

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Edward Rathmill a prisoner at HMP Winchester on 18 February 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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 Edward Rathmill died on 18 February 2016 of acute bronchitis while a prisoner at HMP Winchester. He was 53 years old. I offer my condolences to Mr Rathmill's family and friends.

Mr Rathmill suffered from advanced chronic obstructive pulmonary disease. Healthcare staff at Winchester appropriately reviewed his condition but he refused additional hospital treatment or monitoring at hospital or in the prison's healthcare centre. I am satisfied that Mr Rathmill had the mental capacity to make these decisions and that he received an appropriate standard of care at the prison.

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

January 2017

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Summary

Events

1. Mr Edward Rathmill arrived at HMP Winchester on 23 December 2015, after being recalled to prison. He had been homeless and suffered from advanced chronic lung disease. Mr Rathmill had smoked most of his life but refused any help to stop.
2. Mr Rathmill suffered increasingly from breathlessness. Prison nurses and GPs frequently advised him to be admitted to the prison's inpatient unit or hospital, but he repeatedly refused additional monitoring or treatment, partly because he would not be able to smoke in either environment. He understood the seriousness of his condition and clinicians were satisfied he had the capacity to make decisions about his treatment. To help manage his shortness of breath, Mr Rathmill had a nebuliser in his cell, but his condition continued to decline.
3. At 8.05pm on 16 February 2016, Mr Rathmill agreed to go to hospital when he was suffering from chest pain and shallow breathing. Two officers escorted him and restrained him with an escort chain but this was removed shortly after he was admitted to hospital. A hospital doctor diagnosed end-stage lung disease and withdrew active treatment. Mr Rathmill's condition steadily declined and he died in hospital in the early hours of 18 February.

Findings

4. Prison healthcare staff monitored Mr Rathmill's condition frequently and prescribed appropriate medication to treat his condition. Despite encouragement, he repeatedly refused admission to a clinical setting. We are satisfied that Mr Rathmill had the mental capacity to make decisions about his treatment and received an appropriate standard of care at Winchester. Although Mr Rathmill was restrained by an escort chain when he was initially taken to hospital, without a full risk assessment, restraints were appropriately removed not long afterwards.

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 obtained copies of relevant extracts from Mr Rathmill's prison and medical records.
7. NHS England commissioned a clinical reviewer to review Mr Rathmill's clinical care at the prison.
8. We informed HM Coroner for Hampshire Central 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 Rathmill's ex-wife and daughter, to explain the investigation. They asked the investigation to consider the following points:
 - They believed Mr Rathmill had lost a lot of weight at Winchester and wanted to know if he had eaten and whether anyone helped him.
 - They considered that it took too long for Mr Rathmill to get medical treatment and wanted to know what treatment he had received, including just before his death.
 - They considered that Mr Rathmill did not have the mental capacity to refuse treatment.
10. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.
11. Mr Rathmill's family received a copy of the initial report. They pointed out some factual inaccuracies and/or omissions. This report has been amended accordingly. Mr Rathmill's family also raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

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 (CNWL) NHS Foundation Trust provides health services at the prison. The prison's healthcare centre has 24-hour nursing cover. 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 had first night and healthcare screens in private. 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 that the healthcare provider had consolidated treatment services and provided a seamless service across the prison. A multidisciplinary group regularly assessed all patients with complex needs. Some initiatives, including a walk-in clinic, an end-of-life suite and a day service area for older prisoners, appeared to be affected by budget constraints.

Previous deaths at HMP Winchester

15. Mr Rathmill was the third prisoner at Winchester to die from natural causes since January 2015. There were no significant similarities with the circumstances of the other deaths.

Key Events

16. On 5 December 2014, Mr Edward Rathmill was released on licence from a prison sentence for burglary and possession of an offensive weapon. On 23 December 2015, he was recalled to prison for breaching his licence conditions and was sent to HMP Winchester.
17. When Mr Rathmill arrived at Winchester, he had just spent seven nights in hospital after he had collapsed with breathing difficulties. He had been homeless and had a long history of substance misuse. When he arrived at hospital, he was underweight and malnourished, so a doctor prescribed nutritional supplement drinks.
18. Mr Rathmill weighed only 54kg (just over 7st) when he arrived at the prison. Three years before in prison, he had weighed 55kg (8st 9lb). At an initial health screen, a nurse noted he had chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema) and asthma. He was a lifelong tobacco smoker. The nurse wanted to admit Mr Rathmill to the prison’s healthcare inpatient unit but he refused because he would not be able to smoke there.
19. A prison GP prescribed Mr Rathmill’s medications, according to his hospital discharge letter. These included an anticoagulant, medication for high blood pressure, antibiotics, steroids, an anti-depressant, a multi-vitamin and nutritional supplement drinks.
20. On 24 December, Mr Rathmill was short of breath. A nurse advised Mr Rathmill not to smoke and to prop himself up with an extra pillow he had been given. He used a nebuliser (a machine that creates a mist of medicine, which is breathed in through a mask or mouthpiece), which helped his breathing. The nurse encouraged Mr Rathmill to be admitted to the inpatient unit, but he refused.
21. The next day, Mr Rathmill was short of breath again. A second nurse assessed him and also advised him to stop smoking and prop himself up. Mr Rathmill reluctantly agreed to be admitted to the inpatient unit, but when he got there he became agitated and said he could not stop smoking. Against advice from nurses, he signed a disclaimer and returned to the wing.
22. On 28 December, a clinical team manager assessed Mr Rathmill. He had difficulty breathing but again refused to be admitted to the inpatient unit. His basic observations were normal and his breathing stabilised while she was talking to him.
23. On 31 December, a prison GP reviewed Mr Rathmill. He did not have any chest pain and was able to speak in full sentences, although he said he was short of breath. His basic observations were normal. The doctor prescribed another nebuliser, which he could keep in his cell to use when he needed to relieve his shortness of breath.
24. On 6 January 2016, a healthcare assistant encouraged Mr Rathmill to try to stop smoking. He said he had smoked since the age of 12, but now smoked less. He

