

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man who died in
August 2012 at hospital, while in the custody of HMP
Winchester**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is a report into the death of a man, a prisoner at HMP Winchester, who died at hospital in August 2012. He was 47 years old. A post-mortem showed that he was suffering from cancer and died from severe pneumonia. I offer my condolences to his family and friends.

An investigator and a clinical reviewer reviewed the man's clinical care in custody. HMP Winchester cooperated fully with the investigation.

The man had been diagnosed with cancer of the larynx in November 2011 while he was remanded in custody. He was bailed by the court in January 2012 and underwent treatment. He returned to prison on 3 August, after he was sentenced. Although he had completed his cancer treatment he was still very unwell but not considered to be in the terminal phase of his illness. He was found to be very ill on 12 August and was taken to hospital, where he died a few days later.

The clinical reviewer points to a delay in prescribing pain relief medication when the man first returned to prison in August and that there was no apparent consideration of whether end of life care was appropriate. Nevertheless, he concludes that, overall, the man's care at Winchester was equivalent to that which he could have expected to receive in the community, and I agree.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

May 2013

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SUMMARY

1. The man was remanded to HMP Winchester on 24 May 2011. At his reception health screen it was recorded that he had high cholesterol, for which he was prescribed medication. He also reported a history of alcohol abuse and taking drugs.
2. The man completed an alcohol detoxification programme during his early weeks at Winchester. After this, he had little to do with healthcare until September 2011, when he saw a nurse about a lump in his neck.
3. On 3 October, a prison doctor examined the man and referred him to hospital with suspected cancer. On 21 October, a hospital consultant told him that it was likely he had throat cancer. A nurse offered support, guidance and reassurance to him when he returned to prison that day. She noted that he was calm and accepting of his diagnosis.
4. The man was given smoking cessation advice and was prescribed varenicline tablets to help him to give up smoking. He attended all his smoking cessation sessions and reduced his smoking considerably.
5. After further tests, the man was told on 22 November that he had cancer which had spread to the lymph nodes in his neck. Doctors discussed treatment options with him and he began combined radiation and chemotherapy in December 2011.
6. On 23 January 2012, the court granted the man bail so he could finish the course of treatment in the community. In July, he was deemed fit to attend court and, on 3 August, was sentenced to three years and four months imprisonment. He was returned to Winchester the same day.
7. At his reception health screen, the nurse noted that the man had been treated for throat cancer and his chemotherapy had finished in February 2012. He appeared weak and gaunt and said he was prescribed oramorph (liquid morphine) and thiamine (vitamin B1).
8. A prison doctor saw the man the next day, Saturday 4 August. The doctor noted that he was underweight and had pain in his upper back and throat. The doctor re-prescribed the medications listed in a letter from his community GP, but the list did not include oramorph. This was not given until Monday 6 August, when his community GP confirmed that oramorph had been prescribed.
9. At about 9.30am on 12 August, a nurse went to the man's cell to give him his morning medication. He found him struggling to breathe and very poorly. He administered oxygen and an ambulance was called.
10. Paramedics arrived at 10.20am and tried to stabilise the man. He was taken to hospital where he was put into an induced coma. He died a few days later. His family were with him.
11. The clinical reviewer considers that the man's care at Winchester was equivalent to that he could have expected in the community. However, we

make recommendations about prompt prescribing of pain-relief medication and consideration of end of life care.

THE INVESTIGATION PROCESS

12. This office was informed of the man's death in August 2012. The investigator issued notices about the investigation to staff and prisoners at HMP Winchester, asking anyone who had relevant information to contact her. The man's cell-mate at the time of his death came forward. He had since been moved to HMP Bullingdon. The investigator interviewed him by telephone.
13. One of our investigators visited Winchester on 16 August and obtained copies of the man's prison and medical records.
14. The local Primary Care Trust (PCT) appointed a clinical reviewer to review the clinical care that the man received in custody. The final review was delayed due to the late receipt of the post-mortem report which was not received until 25 January 2013.
15. HM Coroner for Hampshire Central was informed of the investigation. The Coroner provided the post-mortem report and has been sent a copy of this investigation report.
16. One of our family liaison officers wrote to the man's family by letter, to explain the purpose of the investigation. They did not identify any issues they wished the investigation to consider.
17. This report was shared with the man's family at the draft stage, they did not make any comments. The report was also shared with the service, they did not raise any factual inaccuracies; their response to the recommendations are included in the report.

HMP WINCHESTER

18. Winchester is a local prison, serving the courts in Hampshire and holds up to 707 adult remand and convicted men. Most of the prisoners are either held on remand or are serving short custodial sentences. A private healthcare company provides health services at the prison. The healthcare centre contains a 22-bed inpatient unit, mostly for patients with mental health needs, and there is 24-hour nursing cover. Doctors from a local practice run daily surgeries from Monday to Saturday.

