

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in August 2013
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 the investigation report into the death of a man in August 2013, a prisoner at HMP Winchester. A post-mortem examination showed that the man died of respiratory failure, bronchopneumonia, and chronic obstructive pulmonary disease. He was 72 years old. I offer my condolences to the man's family and friends.

An investigator carried out the investigation. A doctor reviewed the man's clinical care at Winchester. The prison cooperated fully with the investigation.

The man had been a prisoner at HMP Winchester since the start of his sentence in January 2013 and had been in poor health when he first arrived. In the early hours of 12 August, he became very unwell and was taken to the Royal Hampshire County Hospital. His condition deteriorated in hospital and he died there on 21 August.

Although more could have been done to ensure that the man had suitable accommodation during his final period of stay in the prison's healthcare unit, the clinical reviewer found, and I am satisfied, that the overall standard of healthcare the man received at Winchester was equivalent to that which he could have expected in the community.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

February 2014

CONTENTS

Summary

The investigation process

HMP Winchester

Key events

Issues

Recommendations

SUMMARY

1. On 25 January 2013, the man was sentenced to three years and nine months imprisonment for drug offences and taken to HMP Winchester. He had been in prison before.
2. At the man's initial health screen, the nurse noted that he was being treated for COPD (chronic obstructive pulmonary disease – a term that covers a number of lung diseases), arthritis, osteoporosis (a condition that makes the bones weak), neck problems and anxiety. The man was admitted to the healthcare centre for observation. The next day, a prison GP saw the man and re-prescribed the medication he had been receiving in the community.
3. On 11 February, a care plan was put in place to help the man with his day to day living. He was reviewed and considered fit to be discharged to a standard residential wing in the main prison, but after three days he was admitted to the healthcare centre again.
4. The man remained under observation in the healthcare centre. In March his COPD got worse and his treatment was adjusted. After a hospital appointment on 2 April, the man was given nebulisers and long-term drug treatment to help him to breathe.
5. On 25 April, the man was discharged from the healthcare centre to a wing in the main prison where healthcare staff checked him twice a day. On 19 May, because of pressure on prison places, officers suggested moving the man to the detoxification wing, although the man was not withdrawing from drugs or alcohol. Instead, it was agreed that he should move back to the healthcare centre, because he was at risk of being bullied for his medication on the detoxification wing.
6. Healthcare staff monitored the man frequently, and noted that his breathing was deteriorating because of the hot weather. In July, a hospital consultant prescribed him oxygen to be administered if he felt short of breath. As other prisoners were admitted to the healthcare centre, the man was moved to another cell, which was poorly ventilated and made his breathing worse. However, the man refused to move cells again.
7. On 5 August, the man said he was not well. The nurse practitioner diagnosed an exacerbation of COPD. On 7 August, he was assessed as not fit enough to appear in court. From this time, his cell door was left unlocked so healthcare staff could check him easily. The doctor reviewed him frequently, but the man refused to go to hospital.
8. The man's condition deteriorated and at 3.44am on 12 August, he was taken to hospital as an emergency. The prison informed his family who visited him in hospital. The man's condition became worse, and he died at the hospital early in the morning on 21 August.
9. This investigation found the care the man received was the equivalent to that he could have expected in the community. We make one recommendation about the need to ensure that inpatients in the prison's healthcare unit have suitable accommodation.

THE INVESTIGATION PROCESS

10. The investigator issued notices informing staff and prisoners at HMP Winchester of the investigation and asking anyone with relevant information to contact her. No one responded.
11. The investigator visited the prison on 22 August and spoke to staff and prisoners who knew the man and met the Governor. She obtained the man's relevant prison and prison medical records.
12. NHS England appointed a doctor to review the clinical care that the man received at the prison.
13. HM Coroner for Hampshire Central was informed of the investigation and provided the post-mortem report. The Coroner has been sent a copy of this report.
14. One of the Ombudsman's family liaison officers telephoned the man's wife on 18 September to explain the investigation. The man's wife wanted to know if his weight loss was promptly identified and appropriately monitored.
15. The man's family received a copy of the draft report. They did not make any comments.

HMP WINCHESTER

16. 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

17. An inspection of HMP Winchester in October 2012 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.
18. 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

19. 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 annual report for the year 2012/13, 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

20. The man was the eighth prisoner at Winchester to die of natural causes since January 2010. Recent reports found that prisoners had received care equivalent to what they could have expected to receive in the community.