- said several members of his family had died of smoking related illnesses in their 50s. He accepted patches and lozenges to help him stop smoking.
25. On 7 January, a doctor reviewed Mr Rathmill and noted his breathing was better. He referred Mr Rathmill to a respiratory specialist and prescribed an additional inhaler and an antibiotic. On 9 January, the healthcare assistant reviewed Mr Rathmill, who said he was not smoking and using the patches and lozenges she had given him. (Five days later, he started smoking again.)
 26. On 11 January, Mr Rathmill's COPD symptoms worsened and a nurse examined him. His blood pressure was normal, but his pulse was high and his oxygen saturation was low at 90%. The nurse reviewed him again an hour and a half later. His blood pressure and pulse were the same, but his oxygen saturations had improved slightly. Mr Rathmill refused to be admitted to the inpatient unit or to go to hospital.
 27. The next day, a prison GP reviewed Mr Rathmill and advised him to go to hospital, but he refused. Later that day, a clinical team manager reviewed Mr Rathmill who still refused to go to hospital or the inpatient unit. The clinical team manager noted that Mr Rathmill was alert, orientated and coherent, and was satisfied he had capacity to refuse treatment. Nurses checked Mr Rathmill three times during the night and had no concerns.
 28. On 13 January, Mr Rathmill's condition had not improved but he still refused to go to hospital. The clinical team manager called paramedics who assessed him and advised that he should be admitted to hospital but he would not go, although healthcare staff spent an hour trying to persuade him. The clinical team manager noted that it would be detrimental to his wellbeing and health to force him to move to the inpatient unit, The nurses and paramedics all agreed Mr Rathmill had the capacity to refuse treatment. Later that day, Mr Rathmill said there were no tests that he had not already had and he could not take any more hospital treatment.
 29. On 14 January, a doctor told Mr Rathmill that he was putting his life at risk by refusing to go to hospital, where he would be more comfortable. Mr Rathmill said he would not be able to smoke in hospital and the doctor prescribed patches to help him stop smoking. Mr Rathmill said he was not depressed and would let staff know if he changed his mind. A community psychiatric nurse was also present and agreed that Mr Rathmill had the capacity to make an informed decision. Later that evening, Mr Rathmill said he did not think he would get any better treatment than he has already received and did not want anyone to contact his family, unless his condition deteriorated significantly.
 30. On 22 January, a healthcare assistant saw Mr Rathmill, who said he had started smoking again. She gave him patches and lozenges and encouraged him to try to give up.
 31. On 1 February, a doctor reviewed Mr Rathmill. His oxygen saturations were 90% and his pulse was high. The doctor considered he showed signs of an infection and prescribed antibiotics and increased his steroid dose. Again he declined to go to hospital and said he was aware of the risks.

