Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lee Packman a prisoner at HMP Winchester on 22 July 2016

A report by the Prisons and Probation Ombudsman
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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*

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 Lee Packman died on 22 July 2016 of a heart attack in his cell at HMP Winchester. Mr Packman was 41 years old. I offer my condolences to Mr Packman's family and friends.

I am concerned that on the morning of Mr Packman's death, prison staff missed opportunities to check on his wellbeing. It also appears staff may have falsified documents to say that a roll check had been completed and I understand that this is now under formal investigation by the prison.

I agree with the clinical reviewer's conclusion that the care Mr Packman received was not equivalent to what he would have received in the community. I have previously recommended that the prison introduce cardiovascular risk assessments for prisoners aged over forty with relevant risk factors. The investigation showed that no such risk assessment took place for Mr Packman. I therefore repeat that recommendation.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **April 2017**

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Summary

Events

1. On 16 April 2015, Mr Lee Packman was convicted of drug offences and, on 2 June, he was sentenced to six years in prison. Mr Packman was transferred to HMP Winchester on 26 January 2016.

2. At a reception health screen at Winchester, a nurse noted that Mr Packman had high blood pressure but noted he was generally fit and well. The nurse did not arrange any follow up tests to check his blood pressure levels. The nurse also did not note Mr Packman's history of illicit drug use and deep vein thrombosis, that he was a smoker and had had heart surgery. Mr Packman had very little subsequent contact with healthcare apart from treatment for eczema and minor ailments.

3. Shortly after 10.30am on 22 July, an officer went to Mr Packman's cell and found him unresponsive on the floor. He immediately radioed a code blue emergency (which indicates that a prisoner is unconscious or not breathing) and began cardiopulmonary resuscitation (CPR). Healthcare staff quickly arrived and continued with CPR.

4. Ambulance staff arrived at 10.54am and took over the resuscitation. They were unsuccessful and paramedics pronounced Mr Packman dead at 11.30am.

Findings

5. The clinical reviewer found that opportunities to identify Mr Packman's risk of sudden death from cardiovascular disease were missed. Healthcare staff did not offer Mr Packman a cardiovascular risk assessment or a full general health assessment. There was no evidence that healthcare staff accurately recorded Mr Packman's health history. We agree with the clinical reviewer that Mr Packman's care was not equivalent to the care that he would have received in the community. We have previously recommended that the prison introduces cardiovascular risk assessments for prisoners aged over forty with relevant risk factors.

6. When Mr Packman collapsed in his cell, there was a delay in finding him, as routine roll checks of the security and welfare of prisoners had not been completed. We are extremely concerned that staff responsible for completing the roll checks signed documents to confirm that they had taken place but during interview it became clear that they had not. We note that these issues are now subject to internal investigation.

Recommendations

- The Head of Healthcare should ensure that significant medical issues identified at reception health screens are investigated quickly and that healthcare staff offer a full general health assessment to every prisoner within a week of their arrival.

- The Head of Healthcare should ensure that cardiovascular risk assessments are offered to all prisoners aged over forty with relevant risk factors, in line with NICE guidance and that offered in the community.
- The Governor should ensure that roll checks are properly carried out and that staff responsible for doing so also satisfy themselves as to prisoners' welfare.
- The Governor should ensure that all staff fully understand that inappropriate alteration or falsification of documents can amount to a serious disciplinary matter.
- The Governor should ensure, in line with PSI 75/2011, that staff check on the welfare of those prisoners who do not leave the wing for a scheduled activity.

Investigation Process

7. 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.

8. The investigator visited HMP Winchester on 25 August 2016. She obtained copies of relevant extracts from Mr Packman's prison and medical records.

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

10. The investigator interviewed five members of staff with the clinical reviewer at HMP Winchester on 25 August 2016.

11. We informed HM Coroner for Winchester of the investigation. Our investigation was suspended for over a month until we received the post-mortem report from the coroner. We regret the consequent delay in issuing this report. We have sent the coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted Mr Packman's family, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Packman's family had no specific issues for the investigation to consider.

13. Mr Packman's family received a copy of the initial report. They did not make any comments.

14. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Winchester

15. 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

16. The most recent inspection of Winchester was in July 2016. Inspectors reported that at the time of inspection Winchester had been operating a restricted routine mainly due to problems with staffing levels and supervision. Health services had improved, but staff shortages had led to problems in managing chronic diseases and running nurse-led clinics.

Independent Monitoring Board

17. 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 2016, the IMB noted that there were good standards of clinical care. The healthcare provider provided a seamless service across the prison. Prison budget constraints had affected some initiatives, including a walk-in clinic, an end-of-life suite and a day service area for older prisoners.

