Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Chris Garitty a prisoner at HMP Winchester on 12 October 2015

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Chris Garitty died of a heart attack at HMP Winchester, on 12 October 2015. He was 54 years old. I offer my condolences to Mr Garitty's family and friends.

Mr Garitty died just two days after he arrived at the prison. I consider that Mr Garitty received a good standard of healthcare during his short time at Winchester and prison staff could not have foreseen or prevented his sudden death. The emergency response was prompt and appropriate, but, sadly, Mr Garitty could not be saved.

This version of my report, published on my website, has been amended to remove the names of the staff and prisoners involved in my investigation

Nigel Newcomen CBE
Prisons and Probation Ombudsman **April 2016**

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Events

1. On Saturday 10 October 2015, Mr Chris Garitty was remanded to HMP Winchester.

2. At an initial health screen, Mr Garitty told a nurse that he had suffered a heart attack six months earlier, due to blocked arteries. Doctors had inserted two stents (small tubes placed in the artery to hold it open) and prescribed medication for high blood pressure and to help prevent a further heart attack. A prison GP re-prescribed the medication Mr Garitty had been taking in the community and also prescribed medication to treat high cholesterol.

3. On the afternoon of Monday 12 October, two days after he had arrived at Winchester, Officer A, found Mr Garitty unresponsive in his cell. He blew his whistle for assistance. Prison staff attended immediately and began cardiopulmonary resuscitation, while a manager radioed an emergency medical code. Nurse attended and took over the resuscitation attempt. Paramedics arrived quickly but, shortly afterwards, recorded that Mr Garitty had died.

Findings

4. Mr Garitty had serious heart problems. When he arrived at Winchester, healthcare staff appropriately assessed him and ensured he had appropriate medication. We consider that Mr Garitty received a standard of care at the prison that was equivalent to that he could have expected to receive in the community. The emergency response was quick and appropriate. Prison staff could not have prevented Mr Garitty's sudden death.

The Investigation Process

5. 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.

6. The investigator visited HMP Winchester on 22 October 2015. She obtained copies of relevant extracts from Mr Garitty's prison and medical records. She later received statements from prison and healthcare staff.

7. NHS England commissioned a clinical reviewer to review Mr Garitty's clinical care at the prison.

8. We informed HM Coroner for Winchester of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

9. One of the Ombudsman's family liaison officers contacted Mr Garitty's family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Garitty's daughter asked about his general medical care at the prison.

10. Mr Garitty's family received a copy of the initial report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

11. The prison considered our initial report and pointed out one factual inaccuracy. This report has been amended accordingly to say that Officer A went to the cell to give Mr Garitty a bag to pack his property.

Background Information

HMP Winchester

12. 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

13. The most recent inspection of Winchester was in February 2014. Inspectors reported that all prisoners received private first night and healthcare interviews. They found reception staff methodical and caring in their approach. Health services had improved, but staff shortages had led to problems in managing chronic diseases and running nurse-led clinics.

Independent Monitoring Board

14. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to May 2015, the IMB noted considerable improvements to the induction processes, including first night assessments to identify healthcare needs.

Previous deaths at HMP Winchester

15. Mr Garitty was the fifth prisoner to die from natural causes at Winchester since January 2014. There were no significant similarities with the circumstances of the other deaths.

Key Events

16. Mr Chris Garitty had been in prison several times and had been released from his last sentence in March 2015. In April 2015, while living in the community, he suffered a heart attack and had two stents fitted. Hospital doctors prescribed medication to prevent further blockages and considered him symptom-free. Mr Garitty smoked, against medical advice.

17. On 9 October 2015, Mr Garitty was arrested and charged with assault. At the police station, a doctor examined him and re-prescribed his existing medication - prasugrel (to reduce the risk of a further heart attack), aspirin (to prevent blood clots forming), and bisoprolol and ramipril (to treat high blood pressure).

18. On Saturday 10 October, Mr Garitty was remanded to HMP Winchester. At his initial health screen, he told a nurse about his heart attack and his prescribed medication. The nurse took his clinical observations, which were normal and had no concerns about him. The prison GP obtained details of Mr Garitty's medication from his community GP and re-prescribed the medication listed previously, with the addition of atorvastatin (to treat high cholesterol).

19. Mr Garitty asked to go to the vulnerable prisoners' wing due to the circumstances of a previous offence. Prison staff agreed to check if there was a space after the weekend and he was given a cell on the induction wing. He mentioned no concerns about his health the next day, Sunday 11 October.

Events on Monday 12 October 2015

20. Just after 12.00pm on Monday 12 October, Officer A, spoke to Mr Garitty from outside his cell, to let him know that he would be moving to the vulnerable prisoners' wing. Mr Garitty ate his lunch in his cell. At 12.24pm, a prisoner collected the plates and three minutes later, an officer counted prisoners on the wing. The officer noted no problems.

21. At 2.25pm, Officer A, went to Mr Garitty's cell to give him a bag to pack his property and take him to the other wing. The officer found him kneeling beside the bed. He touched his shoulder and asked him if he was okay, but Mr Garitty fell to the floor. The officer blew his whistle and several officers and two managers responded straight away. A custodial manager radioed a code blue - for healthcare assistance and an ambulance. A supervising officer started chest compressions immediately. Nurse A, one of four nurses who attended, attached a defibrillator to Mr Garitty but this found no shockable heart rhythm. Nurses continued chest compressions, and fitted an airway.

22. At 2.26pm, the control room staff called an ambulance, which arrived with an emergency car at 2.37pm. Further emergency treatment was unsuccessful and at 2.43pm, the paramedics recorded that Mr Garitty had died.

Contact with Mr Garitty’s family

23. Mr Garitty had named his brother, who lived in Spain, as his next of kin. Prison staff telephoned him but, despite repeated attempts, could not get through. With the help of the police, they contacted Mr Garitty’s ex-partner, who gave alternative contact numbers.

24. The prison appointed a prison chaplain, as the family liaison officer and the prison chaplain contacted Mr Garitty’s brother to offer her condolences and support. She kept in contact with him and other members of his family and arranged his funeral, which was held on 12 November 2015. Mr Garitty’s brother and other relatives attended. The prison contributed to the costs, in line with national policy.

Support for prisoners and staff

25. The Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer his support and that of the staff care team. A member of the ambulance crew also attended, and was positive about the handling of the emergency.

26. The prison posted notices informing other prisoners of Mr Garitty’s death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Garitty’s death.

Post-mortem report

27. A post-mortem examination concluded that Mr Garitty died from acute myocardial insufficiency (the heart failed to pump enough to maintain blood circulation) and ischaemic heart disease.

Findings

Clinical care

28. The clinical reviewer noted that heart attacks sometimes have symptoms of pain. However, at times, the first sign might be electrical failure where the heart stops pumping effectively and a person loses consciousness quickly and dies if they are not immediately resuscitated.

29. When Mr Garitty arrived at Winchester, healthcare staff carried out a thorough health assessment and re-prescribed medication for his existing heart condition. The clinical reviewer was satisfied that the standard of healthcare Mr Garitty received at the prison was equivalent to that he could have expected in the community.

30. The officer who found Mr Garitty collapsed, alerted other staff nearby and a manager called a medical emergency code immediately. The control room called an ambulance within a minute and the ambulance arrived 11 minutes later. We are satisfied that there was no delay in the emergency response. Prison and healthcare staff began appropriate emergency treatment but were unable to resuscitate Mr Garitty and neither could paramedics. We consider that nothing further could have been done to save Mr Garitty and prison staff could not have anticipated or prevented his sudden death.

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