A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in April 2014 at 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 April 2014 at HMP Winchester. The man died from heart failure and a broken neck. He was 63 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 HMP Winchester. The prison cooperated fully with the investigation.

The man was remanded to HMP Winchester in July 2012 and was sentenced to life imprisonment in June 2013. He had a history of heart disease, including heart failure, which healthcare staff managed throughout his time at Winchester, although he did not always take his medication as prescribed. On 5 April 2014, the man was taken to the Royal Hampshire County Hospital with shortness of breath. He was diagnosed with worsening heart failure, his medication was adjusted and he returned to prison.

On 8 April, prison staff found the man collapsed and unresponsive on the floor of his cell. Healthcare staff and paramedics attended, but were unable to save him. It appears that the man had collapsed due to heart failure and broke his neck as he fell.

I agree with the clinical reviewer that, overall, the man received a good standard of care at Winchester, equivalent to that he could have expected in the community. However, it took too long to arrange a hospital appointment which indicates a need to improve the referral system at the prison. Although this would not have changed the outcome for the man, there was also a delay in calling an ambulance, which could be crucial in a future emergency.

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 **September 2014**

CONTENTS

Summary 5

The investigation process 6

HMP Winchester 7

Key Events 8

Issues 13

Recommendations 15

Action Plan 16

SUMMARY

1. The man was remanded to HMP Winchester in July 2012. In June 2013, he was convicted of murder and firearms offences and sentenced to life imprisonment.

2. The man had a history of significant heart disease and had suffered two heart attacks before going into prison. He had coronary stents (tubes placed in the coronary arteries to keep them open) and was being treated for heart failure. He also had high blood pressure and diabetes. His conditions were managed with medication which continued during his time at Winchester, but the man did not always take his medication as prescribed.

3. On 26 February 2014, a prison GP noted the man's deteriorating heart failure and admitted him to the prison's healthcare unit for observation. The doctor referred him for a hospital cardiology appointment, but this was not passed to the hospital until 19 March. An appointment had not been received before the man died.

4. At 12.35am on 5 April 2014, the man rang his cell bell and told an officer he was short of breath. A nurse attended and decided that because of his medical history, an ambulance should be called. Paramedics arrived and recommended that the man should go to hospital for a full examination. The man refused to go until the next morning and signed a disclaimer to this effect.

5. The next morning the man went to the Royal Hampshire County Hospital. After investigations, he was diagnosed with worsening heart failure and returned to prison with an increase in his medication to reduce fluid retention. The hospital arranged a follow up cardiology assessment.

6. At 5.47am on 8 April, an officer found the man unresponsive on the floor of his cell and called for healthcare assistance but did not use an emergency code. A nurse attended and considered that the man had died. Other staff, including another nurse, arrived and began emergency treatment.

7. At 5.56am, staff called an ambulance and paramedics arrived at 6.05am. At 6.35am, paramedics confirmed that the man had died.

8. The clinical reviewer is satisfied that the level of care the man received at HMP Winchester was equivalent to that he could have expected in the community. Although it would not have affected the outcome for the man, the clinical reviewer was concerned that it took too long to action a referral for a cardiology appointment. We are concerned that staff did not use an emergency code when the man was found unresponsive which led to a slight delay in a nurse attending and a further delay in an ambulance being called. While this did not affect the outcome for the man, in other circumstances it could be crucial. We make three recommendations.

THE INVESTIGATION PROCESS

9. 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. One prisoner responded

10. The investigator visited HMP Winchester on 15 April 2014 and obtained copies of the man's prison medical records and relevant extracts from his prison record. He spoke to the Head of Healthcare and to the man's personal officer. He visited the man's cell and the healthcare unit.

11. The investigator interviewed two members of staff and a prisoner at Winchester on 30 May. He gave the Governor feedback about the preliminary findings of the investigation and followed this up in writing

12. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.

13. We informed HM Coroner for Hampshire Central of the investigation, who provided the post-mortem report. We have sent the Coroner a copy of this investigation report.

14. One of the Ombudsman's family liaison officers contacted the man's former partner, his nominated next of kin, to explain the investigation. She asked if the man had continued to take his medication after his unsuccessful appeal and if not, whether this had impacted on his death.

