PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Winchester in October 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 from a presumed epileptic seizure, of a man at HMP Winchester on 1 October 2013. He was 56 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. A clinical reviewer reviewed the clinical care the man received at Winchester. The prison cooperated fully with the investigation.

The man was remanded to HMP Winchester in June 2013 and had a history of epilepsy and diabetes. Despite suffering from chronic health problems, he had little contact with prison or healthcare staff during his time at the prison. On the morning of 1 October, prison staff found the man unresponsive in bed. Nurses arrived and attempted to resuscitate the man. Shortly afterwards, paramedics attended and pronounced the man dead.

The clinical reviewer concludes that the man's care was not equal to that he could have expected in the community. The management of his chronic diseases was inadequate and healthcare staff did not investigate why he failed to collect his medication on the day before his death. More generally and despite his serious health problems, neither healthcare nor discipline staff appear to have known very much about the man or recorded many interactions with him.

Although it would not have changed the outcome in the man's case, staff did not use an emergency code when he was found unresponsive, which delayed the calling of an ambulance. Conversely, it is also a concern that nurses felt obliged to attempt cardiopulmonary resuscitation, even though it was clear the man had been dead for some time, something which might have been addressed had staff received a formal debrief following the incident. Finally, it is unfortunate that the man's next of kin was not informed of his death in person by prison staff.

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 **August 2014**

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SUMMARY

1. In June 2013, the man was remanded to HMP Winchester charged with sexual offences. In July he was sentenced to two months in prison, and was remanded again in September on further charges. He had a history of epilepsy and a brain injury related to alcoholism, and diabetes.

2. After initial health screenings, the man had infrequent contact with prison and healthcare staff. He collected medication twice daily from the nursing station on the wing where he lived. The man saw a hospital consultant on 7 August regarding a swelling on his head, but no concerns were noted in his prison medical record.

3. On 30 September, the man failed to collect his medication in the afternoon. There was no reason for this recorded in the medical record. At around 8.15pm, an officer checked the man's cell, but did not raise any concerns. The man's cellmate later reported that the man woke up and turned on the television during the night, although he couldn't recall the time.

4. At around 6.30am on 1 October, an officer found the man unresponsive in his cell. He showed no signs of life and the presence of rigor mortis indicated that he had been dead for some time. Nurses attended shortly afterwards and unsuccessfully attempted to resuscitate the man. Paramedics attended at around 7.00am and pronounced the man dead.

5. The clinical reviewer concluded that the care the man received a Winchester was not equal to that he could have expected to receive in the community. He notes that chronic disease management at the prison was poor. We were concerned that staff had little knowledge of the man, particularly his health problems. No action was taken when the man failed to collect his medication the day before he died. We are also concerned that staff failed to use the appropriate emergency code after finding the man unresponsive. Although this would not have changed the outcome for the man, in other circumstances it could save a life. Resuscitation was also attempted, despite the presence of rigor mortis, and there is little evidence of support being given to staff after the incident. The man's family were not informed of his death in person, contrary to current prison service guidelines. We make seven recommendations.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at HMP Winchester informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.

7. NHS England commissioned a clinical reviewer to review the man's clinical care in prison.

8. The investigator obtained copies of the man's prison medical records and extracts from his prison record. He visited Winchester on 8 October and met staff from the safer custody team and the deputy governor. He also visited the wing where the man lived and interviewed his cellmate. The investigator and clinical reviewer interviewed staff on 29 October, 5 and 27 November at HMP Winchester and gave the Governor initial feedback on the investigation.

9. We informed HM Coroner for Central Hampshire of the investigation, who provided the post-mortem report. The post-mortem report was received by this office on 18 February 2014. We were unable to conclude our investigation until the post-mortem report was received. We have sent the Coroner a copy of this investigation report.

10. One of the Ombudsman's family liaison officers contacted the man's wife, his nominated next of kin, to explain the investigation. The man's wife was concerned about the cause of his death and asked if he received appropriate care in relation to a previous brain operation.

11. The man's family received a copy of the draft report. They did not make any comments.

12. The service also received a copy of the draft report. Their response to our recommendations and action plan is included at page 16 of this report.

HMP WINCHESTER

13. Winchester is a local prison, serving the courts in Hampshire and holds around 700 adult remand and sentenced men. Central and North West London NHS Foundation Trust provides health services at the prison (before November 2013, healthcare services were provided by Solent NHS Trust). The healthcare centre has 24-hour nursing cover, and doctors from a local practice hold surgeries from Monday to Saturday.

