister who confirmed that the hospital had already contacted her. She told the governor that the hospital had kept her informed of the man's condition throughout the time he spent there.

My investigator has been unable to establish whether the prison already knew the hospital was in regular contact with the man’s sister.

31. Support was offered to her, together with an invitation to visit the prison to speak to staff or have a look around. Winchester subsequently contributed financially to the costs of the man’s funeral.

ISSUES

32. As I say in my foreword to this report, the complexity of the man's health needs has meant I have relied heavily on the specialist input of the clinical reviewer. I was pleased to learn that there is no evidence to suggest that the man's death was directly linked to the care he received, and it is a matter of speculation as to whether it could have been reasonably delayed. Given how poorly he was in the last two weeks of his life, it is debatable whether prolonging his life would have been desirable in any event.

33. That said, the clinical review makes numerous observations about how his case could have been better managed. I will deal with these in turn.

The man's transfer and reception

34. There was a delay of eight days between the man being received at Winchester and seeing a doctor. Given that the rationale for him transferring from Bullingdon to Winchester was for better care to be provided, this is unacceptable. The clinical reviewer has suggested that, if the transfer had been arranged by clinical staff, it is more likely that the man's care would have been continuous. I therefore endorse the following recommendation which I have reworded slightly for the sake of clarity:

    Prisoner patients with chronic disease or complex care management needs should be identified on admission and seen by a doctor at the earliest possible time. Management plans should include regular review.

35. The clinical reviewer has made an associated recommendation that the accuracy of the health status attributed to prisoners, for example 'fit for transfer', should be audited and appropriate action taken if inappropriate handovers are found to occur. Whilst I support this recommendation in principle, I refrain from making it a formal recommendation as the research would be a huge undertaking, disproportionate to the circumstances surrounding the man's death. Since I assumed responsibility for investigating deaths in custody in 2004, I have not noticed that inaccurate information about the health status of prisoners is a widespread problem.

Transfer of clinical records

36. The man who later died was transferred from Bullingdon to Winchester on 7 July. His clinical records, which are extensive, did not go with him and only arrived about a week later (it has not been possible to establish the exact date). The clinical reviewer is of the opinion that this had a negative impact on Winchester's ability to carry out an informed assessment of his needs upon his admission to healthcare. She has recommended that clinical records always accompany transferred prisoners.

37. Prison Service Orders (PSO) 3050 'Continuity of healthcare for prisoners' and 6200 'Transfer of prisoners: inter prison escorts' provide guidance to prisons on how transfers should be managed. However, neither specifies that clinical

records should accompany prisoners and they are often sent at a later date. This is akin to what happens when a person in the community registers with a new doctor – the records are sent at a later date. As the ethos of prison healthcare is that it should be comparable with that in the community, what happened in the man's case would seem at first sight to be entirely reasonable.

38. However, given that the reason for the man's transfer was to provide a level of care better suited to his needs, I am surprised that his records were not transferred with him. Best practice would certainly have indicated that this was desirable, if not essential. I therefore suggest that, when a prisoner is transferred directly from one inpatient unit to another, their clinical records should always accompany them.

    Clinical records should always accompany prisoners who are transferred directly from one healthcare inpatient unit to another.

Ability of prison healthcare services to care for prisoners with complex health problems

39. As the number of prisoners serving indeterminate or life sentences grows, it seems inevitable that the number of more elderly prisoners will increase. It is likely that, as a result, there will be a substantial increase in the number of prisoners suffering from chronic, long term medical conditions.

40. The clinical review has suggested that the Department of Health and Prison Service, which are jointly responsible for the healthcare of prisoners, should conduct a review into the ability of prisons to manage those with complex health needs. I endorse this recommendation, which is similar to a recommendation I have recently made to the National Offender Management Service (NOMS) about the ability of approved probation premises to meet the needs of increasingly frail offenders. In this case, the clinical reviewer thought that clinical interventions were only made in response to specific medical episodes, with no clear objective. She concluded that prison healthcare services currently lack the expertise and resources to manage prisoners like the man who is the subject of this report.

