

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Raymond Bath a prisoner at HMP Winchester on 8 June 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 Raymond Bath died on 8 June of bronchopneumonia at HMP Winchester. He was 73 years old. I offer my condolences to Mr Bath's family and friends.

Mr Bath had a number of chronic health conditions, including cirrhosis of the liver damage and bronchitis. Healthcare staff managed Mr Bath's conditions well and reviewed him frequently. They treated Mr Bath with respect and agreed an appropriate end of life care plan, which allowed him to die with dignity and in line with his wishes. I am satisfied that the care Mr Bath received at Winchester was at least equivalent to that he could have expected to receive in the community.

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

Contents

Summary	1
The Investigation Process	2
Background Information	3
Key Events	4
Findings.....	7

Summary

Events

1. In June 2015, Mr Raymond Bath was sentenced to twelve years in prison for sexual offences and sent to HMP Winchester. He had a history of bowel cancer and suffered from a number of long-term health problems including high cholesterol, high blood pressure and chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema). He also had a history of alcohol dependency.
2. In July, a prison doctor referred Mr Bath to a colorectal surgeon suspecting a reoccurrence of bowel cancer. Further investigations indicated that he had cirrhosis of the liver. Nurses and prison GPs monitored Mr Bath's medical conditions frequently, prescribed medication and created appropriate care plans.
3. In November, a nurse created a palliative care plan following a significant deterioration in Mr Bath's overall health but, over the next five months, his condition stabilised. In April 2016, a nurse restarted Mr Bath on a palliative care pathway after his health started to deteriorate once more.
4. On 19 May, a nurse reviewed Mr Bath and noted that he was accepting very little fluid. He contacted a prison GP and arranged for Mr Bath to go to hospital, where they treated him for dehydration. He returned to the prison on 27 May.
5. On 28 May, a nurse contacted an out of hours GP, concerned that Mr Bath's condition had deteriorated further. The doctor contacted the local hospital for advice and they agreed that Mr Bath should remain in prison to receive palliative care only.
6. Over the next ten days, nurses monitored Mr Bath frequently and doctors reviewed his pain relief, prescribing end of life medication as needed. On 8 June, Mr Bath died in Winchester's inpatient unit.

Findings

7. We are satisfied that healthcare staff managed Mr Bath's chronic illnesses well. They reviewed him frequently and treated his conditions accordingly. His care at the prison was at least equivalent to that he would have expected to have received in the community.
8. Officers restrained Mr Bath with an escort chain when he went to hospital on 19 May. While we are concerned that a prison manager authorised the use of restraints, despite intelligence that he did not present a risk to the public or of escape and being in very poor health, we acknowledge that the prison kept this decision under review and removed the restraints promptly the following morning.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Winchester informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
10. The investigator obtained copies of relevant extracts from Mr Bath's prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr Bath's clinical care at the prison.
12. 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.
13. One of the Ombudsman's family liaison officers contacted Mr Bath's friend, his nominated next of kin, to explain the investigation. His friend identified one specific issue that has been addressed in separate correspondence.
14. Mr Bath's friend received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.
15. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Winchester

16. 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

17. 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

18. 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

19. Mr Bath was the fifth 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

20. On 5 June 2015, Mr Raymond Bath was sentenced to 12 years in prison for sexual offences, and sent to HMP Winchester. He had a history of bowel cancer and suffered from a number of chronic health conditions including high cholesterol, high blood pressure and chronic obstructive pulmonary disease (COPD). Mr Bath had poor mobility and used a wheelchair or Zimmer frame to get around. He was an ex-smoker and had a history of alcohol misuse.
21. At an initial health screen, a nurse noted that Mr Bath had significant health problems and a history of bowel cancer and alcohol dependency. He made a referral to the prison's substance misuse team and requested a GP appointment. Later the same day, a healthcare support worker created an alcohol detoxification care plan. The following day, a prison GP reviewed Mr Bath's prescriptions and prescribed his medication.
22. On 10 June, Mr Bath reported a small amount of rectal bleeding to a doctor. She suspected a re-occurrence of his bowel cancer so she referred him urgently to a colorectal surgeon. On 23 July, a computerised tomography (CT) scan confirmed that Mr Bath's bowel cancer had not returned but indicated that he had cirrhosis of the liver (a disease most commonly associated with excessive alcohol consumption). Healthcare staff monitored Mr Bath's conditions frequently, prescribed appropriate medication and created care plans to look after his general healthcare needs.
23. A prison GP examined Mr Bath on 18 September as he reported food getting stuck in his throat and difficulty swallowing. The doctor made an urgent gastroenterology referral and noted that Mr Bath did not want staff to resuscitate him in the event his heart or breathing stopped. Following the referral, in early October, Mr Bath had an endoscopy and a gastroscopy in hospital, which showed that he had a hernia, duodenitis (an inflammation of the duodenum) and stomach varices (dilated veins at risk of rupturing). Hospital doctors treated this with hemospray (to strengthen the veins), antibiotics and omeprazole (used to decrease the amount of acid produced in the stomach). While in hospital for the gastroscopy, on 10 October, a consultant at the Royal Hampshire County Hospital signed an order confirming that healthcare staff should not attempt resuscitation. The order noted that the consultant did not discuss this decision with Mr Bath, as he was not mentally competent.
24. On 22 November, a nurse noted that Mr Bath's health had declined to such an extent that she started a palliative care pathway to monitor his end of life care needs. However, over the next five months, Mr Bath's condition stabilised, though he experienced varying levels of confusion and occasional aggression towards staff. Healthcare staff monitored his condition frequently.
25. On 13 April 2016, a nurse sent Mr Bath to the Royal Hampshire County Hospital by ambulance following concerns that he appeared confused and disorientated. Hospital staff treated Mr Bath for sepsis (a generalised infection), before later diagnosing hepatic encephalopathy (a decline in brain functions as a result of liver disease). He returned to Winchester on 17 April and a nurse saw him for a review.