HM Inspectorate of Prisons

14. The most recent inspection of HMP Winchester was in October 2012. The Inspectorate found that standards at the prison had deteriorated significantly since the previous inspection and the experience for vulnerable prisoners was particularly poor. The personal officer policy was not operating effectively, and case records indicated infrequent and poor-quality engagement with prisoners. Provision for prisoners with chronic diseases was found to be inadequate.

Independent Monitoring Board

15. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recently published report for the year to May 2013, the IMB noted that that there were now two nurses on duty at night which helped improve prisoner safety. They found that there were problems with the personal officer scheme and prisoners often claimed not to know who their personal officer was. The IMB concluded that quieter prisoners could easily be overlooked.

Previous deaths at Winchester

16. The man was the sixth prisoner at Winchester to die of natural causes since the beginning of 2012. There has since been one more death from natural causes. We repeat previous concerns about the management of prisoners' medication.

KEY EVENTS

17. On 10 June 2013, the man was remanded to Winchester charged with sexual offences. On 24 July, he was sentenced to two months in prison and remained at Winchester after being remanded again on 9 September. He had been in prison before. The man lived on D wing, a unit for vulnerable prisoners. His medical history included epileptic seizures and a brain injury related to alcoholism. The man also had type two diabetes and a splenectomy (surgically-removed spleen).

18. At the man's initial health screening, his chronic health conditions were recorded. A prison GP reviewed the man on 12 June. He prescribed epilim (to treat epilepsy) and thiamine (vitamin B1, to treat the effects of chronic alcoholism). The records show that the man collected this medication twice daily from the nursing station on the wing.

19. On 13 June, the man's GP in the community sent his medical summary to the prison. This showed he was prescribed amoxicillin (an antibiotic) because of his splenectomy and ferrous fumarate (an iron supplement). There is no evidence that healthcare staff reviewed the medical summary and no evidence that either of these medications were prescribed in prison.

20. On 15 June, the nurse saw the man and planned to refer him to a GP to assess his diabetes. There is no record of this review taking place. The nurse noted the man suffered between one and 12 epileptic seizures per year.

21. A nurse reviewed the man on 9 July, after he reported a lump on the left side of his forehead. Another nurse though it could be a cyst and planned for a doctor to review him. On 22 July, the man told a nurse that he had first noticed the lump after arriving at Winchester in June. A GP saw the man on 26 July and noted he had previously had skull surgery. He recorded that the man appeared well and concluded that he had probably suffered a leak of fluid from around the brain and spinal cord (a cerebrospinal fluid leak). The GP referred the man to a neurologist.

22. On 31 July and 6 August, nursing staff unsuccessfully attempted to take bloods from the man (The GP later told us these blood tests were related to diabetic control.) There is no evidence that blood tests were repeated after this.

23. On 7 August, the man attended a neurology clinic at Southampton General Hospital. A consultant neurosurgeon, reviewed him. He was unsure if the man had suffered a cerebrospinal fluid leak and recommended a CT scan followed by further skull surgery after the man was released from prison. There is no evidence that healthcare staff spoke to the man after his appointment with the consultant and he had no further contact with the neurologist (the neurosurgeon wrote to the man's GP in the community to outline his future treatment, but the prison did not receive his letter until after the man's death). After returning to prison, the man continued to collect medication twice daily and no concerns were recorded.

24. On 30 September, records show the man collected his morning medication, but he failed to return for his afternoon medication. There is nothing in the

records to indicate why. The man's cellmate told us that he appeared to have soiled himself in the morning after feeling unwell the previous day. He said that the man returned to his cell in the morning without his medication. He then slept for most of the day and ate a small dinner before going to sleep at around 8.00pm. The cellmate recalled the man panting and groaning during the night. He didn't think this was unusual and said the man was noisy at night. Overnight, the man watched TV for a period, but his cellmate couldn't remember what time this was.

1 October

25. At around 6.30am, an officer was counting prisoners on the wing (She told us she had last seen the man around 8.15pm the day before, and couldn't recall any concerns.) The officer looked through the door hatch and saw the man lying on his bed. She thought he was in a strange position, and was unable to see his chest moving. The officer called out to the man and kicked the door, but he didn't respond. She asked the cellmate to check the man, but he couldn't get a response. He told the officer that the man felt stiff and wasn't moving.

26. The officer returned to the wing office and told a Senior Officer (SO) that the man was unresponsive. They went to the cell together and unlocked the door. The SO recorded that the man was lying across his bed in an unnatural position, as if he had fallen backwards, with his eyes open. The SO was unable to rouse the man by shouting his name and couldn't find a pulse. He recorded that the man was cold and stiff, and he thought he had died.

