



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man on 8 July
2013 while on remand to 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 the investigation report into the death of a prisoner at HMP Winchester who died at Southampton Crown Court on 8 July 2013. He was 76 years old. A post-mortem report recorded his death was caused by heart disease. I offer my condolences to the man's family and friends.

The investigation was carried out by one of my investigators. A doctor reviewed the clinical care the man received at the prison. HMP Winchester and GEOAmev (who were responsible for the man's custody at court) cooperated fully with the investigation.

The man had been at Winchester prison since 10 December 2012. He was in poor health, had a history of high blood pressure and diabetes and had been admitted to hospital a number of times while at the prison.

On 8 July, the man was taken to Southampton Crown Court for sentencing. After he was sentenced, the man returned to a court cell while arrangements were made for him to be released. During a routine check at 4.05pm, the man was found unresponsive by escort staff. The escort staff attempted resuscitation but paramedics subsequently confirmed that the man had died.

The clinical reviewer concludes that, overall, the care the man received at the prison was equivalent to what he would have expected in the community. However, he identified the need for a review of the processes for assessing fitness to attend court and prescribing practices at the prison. The investigation also identified a need for appropriate risk assessments for the use of restraints for prisoners who are elderly and infirm, both by the prison and GEOAmev.

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

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SUMMARY

1. The man was remanded to HMP Winchester on 10 December 2012, when he was 75 years old. During his reception health screening it was recorded that he had history of high blood pressure and type 2 diabetes. On 13 December, information received from his community GP showed that he had a history of gastric and duodenal ulcers, kidney disease and that he had previously vomited blood. The man walked using a stick and later used a wheelchair.
2. During his time at the prison, the man was taken to hospital a number of times. Each time restraints were used but medical opinion about how his health impacted on his risk was not always considered as part of the risk assessment.
3. On 3 June, the man was convicted of sexual offences and was to be sentenced at a later date after the court received a report from the Probation Service. On 8 July, the man was taken to court for sentencing. On the way, the escort vehicle had to stop suddenly and the man fell out of his wheelchair which had not been secured properly. He had minor injuries and a graze to his hand was cleaned and dressed when he arrived at court.
4. The man was sentenced to 12 months imprisonment. As he had already served time in custody the judge directed that he should be released on licence. The man was held in a court cell while arrangements were made for his release to a probation approved premises. Wellbeing checks were conducted by court escort staff throughout the afternoon. At around 4.05pm, the man was discovered unresponsive, and an ambulance was called. GEOAmey staff attempted to resuscitate him but paramedics pronounced him dead at 4.14pm, shortly after they arrived.
5. A post-mortem examination found that the man had died from severe coronary artery atherosclerosis caused by chronic obstructive pulmonary disease.
6. The clinical reviewer considered that the standard of clinical care given to the man was equivalent to that he could have expected in the community. He also found that some aspects of the man's care exceeded what would have been available in an outside hospital or nursing home. However, we make four recommendations relating to health services at Winchester and risk assessments for the use of restraints.

THE INVESTIGATION PROCESS

7. The investigator issued notices at HMP Winchester and Southampton Crown Court informing staff and prisoners of the investigation and inviting anyone with any relevant information to contact him. No responses were received.
8. NHS England commissioned a doctor to review the man's clinical care in prison and court custody.
9. The investigator visited Winchester on 11 July. He met the Governor and spoke to staff involved in the man's care. He obtained copies of the man's relevant prison records, including his prison medical record. The investigator visited Southampton Crown Court on 16 July and met both GEOAmev and court staff. On 26 September, he interviewed staff at Winchester. He gave initial feedback to the Head of Safer Custody at the prison and subsequently followed this up in writing. The investigator interviewed GEOAmev staff at Southampton Crown Court on 3 October. At the draft report stage, the National Offender Management Service (NOMS) responded to the recommendations. That response is included below the recommendations at the end of this report.
10. HM Coroner for Hampshire, Southampton and the New Forest was informed of the investigation and provided the results of the post-mortem examination. The Coroner has been sent this investigation report.
11. One of the Ombudsman's family liaison officers, contacted the man's nominated next of kin, his neighbour, to explain the purpose of the investigation and invite him to raise matters he wished the investigation to consider. His neighbour said that the man appeared to have been well looked after in prison and he had no specific matters for the investigation to consider. The man's next of kin received a copy of the draft report. They did not make any comments that have led to factual changes in this report.

