



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at
HMP Winchester in February 2013**

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 the investigation report into the death of a man at HMP Winchester in February 2013. He died from a brain tumour. He was 81 years old. I offer my condolences to his family and friends.

A clinical review was conducted of the standard of healthcare the man received in custody. The prison cooperated fully with the investigation.

The man was frail when he arrived at Winchester in May 2012 and his health deteriorated. In September 2012, he was taken to hospital as an emergency and diagnosed with a probable brain tumour. When he returned to the prison at the end of October, he had been told that his life expectancy was two months and a palliative care plan was put in place.

There was no formal record that compassionate release had been considered by the prison and I do not consider that the use of restraints for the man's first days in hospital was justified by an appropriately considered risk assessment. I share the clinical reviewer's opinion that his deteriorating health before he was diagnosed could have been more effectively managed, but I am satisfied that this did not affect the outcome. Overall, I agree with the clinical reviewer that the palliative care arrangements for him were appropriate to his needs and that he was nursed commendably well at the prison.

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

February 2014

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SUMMARY

1. The man arrived at HMP Winchester on 8 May 2012 to serve a four and a half year sentence. He was accommodated in the inpatient unit because of his age and frailty following hip surgery earlier that year. He remained largely confined to a wheelchair, chair or bed throughout his stay. He was deaf and had poor eyesight, which impaired communication. Over the next few months, his health deteriorated, his mobility worsened, he became incontinent and he lost weight.
2. On 14 September 2012, the man was admitted urgently to hospital because he was dehydrated, and he had lost a lot of weight. His mobility issues and deteriorating medical condition were not fully taken into consideration in the risk assessment, and for his first days in hospital he was restrained by an escort chain. (A long chain with a handcuff at each end attached to the prisoner and an officer.) No restraints were used after 17 September.
3. The man was treated for a severe infection. Tests revealed that he had an abnormality in his brain. He was transferred to a Neurological Centre on 21 September, where he was diagnosed with a probable brain tumour. This could only have been confirmed for certain by a high risk biopsy, which the consultant decided was not in his best interests.
4. The man returned to hospital on 23 September and was discharged to the prison's inpatient unit on 29 October. He had been told by hospital staff that he could expect to live for two months. A palliative care plan was drawn up to manage his terminal care. His cell door remained open, a special mattress and bed were provided and flexible visiting arrangements were introduced. We agree with the clinical reviewer that the palliative care arrangements were appropriate to his needs and that he received good nursing care.
5. The man did not deteriorate as fast as originally predicted and he remained in the inpatient unit for four months before his death. There is no record that compassionate release was considered. The prison contacted his family after his diagnosis and stayed in touch with them throughout the course of his illness. We are satisfied that family liaison arrangements were sensitively managed.
6. The man died in February with two nurses present.

THE INVESTIGATION PROCESS

7. This office was informed of the man's death on 25 February 2013. The investigator issued notices informing staff and prisoners of the investigation and asking anyone with relevant information to contact him. No one responded.
8. The investigator obtained copies of the man's medical and relevant prison records. The local Primary Care Trust (PCT) appointed a clinical reviewer to conduct a review of the clinical care that the man received at HMP Winchester.
9. The investigator visited Winchester on 26 March, met the Governor, and visited the inpatient unit where the man died. He and the clinical reviewer interviewed six members of staff at HMP Winchester on 23 April.
10. The investigator informed HM Coroner for Hampshire Central of the investigation. A copy of this report has been sent to the Coroner to assist his enquiries.
11. One of our family liaison officers wrote to the man's son to explain the purpose of the investigation. He did not have any specific concerns for the investigation to consider.
12. The man's next of kin received a copy of the draft report. They did not make any comments.

HMP WINCHESTER

13. Winchester is a local prison, serving the courts in Hampshire and can hold more than 700 adult remand and convicted men. Most of the prisoners are either held on remand or are serving short custodial sentences. Solent NHS Trust provides health services at the prison. The healthcare centre contains a 22-bed inpatient unit, which caters mainly for patients with mental health needs and for prisoners with disabilities. There is 24-hour nursing cover. Doctors from a local practice run daily surgeries from Monday to Friday.

HM Inspectorate of Prisons (HMIP)

14. The last inspection of Winchester by HMIP took place in October 2012. The report found the prison had deteriorated sharply since the previous inspection and was “of serious concern”. A health needs assessment had only recently been completed and partnership arrangements were only slowly developing. Provision for prisoners with chronic diseases and mental health issues was found to be inadequate.
15. The Inspectorate found that prisoners in the inpatient unit had a complex mix of both mental and physical health problems. The Inspectorate observed constructive multidisciplinary care, but there was insufficient primary mental health provision and no counselling services. Prisoners were only unlocked for an hour each day for outside exercise and showers. There was no supportive therapeutic activity.

Independent Monitoring Board (IMB)

16. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who 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. The Board noted that individual members of staff often demonstrated outstanding levels of care to prisoners.

