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 in November 2014 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, who died from a heart infection on 25 November 2014, while a prisoner at HMP Winchester. The man was 22 years old. I offer my condolences to his family and friends.

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

The man was serving a 24 weeks prison sentence and had been at Winchester since 1 November 2014. He had a history of intravenous drug use and began a methadone maintenance programme to treat the symptoms of heroin withdrawal. Healthcare staff reviewed him daily. On 21 November, the man reported symptoms of confusion, which appeared to be side effects of pain relief medication. A GP prescribed an alternative. Later that day, a nurse noted that the man had swelling in both legs and a fast pulse. The next day, a GP noted that the man's condition had significantly deteriorated and arranged an immediate admission to hospital. Hospital doctors initially diagnosed a lung infection and subsequently septicaemia, multi-organ failure and a possible infection in his heart. The man suffered a cardiac arrest in hospital and died. The post-mortem indicated that the man had died from the complications of a heart infection.

The man died tragically young, but he had serious drug problems which the clinical reviewer considered were the source of his heart infection. Unfortunately, this would have been difficult to diagnose and I am satisfied that the man received appropriate care for his substance misuse problems and a generally good standard of healthcare. However, I am concerned that staff did not inform the man's family when he was admitted to hospital. I am also concerned that, despite his extremely poor health, officers restrained the man when he went to hospital, without a fully considered risk assessment to justify this.

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 **July 2015**

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SUMMARY

1. On 1 November 2014, the man was sentenced to 24 weeks in prison for theft and sent to HMP Winchester. An initial health screen identified that the man had a long history of drug misuse. He began a methadone maintenance programme to treat the symptoms of drug withdrawal. The man was prescribed pain killers for a knee injury. He was investigated for a deep vein thrombosis but this was ruled out. A GP suspected he had hepatitis C and planned tests, although this had already been diagnosed.

2. On 13 November, the man moved from the prison's specialist wing for prisoners needing substance misuse treatment to the West Hill site of the prison. Nurses continued to monitor him daily. On 20 November, the man told a prison GP he had some breathing difficulty and confusion. Some of his symptoms appeared to be side effects of his pain relief medication and the doctor altered the medication. He returned to the main prison so staff could monitor him more closely. That afternoon a nurse took his clinical observations, which were normal, except his pulse rate was high. The nurse arranged for a GP to see him the next morning.

3. On 21 November, a prison GP examined the man and noted his health had deteriorated significantly. His clinical observations showed his blood pressure and oxygen saturation levels were low and pulse rate was higher than the day before. The doctor sent the man to hospital, by emergency ambulance. He was restrained by an escort chain. No one informed his family, until the hospital contacted them later that evening.

4. Hospital tests indicated a severe lung infection and doctors gave him intravenous antibiotics. However, his condition deteriorated and doctors diagnosed septicaemia and multi-organ failure. At 9.30pm on 21 November, the man was moved to an intensive care unit and doctors considered the possibility of a heart infection. Escort officers removed his restraints shortly afterwards. Later that night, the man had a cardiac arrest and was declared dead at 1.45am on 25 November. The cause of death was complications of bacterial endocarditis (an infection that can seriously damage heart valves).

5. We agree with the clinical reviewer, that the man's standard of healthcare at Winchester was equivalent to that he could have expected to receive in the community. However, we are concerned that staff restrained the man without proper justification when he went to hospital. We are also concerned that the prison did not tell his family when he was admitted to hospital, seriously ill. We make two recommendations.

THE INVESTIGATION PROCESS

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

7. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. She visited Winchester on 3 December 2014 and spoke to the Head of Healthcare and a member of the Independent Monitoring Board. The investigator interviewed five members of staff at Winchester on 25 February 2015.

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

9. 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.

10. The man's family were concerned that he might have been ill for some time before he went to the hospital and asked whether the prison staff should have identified this sooner. They questioned whether his move to West Hill was appropriate and whether he should have been expected to work if he was unwell. They asked for more detail about his behaviour when he was in the West Hill unit. The man's family were concerned that the prison had not informed them when he went to hospital, that officers unnecessarily restrained him and that they did not allow them adequate privacy at the hospital.

11. The man's family received a copy of the draft report. The solicitor representing them wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

12. The draft report was shared with the Prison Service. There were no factual inaccuracies and the action plan has been added to the end of the report.

HMP WINCHESTER

13. HMP Winchester is a local prison, serving the courts in Hampshire. It holds around 700 adult remanded and sentenced men. It includes a separate lower security unit for up to 129 sentenced men nearing the end of their sentences, known as West Hill. Central and North West London NHS Foundation Trust provides health services at the prison. The prison's healthcare centre has 24-hour nursing cover and doctors from a local practice run surgeries from Monday to Friday.