27. At around 6.35am, the officer radioed for urgent medical assistance. A custodial manager, arrived at around 6.40am after hearing the radio call. He was unable to find any signs of life and thought that the man had died. At 6.43am, he radioed for healthcare staff and an ambulance to attend. The custodial manager then started contingency plans for a death in custody and left the area. The officer escorted the man's cellmate away.

28. A clinical team leader, and a nurse arrived shortly afterwards with oxygen equipment and a defibrillator (which analyses heart rhythm and delivers electric shocks to restart the heart). The clinical team leader told the SO he was obliged to start cardiopulmonary resuscitation (CPR) even though it was clear the man was dead. The defibrillator did not detect a shockable rhythm and the nurses continued CPR. At around 7.00am, paramedics arrived and pronounced the man dead.

29. After the man's death, his cellmate was offered support by staff. There is no evidence that a hot debrief was held for staff involved in the emergency response.

30. An operational manager acted as the prison's family liaison officer. He telephoned the man's wife, his next of kin, at 8.20am to inform her of his death. The family liaison officer visited her at home with the prison chaplain later that day.

31. The family liaison officer continued contact with the man's family after his death. The prison provided a notice of death for his family abroad. In line with national guidance, the prison contributed to the funeral costs.

Post-mortem

32. Following a post-mortem, the Coroner gave the cause of death as 1 (a) presumed epileptic seizure; (b) complications of old head injury (surgically treated) and (c) chronic alcoholism and diabetes mellitus (type II).

ISSUES

Clinical care

33. The clinical review concluded that the care the man received at HMP Winchester was not equal to that he could have expected in the community. The man's initial health screening on arrival at Winchester in June 2013 noted his chronic medical conditions (epilepsy and diabetes). The clinical reviewer considers that these conditions appeared to have been well controlled before the man arrived in prison, but that their subsequent management at Winchester was poor.

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34. On 12 June, a GP reviewed the man's medication. He prescribed epilim and thiamine, but not amoxicillin and ferrous fumarate which the man arrived with in prison. The man's GP in the community sent a medical summary to Winchester on 13 June, explaining his current prescriptions which included amoxicillin and ferrous fumarate (to cover his lack of a spleen). However, there is no evidence healthcare staff reviewed the summary or that these additional medications were ever prescribed. The clinical reviewer noted that labelled medications should continue to be prescribed until a doctor has reviewed a prisoner's medical records.

35. The GP told us that he directed diabetic monitoring blood tests for the man on at least two occasions. This is not clearly recorded in the medical record, which the clinical reviewer noted is best practice. Nurses unsuccessfully tried to take blood samples from the man on 31 July and 6 August. No further attempts to take blood were recorded after this. The clinical reviewer concludes that this was unsatisfactory and would not be acceptable in the community.

36. The GP told us that prisoners at Winchester with chronic diseases are reviewed around every 6 months if they have reasonable control. The clinical reviewer stated that people with chronic conditions in a residential institution usually have a medical care plan in place which is communicated to all those involved in their care. No disease management plans appear to have been put in place for the man and there is little evidence of his health being frequently monitored. Staff we interviewed (including the officer who was the man's personal officer) had little or no knowledge of his chronic medical conditions. We agree with the clinical reviewer that this is unacceptable and make the following recommendation:

    The Head of Healthcare should ensure that prisoners with chronic diseases have appropriate management plans in place, that are communicated effectively to both healthcare and relevant prison staff

37. On the afternoon of 30 September, the man failed to collect his prescribed medication. There is no reason given for this in the medical record.

38. Healthcare staff recorded that the man regularly collected his medication until 30 September. However, we are concerned that no-one approached the man when he failed to collect his afternoon medication on 30 September. Healthcare staff told us there is an expectation that SystmOne is updated when a prisoner fails to collect their medication, but this did not happen. The

clinical lead told us he would expect wing nurses to approach prisoners who fail to collect medication for more serious medical conditions. We found no evidence that this happened in this case.

39. The man was receiving medication to control his epilepsy, a chronic condition which it is presumed contributed to his death. We are concerned that no record was made or action taken when he failed to collect his medication on 30 September. The clinical reviewer was not able to say whether the failure to take his medication contributed to the man's death. However, there is a need for staff to actively monitor and support prisoners' adherence to medication regimes, particularly when they suffer from a chronic medical condition. We make the following recommendation:

The Head of Healthcare should ensure that medicine management and record keeping comply with the code of conduct for the administration of medicines and the standards of record keeping specified by the General Medical Council and Nursing and Midwifery Council, and that prisoners who fail to collect medication for serious conditions are followed up.