15. The man's partner received a copy of the draft report. She did not make any comments. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included at the end of the report.

HMP WINCHESTER

16. Winchester is a local prison, serving the courts in Hampshire and holds around 700 adult remanded and sentenced men. Central and North West London NHS Foundation Trust provides health services at the prison. The healthcare centre has 24-hour nursing cover and doctors from a local practice run surgeries from Monday to Friday.

HM Inspectorate of Prisons

17. The most recent inspection of Winchester was in October 2012. The Inspectorate noted that standards at the prison had deteriorated significantly since the previous inspection. Provision for prisoners with chronic diseases was found to be inadequate.

Independent Monitoring Board

18. Each prison in England and Wales 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 2012-13 report, 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 too many prisoners did not know who their personal officer was. The IMB concluded that quieter prisoners could easily be overlooked.

Previous deaths at HMP Winchester

19. The man was the tenth prisoner at Winchester to die of natural causes since 2010. We have raised the issue of the incorrect use of emergency codes before.

KEY EVENTS

20. The man was remanded to HMP Winchester in July 2012. On 18 June 2013, he was sentenced to life imprisonment for murder and firearms offences and remained at Winchester.

21. On 4 July 2012, a nurse carried out an initial reception health screen. She noted the man had a history of heart disease and was being treated for heart failure. He had suffered two heart attacks and had had coronary stents fitted. He also had type 2 diabetes, hypertension (high blood pressure) and gout. The man said he consumed about 70 units of alcohol a week. The man had facial bruising and two black eyes, which he told the nurse was a result of a fall about a month earlier. The nurse recorded an extensive list of prescribed medications, including furosemide (to reduce water retention).

22. Healthcare staff saw the man frequently to help manage his conditions. He kept his medication in his possession; but records show that he said he took whatever quantity he thought he needed, rather than as prescribed. Healthcare staff frequently reviewed and adjusted his medication.

23. In September 2012, a doctor was concerned about the man's mental health and referred him to the mental health team. The doctor from the community mental health team saw him twice and concluded no further input was required.

24. Healthcare staff continued to see the man frequently and a nurse reviewed the man's medication on 25 April 2013. He told her he took furosemide two tablets at a time and not as prescribed, as he believed this worked better. As a result, the man was no longer allowed to keep his furosemide and attended the medical hatch to collect it daily. On 29 April, he told a prison GP that he took his medication at irregular times and in irregular quantities. The doctor advised him to stop taking furosemide for the time being, and to take paracetamol instead of ibuprofen.

25. On 11 May, a prison GP saw the man who was short of breath and concerned that he was no longer on furosemide. The doctor noted that the man had been non-compliant with his medication and advised him of the consequences. The GP re-prescribed a lower dose of furosemide and it appears that he was allowed to keep this in his possession. Two days later, the GP examined the man and increased the dose of furosemide.

26. On 5 July, a community pharmacist saw the man to review his medication. The man said he was well and took most medications in accordance with the GP's instructions. However, he continued to doubt the effectiveness of the current dose of furosemide and said he took three tablets on a Saturday but none in the week. The pharmacist emphasised the need to take his medication as prescribed and referred him to the GP. The GP saw him later that day and increased the dose of furosemide again.

27. On 20 January 2014, a prison GP saw the man and noted his erratic self medication of furosemide. He requested a routine blood test. On 29 January, another prison GP examined the man who reported shortness of breath. He diagnosed possible left ventricular failure (failure of the left side of the heart). The GP requested a chest X-ray and ECG and increased his heart medication. The blood test results received on 31 January showed raised glucose levels but nothing else abnormal. The man's diabetic medication was adjusted.

28. On 11 February, Royal Hampshire County Hospital rejected the referral for the man's X-ray because the referral form was incomplete. A second referral was completed and an appointment was arranged for 25 March.

29. On 17 February, the man told the nurse that the furosemide no longer helped him and he wanted to have other medication. He asked about his chest X-ray and the nurse assured him the referral had been made. He also said he was not sleeping well. The nurse booked a GP appointment and the GP saw him on 20 February and prescribed him nefopam for pain relief. It is not clear what the pain relief was for.

30. On 25 February, the man told the nurse that he had a cough and felt unwell. He thought he must have a chest infection. The man said it was worse in the morning but improved after taking furosemide. The nurse arranged a doctor's appointment for the next day.