HMP WINCHESTER

12. Winchester is a local prison, serving the courts in Hampshire and can hold more than 700 adult remand and sentenced men. 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

13. Winchester was last inspected by HM Inspectorate of Prisons (HMIP) in October 2012. The inspection report found that standards at the prison had deteriorated significantly since the previous inspection and the experience for vulnerable prisoners was particularly poor. A health needs assessment had only recently been completed. Provision for prisoners with chronic diseases and mental health issues was found to be inadequate.
14. The Inspectorate found that prisoners in the inpatient unit had a complex mix of both mental and physical health problems. While there was constructive multidisciplinary care, there was insufficient primary mental health provision. Inpatients were unlocked for only an hour each day for outside exercise and showers. There was no supportive therapeutic activity.

Independent Monitoring Board

15. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In their latest published report, the IMB noted that, under new management, robust systems had been put in place in the healthcare unit and that there were now two nurses on duty at night which helped improve safety.

Previous deaths at Winchester

16. The man is the seventh prisoner at Winchester to die of natural causes since January 2010. We have previously made recommendations about appropriate risk assessment for the use of restraints and do so again in this report.

KEY EVENTS

17. The man was remanded into custody by Southampton magistrates' court on 10 December 2012 charged with sexual offences. He arrived at HMP Winchester on the same day. He was a month away from his 76th birthday and this was his first time in prison. During his reception health screening, it was recorded that the man had a history of high blood pressure (hypertension) and type 2 diabetes mellitus. He used a walking stick and his mobility was limited by gout (a type of arthritis) and his age. His mobility got worse and he later began to use a wheelchair.
18. On 11 December, a prison doctor saw the man and recorded that he had complained of pain in his big toe (which can be a symptom of gout). The prison doctor prescribed metformin (an oral antidiabetic medication), perindopril erbumine (for high blood pressure) and ibuprofen (an anti-inflammatory). On 13 December, information from the man's community GP confirmed he had a history kidney disease, ulcers (gastric and duodenal) and had previously vomited blood.
19. On 20 December, the man had a fall in his cell. A nurse examined him the same day and recorded his blood pressure was slightly low (118/78)¹ and that consideration should be given to moving him to the healthcare centre because of his poor mobility. A prison doctor, admitted him as an inpatient the next day. His blood pressure and pulse rate were normal. He was prescribed naproxen (a strong anti-inflammatory).
20. During the late evening of 30 December, the man vomited and a nurse noted the presence of coagulated blood. His blood pressure was normal but his pulse was slightly high. The out of hours GP service advised that the man should be taken to hospital. It is not clear why this did not happen immediately but a locum prison doctor saw him the next morning when his symptoms had subsided and she decided not to send the man to hospital.
21. At around 7.30am on 2 January 2013, a nurse saw the man after he had vomited three times during the night. The man said that after each episode he felt weaker and there had been blood in his stools. On examination the man was found to be short of breath and looked grey. His blood pressure was low (90/68) and his pulse was normal. The man was taken to the local hospital by ambulance. His risk to the public was assessed as high and the risk of escape was medium and he was escorted by two officers and restrained by an escort chain. The security risk assessment did not include any medical information. The risk assessment was reviewed at around 4.00pm and the restraints were removed and not reapplied.
22. An X-ray of the man's spine showed a fracture of the vertebrae in his lower back and he was fitted with a spinal/back brace (it is not clear from the records when this injury occurred). An endoscopy (a test that used a long flexible tube

¹ Blood pressure and pulse - most adults in the UK have blood pressure readings in the range from 120/80 to 140/90 and normal pulse rate is between 60 and 100 beats per minute

with a camera to look inside the body) showed an inflamed oesophagus. The man was fitted with a catheter, to drain urine and treated with antibiotics for a urine infection.

