Investigation into the circumstances surrounding the death of a man at HMP Winchester in October 2007

Report by the Prisons and Probation Ombudsman for England and Wales

September 2008

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This is a report of an investigation into the death of a man who died from a heart attack at HMP Winchester in October 2007. He was 42 years old and had been in custody at Winchester for just over three months.

I would like to offer my sincere condolences to the man's family for their loss.

The investigation was undertaken by an investigator from my office. We would both like to thank the Governor of Winchester and his staff for their participation and assistance. Particular thanks are due to the prison's liaison officer.

The Associate Clinical Director, Primary Care and Governance for the local Primary Care Trust (PCT) carried out a helpful and thorough clinical review, including a panel review. Unfortunately, the clinical review was not received until nine months after the man's death and this has contributed to the delay in issuing this report for which I must apologise.

The clinical review raises questions about the man's health screening whilst at Winchester and this is explored further in my report. I make seven recommendations to the Head of Healthcare at Winchester and a further recommendation to the Governor regarding the prison's anti-bullying policy. I raise a further issue relating to the location of non-vulnerable prisoners on a vulnerable prisoners landing. However, the Governor will already be acutely aware of this matter and, in these circumstances, I have judged that I do not need to make a formal recommendation.

A copy of this report has also been forwarded to the PCT and to HM Coroner.

Stephen Shaw CBE
Prisons and Probation Ombudsman **September 2008**

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SUMMARY

The man was remanded into custody as an unconvicted prisoner to HMP Winchester on 19 July 2007. He was convicted on 14 September and received a custodial sentence. His release date would have been in July 2008.

When the man arrived at Winchester he was assessed by healthcare staff in reception. His height, weight, blood pressure were noted as was the fact that he was a smoker. Despite being a smoker and moderately obese, no further health tests or a secondary health assessment were carried out.

The man underwent a mental health review in August, and as a result was prescribed an anti-depressant. He subsequently told staff that he felt better in mood and was given a repeat prescription a month later.

He seemed to be a quiet man and did not come to the attention of staff at all. He liked to spend time in his cell watching television and reading a newspaper. He appeared to get on well with his cell-mate and seemed to have settled into prison life.

About two weeks before he died, the man sustained two black eyes when he was assaulted in the shower on the wing. He did not report the assault to staff and was reluctant to speak about it in detail to his cell-mate. The cell-mate said in his police statement the investigator that he did alert staff to the man's injuries, but no action appears to have been taken, perhaps because the man did not want to report it.

On the morning of 27 October, the man complained of feeling sick and unwell. He went to lie down in his cell and said that he did not want any lunch, although he asked his cell-mate to collect his newspaper for him.

Just after mid-day (when prisoners are locked in their cells), the man was still lying on his bed when his cell-mate heard him make some gasping noises and his eyes appeared to roll back. The cell-mate felt for a pulse on the man's neck and wrist, but could not find one. He raised the alarm by pressing the cell bell and an officer arrived almost immediately. After assessing the situation, the officer entered the cell and checked the man's vital signs. The officer could not detect a pulse or establish whether the man was breathing and so made an emergency call.

Healthcare staff arrived at the cell very quickly and attempted to resuscitate. Staff carried out cardio pulmonary resuscitation (CPR) until the prison doctor arrived at approximately 1.00pm. After examining the man, the doctor pronounced him dead at 1.05pm.

THE INVESTIGATION PROCESS

1. I appointed my colleague to conduct the investigation on my behalf. Notices were issued to both prisoners and staff inviting anyone who had information relating to the man's death to make themselves known to the investigator. However, no further witnesses came forward.

2. My investigator was given access to all the man's prison records, including his medical records, and police statements taken after he died. All of these documents were forwarded to my investigator within a few days of the man's death.

3. My investigator visited Winchester to carry out taped interviews with staff on 12 February 2008. She had also arranged to speak to the man's cell-mate, but unfortunately he had been transferred to another prison without notice. Instead, a copy of his police statement was provided and so she did not need to interview him.

4. One of my Family Liaison Officers (FLOs) contacted the man's brother to explain the role of the Prisons and Probation Ombudsman and to offer him the opportunity to participate in the investigation process. His brother did not ask any questions and said he would await the outcome of my report.