31. On 26 February, the GP noted the man's deteriorating heart failure and admitted him to the healthcare unit for observation. The GP referred him for a hospital cardiology appointment, but healthcare administrative staff did not action this until 19 March. There is no explanation in the records for the three week delay in dealing with the GP's referral. An appointment date was not received before the man died.

32. The date the man was discharged from healthcare back to his wing is not recorded, but the nurse saw him at the medication hatch on 12 March. The man said he had a persistent cough which was worse at night. The nurse recorded the man did not have chest pain, was not short of breath and was not producing sputum. His skin colour was good. She arranged a GP appointment for the next day.

33. On 13 March, a prison GP saw the man, who said he took his furosemide every three days, not daily as prescribed, as otherwise it affected his gout. The GP advised him to take his medication daily.

34. On 25 March, the man went to the Royal Hampshire County Hospital for his chest X-ray. On 27 March, the man asked nursing assistant for antibiotics because of his ongoing cough. The nurse referred him to a GP. The GP saw the man on 29 March, when he reported an ongoing cough and shortness of breath when lying down. The doctor reassured him that the referral to cardiology had been made and prescribed an antibiotic.

35. At 12.35am on 5 April 2014, an operational support grade (records do not show who this was) answered the man's cell bell and requested healthcare assistance. The officer attended moments later and the nurse arrived shortly after. The man said he was short of breath and his chest infection had worsened because he had not received his medication prescribed on 29 March. Because of the man's medical history, the nurse asked for an ambulance to be called.

36. Records show the control room called an ambulance at 1.05am and it arrived at the prison forty minutes later. Paramedics examined the man and carried out an ECG. They advised that the man should go to hospital for further examination, but he refused and said he would go the next morning. The man signed a disclaimer to this effect. The paramedics left the prison at 3.05am and officers checked the man throughout the rest of the night. At 7.07am, the nurse confirmed that an antibiotic had been prescribed and issued to the man on 29 March.

37. At 9.16am, the man went to the Royal Hampshire County Hospital and had haematology and biochemistry examinations and a chest X-ray. Hospital staff diagnosed a worsening of his heart failure, increased his furosemide medication and arranged a follow up cardiology assessment. He was discharged back to prison at 1.45pm but the hospital did not send a discharge summary with him. When the man got back to Winchester' he went to his cell on the wing. Healthcare staff were not informed of his return and did not see him that day. It is unclear when healthcare staff became aware that the man had returned from hospital.

Events of 7 April 2014

38. At 8.35am on 7 April, a nurse saw the man at the medication treatment hatch. He requested antibiotics and she referred him to another nurse. He left, but returned shortly afterwards and asked for a repeat issue of his furosemide. The nurse did not give him this. Later that morning, an administrator contacted the hospital to request a discharge summary for the man.

39. In the afternoon of 7 April, nurse manager and a pharmacist reviewed the man at the clinic. They asked him why he had not gone to hospital when the paramedics advised this on 5 April. The man explained that he had not wanted to go in the early hours of the morning but had agreed to go the next day. The manager noted that there was still no hospital discharge information in the records and requested a copy.

40. The manager recorded that the man appeared reasonably well. He was not coughing and had no shortness of breath. His respiratory rate and pulse were normal, but his blood pressure was low. The nurse manager suggested that because of his low blood pressure the man should consider not working that day. (The man worked as a painter on the wing and worked almost every day.) He said he felt fine, and asked for antibiotics again. The nurse manager referred him to the GP for the next day. The man went to work as normal that day.

41. The nurse contacted the Royal Hampshire County Hospital to discuss the man's discharge from hospital on 5 April. They gave him information over the phone and advised that the man should stop taking furosemide for that day, because of his low blood pressure, but should continue with an increased dose thereafter. At 3.30pm, the man's blood pressure had risen to 110/80 (within normal limits). [The clinical reviewer says this temporary omission of furosemide was appropriate.]

42. The officer completed the evening duty count on 7 April at approximately 8.00pm. He told us that he saw the man alive in his cell at that time.