The man's contact with staff

40. Our interviews revealed that discipline staff knew very little about the man. The officer, who was the man's personal officer (an officer responsible for providing regular monitoring and support) during his time at Winchester, was not aware of the man's chronic medical conditions. Between June and October, she made only three entries in the man's prison record. The prison's personal officer scheme requires that officers actively engage with prisoners and record interactions in the P-NOMIS (computerised) case notes every fortnight. The entries made regarding the man lacked detail and noted he was a quiet man, but revealed little else.

41. As the man suffered from chronic health problems, we would expect staff to have had a better knowledge of him. However, his interaction with staff appears to have been minimal and we cannot be assured that he received an appropriate level of support. The prison has a comprehensive personal officer protocol, but it is clear that this is not being implemented effectively. We make the following recommendation:

The Governor should ensure that officers have meaningful contact with every prisoner, and that personal officers understand their responsibilities as set out in the personal officer protocol.

Emergency Response

42. The officer discovered the man unresponsive at around 6.30am. An emergency code should have been called immediately. However, healthcare staff were called via the radio around five minutes later, after the officers had unlocked the cell and checked the man for signs of life. An emergency ambulance was not called until 6.43am, which was an unacceptable delay. The paramedics arrived in the cell at around 7.00am.

43. Prison Service Instruction 03/2013 required governors to have a medical emergency response code protocol based on the instruction and we are satisfied that Winchester has an appropriate local protocol. The protocol ensures that an ambulance is called immediately an emergency code is called. Although the staff we interviewed were aware of this protocol, they did not use an emergency medical code during the response. Had they done so, an ambulance would have been called immediately. Although the failure to call an ambulance earlier did not affect the outcome for the man, in other circumstances it could very well impact on the preservation of life. We make the following recommendation:

The Governor should ensure that all staff fully understand and adhere to the local protocol for the use of emergency codes and that an ambulance is called automatically in such circumstances.

44. The nurse told us it was clear that the man had died. He found no signs of life and the presence of rigor mortis indicated that the man had been dead for some time. However, he said that the nurses were obliged to attempt resuscitation. CPR continued for around 15 minutes, but when paramedics arrived they pronounced the man dead.

45. We are concerned that the nurses felt obliged to attempt resuscitation when the man had clearly been dead for some time. A local protocol for prison staff at Winchester states that CPR should be attempted unless rigor mortis of the limbs has clearly set in. It seems that healthcare staff have not received similar advice. We do not consider that any staff should be expected to carry out CPR in circumstances when it is clear from the presence of signs such as rigor mortis that the person is dead. The European Resuscitation Council Guidelines for Resuscitation 2010 state that "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile". We make the following recommendation:

The Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate.

Hot Debrief

44. Prison Service Instruction (PSI) 64/2011 Safer Custody, requires that a hot debrief should be held immediately after a death in custody for all staff involved in the incident, including healthcare staff. We found no evidence of a hot debrief for staff involved in the incident on 1 October.

45. Giving staff the opportunity to collectively discuss an incident and reflect on all aspects of how it was managed is fundamental to providing the prison with feedback on any issues that need to be addressed or to identify what went well. It provides those directly involved with an opportunity to process events and to provide mutual support. The prison should have ensured that a hot debrief took place on 1 October. We make the following recommendation:

The Governor should ensure that all staff involved in an incident are invited to a hot debrief following a death in custody.

Family contact

46. The duty governor, acted as the prison's family liaison officer (FLO). He telephoned the man's wife, his next of kin, at 8.20am to inform her of his death. The duty governor visited her at home with the prison chaplain later that day.

47. PSI 64/2011 Safer Custody, states "Wherever possible, the FLO and another member of staff must visit in person the next of kin or nominated person to break the news of the death. Prison Service Order 1400 'Incident Management' states that the prison should try to deliver the news themselves or at the very least via prison staff from a prison local to the next of kin.

48. The family liaison officer told us that he decided to telephone the man's wife as he felt she needed to be informed of his death as soon as possible. He was also unsure which language she spoke, and was unaware how she would respond to the news as she and the man lived separately.