    The Department of Health and Prison Service should jointly review their ability to manage prisoners with complex, long term medical conditions. This review should encompass the resources, expertise and training that is required to manage those with complications, difficult behaviour or complex nursing needs.

Other issues

Quality of record keeping

41. The clinical reviewer has found that the quality of record keeping, from the day the nurse visited the man at Bullingdon to assess his needs until he was transferred to the Royal Hampshire County Hospital, left a lot to be desired. She cites examples of referral letters not being dated, clinical entries being

deleted or rendered ineligible, care plans not being updated and medication being brought into the prison on transfer without being recorded.

42. Accurate and timely record keeping should be an integral part of any organisation's day to day practices. However, when the records in question relate to the care and treatment of a person with significant health problems, it is imperative that decisions and actions are clearly documented. This is the only way in which care can be delivered consistently and the health needs of the prisoner met. I therefore fully endorse the following recommendations, some of which I have reworded slightly:

Healthcare reception documentation should be audited to ensure it is filled in accurately and signed by the person completing the assessment. Where a prisoner's history indicates that a full medical assessment is required, this should be recorded and an appropriate referral made.

A record of medicines should be made from the day of admission. Medication brought into the prison on transfer must be recorded and, if it is deemed to be for use 'in possession', this must be made clear.

Care plans should be updated at regular intervals, and always when requested. The person completing the review must sign the review.

All referral letters must be dated. Where appropriate they should include details of current medication as well as the medical condition and the reason for the referral.

Entries in clinical records must never be deleted or otherwise rendered ineligible. If they are incorrect they should be crossed through once and initialled by the person overwriting them.

Arrangements between Winchester and Friarsgate GP Practice

43. The clinical review describes aspects of the man's care that fell short of what is expected. She suggests this was because of a lack of clarity about the respective roles of prison healthcare and Friarsgate Practice which provides GP services to the prison. In particular, the clinical reviewer criticises the apparent failure to follow up and review a set of blood tests requested on 20 July.

44. I have addressed one of the associated recommendations directly to the Chief Executive of the PCT in a separate letter as I do not think it is directly relevant to my investigation. However, I am concerned that the man's blood test results were apparently not followed up and therefore endorse the recommendation that:

Winchester and the Friarsgate Practice should agree a protocol for following up and reviewing prisoners' test results.

RECOMMENDATIONS

To the Department of Health and Prison Service

1. The Department of Health and Prison Service should jointly review their ability to manage prisoners with complex, long term medical conditions. This review should encompass the resources, expertise and training that is required to manage those with complications, difficult behaviour or complex nursing needs.

2. Clinical records should always accompany prisoners who are transferred directly from one healthcare inpatient unit to another.

   The Department of Health and the Prison Service, in their joint response to the draft version of this report, have accepted recommendation 2 and say that procedures are already in place to ensure that records are always transferred. At the time of writing they have not provided a response to recommendation 1. I have been assured that I will receive one in due course.

To the Primary Care Trust

3. Prisoner patients with chronic disease or complex care management needs should be identified on admission and seen by a doctor at the earliest possible time. Management plans should include regular review.

4. Healthcare reception documentation should be audited to ensure it is filled in accurately and signed by the person completing the assessment. Where a prisoner's history indicates that a full medical assessment is required, this should be recorded and an appropriate referral made.

5. A record of medicines should be made from the day of admission. Medication brought into the prison on transfer must be recorded and, if it is deemed to be for use 'in possession', this must be made clear.

6. Care plans should be updated at regular intervals, and always when requested. The person completing the review must sign the review.

7. All referral letters must be dated. Where appropriate they should include details of current medication as well as the medical condition and the reason for the referral.

8. Entries in clinical records must never be deleted or otherwise rendered ineligible. If they are incorrect they should be crossed through once and initialled by the person overwriting them.

9. Winchester and the Friarsgate Practice should agree a protocol for following up and reviewing prisoners' test results.

   Hampshire PCT has accepted all of these recommendations and at the time of writing has either implemented them or has plans to do so.

GOOD PRACTICE

1. The way in which Winchester maintained contact with the man whilst he was in hospital is worthy of note. I was particularly pleased to learn that the prison chaplain visited on a number of occasions.