5. The Clinical Governance Manager for the Primary Care Trust (PCT), was invited to arrange for a clinical review to be carried out into the medical care that the man had received during his time at HMP Winchester. This was completed and forwarded to my office on 22 July 2008.

6. An inquest into the man's death was held on 15 July 2008. The jury found that he had died of natural causes from acute myocardial ischaemia. Although the inquest has already taken place, a copy of this report will be sent to HM Coroner.

HMP WINCHESTER

7. HMP Winchester is a category B local male prison, located just outside of the main city centre. Built in 1846, most of the prison is of a traditional Victorian radial design. It has a maximum capacity of 697 prisoners.

8. The prison contains four residential units and one separate unit, West Hill, which is a training unit for category C adult men. In January 2007, C wing was closed for refurbishment.

Assessment, Care in Custody and Teamwork (ACCT)

9. ACCT requires any member of staff who identifies concerns about a prisoner they believe to be at risk of suicide or self harm to take action and to record those actions. The ACCT document should be available to all staff where the prisoner is located, including workshops and visits. Within 24 hours of an ACCT being opened, the prisoner is seen by an assessor and has a case review meeting. ACCT reviews are held at appropriate intervals and are attended by the prisoner and a case manager, together with other members of staff.

Bullying

10. Reported incidents of bullying are reviewed and closely monitored at a monthly Safer Custody meeting. Each wing has an anti-bullying representative. This is a prisoner who other prisoners can speak to in confidence and who can also bring issues on the wing to the attention of wing staff or the Safer Custody Manager.

Canteen

11. Canteen is the commonly name both for the prison shop where prisoners can buy or order goods each week to a limited value, and for the goods themselves. The shop mostly sells food, confectionery, stationery, toiletries and tobacco. Prisoners can purchase goods with money they earn from working in the prison, and from their own private cash.

D wing

12. Two landings on D wing are allocated to vulnerable prisoners (predominantly those charged with or convicted of sexual offences). However, due to the high number of prisoners overall, non-vulnerable prisoners are sometimes accommodated there.

Healthcare

13. Winchester provides nurse-led primary care, inpatient care and a pharmacy service. The healthcare centre is separate from the main prison, although some healthcare and treatment takes place in treatment facilities on A and B wings. Healthcare services are commissioned by the local PCT and the doctors are provided by a local general practice.

14. Healthcare introduced an electronic record keeping system in June 2007. The system is designed to provide a full audit trail of medical histories and the interventions that each prisoner receives or is due to receive.

15. On arrival in reception each prisoner is seen by a nurse or healthcare officer (HCO) and is screened in order to identify immediate healthcare needs. Prisoners then have the opportunity to see a doctor within 24 hours if required and a secondary health screening should be carried out where further details are taken (such as the prisoner's community doctor and next of kin details) and any existing health issues are explored. Prisoners are also asked to sign a medication compact that gives consent for the prison to access their previous medical history.

Listeners

16. Listeners are volunteer peer supporters selected, trained and supported by Samaritans, using their same guidelines, to listen and offer emotional support in complete confidence to their fellow prisoners who may be in crisis, feel suicidal or who need a confidential sympathetic ear. The principle of total confidentiality is central to the work of the Samaritans and this applies equally to their work in prisons, including that of prisoner Listeners. Samaritans allow exceptions to its principle of confidentiality only in the following very specific circumstances: if information is given about terrorism, if they received a court subpoena to divulge information, if the person is attempting to take their own life or if the contact threatens the Listener.

Independent Monitoring Board (IMB) report

17. IMB members are appointed to each prison by the Secretary of State for Justice. They are not members of the Prison Service, nor are they part of the prison's management team. They are required to produce an annual report to the Secretary of State, highlighting both good practice and areas of concern.

18. The IMB's report for Winchester for the period 2006/2007 notes that, prior to its closure, C wing held remand prisoners who are now housed on B and D wings. D wing therefore holds both vulnerable and remand prisoners. This has led to a reduction in the options for housing prisoners safely and increases the potential for bullying.