49. We accept that the family liaison officer wished to inform the man's family of his death quickly and had some concerns regarding the reception he might receive. However, we do not consider this was justification for not informing the family in person. The man's wife lived around 40 minutes away from the prison, so it would have been relatively easy to visit her home. Regarding the language she spoke, this would have been an issue whether or not he visited in person. It would be useful for the prison to record the language spoken by a prisoner's nominated next of kin, in case they need to contact them in an emergency.

50. We consider that, as the PSI recognises, it is preferable for prisoners' families to hear of their deaths in person from Prison Service staff. We make the following recommendation:

The Governor should ensure that in the event of a death, prisoners' families are informed in person by a member of Prison Service staff in line with national guidance.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that prisoners with chronic diseases have appropriate management plans in place, that are communicated effectively to both healthcare and relevant prison staff

2. The Head of Healthcare should ensure that medicine management and record keeping comply with the code of conduct for the administration of medicines and the standards of record keeping specified by the General Medical Council and Nursing and Midwifery Council, and that prisoners who fail to collect medication for serious conditions are followed up.

3. The Governor should ensure that officers have meaningful contact with every prisoner, and that personal officers understand their responsibilities as set out in the personal officer protocol

4. The Governor should ensure that all staff fully understand and adhere to the local protocol for the use of emergency codes and that an ambulance is called automatically in such circumstances.

5. The Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate.

6. The Governor should ensure that all staff involved in an incident are invited to a hot debrief following a death in custody.

7. The Governor should ensure that in the event of a death, prisoners' families are informed in person by a member of Prison Service staff in line with national guidance.

ACTION PLAN:

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that prisoners with chronic diseases have appropriate management plans in place, that are communicated effectively to both healthcare and relevant prison staff	Accepted	SystmOne training took place for all Healthcare staff in June which included use of the new standardised care plans, which are recognised nationally by the National Institute for Clinical Excellence (NICE). These care plans contain relevant guidance from NICE and allow healthcare professionals to follow a checklist of required actions and include any comments which are personal to the prisoner's care plan. SystmOne drop in clinics were offered to the clinical staff team to raise awareness of the implementation of the new standardised templates throughout July 2014. A multi-agency information sharing agreement is in place which includes the prison service and supports "Needs to know" information to be shared by Central and North West London (CNWL) staff with prison staff.	complete complete complete	

2	The Head of Healthcare should ensure that medicine management and record keeping comply with the code of conduct for the administration of medicines and the standards of record keeping specified by the General Medical Council and Nursing and Midwifery Council, and that prisoners who fail to collect medication for serious conditions are followed up.	Accepted	All Nursing Staff have been issued with the NMC Code of conduct for the administration and the standards of record keeping ands this was also discussed at a healthcare staff meeting 13th June 2014 for refresh and clinical discussion. There is a "prevention of omitted doses" pathway in place at HMP Winchester which details actions nurses must follow in the case of a patient not collecting their medication. This pathway was revised in June 2014 and includes actions to be taken for those with chronic conditions.	complete complete	
3	The Governor should ensure that officers have meaningful contact with every prisoner, and that personal officers understand their responsibilities as set out in the personal officer protocol.	Accepted	, Staff have specific objectives set within their annual appraisals stipulating the need to conduct regular and meaningful meetings with all prisoners within their caseload. This is reinforced with regular managerial checks.	completed	
4	The Governor should ensure that all staff fully understand and adhere to the local protocol for the use of emergency codes and that an ambulance is called automatically in such circumstances.	Accepted	A local notice to staff has been issued regarding the protocol for the use of emergency codes, in line with PSI 03/2013. Local contingency plans instruct that an ambulance will be called automatically in such circumstances. Local contingency plans are reviewed regularly. Staffs actions and establishment procedures are reviewed on each and	complete	

			every occasion.		
5	The Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate.	Accepted	Central and North West London Cardiopulmonary Resuscitation Policy will be reviewed to ensure guidance for staff is clear and CNWL will communicate any changes made to the Policy following the review. Clinical staff have provided Defibrillation training for prison staff at Function meetings.	31st August 2014	
6	The Governor should ensure that all staff involved in an incident are invited to a hot debrief following a death in custody.	Accepted	Local contingency plans instruct the In charge Governor to facilitate a hot debrief following any death in custody.	complete	
7	The Governor should ensure that in the event of a death, prisoners' families are informed in person by a member of Prison Service staff in line with national guidance.	Accepted	Local contingency plans stipulate that where the next of kin is within travelling distance a nominated Governor will inform them in person, and alternative arrangements will be made if the next of kin's location means that the FLO cannot visit them promptly (for example, an FLO from another prison may visit the next of kin)	complete	