23. During the evening of 7 January, the man was discharged from hospital and returned to the healthcare unit at Winchester. On 11 January, records show that the man was doubly incontinent. This, combined with his limited mobility, continued to be a problem throughout his time in custody. On 16 January, it was recorded that the man had inappropriately touched the nurse who was caring for him
24. On 23 January, a mini mental health examination (a brief 30 point questionnaire test used to screen for cognitive impairment) was carried out with the man. He scored 30 out of 30 (a score of 27 and above is considered normal). An entry in the wing observation book said: "The man has been informed that his behaviour towards other adult males is unacceptable. He keeps making sexual advances and highly inappropriate comments". The man was subsequently not allowed to associate with other prisoners in the healthcare centre for his own safety. On 25 January, the man was warned for being verbally abusive towards staff.
25. On 29 January, a prison doctor recorded that the man was fit to attend court for his hearing due on 4 February. However on 4 February, the man complained of chest pains and breathlessness. His blood pressure was low and he was taken by ambulance to hospital. The initial risk assessment is incomplete but concluded that the man was to be escorted by two officers and restraints were used.
26. In hospital, the man was diagnosed with a pulmonary embolus (blockage of one of the main arteries leading to the lung) and prescribed warfarin. On 13 February, the man was discharged from hospital and returned to the prison.
27. On 21 February, the man declined to attend an orthopaedic clinic in relation to his back problems. On 2 March, a nurse recorded that the man was reluctant to wear his spinal/back brace and he removed it the next day. Blood tests conducted on 12 March showed that his cholesterol and diabetic control were both good.
28. On 24 March, the man was taken to hospital after complaining of abdominal pain. After he had blood tests and an X-ray he returned from hospital later that same day. On 25 March, another prison doctor saw the man and recorded that he was still weak and not fit for court. However, he was fit to be interviewed by the police in the healthcare centre about allegations of sexual assault against staff but not fit enough to leave the prison.
29. On 28 March, a prison doctor decided that the man should be referred to hospital. He was accompanied by two officers and restraints were used. The security risk assessment did not include any healthcare information. While the man was in hospital the risk assessment was reviewed but remained

unchanged. A brain scan conducted by the hospital showed evidence of an old stroke and the man was discharged from hospital five days later, on 2 April.

30. On 5 April, the man became ill while having a dressing on his hand changed and was taken to hospital. He was accompanied by two officers and restraints were used. A healthcare contribution to the risk assessment did not object to restraints being used.
31. On 12 April, the man was discharged from hospital following treatment for dehydration. It was noted on his discharge summary that the man had behaved inappropriately towards a number of hospital staff.
32. On 13 April, the man attended a disciplinary hearing about an alleged physical assault of one of the escort officers on 11 April. The hearing was adjourned pending outcome of a police investigation which was not completed before the man died.
33. On 15 April, the man was taken to Southampton Crown Court. After his court appearance his solicitors wrote to the prison to ask whether he was fit to attend court. A prison doctor responded on 26 April and said that the man had been admitted to hospital on 5 April, after suffering from dehydration following a bout of diarrhoea. He was treated with fluid and electrolyte replacement before he was discharged. The prison doctor's assessment was that although the man had problems with his mobility, he would be fit enough to attend court.
34. On 28 April, it was recorded that the man continued to be incontinent and had blood in his stools. The next day, he was taken to hospital. The man was accompanied by two officers and restraints were used. On 4 May, the man had tests which revealed he had diverticulitis (a common digestive disease) and was to receive antibiotics. The next evening, on 5 May, the man was discharged from hospital.
35. On 10 May, a nurse recorded that the man was fit to attend court provided he had suitable transport and a wheelchair. On 23 May, he was taken to hospital where he received a blood transfusion for low haemoglobin levels and was given an oral potassium supplement. The man was accompanied by two officers and restraints were used. The security risk assessment included medical information which did not object to restraints being used but indicated that his illness and incapacity meant he was incapable of escape. This was the man's last hospital admission. His discharge summary the next day indicated that an outpatient colonoscopy had been arranged.
36. On 3 June, the man attended Southampton Crown Court and was convicted of sexual offences. He was to be sentenced at a later date pending a report from the Probation Service. At around 11.45am, while he was in the court cells the man was unwell and vomited. A medical technician assessed the man as fit
37. After the man was convicted, the court had asked for a report from healthcare at Winchester. In his letter to the court dated 27 June, a prison doctor wrote that the man was in a poor state of health and had been confined to his bed for

some time. He confirmed that the man had oesophagitis (inflammation of the lining of the gullet), diabetes, impaired kidney function and had been treated for raised blood pressure. The doctor also wrote that the man had been admitted to hospital to treat rectal bleeding and was also due to have a colonoscopy examination of his large bowel,