Previous deaths at Winchester

17. The man is the sixth prisoner at Winchester to die of natural causes since January 2010. Recent reports found that the men involved received care equivalent to what they could have expected to receive in the community.

ISSUES

The diagnosis of the man's terminal illness

18. The man's health deteriorated over the four months between his arrival at HMP Winchester in May 2012 and September. His weight dropped from 76.4 kilograms at reception to 60 kilograms, and he became doubly incontinent. He was reluctant to keep himself clean, and ate and drank less as time passed.
19. On 18 July, one of the prison doctors examined the man in his cell, and he told her that his left eye was filmy. She concluded that he was old and frail and referred him to an optician.
20. On 22 August, another prison doctor examined the man twice because of an upset stomach and vomiting. He requested blood tests and concluded that he might have emphysema.
21. On 28 August, a doctor analysed the results of the man's blood tests from 22 August. The blood test results showed that he had an elevated erythrocyte sedimentation rate (ESR), which can be caused by infections, inflammations or cancer. There was no recorded follow up to this consultation.
22. On 14 September, the clinical team manager examined the man because officers were concerned about him. His pulse, blood pressure and oxygen levels were all normal. As he was dehydrated, and had lost a significant amount of weight, the manager decided that he should go to hospital.
23. The man was admitted urgently to hospital that day. He was treated for a severe infection and given antibiotics intravenously, but his condition continued to deteriorate. On 21 September, he was transferred to another hospital as he had a fungal abscess and needed further tests.
24. The man was taken to a Neurological Centre where he had a magnetic resonance imaging (MRI) scan the next day. The MRI showed a lesion on his brain. He returned to back to hospital on 23 September and was referred to an oncologist, while the hospital waited for the results of the MRI scan. On 11 October, the Neurological Centre wrote a discharge letter to the hospital, indicating that he was most likely to have a brain tumour.
25. The man's diagnosis was not confirmed before his death, because to do so would have been too intrusive, but the post-mortem report confirmed that he had died from a brain tumour.
26. The clinical reviewer notes that there was no clear responsibility for one person to have oversight of the man as an inpatient at the prison. Some of his previous consultations could have been symptoms of a brain tumour but were never considered in the round. She notes that the records of consultations were often brief and took a narrow view of a presenting problem. The Modern Matron said that there are no routine ward rounds with

a regular doctor and that the doctor's time is very limited on the inpatient unit. Multidisciplinary ward rounds would give a fuller picture of a patient's condition.

27. The clinical reviewer does not consider that an earlier diagnosis of the tumour would have made a difference to the outcome for the man. However, a more coordinated approach to his care could have led to a more prompt diagnosis and palliative treatment.

The Head of Healthcare should ensure a coordinated approach to prisoners' clinical care in the inpatient unit, including through regular multidisciplinary ward rounds.

Informing the man about his condition and treatment

28. The man was told of his diagnosis and prognosis in hospital although his medical records suggest that he might not have fully understood the implications. No curative treatment was possible but an oral steroid was used to help shrink the tumour temporarily. On 4 November it is recorded that he did not know the location of the tumour. A doctor said that the man was not able to understand his illness, although staff tried to explain it to him.
29. Towards the end of his life, the man became confused and communication became increasingly difficult. It is noted on his medical record on 15 January 2013 that he did not have the capacity to make decisions.
30. We are satisfied that the evidence indicates that the man was told about his condition once he was diagnosed. Staff continued to explain his treatment to him, although he could not always understand.

Appointments and treatment

31. Before the man was admitted to hospital in September, three tests ordered by doctors were not carried out. A urine test requested on 22 August and a urine and sputum test requested on 7 September were not completed and a referral to the geriatric day service was overlooked.
32. A doctor explained that there is no system of ensuring that the doctor who orders a test looks at the results. As there is little evidence of coordination of care in the inpatient unit, outstanding actions are not noticed or followed up. This underlines the importance of the multidisciplinary ward rounds as recommended above to improve communication and coordination of clinical care.
33. We agree with the clinical reviewer's concern about the failure to undertake the urine and sputum tests.

The Head of Healthcare should ensure that actions arising from consultations are clearly recorded and followed up by an identified

member of the healthcare team.

Pain relief and medication

34. Once he got back from hospital, the clinical reviewer considers that the man's pain and symptoms were managed well. A syringe driver was available if needed. As he became less able to swallow his medication, an appropriate decision was taken to stop his oral medication and to use a transdermal patch to deliver effective pain relief. The dose of this was adjusted when required.
35. We agree with the clinical reviewer that the man's pain was managed appropriately and his medication was adjusted when his condition changed.

Family liaison

36. The prison contacted the man's son and daughter in law on 19 September 2012, five days after he was admitted to hospital, because his condition had deteriorated and was considered serious. The prison kept in touch with his family about his condition throughout his illness.
37. When the man returned to the inpatient unit, flexible visiting arrangements were agreed. He did not have to send out visiting orders and visits could take place during the afternoons in his cell in the inpatient unit. His care plan also gave individually named members of staff responsibility to liaise with the family.
38. The dedicated Family Liaison Officer (FLO) and other staff were in regular telephone contact with the man's son in the days leading up to his death. His family were content to be notified of his death by telephone and said that if he died during the night, they would prefer to be contacted the next morning. He died in February in the inpatient unit at Winchester. The FLO spoke to the man's son that morning at 8.50am to let him know that his father had died.
39. The prison offered his family a contribution towards funeral expenses in line with national requirements.
40. We are satisfied that the prison supported the family with sensitivity during the man's illness and after his death.