HM Inspectorate of Prisons

14. The most recent inspection of Winchester was in February 2014. The Inspectorate noted that substance use services had improved since the previous inspection in 2012, although prisoners who needed stabilisation or detoxification were not always placed on the stabilisation unit. Day-to-day care and treatment for prisoners on opiate substitution was very good. A new health services provider had made improvements, but chronic staff shortages were having an impact on service delivery. Prisoners had reasonable access to a GP, but the number of nurse led clinics was too limited. The 2012 inspection had found serious concerns about the general operation of the prison and the 2014 inspection noted that progress had been slow, although much better on the West Hill site.

Independent Monitoring Board

15. Each prison in England and Wales has an Independent Monitoring Board of unpaid volunteers who help ensure that prisoners are treated fairly and decently. In its most recent published report, for the year to May 2014, the Board commented that the promising start made by the integrated substance misuse service had continued through the reporting year. There was strong integrated working between the clinical and psychological staff. The IMB reported that the new healthcare provider had brought extensive knowledge of prison based healthcare management and noted a number of improvements. However, the IMB was concerned about poor arrangements to bring prisoners to clinics and the extensive reliance on agency staff, which was costly and affected the service that could be delivered.

Previous deaths at Winchester

16. The man was the eighth prisoner at Winchester to die of natural causes since 2012. We have raised the issue of inadequately justified use of restraints before.

KEY EVENTS

17. On 1 November 2014, the man was sentenced to 24 weeks in prison for theft and sent to HMP Winchester the same day.

18. A nurse carried out the man's initial health screen and noted that hospital staff had assessed him earlier that day while he was in police custody. He was treated for a knee injury and investigated for a possible deep vein thrombosis (DVT) as his left calf was swollen. A doctor prescribed daily blood thinning injections until this could be followed up at a further hospital appointment. The man had asthma and had a ventolin inhaler. The nurse assessed the man as fit for a standard prison location and to work. She noted the man was a long term drug user and referred him to the substance misuse team. The man was allocated to C Wing, the wing for prisoners receiving treatment for substance misuse.

19. Another nurse saw the man later that day in the substance misuse clinic. The results of a urine test showed the presence of opiates, cocaine and benzodiazepines. The nurse prescribed 20mls of methadone a day to help alleviate the symptoms of drug withdrawal. The next day, a nurse created a methadone stabilisation care plan to help the man's safe withdrawal from opiod dependency and minimise the risk of him taking illicit drugs in prison.

20. On 3 November, the prison's substance misuse GP assessed the man's drug withdrawal. He increased the methadone dose to 40mls a day and prescribed nefopam (a non-opiod drug) for pain relief for his leg.

21. On 5 November, the man went to hospital for an ultrasound scan of his leg. This showed no evidence of a deep vein thrombosis.

22. On 10 November, a prison GP reviewed the man. He noted he was poorly nourished and prescribed nutritional supplements. The doctor thought that the man looked jaundiced and suspected he might have hepatitis C (a virus in the blood which can cause liver damage). The doctor planned for him to see the prison hepatitis C nurse and to obtain copies of previous hospital liver function tests, but it appears that the man's health deteriorated before this was done. The GP noted that the prison had not received the results of the scan on 5 November. Healthcare staff obtained them the next day and discontinued the blood thinning injections, as a result.

23. On 13 November, the man moved to the West Hill unit of the prison. Substance misuse nurses checked him each day to monitor his drug withdrawal. Regular urine tests showed he complied with his treatment plan and did not take additional drugs. On 18 November, a nurse was

concerned that the man appeared a little over-sedated, but the results of a urine test were normal.

24. On 20 November, the GP reviewed the man who said he had been experiencing some difficulty breathing, but did not have an asthma inhaler, which he had previously used occasionally. The GP prescribed an inhaler. The man also said he had been feeling confused, was having nightmares and waking in a panic. Prison officers had also told the doctor that the man had been behaving strangely, including that they had seen him urinating in odd places. The GP stopped the prescription of nefopam, as possible side effects can include confusion, dizziness, hallucinations and insomnia. The man moved back to the C Wing in the main prison that day, so that staff could monitor him more closely.

25. Shortly after 4.00pm that afternoon, a nurse examined the man and noted some swelling in both his legs. His oxygen saturation level and blood pressure were normal, but his pulse rate was high at 118 beats per minute. The nurse arranged for a GP to review the man the next day.