19. The IMB also had concerns that beds in healthcare were being used for prisoners without health problems because of overcrowding in the rest of the prison.

20. There were three deaths at Winchester during the IMB's reporting year, all from natural causes.

Her Majesty's Chief Inspector of Prisons' report

21. The HM Chief Inspector of Prisons undertook an announced inspection of Winchester in April 2007. Her inspection report noted that Winchester remained a reasonably well-performing local prison, in spite of the pressures on the system as a whole. However, the HM Chief Inspector of Prisons noted that

there were some warning signs including “the lack of sufficient activity spaces in the main prison, dislocated resettlement arrangements and, in particular, the fact that residential staff are not fully engaged in the support and rehabilitation of prisoners”.

22. The report said that Winchester was a reasonably safe prison, and that suicide and self harm was managed well. However, although there was little indication that bullying was a major problem, the anti-bullying arrangements were weak and vulnerable prisoners continued to be identifiable and to feel less safe than others. Only four incidents of bullying had been identified at the time of the inspection in 2007, which seemed unfeasibly low, and not all of the suspected bullies were being monitored. Vulnerable prisoners on D wing were wing were easily identifiable by different colour cell cards. They felt less safe than other prisoners and the wing was not an appropriate place to hold the mix of prisoners it contained.

23. The HM Inspector of Prisons reported that new arrivals were seen in reception by a nurse or healthcare officer using the standard prison reception screening form. A prisoner could see a doctor within 24 hours if necessary. No secondary health screening took place and there was no input from healthcare during a prisoner’s induction which meant that prisoners’ healthcare and health promotion needs were not fully assessed.

24. Winchester has policies to cover the provision of chronic disease management. The HM Chief Inspector of Prisons noted that prisoners with diabetes received a good standard of care and patients with asthma were able to see a nurse on request, although regular long term monitoring was not available. Input into other long term conditions, such as heart disease, was provided by the doctors rather than nurses.

KEY FINDINGS

25. The man arrived at Winchester prison on 19 July 2007 as an unconvicted prisoner. He was convicted on 14 September and sentenced to 12 months imprisonment at Crown Court. His prospective release date was in July 2008. he was located onto D wing as he was regarded as a vulnerable prisoner due to the nature of his offence.

26. A health reception screening was undertaken on 19 July by a member of healthcare. During the screening, the man's blood pressure was taken and his height and weight recorded. The clinical reviewer notes that, despite his being a smoker and moderately obese, no cholesterol screening or other health screening for chronic disease was undertaken. The man's medical history was not recorded and it was also not noted whether he had had any significant clinical episodes, including depression. It was also not recorded whether he was prescribed any medication or whether they discussed any pre-existing medical conditions. There is no evidence in his medical records that a secondary health screening was ever carried out.

27. On 2 August, healthcare received a fax from an outside Community Mental Health Team confirming that a consultant psychiatrist was to visit the prison to see the man to carry out an initial assessment (indicating that he had been assessed in the community for mental health issues). This took place on 10 August.

28. Four days later, the man saw a doctor at the prison as he was feeling depressed. The doctor prescribed an anti-depressant (Fluoxetine), but an ACCT was not opened. On 17 August, the man had a mental health review when it was noted that his mood had improved slightly and that he had a new cell-mate who he got on well with. He also started taking the anti-depressants later that day. There is no reason recorded in his records to explain why there was a three day delay in his being prescribed, and taking, the anti-depressants.

29. The man had another mental health review on 24 August. He reported that he felt physically unwell. There was a discussion about his mental health and a note for healthcare to 'discuss physical health issues with C2. Letter to follow'. It is unclear what this referred to and no follow up action appears to have been taken.

30. On 30 August, the Community Mental Health Team forwarded a letter to healthcare requesting a follow up appointment with the man. There is no evidence that this took place either.

31. The man was assessed by a nurse in the mental health clinic on 17 September. The man said that he no longer felt down in mood (he had told the doctor on 14 August that he felt depressed) or had any thought of self harm. He told the nurse that he had applied for a transfer to HMP Usk and asked to be considered for employment in workshop five to earn more canteen, as he was not receiving any visits. This was the last entry made in his medical records before he died.