KEY EVENTS

21. The man was convicted of drug offences and sentenced to three years and nine months in prison at Portsmouth Crown Court on 25 January 2013. He was taken to HMP Winchester.
22. At his initial health screen, a nurse noted that the man suffered from COPD, arthritis in his hands, wrist and feet, osteoporosis, neck problems and anxiety. He was being treated for these conditions in the community, so the nurse requested his GP records. These were received on 5 February. The man was admitted to the prison healthcare unit for observation. The next day a prison GP reviewed the man and continued his prescriptions.
23. On 5 February a prison GP saw the man who was unwell and referred him for a spirometry test to measure his lung function. He prescribed antibiotics, and omeprazole to reduce stomach acid, a side effect of the man's arthritis medication.
24. A care plan was put in place on 11 February to manage the man's mobility needs and medication. He needed help to shower, his respiration was to be monitored and nurses were to ensure there was enough medication over weekends. The same day, the duty governor asked the doctor to consider whether the man could be discharged to a residential wing in the main prison. It was agreed that he was fit enough and the man moved from the healthcare unit to a residential wing. On the wing, officers recorded that he became breathless easily, and relied on the lift to get to his ground floor cell because of the layout of the prison wing. After three days, the clinical manager reviewed the man and noted that he could not move around the wing freely, shower or collect meals. As a result he returned to the healthcare unit on 15 February.
25. On 20 February, a multidisciplinary meeting was held to discuss the man's fitness to return to the main prison, but it was agreed that he should stay in the healthcare unit.
26. On 21 February, the prison GP referred the man to a chest physician to be considered for long term oxygen therapy. The healthcare team continued to review him. He moved to another cell in the healthcare unit on 25 February, because he said his cell was too cold.
27. The man was seen by another prison GP on 18 March because his COPD was significantly worse. The GP prescribed antibiotics and prednisolone, which is used to treat or prevent COPD flare-ups. Records show that the man got better over the next week.
28. On 2 April, the man went to an appointment at the Royal Hampshire County Hospital. The hospital consultant advised that the man should be given long term theophylline (to help with breathing problems) and regular nebulisers (a machine to help administer drugs as a mist to inhale). The nebulisers were started on 15 April, once the consultant's advice had been confirmed in

writing. The man was given an aero chamber (a device to help with inhalation) because he found it hard to inhale using the nebuliser.

29. On 21 April, a care plan was drawn up in preparation to discharge the man to a residential wing. He was not managing his nebulisers himself, so nurses were asked to encourage him to do so. Despite the nurses' encouragement, the man refused the nebulisers because he said they made him feel worse. His other medication was continued.
30. The man was discharged from the healthcare unit on 25 April. Healthcare staff visited him on the wing twice daily and no concerns were noted. On 24 May, Officers wanted to move the man to the detoxification wing because of pressures in the prison for cell space. A nurse felt the move was not appropriate because the man was at risk of being bullied for his medication. It was therefore agreed that he should return to the healthcare unit the same day.
31. The man had trouble swallowing saliva because of his breathing difficulties and his dentures were causing him pain. On 29 May the man was advised to eat soft food and healthcare staff began to monitor and record his food and fluid intake in his clinical record. The same day, the possibility of discharging the man from the healthcare centre again was discussed. On 31 May, the pharmacist reviewed the man's medication. The man said he was remembering to take it but refused the nebulisers and also felt naproxen made his breathing worse. The pharmacist did not record the outcome of the review, but his medication continued as prescribed.
32. On 13 June, the man was assessed as too ill for a proposed move to West Hill, the category C area of the prison. The same day, he attended court. Records show that staff were concerned that the hot weather was affecting the man's breathing.
33. On 3 July, the man attended an appointment with the respiratory medicine team at Royal Hampshire County Hospital. His spirometry results showed that his breathing was severely obstructed, so the hospital consultant prescribed oxygen when he was short of breath. A CT scan (which gives detailed images) was arranged for 30 August.
34. On 5 July, the man was moved to a different cell in the healthcare unit to accommodate a new prisoner. A week later, the clinical team manager raised concerns that the move had affected the man's breathing because the cell had poor ventilation. However, the man refused to move again, although he found the heat and humidity difficult.
35. At the end of July, a cardiology appointment was arranged for 28 August. A daily living assessment determined the man was still independent, although he could not manage stairs and could walk only short distances.
36. On 5 August, the man said he felt chesty, lethargic and nauseous and was coughing up sputum. The nurse practitioner diagnosed an exacerbation of COPD and prescribed antibiotics and prednisolone.