38. On 6 July, a nurse completed the person escort record form to assess the man's fitness to travel to court on 8 July. He did not see the man but said there were no medical or mental health concerns at that time to prevent him attending.
39. At around 8.00am on 8 July, a nurse gave the man his medication. She said at first he was very chatty and engaging but when she was helping him get ready for court he said he was unhappy and felt scared. His mood changed and he no longer wanted to talk and avoided eye contact. He was uncooperative and another nurse had to help her dress him. The nurses persuaded the man that it was in his best interest to attend court. The man then became more positive and, with minimal assistance, got into his wheelchair. Restraints were not used when the man left healthcare or during his journey to court.
40. GEOAmeey escort staff moved the man into their vehicle for the journey to court. During the journey, he slid out of his wheelchair onto the floor when the van braked abruptly as he was not properly secured in his chair. The escort officers helped the man back into his wheelchair, ensured he was fastened in and sat with him for the rest of the journey to court. When they arrived at Southampton Crown Court, the man was treated for grazes to his hands and arms before he entered the custody suite.
41. The man arrived at court at around 10.10am and was taken to a holding cell. At around 10.45am, the man's barrister spoke to him for around 10 minutes. The investigator contacted the barrister on a number of occasions to request that he forward a statement detailing his recollections of events and the man's state of health at this time. This had still not been forwarded at the time this report was completed. The Senior Custody Officer (SCO) checked the man at around 11.20am and, in her statement, said that the man was slouched to the left, propped up on the armrest of his wheelchair and appeared asleep.
42. At around 12.00pm, the man was taken to the court room by three members of GEOAmeey staff. An escort chain² was used while the man was taken through the public area. One of the GEOAmeey staff said that he kept the escort chain on when he took the man into court as he could not get to the dock area. However, the court manager believes he was not restrained. A solicitor and a barrister saw the man being escorted to court and had concerns about how he was treated and that he was restrained and reported their concerns to the court manager.
43. The solicitor told the investigator that when she saw the man he was in a wheelchair, not sitting upright and his head was resting on the armrest. She

² According to GEOAmeey Standard Operating Procedures (SOP) 059 mechanical restraints must always be applied to prisoners prior to entering an insecure area.

said he looked extremely unwell and was yellow and very pale and appeared unconscious. She considered that the GEOAmeY staff were being unkind towards him and were quite rude about him, suggesting that he was pretending to be unwell. The barrister was not available to be interviewed.

44. The escort staff denied that he or his colleagues were rude about the man and told the investigator that the use of restraints was a standard operational policy when moving a prisoner to court through the public area. This was for security and to ensure that the man was safe from any possible reprisals due to the nature of his offence. The two other members of staff were interviewed as part of an internal investigation conducted by GEOAmeY. They both denied that the man was mistreated. One said that as the man was slumped to one side he had supported his head as they moved him around the court as some of the corridors were narrow. He recalled that the solicitor and barrister had asked whether restraints were necessary and he had told them that this was standard procedure.
45. When the man arrived at the courtroom the restraints were removed. He did not enter the dock due to his mobility issues. He was sentenced to 12 months imprisonment at around 12.45pm. The man had already served his time in custody on remand and he was to be released on licence. The restraints were reapplied and the man was then taken back to the holding cells while arrangements were made about his release to a probation approved premises. At around 1.30pm, the man was asked to sign the sex offenders register, but he refused. Shortly after this, the man pressed his cell bell and requested a drink of water, which he was given. He was checked again at 2.00pm and no concerns were noted.
46. At 3.00pm, the SCO checked the man who was asleep and slouched to the left hand side of his wheelchair. She tapped the man on the shoulder and he woke up. At 3.40pm, the SCO checked him again. In her statement to the police, she wrote that the man was slumped forward but she did not open the cell as he looked the same as he had all day. She said he was breathing normally at the time.
47. At around 4.05pm, one of the GEOAmeY staff went to see the man to get him to sign his release documents. He told our investigator that the man was in his wheelchair in the middle of the room. His body and head were both slumped over to the left. The GEOAmeY member of staff told the man that he needed to sign the licence before he could be released, but he did not respond. He went back to the custody office and told the SCO what had happened and asked a colleague to come back with him to the man's cell to see if they could get a response from him. His colleague went into the cell and as he could not get a response, he touched the man's cheek which was cold. He then tried to find a pulse in his neck but could not find one. They informed the SCO who then called an ambulance. GEOAmeY staff moved the man onto the floor and

began cardiopulmonary resuscitation³ which they continued until paramedics arrived. The paramedics pronounced death at 4.14pm.