HM Inspectorate of Prisons (HMIP)

19. The last inspection of Winchester by HMIP took place in September 2010. The report noted that health services had improved from the previous inspection, with reduced waiting times to see a prison doctor and a range of clinics. The Inspectorate also reported that local policy was to use the Liverpool end of life pathway although, at the time, this had not been used in practice.

Independent Monitoring Board (IMB)

20. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community whose role is to monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. The most recent IMB report for Winchester covers the period from June 2011 until May 2012.

21. The Board noted that individual members of staff often demonstrated outstanding levels of care to prisoners. However, they expressed concern about the appropriate prescribing of medication on arrival at the prison:

“Prisoners have been unable to access regular medication (anti-epilepsy on one occasion) on arrival. We are not able to establish whether these have been clinically acceptable misdiagnoses or poor medical care”.

Previous deaths at Winchester

22. The man is the fifth prisoner at Winchester to die of natural causes since January 2010. Recent reports reflected well on prison healthcare and found that the men in question received care equal to what they could have expected to receive in the community.

KEY EVENTS

23. The man was born in February 1965. On 24 May 2011, he was remanded to HMP Winchester charged with a serious violent offence.
24. A clinical team manager carried out an initial healthcare screen and recorded that he had high cholesterol and had been prescribed a statin for this by his GP. He said he had suffered a slipped disc some time previously and had experienced a nervous breakdown eight years before. He had a longstanding history of alcohol abuse and had taken drugs in the past. He was a smoker. A psychiatrist saw him the same day. He began an alcohol detoxification programme, which he completed on 31 May. In the following months, he had very little contact with healthcare staff except for some minor health matters.
25. On 23 September 2011, a nurse saw the man after he found a lump in his neck. He explained that it was not causing him any pain or discomfort, and he did not feel unwell because of it. She booked an appointment for him to see a doctor.
26. On 27 September, a doctor reviewed the man's medication. There is no record that he or the doctor mentioned the lump in his neck at this appointment. On 3 October, another doctor examined the lump and referred him to hospital under the "two week rule". (There is an NHS target for patients with suspected cancer to be seen by a consultant within two weeks.)
27. On 21 October, a consultant at the hospital told the man that it was likely that he had carcinoma of the larynx (throat cancer) and that he would require further treatment.
28. The man returned to prison the same day. A clinical team manager noted that he needed to be seen by someone for support, guidance and re-assurance. A nurse spoke to him at length. He noted that the man appeared to be calm and accepting of his diagnosis. He told the nurse that he had growths that could be treated possibly by surgery, or with chemotherapy. He said he did not need emotional support at that stage. The nurse told him to speak to any of the nurses if he wanted to discuss anything further and noted that he would be monitored daily.
29. A note of 21 October on the man's medical record indicated that all his hospital appointments were to be given high priority.
30. The man attended an appointment for smoking cessation advice on 26 October. On 1 November, he was prescribed varenicline tablets to reduce nicotine addiction. He continued to attend his appointments for smoking cessation.
31. On 9 November, the man went to hospital for a laryngoscopy and pharyngoscopy (internal examination of the nose and throat). He returned to the prison the same day with a prescription of diclofenac (anti-inflammatory medication used to treat pain and inflammation).

32. On 22 November, the man attended hospital for an appointment to give him a diagnosis and treatment options. The records show that the diagnosis was cancer, which had spread to the lymph nodes on both sides of his neck. He was booked to undergo combined radiation and chemotherapy.
33. Although the man was expecting the diagnosis, the records show he was still shocked. He had been told by the hospital that the treatment was not about curing the disease but about "containment". Healthcare staff at Winchester offered him extensive support and guidance.
34. The man started chemotherapy in December 2011. He was fitted with a nasogastric tube (which would allow him to receive fluids and nutrition if he could not swallow). He attached and ran the feeding tube himself, but healthcare staff were responsible for maintaining and cleaning the tube. Records show that this was carried out efficiently.
35. On 23 January 2012, the man was granted bail by the court and went home to finish the course of treatment in the community.