32. On 6 February, Mr Rathmill told a nurse that he was feeling unwell and had used the nebuliser twice. His pulse was high and his oxygen saturation was very low at 80%. Mr Rathmill said he might go to hospital if his oxygen saturation level did not improve. He used the nebuliser again, but his oxygen saturation remained low at 83%, so he agreed to go to hospital. Paramedics attended and examined Mr Rathmill. He was smoking and it was apparent he had not been taking his antibiotics, as the supply was still in his cell. His oxygen saturation level had improved to 92%, so he refused to go to hospital or the inpatient unit.
33. Three days later, a clinical team manager saw Mr Rathmill, who was breathless. His oxygen saturations were 90% and 92%, and his blood pressure was high. The manager recommended that Mr Rathmill move to the inpatient unit but he refused. The manager asked the duty governor to authorise prison staff to move Mr Rathmill to the inpatient unit under restraint but the duty governor refused this.
34. On 12 February, a prison GP reviewed Mr Rathmill, who said he was feeling a lot better. He was speaking in full sentences and his oxygen saturations were 98%.
35. Two days later, a nurse saw Mr Rathmill, who was breathless. His oxygen saturations were 96% and his pulse was high. Mr Rathmill said that he was prepared to go to hospital if he deteriorated further but he preferred to take his nebuliser. The nurse made an appointment for Mr Rathmill to see the nurse practitioner the following day, though Mr Rathmill did not attend the appointment.
36. At 8.05pm on 16 February, a clinical team manager reviewed Mr Rathmill, who said he had chest pain. His breathing was shallow and his oxygen saturations were 85%. (They had been 98% that morning.) Mr Rathmill agreed to go to hospital. At 8.10pm, the clinical team manager called an ambulance, which arrived at 8.25pm and took Mr Rathmill to the Royal Hampshire County Hospital. Two officers accompanied him 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.)
37. At 11.40pm, a hospital doctor explained to Mr Rathmill that, if they were not able to settle his breathing, he would become very ill and possibly die. At 1.30am on 17 February, a prison manager, decided that the escort chain should be removed. A hospital doctor diagnosed Mr Rathmill with end-stage COPD. The doctor decided that hospital staff should not try to resuscitate Mr Rathmill if his heart or breathing stopped. At 11.20pm, a doctor decided to stop all active treatment and to treat Mr Rathmill's symptoms palliatively.
38. Mr Rathmill's condition deteriorated quickly and he died in hospital at 12.59am on 18 February.

Contact with Mr Rathmill's family

39. At 12.20am on 17 February, a hospital doctor advised that Mr Rathmill's next of kin should be informed, as his condition was deteriorating. A prison manager contacted Mr Rathmill's ex-wife and gave her the hospital contact number so she could contact them directly for an update.
40. Mr Rathmill's daughters visited him on the afternoon and evening of 17 February. Another prison manager met his family at the hospital and offered support. The

next morning, the prison appointed a prison chaplain as the family liaison officer. She gave Mr Rathmill's ex-wife and daughters ongoing support.

41. Mr Rathmill's funeral was held on 9 March. The prison contributed to the costs of the funeral, in line with national instructions.

Support for prisoners and staff

42. After Mr Rathmill's death, a prison manager debriefed the escort staff to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
43. The prison posted notices informing staff and prisoners of Mr Rathmill's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Rathmill's death.

Post-mortem report

44. The coroner provided the post-mortem report, which confirmed that Mr Rathmill died of acute purulent bronchitis, caused by chronic obstructive airway (pulmonary) disease.

Findings

Clinical care

45. Mr Rathmill had been homeless before being recalled to prison. He suffered from COPD, and was weak and malnourished when he first arrived at Winchester. Healthcare staff prescribed nutritional supplements and Mr Rathmill gained two kilograms while he was at the prison. Despite encouragement from officers, nurses and prison GPs, Mr Rathmill continued to smoke, which exacerbated his condition. Nurses and prison GPs monitored Mr Rathmill frequently and prescribed appropriate medication. The clinical reviewer considered that Mr Rathmill's care at Winchester was equivalent to that he could have expected to receive in the community. We are satisfied that he received an appropriate standard of care at the prison.

Mr Rathmill's mental capacity

46. Guidance to staff on prisoners who refuse medical treatment is contained in Prison Service Instruction (PSI) 64/2011 'Safer Custody', which says:

"Some prisoners may decide to refuse food and/or fluids, or medical treatment for a variety of reasons. These decisions will be valid provided that the prisoner is deemed to have the mental capacity to make the decision. Mental capacity can only be assessed by a healthcare professional."

47. The PSI also notes that the decision to refuse medical treatment is not considered in law to be a form of self-harm. Regarding mental capacity the instruction states:

"The Mental Capacity Act 2005 provides clear guidance that any individual has the legal right to refuse any treatment including food and/or fluid or resuscitation if they are mentally capable. The Act states that a person is assumed to have capacity unless it is established that they lack capacity and must not be considered unable to make a decision merely because they make an unwise decision."

48. Mr Rathmill repeatedly refused to be admitted to hospital or the prison's inpatient unit for additional treatment and observation. He was reluctant to move, as he knew he would not be able to smoke in a clinical environment. He also said there were no additional tests that had not already been done. His decisions were against medical advice and he was aware that he was putting his health and life at risk.
49. The clinical reviewer noted that Mr Rathmill's decisions not to be admitted to hospital or the prison's inpatient unit were unwise. However, there was nothing to indicate that he did not have full mental capacity to make decisions about his care and treatment. Clinicians considered his mental capacity several times and were satisfied he was able to make informed decisions. We are satisfied that healthcare staff appropriately supported Mr Rathmill, actively encouraged him to accept medical treatment and that he made informed decisions about his care.

Restraints

50. When prisoners have to travel outside prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility.
51. When Mr Rathmill was first taken to hospital on 16 February, there was no medical input into the risk assessment and a prison manager decided that officers should use an escort chain to restrain him. However, another manager reviewed the decision a few hours later and decided that the chain should be removed. He was not restrained again. While an earlier full risk assessment with healthcare advice would have been preferable, we are satisfied that restraints were removed soon after the seriousness of his condition was recognised.

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