32. About a week before he died, the man sustained two black eyes. His cell-mate was the anti-bullying representative on the wing and asked what had happened. The man said he had been punched in the face whilst he was in the shower, but would not give any further details and did not report it to staff. In his police interview, the cellmate said that he told some prison officers on the wing about this and they advised him to speak to the man and try to find out what had happened. The man told him that he had been punched twice in the face whilst he was in the showers, but said he had not seen who had done this. He also told the cellmate that he did not want to speak to staff about it.

Events on 27 October 2007

33. The cellmate recalled in his police interview that on the morning of 27 October he made the man a cup of tea at approximately 10.15am. At about 10.30am the wing was unlocked for association (when prisoners are free to move about the landing). The man collected some clean bedding and took a shower. The cellmate noticed that on the way back from the shower the man was crouched outside of their cell, holding on to the balcony rail. The cellmate asked the man what he was doing, and he replied that he did not feel too good and felt sick. The cellmate remembered that the man looked white and was shaking. He then said he had pains in his chest. The cellmate told him to go into the cell and lie down, which he did. He turned the light off and pulled the cell door to, to allow the man to rest.

34. The cellmate said he spoke to a prison officer and told him that the man did not look well and was very white. The cellmate said that the officer made a joke about this, so he walked away. The officer told my investigator that he did not recall having this conversation with the cellmate, but if he had been informed of an emergency situation he would have dealt with the matter accordingly. The cellmate returned to the cell at about 11.00am, ready for lock up. He said that the man was still on his bed and still looked white. Nevertheless, the man said that he felt better.

35. At approximately 11.45am, the prisoners were unlocked for lunch. The man told his cellmate that he was not hungry, but asked if he would collect his paper for him. The cellmate collected his own lunch and then asked a second officer if he could collect the man's paper as the man was not feeling very well. The man was still on his bed and watching television when his cellmate returned to their cell. The man told him that he felt sick, so he gave him some of his own Gaviscon indigestion mixture.

36. Approximately 15 to 20 minutes later the cellmate heard the man make a noise, as if he were gasping for breath. One of his eyes closed and the other seemed to roll back. The cellmate thought that the man might have been having an epileptic fit. He told the man to try to breathe slowly and thought that he could hear him say this. The man seemed to take a big breath and then appeared to stop, making no further noise. The cellmate placed his hand on the man's neck and wrist, but could not feel a pulse. The man felt cold and his lips appeared blue in colour. The man then pressed the cell bell to call for help.

37. An officer was carrying out lunchtime patrol duties and checking prisoners who were on Assessment, Care in Custody and Teamwork documents (ACCTs) on

D wing. The man's cellmate called out to him that he did not think his cell-mate was very well.

38. As the wing was on lunchtime patrol state (when all prisoners are locked in their cells and a skeleton staff patrol the landings), and there were very few staff available, the officer who was carrying out lunchtime patrol duties needed to appraise the situation before entering the cell. He looked through the door observation panel and could see the man lying motionless on his bed. He then entered the cell and attempted to get a response by shaking him and shouting his name. The officer raised a Code One alarm call (an emergency call) for assistance using his radio and shouted for another officer on the wing to help. In the meantime, the officer checked for a pulse in the man's neck, but found none. He then placed him in the recovery position.

39. As soon as the other officer on the wing arrived at the cell, he moved the man's cellmate, who seemed upset and located him with one of the Listeners on the wing. The officer who was carrying out lunchtime patrol duties was still trying to gain a response from the man when two healthcare nurses, arrived. They had heard the emergency call over their radios at 12.45pm and arrived with their emergency bag and a defibrillator (a machine that is used to administer an electric shock to the heart in order to re-establish normal heart rhythm) within two minutes.

40. The officer who was carrying out lunchtime patrol duties told the nurses that he could not find a pulse and moved out of the way to allow them to examine the man. One of the nurses turned the man on to his back and tilted his head to clear his airway. The nurse recalled that the man's eyes were open and his pupils appeared to be fixed and dilated. He did not appear to be breathing, there was no rise and fall from his chest and he had no carotid (neck) or radial (wrist) pulse. He appeared blue in colour (cyanosed).