Location

41. After his terminal diagnosis and discharge from hospital, it was agreed that the man should remain in the prison's inpatient unit. His care plan allowed for his cell door to be open, with a screen around it to provide an appropriate level of privacy.
42. As the man had not been to any other wing of the prison, and due to the complexities of this condition, we consider that his location in the inpatient unit was appropriate to his needs.

Compassionate release

43. Release on compassionate grounds is a means by which prisoners who are seriously ill (generally with a life expectancy of less than three months) can be released from custody. The principles that underlie the approach for early release on compassionate grounds are that the release of the prisoner will not put the safety of the public at risk; that a decision to approve release would not normally be made on the basis of facts which the sentencing or appeal court was aware; and that there is some specific purpose to be served by early release.
44. The prison told the investigator that the Governor had considered compassionate release for the man shortly after his terminal diagnosis, but did not consider it appropriate. This was because of the nature of his offences and the fact that he did not have a suitable address to which he could be released.
45. While we understand that it might have been difficult to arrange compassionate release for the man, there is no evidence of this consideration. Compassionate release needs to be fully and properly considered and a written record kept.

The Governor should ensure that the possibility of early release on compassionate grounds is considered and documented for all terminally ill prisoners with a short time left to live.

Palliative care

46. When the man returned to the inpatient unit with a terminal diagnosis, he was given an estimated life expectancy of two months. He had a hospital profile bed with a pressure relieving mattress and an emergency call bell. His cell door was to remain unlocked.
47. The man's palliative care plan was based on the recommendations of the Liverpool Care Pathway to ensure that his pain level was assessed daily, his continence was checked every four hours, and that he was encouraged to eat and drink. The clinical reviewer considers that the planning of his palliative care was of a high standard.
48. Throughout his terminal illness the man received regular clinical monitoring of his condition, good symptom control and good nursing care. The clinical reviewer is satisfied that the palliative care he received in prison was at least equivalent to that he could have expected to receive in the community and commends the skill of the nursing which ensured that he had no bedsores despite being bedridden for some months.

Restraints

49. 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 also takes into account factors such as the prisoner's health. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that a medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process.
50. When the man was taken to hospital on 14 September 2012, a risk assessment was undertaken about the level of security required while being escorted and monitored at hospital and he was considered medium risk to the public and a medium risk of escape. There is no indication that his mobility or the circumstances of his offences some years previously were considered. Although not clear from the risk assessment, the escort log indicates that he was restrained by an escort chain to an officer. The assessment was reviewed the next day but not changed. At 10pm on 17 September, the escort chain was removed as escorting officers were concerned about his condition. This was formally agreed by a new risk assessment the next day and restraints were not used again.
51. Security measures must be proportionate to a prisoner's individual circumstances. It is surprising that when the man, an 81 year old man in a wheelchair, was taken to hospital he was not assessed as a low risk of escape. Although his risk assessment was reviewed, we are not satisfied that his medical condition was given sufficient weight. The further risk assessment on 18 September decided that he did not need to have restraints applied but still assessed him as a medium risk to the public and medium risk of escape. We make the following recommendation:

The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.

RECOMMENDATIONS

1. The Head of Healthcare should ensure a coordinated approach to prisoners' clinical care in the inpatient unit, including through regular multidisciplinary ward rounds.
2. The Head of Healthcare should ensure that actions arising from consultations are clearly recorded and followed up by an identified member of the healthcare team.
3. The Governor should ensure that the possibility of early release on compassionate grounds is considered and documented for all terminally ill prisoners with a short time left to live.
4. The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.

ACTION PLAN: The Man – HMP Winchester February 2013

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure a coordinated approach to prisoners' clinical care in the inpatient unit, including through regular multidisciplinary ward rounds.	Accepted	In-patients needing to be seen by a GP will be seen at the end of morning surgery.	12 th July 2013	
2	The Head of Healthcare should ensure that actions arising from consultations are clearly recorded and followed up by an identified member of the healthcare team	Accepted	The nurse in charge for each shift will ensure that tasks resulting from the GP clinic are forwarded to the appropriate department or individual.	12 th July 2013	

3	The Governor should ensure that the possibility of early release on compassionate grounds is considered and documented for all terminally ill prisoners with a short time left to live.	Accepted	Consideration for early release on compassionate grounds will be documented for all prisoners who are terminally ill. A copy of the decision will be held with the FLO log and file in Safer Custody.	1 st July 2013	
4	The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.	Accepted	All hospital escort risk assessments will take into account the medical condition of the individual and the actual risk the prisoner presents.	15 th July 2013	