Events after the man's death

48. Police were present at the court and interviewed court staff and found no suspicious circumstances.
49. A prison chaplain and a member prison staff informed the other prisoners in the prison's healthcare centre individually of the man's death. They were offered support and the opportunity to speak to a Listener (prisoners who are selected and trained by the Samaritans to offer confidential emotional support). Prisoners who had been identified as at risk of suicide or self-harm were reviewed. An area manager visited GEOAmey staff and offered support.
50. The prison appointed a family liaison officer. He and the prison chaplain visited the man's neighbour, who he had nominated as his next of kin to inform him of his death and to offer support. In line with national policy, the prison offered financial assistance towards the cost of the man's funeral.

Post-mortem report

51. The cause of death was severe coronary artery atherosclerosis (heart disease) and this was as a consequence of chronic obstructive pulmonary disease (narrowing of the airways). Neither diagnosis was made during his life but according to the clinical reviewer "both are often silent killers in sufferers".

³ Cardio-pulmonary resuscitation (often described as mouth-to-mouth resuscitation) is a combination of rescue breaths and chest compressions to keep blood and oxygen circulating in the body.

ISSUES

Medical care

52. The clinical reviewer made a number of recommendations in his review, not all of which are repeated in this report but which the Head of Healthcare will wish to consider. The man's challenging behaviour made it difficult for those caring for him but the clinical reviewer found that the care provided to the man was equivalent to that which he could have expected to receive in the community. He said that, in some respects, the care exceeded that which would have been available outside hospital or a nursing home; particularly the nursing care he received for his double incontinence and poor mobility.
53. The man had a history of high blood pressure, diabetes, vomiting blood and gastric and duodenal ulcers. The clinical reviewer states that the man was initially prescribed naproxen without co-prescribing a protective medicine for his stomach such as omeprazole (which reduces stomach acid). Once information was received from his GP, on 13 December, the history of previous vomiting blood and gastric ulceration made this unsafe prescribing, which should have been reviewed.
54. The man also had impaired kidney function which the clinical reviewer says also affects the advisability of prescribing any of the anti-inflammatory drugs including naproxen and ibuprofen, particularly in an elderly patient. He was concerned that the man was prescribed the maximum dose (2 grams daily) of metformin, when the tablets he arrived with at the prison were for half the strength. Although the man was treated for gout (and therefore prescribed anti-inflammatory medication) there was no mention of this in the GP summary and a confirmatory blood test was not carried out.
55. The clinical reviewer finds that there were some shortcomings in the prescribing practices at Winchester which might have triggered the man's admission to hospital with internal bleeding, but notes that this did not have serious long term consequences. However, it is important that systems are put in place to ensure safe prescribing at the prison. We make the following recommendation:

The Head of Healthcare should ensure that all prescribing at HMP Winchester is in line with best practice as recommended in the British National Formulary and by the National Institute for Health and Care Excellence.

The man's fitness to attend court

56. We are concerned that decisions regarding the man's fitness to attend court hearings appear inconsistent and were usually based just on documentation rather than an assessment in person. The man was considered unfit to appear on 25 March yet fit on 10 May. He was considered unfit on 23 May when he was readmitted overnight to hospital, yet fit to attend on 3 June. He was also considered fit to attend on 6 July, although a letter, dated 27 June, from the

prison doctor to court detailed that the man was in a poor state of health, had been confined to his bed for some time and had poor mobility. A nurse told the investigator that he did not actually see the man on 6 July when he assessed him as fit to attend court on 8 July, two days later. He said that it was standard practice to review the medical records and make an assessment on fitness to attend court from this information. His assessment was that there were no medical or mental health concerns at the time. The nurse said that it was very unusual for a prisoner to be considered not to be fit to attend court.