41. The nurse requested an emergency ambulance, indicating the urgency of the situation, and the attendance of the prison's duty doctor. The nurse then began to attempt cardio pulmonary resuscitation (CPR) with the officer who had been carrying out the lunchtime patrol duties. The nurse placed a mouth-to-mouth resuscitation aid in the man's mouth so the officer could administer breaths safely. The nurse commenced chest compressions at a ratio of 30 compressions to two breaths.

42. After 90 compressions, the nurse assessed the man. There was still no response and he still did not appear to have a pulse. The second nurse attached a pulsometer to the man's finger to determine his oxygen saturation level, but there was no reading on the machine (indicating no oxygen).

43. The second nurse attached the pads of the defibrillator to the man's chest. The first nurse on scene shocked the man twice on the instruction of the machine, but it did not result in his circulation returning so they recommenced CPR. The first nurse on scene also attempted to insert an airway into the man's mouth, but this was unsuccessful. At this point, the first nurse on scene also attempted to administer oxygen to the man by using an 'ambu-bag', whilst the second nurse continued with chest compressions.

44. The first nurse on scene said that he believed at this stage that the man had already died, but they continued with CPR. He thought that rigor mortis had begun to set in as he had difficulty inserting the airway into the man's mouth.

45. The prison duty doctor arrived shortly afterwards. The nurses and the officer moved away to allow the doctor to examine the man. After carrying out checks, the doctor confirmed that he had died and certified this at 1.05pm.

46. A matter of minutes later, the ambulance crew arrived at the cell. They did not attempt CPR or examine the man as the duty doctor had already examined him and pronounced that he had died.

47. The officer who had been carrying out lunchtime patrol duties began to keep a log of events and continued to update this until the police arrived. The log was passed to the police who secured the cell and began to take statements from staff and prisoners. Afternoon association was cancelled on D wing. The officer spoke to a number of prisoners to let them know what had happened and that there would be no afternoon association. I understand the prisoners were very understanding of the situation.

48. The officer who had been carrying out lunchtime patrol duties and a prison governor went to speak to the cellmate. He had seemed to be very shaken and was obviously upset by what had happened to the man. He remained with the Listener for the rest of the day. All prisoners who were on an ACCT on D wing when the man died were reviewed.

49. Later that day a briefing was held for staff, and all those who were involved in discovering the man and attempting to resuscitate him were invited to attend. Staff were also reminded of the availability of the prison's Care Team if they needed to speak to somebody.

Events after 27 October

50. A post mortem was held on 29 October at hospital. It found that the man had severe coronary artery disease and died from an acute myocardial ischaemia (heart attack).

51. The man's brother told my FLO that Winchester had explained to him what had happened and had been very helpful. They offered to assist with the man's funeral costs and returned his belongings.

52. The parents of the man's cellmate wrote to the prison on 4 November. In their letter they thanked staff for the kindness and care they had shown to their son and for allowing him to telephone them as he had been distressed.

53. An inquest was held on 15 July 2008. The jury concluded that the man had died from natural causes.

ISSUES

Clinical care

54. The clinical reviewer found that there was a lack of information in the man's medical records relating to his general physical health. Despite the reception screening indicating that he was a smoker and moderately obese, no cholesterol screening or other health screening for chronic disease was undertaken. There was also no evidence of a secondary health screening being carried out, despite this being usual practice in the Prison Service.

    The Head of Healthcare should ensure that reception health screenings and secondary health screenings are carried out for every prisoner and all findings are recorded in the prisoner's medical records.

    The Head of Healthcare should ensure that the process for assessing prisoners on reception health screenings complies with the assessment screening tool. This recommendation was also made in a report into a death of a man at Winchester in January 2008.

    The Head of Healthcare should put in place a system to ensure that all prisoners with chronic disease are identified on admission and seen by a doctor at the earliest possible time. I also made this recommendation in a report in January 2008.