26. On 20 April, the same nurse noted that Mr Bath's condition had deteriorated and he appeared noticeably jaundiced (a yellow discolouration of the skin linked to liver malfunction). She restarted him on a palliative care pathway and requested an urgent GP review, but there was no record of an appointment taking place. Healthcare staff continued to monitor Mr Bath's deteriorating condition frequently, issue medication and liaise with social care staff regarding his limited mobility.
27. On 19 May, a nurse saw Mr Bath and noted that he had difficulty moving without assistance and drank very little fluid. He discussed this with a prison GP before arranging for Mr Bath's transfer to the Royal Hampshire County Hospital. Two prison officers escorted him and restrained him with an escort chain. (An escort chain is a long chain with a handcuff at each end, one of which is attached to a prison officer). At 11.40am on 20 May, a prison manager authorised the officers to remove the escort chain. Hospital staff treated Mr Bath for dehydration and discharged him on 27 May. A nurse reviewed Mr Bath and noted that he took small quantities of fluids.
28. A nurse arranged for an out of hours GP to review Mr Bath on 28 May, after he started showing signs of rapid deterioration. The doctor contacted the Royal Hampshire County Hospital for advice and they agreed that Mr Bath should remain in prison to receive palliative care only. The doctor prescribed oramorph (a pain medication). From 29 May, nurses reviewed Mr Bath's palliative care plan and doctors examined him frequently, prescribing fentanyl patches (pain relief) and oramorph to treat breakthrough pain when required. The hospital also reiterated that there was an order confirming that staff should not attempt resuscitation if his heart or breathing stopped, and a copy of this order was stored in the nurses' office in the healthcare centre.
29. On 8 June, at 6.27pm, a healthcare support worker checked on Mr Bath and noticed that he did not appear to be breathing. After checking for visible signs of life, she alerted another healthcare support worker, a prison manager, and an officer. The healthcare support worker subsequently notified a nurse, who, at 6.35pm, confirmed that Mr Bath had died. At 8.25pm, an out of hours GP verified Mr Bath's death.

Contact with Mr Bath's family

30. On 29 May, a prison manager informed Mr Bath's friend, his next of kin, that he was reaching the end of life. He arranged for her to visit Mr Bath and the prison's assigned family liaison officer facilitated this the same day. The family liaison officer offered ongoing support to Mr Bath's friend and arranged for daily visits thereafter.
31. On 8 June, at 7.05pm, the family liaison officer received notification that Mr Bath had died. At 7.15pm, she spoke to Mr Bath's friend over the telephone and broke the news. The family liaison officer offered her condolences and continued to provide support.
32. Mr Bath's funeral took place on 1 August 2016. The prison contributed towards the cost in line with national policy.

Support for prisoners and staff

33. After Mr Bath's death, a prison manager spoke to the staff involved in the emergency response and offered support.
34. The prison posted notices informing other prisoners of Mr Bath'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 Bath's death.

Post-mortem report

35. A post-mortem examination indicated the cause of Mr Bath's death was pneumonia, caused by underlying chronic obstructive airways disease. Cirrhosis of the liver was a contributory factor.

Findings

Clinical care

36. Mr Bath suffered from several complex chronic conditions, including high cholesterol, high blood pressure, cirrhosis of the liver and COPD. Healthcare staff reviewed him frequently, prescribed appropriate medication and planned his care using appropriate care plans. The clinical reviewer was satisfied that healthcare staff managed Mr Bath's medical conditions well and made timely hospital referrals when required. As Mr Bath's condition declined, healthcare staff implemented good end of life care plans and doctors prescribed appropriate pain relief and end of life medication.
37. We agree with the clinical reviewer that Mr Bath's care and treatment in prison was at least equivalent to that he could have expected to receive in the community.

Restraints, security and escorts

38. 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. Decisions should be kept under review as circumstances change.
39. When Mr Bath went to hospital on 19 May, an intelligence analyst stated that Mr Bath did not present a risk to the public or of escape, though he had assaulted a member of staff in December 2015. An unidentified nurse stated that there were no objections to the use of restraints and that Mr Bath had poor mobility, though they did not provide an indication of how his health affected his risk at the time. Using this information, a prison manager decided that officers should restrain him with an escort chain. We think this was an overly cautious and restrictive decision in the circumstances.
40. At 11.40am on 20 May, as part of a management check, another prison manager authorised the escorting officers to remove the escort chain. They did not reapply it.
41. While we are concerned that initially a prison manager authorised the use of restraints despite Mr Bath not presenting a risk to the public or of escape, we are satisfied that the prison promptly reviewed this decision and removed the escort chain within 12 hours of his arrival into hospital. On that basis, we do not make a recommendation.

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