26. At 11.05am on 21 November, a prison GP examined the man. He took his clinical observations and noted that his physical condition had deteriorated significantly. His oxygen saturation level was low at 87%, his blood pressure was low at 98/57 and his pulse rate had increased to 128 beats per minute. The man did not have a temperature but he was breathless and his legs were still swollen. The GP gave the man oxygen and arranged for him to go to hospital immediately, as he appeared very ill.

27. The ambulance arrived at the prison at 11.39am and took the man to Royal Hampshire County Hospital, Winchester, which is directly opposite the prison. Two officers escorted the man and used an escort chain to restrain him. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.)

28. At the hospital, a number of investigations, including a chest X-ray and CT scan, showed the man had serious and complicated chest and lung conditions. As a consequence of infection, his blood clotting mechanisms began to fail. Doctors treated the man with intravenous antibiotics. At 6.00pm, the duty governor, gave officers permission to remove the man's restraints to allow a medical procedure. One of the escort officers, said that the man's restraints were reapplied once the procedure was completed. A hospital doctor told the escorting officers the man was extremely unwell and the hospital intended to move him to the intensive care unit when a bed was available.

29. At 9.30pm, the man moved to the intensive care unit. When he arrived one of the escorting officers telephoned the prison for permission to

remove the man's restraints to enable hospital staff to carry out a further medical procedure. It was agreed and officers removed the restraints at 9.45pm, and did not reapply them after that. At 10.30am the next day, the escort was reduced to one officer who was based in the unit's family room and checked the man hourly.

30. The man's condition continued to deteriorate. Hospital consultants diagnosed pneumonia, septicaemia and multi-organ failure. On 24 November, an echocardiogram (an ultrasound scan of the heart) showed some enlargement of the heart and possible growth on a valve one of his heart valves, usually due to infection. In the early hours of 25 November, the man went into cardiac arrest. Hospital staff were unable to resuscitate him and at 1.45am confirmed that he had died.

Liaison with the man's family

31. At 6.35pm on 21 November, hospital staff telephoned the man's mother and told her he was in hospital. The man's family arrived at the hospital at 7.50pm and stayed with the man.

32. On 24 November, the prison appointed a family liaison officer. The family liaison officer met the man's family at the hospital that day and offered support.

33. At 10.50am on 26 November, the family liaison officer telephoned the man's mother and offered condolences. She visited his mother later that day for further support.

34. The man's funeral was held on 11 December. The prison contributed to the costs, in line with national guidance.

Support for staff and prisoners

35. A Governor's notice informed prisoners and staff that the man had died. At 5.25am on 25 November the deputy governor debriefed the escort officers and the prison's care team offered them support. Staff reviewed prisoners being managed under suicide and self-harm prevention procedures, in case they had been adversely affected by the news of the man's death.

Cause of death

36. A post-mortem examination found the cause of death was complications of bacterial endocarditis (an inflammation of the inner tissues of the heart). Toxicology tests showed no evidence of illicit drugs.

ISSUES

Clinical care

37. The clinical reviewer was satisfied that the man's care at Winchester was equivalent to that he could have expected to receive in the community. He was appropriately referred to the prison's substance misuse service when he arrived and he received immediate and effective help and support for opiate dependency. There was little to indicate any other serious health problems until one of the prison GPs reviewed the man on 21 November and sent him to hospital.

38. When a GP saw the man on 10 November, he suspected that he had hepatitis C and planned to investigate this further. In fact, the man had been diagnosed with hepatitis C some years earlier. It is concerning that this information was not highlighted in his medical records so that subsequent clinicians would have been aware of it. Hepatitis C was not a direct contributory cause to the man's death, but the clinical reviewer has made a recommendation about the need to record major health problems appropriately on the electronic health record, which the Head of Healthcare will need to address.

39. The GP appropriately sought information about the man's scan for possible deep vein thrombosis. (The hospital had inadvertently sent the results to his community GP.) This resulted in the anti-clotting injections stopping. Although the injections continued longer than strictly necessary, the clinical reviewer said that it is usual to begin and continue such treatment until a deep vein thrombosis has been ruled out. This had no part in the man's subsequent deterioration in health.

40. On 20 November, a prison GP reviewed the man and altered his pain relief medication, as he appeared to be suffering symptoms indicative of the side effects of the medication. He also described some symptoms of difficulty in breathing, which appeared consistent with asthma. Later that day, a nurse noted that the man had some swelling to his legs. The clinical reviewer noted there can be a number of causes for these symptoms, including asthma and poor nutrition, both of which the man had. The nurse noted that the man's pulse rate was high but his other clinical observations were normal. We are satisfied that there was nothing to indicate that the man was seriously ill at the time.