Previous deaths at HMP Winchester

18. Mr Packman was the sixth prisoner to die from natural causes at Winchester since January 2015. There has been one death since. We have made a previous recommendation about the need for the prison to introduce a cardiovascular risk assessment for prisoners aged over forty with relevant risk factors.

Key Events

19. On 16 April 2015, Mr Lee Packman was convicted of drug offences and, on 2 June, he was sentenced to six years in prison. Mr Packman progressed through his sentence and transferred to HMP Winchester on 26 January 2016.

20. At a reception health screen at Winchester, a nurse noted that Mr Packman had arrived from HMP Ranby and was generally fit and well. He checked Mr Packman's blood pressure, which was high, but did not do any other checks and decided that there was no need for any healthcare follow up. Following this, Mr Packman had little contact with healthcare apart from treatment for eczema and minor ailments.

21. On 21 July, Mr Packman was at work in the yards party. His manager told the investigator that Mr Packman was in a good mood and nothing was out of character. He said Mr Packman did not complain of any chest pain or other medical conditions during his shift.

22. Mr Packman lived in a single cell and was last seen alive at 10.00pm on 21 July on CCTV footage when he was seen walking in the corridor.

Events of 22 July 2016

23. An operational support officer (OSG) was the night duty cover for the unit where Mr Packman lived. He said he watched the cameras all night and did not observe anything untoward. He said in the morning he locked the fire exits and waited for the day staff to arrive. He said he did not know anyone was unwell and during his handover to day shift staff, he said there was nothing to report. He said he signed the daily log, relying on the information he had been given from the officer the day before, that the roll was correct. He left the prison at the end of his shift at 7.45am.

24. At approximately 7.15am, the OSG gave a verbal handover to Officer A, the early day shift officer, and said there had not been any problems. At 7.30am, Officer A said that he signed the unit log to confirm he had checked that the roll was correct and he signed paperwork to that effect. At interview, he said he had not in fact completed the checks but had signed the paperwork to say that he had. He left the unit just after 7.30am as he was working elsewhere in the prison.

25. Officer B relieved Officer A and started work at 7.45am. He said that he had checked the wing observation book and checked the names of prisoners who would be going to work. By 9.15am, prisoners who needed to leave the unit for work or activities around the prison would have left. He said that later that morning, after 10.30am, a member of the administration team asked him if Mr Packman was around, as she wanted to speak to him.

26. Officer B said that he went to check Mr Packman's cell. The door was closed so he opened the observation flap and saw Mr Packman lying on the floor. He entered the cell and found that Mr Packman was not breathing. At 10.46am, he immediately radioed an emergency code blue (which indicates that a prisoner is unconscious, not breathing or having breathing difficulties). The control room

called an ambulance immediately. He then started cardiopulmonary resuscitation (CPR).

27. Two nurses and a prison GP attended promptly with appropriate emergency equipment. They took over CPR and fitted a defibrillator. The reading from the defibrillator said no shockable rhythm was advised so the nurses continued with CPR.

28. Ambulance records show that an ambulance arrived at 10.54am. Paramedics took over the resuscitation attempt but it was unsuccessful and they confirmed that Mr Packman had died at 11.30am.

Contact with Mr Packman's family

29. On 22 July, the prison appointed a prison manager as the prison's family liaison officer. She and a prison chaplain visited Mr Packman's grandmother, as she was his named next of kin. Due to her advanced age, they also contacted other family members. Mr Packman's aunt and uncle were able to get to the family home. The manager broke the news to Mr Packman's grandmother, aunt and uncle and offered her condolences and support.

30. The manager arranged a memorial service on 3 August at the prison, which seven family members and friends attended. She remained in contact with Mr Packman's family until after his funeral, which was held on 1 September. The prison contributed to the costs, in line with national policy.

Support for prisoners and staff

31. After Mr Packman's death, a governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

32. The prison posted notices informing staff and prisoners of Mr Packman's death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures, in case they had been adversely affected by Mr Packman's death.

Post-mortem report

33. A post-mortem examination concluded that Mr Packman died from coronary stenosis (narrowed heart arteries) and atheroma (fatty deposits found in the arteries). The pathologist noted that these would have compromised the ability of the heart to maintain an adequate output or rhythm.

Findings

Clinical care

34. The clinical reviewer said that Mr Packman died suddenly and without obvious warning which could not have been foreseen. However, he had concerns about the monitoring of his health.