Winchester – August 2012

36. The man returned to court on 9 July 2012 after he was deemed fit to stand trial. On 3 August, he was sentenced to three years four months imprisonment at Crown Court and returned to HMP Winchester the same day.
37. A nurse completed an initial health screen and noted that the man had been treated for throat cancer and his chemotherapy had finished in February 2012. The nurse recorded that he said he was prescribed oramorph (liquid morphine) and thiamine (vitamin B1) and that he appeared weak and gaunt.
38. A doctor saw the man the next day, Saturday 4 August. The doctor recorded that he had been treated for throat cancer and that this was confirmed by a letter that he had brought into the prison from his community doctor. He told the doctor that he had pain in his upper back and throat region. His body mass index was recorded at 17, which is in the underweight range. Medications listed as prescribed by his community doctor were re-prescribed and he was given fluoxetine (anti-depressant), co-codamol (pain killer), vitamin B compound, thiamine and simvastatin (medication to lower cholesterol).
39. The next day, Sunday 5 August, he was prescribed Ensure Plus to help him put on weight, as he had lost 27kg in the previous six months. Oramorph was not on the list provided by his community doctor and it was noted that this would be discussed with his GP the next day. It was also noted that the man had two follow-up hospital appointments on 14 and 21 August. He was prescribed oramorph on 6 August, after his community GP confirmed the prescription.
40. On 8 August, a nurse spoke to the man about his location in the prison. He said that he would prefer to stay in his shared cell, but that he realised he would need to eventually move downstairs or to the healthcare inpatient unit. He requested that this did not happen until it was absolutely necessary.

41. A nurse saw him on 9 August, when he said he felt okay, but had not moved much that day as he felt very tired. The nurse advised him about the importance of moving around his cell and getting out of his cell to associate with other prisoners.

Events leading up to the man's death.

42. On 12 August, a nurse recorded that he went to the man's cell to give him his morning medication. (This was about 9.30am.) He found him struggling to breathe and looking very poorly. He had a high temperature, a fast pulse and low blood pressure and the nurse administered oxygen.

43. An ambulance was called at 9.50am. Records show that it arrived at the prison at 10.20am. Paramedics tried to stabilise the man before they left the prison at 11.35am. He was taken to Accident and Emergency. Records show that he was handcuffed to an officer by an escort chain when he left the prison, but this was removed at the request of medical staff when he arrived at the hospital. He was transferred to the intensive care unit where he was diagnosed with pneumonia and placed in an induced coma.

44. On 13 August, a nurse visited the man at the hospital and recorded that his prognosis was not good. The prison then began steps to contact his next of kin.

45. The man's cellmate told us that at approximately 4.00am on 12 August he had woken to find him collapsed on the toilet. He said that he had pressed the cell bell to alert staff and that an officer attended. He told us that the officer explained that they would have to wait until the morning for medical attention. The cellmate said that he laid him on the bed.

46. The cellmate said that he pressed the cell bell again between 9.00 and 9.30am as the man was having difficulty breathing and looked pale. He said that he felt he needed medical attention, so requested a nurse. He told us that the man was not seen by a nurse until approximately 1.30pm. (He had been in hospital for almost two hours by that time, so clearly this time is incorrect.)

Contact with the man's family

47. When the man was admitted to hospital on 12 August he said that the only person he wanted to be contacted was his former partner, as she could let their daughter know if anything happened. The prison did not have details of his former partner, but obtained a telephone number from the police. An operational manager informed his former partner that he was very ill in hospital. The prison passed her contact details to the hospital to allow them to contact her directly if necessary.

48. On 14 August, the prison was informed that the man was dying. A Senior Officer (SO), who was the appointed prison family liaison officer, a Principal Officer (PO) and the healthcare manager went to the hospital and met the man's family, who were already there.

49. The SO offered support and explained what would happen after the man's death.

50. The man died with his family by his side. In line with national guidance, the prison offered to assist with the funeral costs.

Informing staff and prisoners

51. Staff and prisoners were informed of the man's death by a notice from the Governor and support was offered if needed. On the day of his funeral, a service was held in the prison chapel so his friends in the prison were able to attend.

52. Escort and healthcare staff involved in the man's care were appropriately debriefed and supported.

Post-mortem report

53. The post-mortem report gave the cause of the man's death as severe pneumonia.

ISSUES

Clinical Care

54. The clinical reviewer reports that the man received a high level of care at Winchester during the extended period of his combined chemotherapy and radiotherapy and that his care was equivalent to that which he could have expected in the community.
55. When the man saw the doctor with a lump in his neck, this was dealt with appropriately and an urgent referral for suspected cancer made. We are satisfied that he was kept informed and well supported by prison healthcare staff as he came to terms with his diagnosis and treatment.
56. The man's treatment was largely outpatient based and he missed no appointments while he was at Winchester. The clinical reviewer points out that, once he started his cancer treatment, he had a nasogastric tube inserted to help maintain his fluids and nutrition and this was well managed by healthcare staff at the prison before he was released on bail.
57. The man had been back in prison only nine days when, on 12 August, he became suddenly and seriously unwell. His condition was immediately acted upon: he was given fluids, glucose and oxygen before being taken as an emergency to hospital. He was transferred to intensive care and died two days later.
58. The clinical reviewer was concerned that there was a delay in prescribing the man his oramorph pain-relief when he returned to prison, because this had been omitted from the list of medications supplied by the community GP. He arrived at the prison on a Friday and told the nurse at his initial screening that he was taking oramorph, yet his medication was not reviewed until the following day. As it was the weekend, it was not possible to check the prescription with his community GP until the Monday. This meant there was a 72 hour delay in him getting his pain relief medication, which is not acceptable. His oramorph prescription ought to have been checked with his GP the day he arrived.