Events of 8 April 2014

43. At 5.47am on 8 April 2014, an operational support grade (OSG) carried out the morning roll check count. She turned on the light of the man's cell, looked inside and saw him lying face down on the floor. An officer banged on the door and called out the man's name but he did not respond.

44. The officer radioed for assistance but did not use an emergency medical code. Two other officers arrived almost immediately. The prison was still in night patrol state, so officers obtained a cell key from a sealed pack and opened the man's cell.

45. The officer checked the man but could not find a pulse and noted he was cold to touch. At about 5.54am, the officer radioed for healthcare assistance.

46. The night duty manager and nurse arrived at 5.55am. The nurse requested an emergency ambulance at 5.56am before he left to collect the primary care nurse from the healthcare unit. (There are two nurses on duty during the night, one on the wings and one based in the healthcare unit. The primary care nurse does not hold internal prison keys when the prison is in night patrol state).

47. The nurse went into the cell and tried to get a response from the man. She noted there was blood on the floor by his head. The nurse described the man as cold and rigid and his right arm was clutching his chest area. She did not attempt resuscitation as she considered the man was dead.

48. The custodial manager returned with the nurse who brought an emergency equipment bag. The nurse joined the other nurse in the cell. They gave the man oxygen and the nurse began cardiopulmonary resuscitation (CPR). This continued until the first paramedic arrived at 6.05am and attached a defibrillator. The defibrillator found no shockable heart rhythm and nurses and paramedics continued with CPR and oxygen. A second paramedic arrived approximately five minutes later. He examined the man and advised that resuscitation efforts should stop. Paramedics formally pronounced the man's death at 6.35am.

Liaison with the man's family

49. A safer custody officer was appointed as prison family liaison officer after the man's death. His nominated next of kin was his former partner but the prison did not have her up to date contact details. Local police supplied the prison with her son-in-law's telephone number. At 9.45am, a senior manager telephoned and explained the prison's family liaison procedures including the requirement to inform the nominated next of kin in person about the death. However, following a conversation between members of the man's family, the prison were informed that it was not necessary for the news to be broken in person.

50. The manager called the man's ex-partner at 10.05am and arranged for the prison's family liaison officer to visit later that day. The family liaison officer and a senior manager visited the man's former partner at her home at 1.45pm. They offered her the opportunity to visit the man's cell and attend a memorial service in the prison chapel. The man's funeral was held on 24 April. The prison contributed towards the cost of the funeral, in line with national guidance.

Support for prisoners and staff

51. The Governor issued a notice to prisoners and staff informing them of the man's death, expressing his condolence and informing them of the support available. All prisoners subject to self-harm prevention procedures were reviewed in case they had been affected by his death. A memorial service for staff and prisoners was held in the prison chapel on 15th April.

52. At 7.30am, on 8 April, the Governor held a debrief for prison and medical staff, to discuss the circumstances of the man's death. The care team were present and available to support staff.

Post-mortem report

53. A post-mortem report concluded that the man had died of a fractured cervical spine (broken neck) and congestive heart failure due to ischaemic heart disease. The pathologist did not give an opinion about the cause of the broken neck but the post-mortem showed that the man had facial injuries possibly caused by a fall. The clinical reviewer said that, in the circumstances, it was reasonable to suggest that the man had collapsed due to heart failure and had hit his head on something as he fell, breaking his neck.

ISSUES

Clinical Care

54. On 26 February, the GP referred the man for a cardiology appointment. Records show that an administrator did not deal with this until three weeks later, on 19 March. There is no reason recorded for this delay. The clinical reviewer is concerned about the delay given the man's symptoms of deteriorating heart failure, although he says that the delay is unlikely to have changed the outcome. (The man went to hospital and had a cardiology review on 5 April.) The GP's referral does not show the priority or reason and we were unable to find a clear system that would indicate this. We make the following recommendation:

    The Head of Healthcare should ensure the system for hospital referrals clearly indicates the priority level and reasons for referral and that any referrals are actioned without delay and followed up as required.

55. The man went to hospital on 5 April, after an episode of shortness of breath the night before and underwent various investigations and an X-ray. He was discharged back to prison the same day without any information about his diagnosis or treatment.

56. Healthcare staff were not aware that the man had returned and there was no record of the hospital attendance or discharge summary in his medical notes. The clinical reviewer points out that this meant important information from the hospital was not available to the clinicians who saw the man two days later, which is concerning given his serious medical condition.