35. On arrival at Winchester, the nurse made a note that Mr Packman was fit and well. However, the nurse found that Mr Packman's blood pressure was high yet he did not take any other physiological measurements and he recorded "no need for healthcare intervention at this time". We agree with the clinical reviewer that if a patient presented with high blood pressure in the community, a second reading would have been taken. A community practice would also have noted Mr Packman's history of deep vein thrombosis and chest surgery, along with the fact that he was overweight and a smoker.

36. Prison Service Order (PSO) 3050 'Continuity of Healthcare for Prisoners' gives guidance on the clinical management of prisoners. It contains a mandatory instruction that:

> "*In the week following first reception, every prisoner must be offered a general health assessment. This assessment is equivalent to a primary care assessment when registering with a new practice in the community…*"

37. The secondary screen is an opportunity for care planning and a more in depth assessment and investigation of healthcare issues. However, Mr Packman was not offered and did not receive a secondary health assessment.

38. Additionally, the clinical reviewer said that, in line with guidance from the National institute of Health and Care Excellence (NICE), people over the age of forty should have their cardiovascular risk assessed on an ongoing basis. The Head of Healthcare told us that Winchester does not offer cardiovascular risk assessments to prisoners who transferred to Winchester from other prisons, as they assume that health problems would have been highlighted on their first admission.

39. As Mr Packman was male, over the age of forty, a smoker and overweight, he would automatically have been considered high risk. If he had received a cardiovascular risk assessment, healthcare staff could have determined which lifestyle modifications or therapies might have reduced his cardiovascular risk. Without the assessment, the clinical reviewer said that opportunities to reduce his risk of sudden death from cardiovascular disease were missed.

40. For these reasons, the clinical reviewer concluded that the care Mr Packman received at Winchester was not equivalent to the care that he would have received in the community.

41. In May 2016, in response to the death of another prisoner, Winchester confirmed that healthcare staff were reminded that they must offer cardiovascular risk assessments for prisoners aged over forty and that, by 1 July, a cardiovascular

risk assessment tool would be used as part of the secondary screening process. However, it is clear from the interview with the Head of Healthcare in August that these arrangements have not been implemented effectively. We make the following recommendations:

The Head of Healthcare should ensure that significant medical issues identified at reception health screens are investigated quickly and that healthcare staff offer a full general health assessment to every prisoner within a week of their arrival.

The Head of Healthcare should ensure that cardiovascular risk assessments are offered to all prisoners aged over forty with relevant risk factors, in line with NICE guidance and that offered in the community.

Roll check

42. The roll check is important, as it ensures the security and integrity of the prison and allows a welfare check on all prisoners. A prison manager said that the OSG and Officer A had signed the formal document to confirm they had completed the roll check for the early hours of 22 July. It became apparent during the investigation that staff had signed the document but did not carry out the roll checks.

43. The manager said that as prisoners had their own keys and were able to move around the unit when they wanted, prison staff would not enter the landing to check on prisoners in their cells. To complete a roll check, prison staff have to go to the end of the landing, call the prisoners out onto the landing and conduct a head count.

44. The manager said the morning check was due around 7.00am, when the day staff came on duty and the night staff were about to go off duty. Officer A admitted during interview that he and the OSG had not completed the check. Prison staff missed an opportunity to check on Mr Packman's welfare because of this omission. Officer A's admission also indicates a falsification of the document by both members of staff. We understand that these issues are now being formally investigated by the prison.

45. We are concerned that Officer B appears to have missed a second opportunity to check on Mr Packman's welfare when prisoners went to work later that morning. Prison Service Instruction (PSI) 75/2011 'Residential Services' says that staff should check on the welfare of any prisoner who does not leave their cell for an activity, such as going to work. There was no evidence that he checked on Mr Packman before he found him unresponsive at around 10.30am.

46. While we cannot be sure whether completion of these checks would have affected the outcome for Mr Packman, they could make a difference in the future. We make the following recommendations:

The Governor should ensure that roll checks are properly carried out and that staff responsible for doing so also satisfy themselves as to prisoners' welfare.

The Governor should ensure that all staff fully understand that inappropriate alteration or falsification of documents can amount to a serious disciplinary matter.

The Governor should ensure, in line with PSI 75/2011, that staff check on the welfare of those prisoners who do not leave the wing for a scheduled activity.

Emergency response

47. Officer B called a code blue emergency and began cardiopulmonary resuscitation when he found Mr Packman collapsed on 22 July. He continued this until healthcare staff arrived. He had worked at the prison for only nine weeks and had just completed his first aid training. While Mr Packman's core temperature (32°C) indicated that he had been dead for some time, we agree with the clinical reviewer that the resuscitation attempt was appropriate and commendable.

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