41. On 21 November, when a doctor reviewed the man, he noted that his clinical observations now indicated that he was very ill. He promptly arranged an emergency transfer to hospital and we consider he and other healthcare staff at the prison acted appropriately. The clinical reviewer

noted that the man died from complications of bacterial endocarditis, which is difficult to diagnose and was not identified until after the man's death. The clinical reviewer considered that it was likely that the man's history of intravenous drug misuse was the source of this heart infection and his hospital notes indicate that he had no clinical signs of endocarditis, such as splinter haemorrhages or a cardiac murmur. It would therefore have been difficult for healthcare staff at the prison to have identified sooner, that the man was seriously ill.

The man's move to West Hill

42. On 13 November, the man moved from C Wing to the West Hill site of the prison. Substance misuse nurses assessed the man daily while he was at West Hill and he complied with his drug treatment plan. The man was serving a short sentence and we consider the more relaxed environment of the West Hill site was an appropriate allocation for the man. The move allowed the man to attend educational lessons in the morning and afternoon between 17 and 20 November. The man did not work during his time at West Hill. On 20 November, after he appeared to have suffered from side effects of his pain relief medication, it was appropriate to move him back to the C Wing, the prison's substance misuse unit, where staff could monitor him more closely.

Family liaison

43. The man was taken to hospital by emergency ambulance before midday on 21 November and was seriously ill at the time. However, no one from the prison informed the man's family of his admission to hospital. At 6.35pm, nearly seven hours after his admission, a member of hospital staff contacted the man's family as his condition was critical.

44. Prison Rule 22 requires the governor to inform "at once" the prisoner's spouse or next of kin and "any person who the prisoner may reasonably have asked should be informed" when a prisoner is seriously ill. The man was extremely unwell and someone from the prison should have contacted his next of kin immediately he was taken to hospital. We make the following recommendation:

The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible.

Restraints and escort

45. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has 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 and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgement indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

46. When the man went to hospital on 21 November, a security risk assessment considered that he was a medium risk of escape and a medium risk to the public. There was no history of escape recorded. The risk assessment recorded known instances of drug abuse and a history of violence. The healthcare section did not record any objection to the use of restraints but did not comment on how his condition affected his risk of escape. It appears that the nurse who completed it might not have been aware of the man's condition at the time. Two officers escorted the man and restrained him with an escort chain.

47. At 6.00pm the duty governor gave permission for officers to temporarily remove the restraints for a medical procedure. At 9.40pm, at the request of one of the escorting officers, the duty governor gave permission again and officers permanently removed the restraints.

48. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances which must be fully considered, taken into account and balanced against the security risks. We note that the man was extremely unwell when he went to hospital and had been regarded as critically ill for some time before the restraints were removed. The risk assessment did not consider how the man's state of health at the time he left the prison impacted on his risk of escape, a requirement of the 2007 High Court judgment.

49. While we would not expect a risk assessment to hold up an emergency admission to hospital, the healthcare section should be completed by someone with knowledge of his condition. The clinical reviewer noted that the man was very short of breath, had low blood pressure and oxygen levels and it would have been physically impossible for him to escape from two officers. The matter of appropriate risk assessments is one we have raised with the prison before. Ultimately, it is the Governor's responsibility

to ensure that the process is managed properly, but the Head of Healthcare also needs to ensure that healthcare staff understand their responsibilities and have appropriate input into the risk assessment process. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

50. At 10.20am on 22 November, the duty governor reduced the escort to one officer, who checked the man every hour. His family were able to spend private time together with the man at this bedside. The escort records show that the man's family was unhappy that the escort officer was based in the family room on the ward between making checks. At 5.00pm on 23 November, the ward manager allowed the escort officer to use their staff room, which the officer did from that point. We are satisfied that this was appropriate and that the prison allowed the man's family private time with him at the end of his life.

RECOMMENDATIONS

1. The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible.

2. The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible
1.	The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible.	Accepted	All managers have been reminded of the importance of this and the issue discussed at an operational briefing event.	Completed Governor
2.	The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.	Accepted	The balance between health, security and dignity is something that is always considered before an escort is dispatched. All managers have been reminded of the need to consider all aspects dynamically with medical opinion about the prisoner's ability to escape considered as part of the assessment process and kept under review as circumstances change.	Completed Governor/ Head of Healthcare