57. There is an expectation that when a prisoner returns from hospital or any other appointment, scheduled or unscheduled, healthcare staff are informed and make an entry in the medical record (SystmOne). In this case this would have highlighted the absence of a discharge summary. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that healthcare staff are informed when a prisoner returns from hospital, the prisoner is assessed if appropriate and details of treatment and discharge plans are recorded in the medical record.

The man's medication

58. The man was often not compliant with his medication, especially his furosemide. However, there is no evidence that he had stopped taking it completely during his time at HMP Winchester, or that this behavior impacted upon his death. The man's ex-partner asked whether he stopped taking medication after his unsuccessful appeal. We understand that the man had his appeal dismissed the week before he died. Although the man often did not take medication as prescribed, the records indicate that the man continued to request and take medication up until the day he died.

Emergency Response

59. Prison Service Instruction (PSI) 03/2013 which was issued at the beginning of February 2013 required governors to have a medical emergency response code protocol based on the instruction. This should instruct staff how to communicate the nature of a medical emergency using agreed emergency codes and ensure that the control room calls an ambulance automatically as soon as an emergency code is called.

60. The OSG did not use an emergency medical code when she first discovered the man unresponsive on the floor of his cell. A request for healthcare staff had to be made six or seven minutes after the original call for assistance and the first responder was unaware of the nature of the emergency. An ambulance was not called until the custodial manager arrived and requested one, almost ten minutes after the man was discovered unresponsive.

61. Winchester has a Medical Emergency Response Code Protocol in line with the PSI and the staff interviewed during this investigation were aware of the protocol and its contents yet did not follow it. While the use of an appropriate emergency code and the earlier attendance of an ambulance would not have altered the outcome in this case, in other circumstances it could be crucial. We make the following recommendation:

    The Governor should ensure that all prison staff follow the prison's protocol for medical emergencies and use an appropriate emergency code so that healthcare staff bring the correct equipment and the control room called an ambulance immediately an emergency code is used.

RECOMMENDATIONS

1. The Head of Healthcare should ensure the system for hospital referrals clearly indicates the priority level and reasons for referral and any referrals are actioned without delay and followed up as required.

2. The Governor and Head of Healthcare should ensure that healthcare staff are informed when a prisoner returns from hospital, the prisoner is assessed if appropriate and details of treatment and discharge plans are recorded in the medical record.

3. The Governor should ensure that all prison staff follow the prison's protocol for medical emergencies and use an appropriate emergency code so that healthcare staff bring the correct equipment and the control room called an ambulance immediately an emergency code is used.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible
1	The Head of Healthcare should ensure the system for hospital referrals clearly indicates the priority level and reasons for referral and any referrals are actioned without delay and followed up as required.	Accepted	Referrals to attend outside hospital are now clearly marked as emergency/ urgent/ within 24hrs by the clinician. There is a disclaimer in place for patients to sign if they choose not to get in the ambulance or attend an appointment. An Emergency Hospital Process flowchart has been implemented to support the nurses when sending a prisoner out when there is not time for a referral to be written.	Complete Head of Healthcare
2.	The Governor and Head of Healthcare should ensure that healthcare staff are informed when a prisoner returns from hospital, the prisoner is assessed if appropriate and details of treatment and discharge plans are recorded in the medical record.	Accepted	There is a pathway in place for all prisoners who pass through reception to be seen by a clinician. Reception staff are now responsible for communicating with the Healthcare Team when someone returns from hospital or arrives at the establishment, and the Orderly Officer has overall responsibility for ensuring this is completed. A notice to all orderly officers has been generated to remind them of the need to inform the Healthcare Team when prisoners return from hospital.	Complete Head of Healthcare
3.	The Governor should ensure that all prison staff follow the prison’s protocol	Accepted	A Governor’s Order has been published to this effect as a reminder to staff to follow the prison’s medical emergency protocol. Night	01/10/2014 Head Of Security

	for medical emergencies and use an appropriate emergency code so that healthcare staff bring the correct equipment and the control room called an ambulance immediately an emergency code is used.		orders are currently being amended to ensure all night staff are briefed accordingly before commencement of their duty.	and Operations