The Head of Healthcare should ensure that medication reviews are held at the earliest opportunity for prisoners arriving with a serious illness such as cancer, so that there is no delay in prescribing appropriate pain relief.

59. The NHS document "The route to success in end of life care – achieving quality in prisons and for prisoners" sets out how an end of life care pathway might be implemented in prisons. Among the benefits of an end of life pathway are that it helps carers to plan when and how care will be delivered, and helps patients make choices about how they are to be cared for towards the end of their lives. The clinical reviewer notes that, when the man returned to Winchester there does not appear to have been any consideration given to whether an end of life pathway was appropriate. In the light of his cancer diagnosis and obvious poor state of health this should have happened.

The Head of Healthcare should ensure that formal end of life pathways are considered when appropriate and implemented for prisoners with a terminal illness.

Use of cell-bell

60. The man's cellmate told the investigator that he rang the cell emergency bell after he found him collapsed in the cell at around 4.00am on 12 August. He said that an officer came to the cell and said that the man would have to wait until morning for medical assistance. The cellmate said that he rang the bell again at around 9.00am or 9.30am, but that the man was not seen until 1.30pm.
61. The cell-bells at Winchester are automatically recorded, and we asked for a print-out for the night of 11/12 August. We were given records running from just after midnight on 10/11 August through to 9.51pm on 12 August. The records show that the only cell-bell activity from the man's cell during that period was on 11 August at 7.14pm. According to the records, there was no cell-bell activity for long periods on both nights. On 10/11 August, there was no cell-bell activity on B wing, where he lived, from 12.51am until 8.29am. On 11/12 August, there was no cell-bell activity on B wing from 10.03pm until 8.57am.
62. This lack of cell-bell activity appeared unusual so we asked the prison to check whether the cell-bell recording system was working effectively. A further check was made and we were assured that the system is in working order. The prison was unable to explain the apparent low cell-bell usage on those nights. At our request, the prison carried out a second set of cell-bell checks overnight and these also showed that recording system was working correctly. The wing log book/observation book for 11/12 August contains no entries relating to the man that night, or that anyone attended his cell.
63. We know that the man was seen by a nurse on the morning of 12 August, and that an ambulance was called at 9.50am. Paramedics treated him for over an hour before taking him to hospital at 11.35am. This means that the cellmate's recollection that he was not seen until 1.30pm is incorrect and neither is there any evidence to support his account of what happened earlier in the morning.

Use of restraints

64. The Prison Service has a duty to protect the public when escorting prisoners to hospital, and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility.
65. The man was handcuffed by an escort chain to an officer when he left the prison by ambulance on 12 August. The restraints were removed at the request of medical staff (for treatment purposes) when the ambulance arrived at the hospital and were not reapplied.

66. The risk assessment document indicates that the man was considered high risk to the public (relating to threats made to one person) and a medium risk of escape, with a history of violence. Although clearly very ill, he was conscious and the prison considered he was capable of escape at the time. We consider it very unlikely that this assessment accurately took into account his state of health. As this was an emergency and restraints were used for only a very short period on the journey to the hospital, we make no formal recommendation, but the prison needs to note that risk assessments should take full account of a prisoner's health at the time. Once at the hospital, the restraints were removed, and following a further risk assessment were not reapplied due to his serious condition. We are satisfied that this later assessment was appropriate.

RECOMMENDATIONS (*service response in italics*)

1. The Head of Healthcare should ensure that medication reviews are held at the earliest opportunity for prisoners arriving with a serious illness such as cancer, so that there is no delay in prescribing appropriate pain relief.

Accepted: *Prisoners received into HMP Winchester who are identified as having a serious illness will be offered a GP appointment for the next clinic. Slots are available for this purpose. For those prisoners taking medication prescribed by their own GP, confirmation will be sought at the earliest opportunity.*

2. The Head of Healthcare should ensure that formal end of life pathways are considered when appropriate and implemented for prisoners with a terminal illness.

Accepted: *'End of Life' care pathways will be considered and implemented where appropriate for prisoners with terminal illness.*