55. The man was prescribed Fluoxetine on 14 August 2007, although his medical chart indicates that he did not start taking this medication until 17 August. This delay is not accounted for in the medical records, nor was it explained to the clinical reviewer. This particular anti-depressant is noted as having indigestion as a known side effect. The British National Formulary (BNF, which provides healthcare professionals with authoritative and practical information on the selection and clinical use of medicines) advises caution of the use of this type of anti-depressant in patients with chronic heart disease. However, healthcare had not identified this risk in the man. There appears to have been no review carried out for him, once he had started on the Fluoxetine.

    The Head of Healthcare should ensure that all prescriptions for medication are recorded accurately and any delays in issuing medication are accounted for.

    The Head of Healthcare should ensure that every effort is made to obtain the medical records of prisoners, including a copy of the prisoner's general medical practice records. The medical history should be appropriately summarised in the prisoner's medical record.

56. The clinical reviewer has also said that his medical records appeared to be factual, consistent and accurate. However, they were not comprehensive and did not provide current information regarding his care and condition. Also, no care plan was provided for him. The clinical reviewer noted that the records were legible and accurately dated as they are computerised, but they were not timed. Also, there was no clear audit trail of dispensing of medication (indicated by the gap of three days between Fluoxetine being prescribed and

being dispensed). The clinical reviewer also said that the medical records did not provide an accurate audit of events on the day the man died. He has judged that there was a delay in alerting staff to the emergency whilst the man's cell-mate attempted to rouse him.

The Head of Healthcare should remind staff that medical records should always be kept in chronological order and updated appropriately. This recommendation was also made to Winchester in January 2008 in relation to a death of another prisoner.

The Head of Healthcare should consider the advice given to all prisoners regarding their health and the health of others. This should ensure that all prisoners are aware of the procedures to follow should they become concerned about their own health or the health of another prisoner.

Use of D wing

57. Whilst accepting that the high prison population places a great strain on local prisons like Winchester, I do not believe it is acceptable to mix vulnerable prisoners and non-vulnerable prisoners on the same landing unless this is part of an expressly integrated regime. This point is also made in Ms Owers' inspection report. However, I am confident that the Governor is aware of this issue and have decided that in the circumstances any formal recommendation I might make would be otiose.

Bullying

58. Despite being assaulted in the showers about a week before he died, the man did not want or feel able to report this to staff. He was also reluctant to discuss this in any detail with his cell-mate who by chance was also the wing's anti-bullying representative. This may have been due to the weakness of the prison's anti-bullying policy which was highlighted in the Ms Owers' inspection report. However, it is hard to imagine that the man's two black eyes could have gone unnoticed by all the wing staff.

The Governor should revisit the prison's anti-bullying policy to ensure that a system is in place for prisoners to report instances of bullying and feel safe in doing so. These incidents should be monitored at the monthly Safer Custody meetings.

RECOMMENDATIONS

To the Head of Healthcare

1. The Head of Healthcare should ensure that reception health screenings and secondary health screenings are carried out for every prisoner and all findings are recorded in the prisoner's medical records.

2. The Head of Healthcare should ensure that the process for assessing prisoners on reception health screenings complies with the assessment screening tool. This recommendation was also made in a report into a death of a man at Winchester in January 2008.

3. The Head of Healthcare should put in place a system to ensure that all prisoners with chronic disease are identified on admission and seen by a doctor at the earliest possible time. I also made this recommendation in a report to Winchester in January 2008.

4. The Head of Healthcare should ensure that all prescriptions for medication are recorded accurately and any delays in issuing medication are accounted for.

5. The Head of Healthcare should ensure that every effort is made to obtain the medical records of prisoners, including a copy of the prisoner's general medical practice records. The medical history should be appropriately summarised in the prisoner's medical record.

6. The Head of Healthcare should remind staff that medical records should always be kept in chronological order and updated appropriately. This recommendation was also made to Winchester in January 2008 in relation to a death of another prisoner.

7. The Head of Healthcare should consider the advice given to all prisoners regarding their health and the health of others. This should ensure that all prisoners are aware of the procedures to follow should they become concerned about their own health or the health of another prisoner.

To the Governor

8. The Governor should revisit the prison's anti-bullying policy to ensure that a system is in place for prisoners to report instances of bullying and feel safe in doing so. These incidents should be monitored at the monthly Safer Custody meetings.