57. We understand that some of the differences in the assessments of fitness to attend court might not be inconsistencies but could represent real differences in the man's state of health on a particular day. However, given his very poor state of health and the variance in his condition from day to day, we consider an assessment should have been done in person on the day he was due to attend court. The man had lived as an inpatient in the prison's healthcare unit for some time because of his very poor state of health and was mostly confined to bed. We are not convinced that assessing the man through documentation alone would have been sufficient, particularly when assessments often took place a day or so before his court appearances. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prisoners who are inpatients in the healthcare unit are assessed in person for their fitness to attend court on the day that they are required to attend.

Restraints and security

58. 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. 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, the prisoner's category and which also takes into account factors such as the prisoner's health and mobility.
59. 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 medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process.
60. The man was handcuffed and an escort chain used each time he went to hospital. For most assessments his risk to the public was regarded as medium and the risk of escape as low. Few of the risk assessments contained specific information about how his health or mobility impacted on his risk as the court judgement requires. However, on his last visit to hospital in May 2013, the risk assessment recorded that healthcare staff indicated that the man was "so ill or incapacitated as to be incapable of escape". He was assessed as a low risk of escape but restraints continued to be used.

61. Security measures must be proportionate to a prisoner's individual circumstances. We recognise that during his time in custody the man acted inappropriately towards hospital and prison staff. However, the use of restraints did not prevent this behaviour. Their primary purpose is to prevent escape not to control conduct. The man was an elderly man in a very poor state of health, with limited mobility and reliant on a wheelchair, whose risk of escape was considered low. We are not satisfied that the risk assessments fully took into account his health and mobility. We make the following recommendation:

The Governor should ensure that a prisoner's health, mobility and actual risk at the time are considered and taken fully into account in deciding the level of escort and whether restraints are needed.

Journey to court

62. It is apparent from the information provided by GEOAmev vehicle escort staff that the man was not appropriately secured in his wheelchair when he was taken to court on 8 July. The escort staff were not familiar with how to ensure a wheelchair user was safe which resulted in the man falling from his wheelchair when the van stopped suddenly.
63. It was fortunate that the prison transport was travelling slowly when it braked and the man was not seriously injured when he fell from the wheelchair. However, it is likely that he was considerably shaken by the incident. An investigation conducted by GEOAmev found that "The man and his wheelchair were not properly secured for transit in the MPV. Staff training is at best minimal, and guide sheets are inadequate". We agree with the investigation recommendation that GEOAmev: "Review all procedures, training, and training materials used for ensuring the safe and secure transportation of wheelchair-bound prisoners" and do not make a further recommendation in this report.

Events at Southampton Crown Court

64. When the man was taken to the courtroom from the cells an escort chain was used and he was accompanied by three GEOAmev officers although he was in a wheelchair. A barrister and solicitor were so concerned at his appearance that they queried whether the restraints were necessary and whether the man was okay. The officers told them that use of the restraints was standard procedure and that the man was fine. The barrister and solicitor had concerns about how the man had been treated and the solicitor told the investigator that the staff escorting the man had been disrespectful towards him. We have not been able to ascertain exactly what happened, but it is notable that two legal representatives, familiar with court procedures were sufficiently concerned about The man's appearance that they intervened in this way.
65. GEOAmev procedures (SOP 059) for the use of restraints in an insecure area in a court state that a prisoner should be mechanically restrained either by handcuffs or an escort chain. Due to his health issues, the Senior Custody Officer decided that an escort chain should be used and that three staff should

accompany the man. However, we are concerned that there is no option for the removal of restraints when the health and mobility of a prisoner clearly indicates a very low risk of escape. In the man's case it is evident that he was incapable of escape and it is difficult to understand how the use of restraints would have protected him from potential assailants as one of the officers suggested. When he was taken to court he was assessed as low risk of escape and restraints were not used yet were deemed necessary in the public areas of the court. The use of restraints in such circumstances has the potential to be regarded as inhumane and degrading treatment unless fully justified. There is a conflict of evidence about whether the man was restrained when he was in the courtroom and, as the man had been released on licence by the judge, the further use of restraints after he was sentenced seems difficult to justify. We make the following recommendation:

GEOAmev should ensure that their operating policy provides for an appropriate level of risk assessment that allows restraints to be removed when the health and mobility of prisoners indicates there is no risk of escape or harm to the public.