37. The man was assessed as not well enough to go to court on 7 August. A nurse and the GP reviewed him and asked for an ECG (which records the rhythm and electrical activity in the heart) to exclude heart failure, but he refused to go to hospital. The prison GP saw him again that day and diagnosed him with probable infarction (tissue death because of a lack of oxygen) with no chest pain. The man still refused to go to hospital. The next day he indicated that he might agree to go to hospital but subsequently changed his mind. The man was given oxygen and it was agreed that his cell door should be left open at all times to allow regular monitoring. An occupational therapy assessment was booked to consider cell adaptation and aids to make the man more comfortable. From 9 August, a doctor prescribed a food supplement as the man was not eating well.
38. At 3.44am on 12 August, the man was finding it difficult to breathe. His oxygen saturation levels were low, but he refused oxygen therapy. Paramedics were called and the man was taken to hospital and admitted to the intensive care unit. He was not restrained, but was accompanied by one escorting officer. The prison family liaison officer and a deputy were appointed. The family liaison officer informed the man's son at 5.36am about his father's admission to hospital. The man's wife and son visited later that day. Nurses or the duty governor visited the man daily.
39. After a week in hospital, the man's condition had stabilised and he was expected to recover. However, he needed a ventilator to assist his breathing, and was not able to spend much time without it, before becoming very tired.
40. On 20 August, the man was unable to breathe without the ventilator and his condition deteriorated. The family liaison officer contacted the duty governor, to discuss the possibility of release on temporary licence. They decided that release on temporary licence was not appropriate because the man had too much of his sentence left to serve. However, the escort officer withdrew from the man's bedside, so he could be alone with his family.
41. The man's health did not improve and in the evening of 20 August his ventilator was turned off. His wife and son were with him at the time. The man died at about 3.00am on 21 August and hospital staff contacted his family to inform them of his death. The deputy family liaison officer then contacted the man's wife to offer support. The prison offered to contribute towards funeral expenses in line with national guidelines.

Support for staff and prisoners

42. The duty governor held a debrief with the two members of staff who had most recently escorted the man. A notice was put up in the prison to notify prisoners and staff of the man's death, and inform them what support was available if they had been affected by his death.

Post-mortem report

43. The post-mortem report concluded that the man died of respiratory failure, caused by bronchopneumonia, as a result of COPD.

ISSUES

Clinical care

44. The clinical reviewer finds that the man received a standard of care equivalent to that which he could have expected in the community. He reports that the man had end stage chronic obstructive pulmonary disease when he was first sentenced to prison, and he was well monitored and treated by healthcare staff at the prison. His physical needs and mobility were also well managed.
45. The man's wife asked whether his weight loss was promptly identified and addressed by the prison. The clinical reviewer notes that the man lost two kilograms during his time in prison, and considers that this was not significant over eight months for someone with end stage COPD. Even though the man had not lost much weight, healthcare staff provided a soft diet from 29 May onwards, because the man had difficulty eating. They also monitored his food and fluid intake, and the man was prescribed a nutritional supplement towards the end of his life. The clinical reviewer considers that the man's weight and diet were appropriately managed by the prison.
46. We are satisfied that the man received appropriate care at Winchester.

The man's location

47. The man was discharged from the healthcare unit twice at Winchester when it was considered he could manage on a standard residential wing. The first time he returned to the healthcare centre after just three days. The second time he lived on a wing without apparent difficulty for a month. We consider that these discharge decisions were appropriately considered by a multi-disciplinary team. However, after his return to the healthcare unit on 24 May, the man was then moved to another cell in the unit. This cell was poorly ventilated and therefore not ideal for someone with breathing difficulties. The man then refused to move again because he had moved so many times before. We consider that the man's breathing difficulties should have been taken into consideration before he was moved to another cell in the healthcare unit and that healthcare staff should have ensured he was located appropriately to meet his needs. We make the following recommendation:

The Head of Healthcare should ensure that inpatients in the healthcare unit are allocated cells which are appropriate for their health conditions.

Early release on compassionate grounds and release on temporary licence

48. Prisoners can be considered for release on compassionate grounds for medical reasons. In order to be released on these grounds, a prisoner must have been diagnosed with a terminal illness and there must be an indication that death is likely to occur soon (usually within three months). One of the fundamental principles of such early releases is that a decision to approve release would not normally be made on the basis of facts of which the sentencing court was aware. The deputy governor explained to the investigator that early release on compassionate grounds was not considered

for the man because he was already seriously ill when he was sentenced and thus the court was aware that he might not have long left to live. We are satisfied that this was appropriate.

49. Subject to a risk assessment prison governors are able to grant release on temporary licence and can decide whether the prisoner is to be accompanied by staff. When the man's condition deteriorated, ROTL was considered. The deputy governor discussed this with the duty governor on 20 August, and concluded that ROTL was not appropriate because it was too soon in the man's sentence. It was noted that the escorting officer was not in the intensive care unit with the man but in the family room at the hospital to provide a link to the prison and potential support for the man's family. While release on special purpose licence for inpatient treatment does not require a minimum period to be served before a prisoner is eligible for release, we are satisfied that in practice this made little difference to the man. Restraints were not used in hospital and he was not closely guarded by escorting officers.

RECOMMENDATION

The Head of Healthcare should ensure that inpatients in the healthcare unit are allocated cells which are appropriate for their health conditions.

ACTION PLAN: The man – HM Prison Winchester

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and Function Responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that inpatients in the healthcare unit are allocated cells which are appropriate for their health conditions.	Accepted	As part of the daily programme, there is a 09.30 meeting every morning in Healthcare. This meeting reviews appropriate allocations and cell state as well as reviewing inpatient needs.	Completed – Head of Healthcare	