The emergency response

66. The man was discovered unresponsive by a member of staff at around 4.05pm when he tried to ask him to sign his release paperwork. The man did not respond and the officer first assumed his silence was in keeping with his usual behaviour. The officer asked colleagues to assist and they discovered that the man was unresponsive and unconscious. Within a few minutes they had received assistance from other staff and an ambulance had been called. Paramedics arrived at the cell five minutes after being called and pronounced death at 4.14pm.
67. From both the records and interviews with staff it appears that, after the man was discovered, all of those involved acted quickly and in a professional and considerate manner.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that all prescribing at HMP Winchester is in line with best practice as recommended in the British National Formulary and by the National Institute for Health and Care Excellence.
2. The Governor and Head of Healthcare should ensure that prisoners who are inpatients in the healthcare unit are assessed in person for their fitness to attend court on the day that they are required to attend.
3. The Governor should ensure that a prisoner's health, mobility and actual risk at the time are considered and taken fully into account in deciding the level of escort and whether restraints are needed.
4. GEOAmey should ensure that their operating policy provides for an appropriate level of risk assessment that allows restraints to be removed when the health and mobility of prisoners indicates there is no risk of escape or harm to the public.

ACTION PLAN: HMP Winchester

| No | Recommendation | Accepted/Not accepted | Response | Target date for completion and function responsible |
|----|--|-----------------------|---|---|
| 1 | The Head of Healthcare should ensure that all prescribing at HMP Winchester is in line with best practice as recommended in the British National Formulary and by the National Institute for Health and Care Excellence. | Accepted | <p>Since 1 October 2013, Central and North West London NHS Foundation Trust has taken action to ensure that prescribing across the prison falls within National Institute for Health and Care Excellence (NICE) guidelines. Prescribing is monitored through the Clinical Governance and Medicines Management groups which are attended by doctors, non-medical prescribers, pharmacy and senior management from the prison and the provider trusts.</p> <p>Since 18 November 2013 a weekly prescribing committee has been taking place, monitoring prescribing practice and use of medicines throughout the prison.</p> <p>On 1 October a decision was taken to increase pharmacy provision within the prison, in order to ensure compliance with all key policies and procedures.</p> | <p>Completed and ongoing</p> <p>Head of Healthcare</p> |
| 2 | The Governor and Head of Healthcare should ensure that prisoners who are inpatients in the healthcare unit are assessed in person for their fitness to attend court on the day that they are required to attend. | Accepted | <p>All patients residing in healthcare will be assessed for their attendance at court by a GP, nurse practitioner or other suitably qualified healthcare professional on the day that they are required to attend. The assessment will be fully recorded in the patient's notes held on SystemOne. The prison transfer document (PER) will not be signed until fitness to attend court has been ascertained. A GP letter will be provided for prisoners with complex health needs and this will accompany the prisoner to court.</p> <p>Reception and the relevant court will be notified immediately if the prisoner is unfit to attend.</p> | <p>Completed and ongoing</p> <p>Governor & Head of Healthcare</p> |
| 3 | The Governor should | Accepted | A full review of restraints, including the necessity to use | 28 February 2014 |

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| | ensure that a prisoner's health, mobility and actual risk at the time are considered and taken fully into account in deciding the level of escort and whether restraints are needed. | | them, is currently being undertaken. All risk assessments will take into account a prisoner's health, mobility and the risk they present at the time. | Governor |
| 4 | GEOAmeY should ensure that their operating policy provides for an appropriate level of risk assessment that allows restraints to be removed when the health and mobility of prisoners indicates there is no risk of escape or harm to the public. | Accepted | Standing Operating Procedure (SOP) 059 - <i>Restraints</i> will be reviewed by GEOAmeY SOP Policy group. Any changes or recommendations will be forwarded for wider consultation with the GEOAmeY operations group. The GEOAmeY SOP Policy group will review and consider feedback from the operations group. Changes to SOP 059 will be agreed and the SOP re-issued. | 30 January 2014 Head of Compliance GEOAmeY PECS Ltd |